Newton Wellesley
Interventional Spine

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

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Patient Policy for Missed Appointments

If you know that you will be unable to keep your appointment, please notify us within 48 hours of your scheduled appointment so that we may accommodate other patients that may require our services. This will assist us in meeting the medical needs of the community that may require immediate attention.

You will be charged a $25.00 fee for missed new patients and follow up appointments when you do not provide a 48 hour notice. A $100.00 fee will be charged for missed procedures.

We appreciate your business and look forward to serving you and your medical needs in the future.

Patient Name (PRINT): _____ Date ____/____/____

Patient Signature: _____

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Assignment of Benefits

Assignment of Insurance benefits/Release of Information

I hereby authorize Newton Wellesley Interventional Spine, LLC to release to my insurance company(ies) and their bona fide agent(s) including medical care review organizations, and worker's compensations, such medical record information as may be required to adjucate my claim for this admission/service.

I hereby give my permission to my third party payer (my insurance earner, HMO, PPO, Medicare, Medicaid, or my employer) to directly pay Newton Wellesley Interventional Spine, LLC for services each has rendered to me. I understand that I am financially responsible for charges not covered by this assignment and unconditionally guarantee to pay for all services rendered at the established rates at the time of said service including all items which may be ordered by the physician, hereby waiving demand and notice.

Signature: _____ Date/Time: _____

Relationship to Patient: _____

Medicare Patient's Authorization to Release Information and Payment Request for Medicare

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Secuirity Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance.

Signature: _____ Date/Time: _____

Relationship to Patient: _____

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Questionnaire

Name _____

Date of Appointment ____/____/____

How were you referred to Newton Wellesley Interventional Spine?

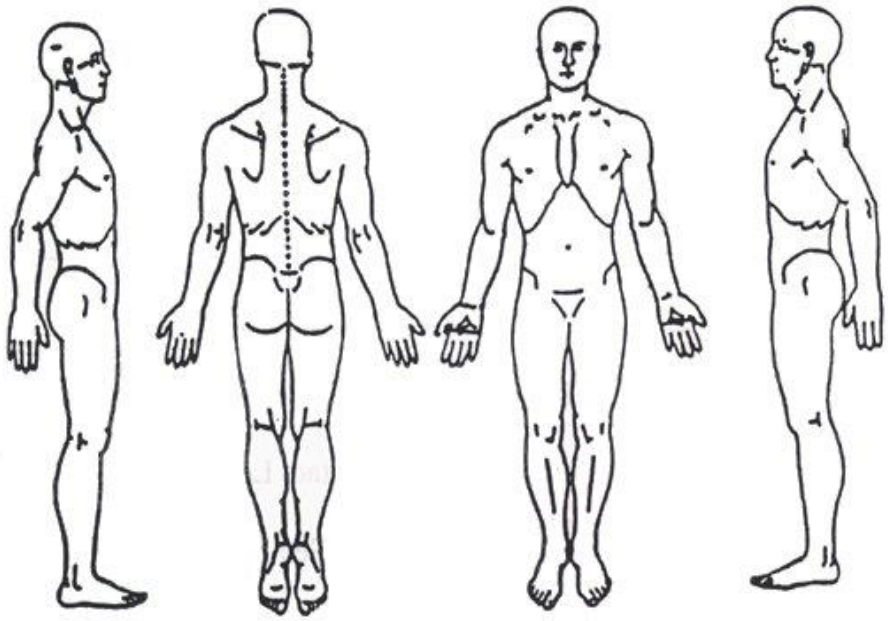
- ☐ Physician: _____
- ☐ Other: _____

Reason for the visit?

☐ Lower back pain ☐ Hip/Leg Pain ☐ Right ☐ Left ☐ Both ☐ Weakness

☐ Neck pain ☐ Shoulder/Arm Pain ☐ Right ☐ Left ☐ Both ☐ Weakness

☐ Mid Back Pain ☐ Weakness



PAIN LINE Draw a perpendicular line or arrow to indicate your usual level of pain

|----------|

no pain (0/10) severe pain (10/10)

Have you had a previous history of these symptoms or is this a new problem?

☐ Previous History ☐ New Problem

How would you describe your pain?

☐ Deep ☐ Electrical ☐ Sharp ☐ Stabbing ☐ Dull ☐ Burn ☐ Ache ☐ Other

☐ Constant ☐ Intermittent

What position makes the pain worse? _____

What position makes the pain better? _____

Is your condition caused by an injury? ☐ Yes …Injury date/type_____ ☐ No

How quickly did the pain start following the injury if any?

___Minutes ___Hours ___Days ___Weeks ___Months ___Years

If you had symptoms prior to the injury, are your current symptoms

☐ Better ☐ Worse ☐ Come and go

Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)		
Treatment	**Approximate Month & Year**	**Result (+ or -)**
Surgery		
Physical Therapy		
Chiropractic Treatment		
Injections in the Office		
Injections Guided by X-Ray		

Have you had any spine diagnostic imaging (MRI, CT, X-Rays, bone scan) within the past 6 months, if so, at what facility? _____

What medications are you <u>CURRENTLY</u> taking? (Enclose a separate list if needed)

Surgical History – Please list any previous surgeries and their respective dates

Date	Surgery

Are you allergic to any of the following? (Describe type of reaction)

a. Shellfish ☐ Yes ☐ No _____
b. Contrast Dye ☐ Yes ☐ No _____
c. Local anesthetic ☐Yes ☐ No _____
d. Medications ☐ Yes ☐ No _____

If 'Yes', indicate which medications: _____

Do you have a kidney disease?

☐ Yes

☐ No

Do you have a bleeding problem or <u>taking blood thinners</u>?

☐ Yes

☐ No

Medical history – Check (√) any of the following conditions if applicable

○ High Blood Pressure ○ Heart Disease ○ Arrhythmia ○ Thyroid ○ Asthma/COPD ○ Gastritis/Ulcer	○ Kidney Disease ○ Liver Disease ○ Bleeding Disorder ○ Migraine Headaches	○ Seizure Disorder ○ Cancer • Type _____ • Management _____ _____ _____	○ Vascular Disease ○ Diabetes ○ Cataract ○ Glaucoma

Social/Vocational/Work History

Do you smoke cigarettes? □ Yes □ No

Do you have a history of alcohol or drug abuse? □ Yes □ No

Marital status □ Single □ Married □ Separated □ Divorced □ Widowed

Employment status □ Unemployed □ Employed ___Full Time ___Part Time

If unemployed right now, indicate the last date worked: ___/___/___

If out of work, is it because of this spine condition? □ Yes □ No

Functional History

Exercise _____

Work Activity _____

Assistive Device of Ambulation _____

Assistance in Activity of Daily Living _____

Patient Name _____ Signature _____ Date ___/___/___

Reviewed by _____ Date___/___/___

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PHARMACY INFORMATION

Whenever possible, Newton Wellesley Interventional Spine, LLC will electronically transmit your prescription(s) directly to your pharmacy. Please provide us with your pr4eferred pharmacy information in the space below

Pharmacy Name _____ Phone number _____

Pharmacy Address _____

PRIMARY CARE PHYISCIAN

Primary Care Physician _____ Phone Number _____

Address _____

REFERRING PHYSICIAN IF NOT PRIMARY CARE

Referring Physician _____ Phone Number _____

Address _____

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

Patient's signature _____ Date _____