The Southeastern Spine Institute

New Patient Packet

Appointment Date: _____ Time: _____

Physician: _____ Building: _____

Please arrive 30 minutes prior to your appointment to review the new patient packet.

If you need to reschedule please do so within 48 hours of a scheduled appointment.

If you arrive late for your appointment, we may reschedule your appointment.

Please review the following information carefully.

Enclosed is a map to our office, a statement regarding our payment policies and other information regarding your medical care.

You will need to bring the following:

- A COMPLETED NEW PATIENT PACKET
- X-RAYS FILMS
- CT SCANS-**THE ACTUAL DISC & REPORT**
- MRI SCANS-**THE ACTUAL DISC & REPORT**
- INSURANCE INFORMATION
- ATTORNEY INFORMATION
- DRIVER'S LICENSE OR PICTURE IDENTIFICATION
- **ALL WRITTEN RECORDS REGARDING SPINE TREATMENT WITHIN THE PAST 5 YEARS** including Operative/Surgical Reports, Injections, Myelogram, Disogram and Lab Reports..

If you have difficulty obtaining records, please call the New Patient Coordinator 2-3 days before scheduled appointment and we will assist you. Records can also be faxed to our Coordinator at 843-284-0156.

Without records, it may be necessary to reschedule your appointment.

Please contact us at **843-849-1551** if you have any additional questions.

SSI SOUTHEASTERN SPINE INSTITUTE
ALWAYS ONE STEP AHEAD

Date_____

Name_____ DOB_____

Social Security# _____

Patient's Address_____

Email Address_____

Primary Phone_____ Secondary Phone_____

Reminder Style:

Telephone Call _____Mail _____ Secure Message _____ Decline_____

Race _____Religion_____

Primary Language_____

Ethnicity: (please circle one)

Decline Hispanic/Latino White Not Hispanic/Latino

American Indian/Alaska Native Black African American Asian Native

Hawaiian Other Pacific Islander

How were you referred?

Website Workers compensation Attorney Physician_____

New Injury? YES NO If yes, date of injury_____

Is this a workman's compensation case? YES NO

Is this an attorney case? YES NO

If yes, name of the attorney_____

Primary Insurance_____

Insured Name: _____

Insured DOB: _____ Insured SS#_____

Secondary Insurance_____

Insured Name: _____

Insured DOB: _____ Insured SS#_____

PATIENT MEDICATION AGREEMENT

Patient Name: _____ Pharmacy: _____

Doctor: _____ Family Doctor: _____

Please read and initial the following:

____ Only your physician at The Southeastern Spine Institute will prescribe narcotic medication for you. It is our legal obligation to contact DHEC if we find you are getting medication from any other providers.

____ You agree not to ask for narcotic medications from any other doctor without the knowledge and assent of your physician at The Southeastern Spine Institute.

____ You agree to keep all scheduled appointments, not just with your physician, but also with recommended therapists and physicians. Three or more missed appointments or same day cancellations will lead to patient dismissal.

____ You agree to provide regular urine samples for drug screens. Positive tests for any Illegal substances, or narcotics not prescribed by your pain doctor, may result in your dismissal and referral elsewhere for substance abuse evaluation and management.

____ No prescriptions will be refilled early.

____ No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen.

____ Prescription refills will be authorized only during regular office hours. If you want to refill your prescription, call <u>two</u> working days in advance of renewal date.

____ Patients taking chronic narcotics should NOT drink alcohol.

____ No prescription dosage changes will be made without an office visit.

____ Only one pharmacy may be used.

____ You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended. Failure to do so may result in discontinuation of your medication and referral to another provider or treatment center.

____ Successful pain management includes using multiple interventions, including active participation in regular exercise and use of psychological coping strategies. Failure to follow the prescribed treatment plan including medication, therapy, etc., may result in discontinuation of medications and/or referral to another provider or treatment center.

Side Effects:

Opioids (narcotics) may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. Use care when driving and operating machinery. An overdose can cause severe side effects, even death.

Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels (in men) may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient. Having side effects on one opioid does not necessarily mean there will be side effects on another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use, but does not by itself indicate addiction; this means that a withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain relieving effects of opioids; this means that the pain relief may decrease over time, but in chronic pain states this usually occurs slowly, if at all.

Not all pain conditions respond to opioids. Some pain may only be partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Increasing dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may need to be done under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dosage increases, or inability to comply with the treatment agreement.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

I, the undersigned, give permission to my pain doctor to contact my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care.

If I do not follow these guidelines fully, my doctor may stop opioid treatment and refer me elsewhere for care.

A copy of this document has been given to me, if requested.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2: Personal care (eg. washing, dressing)

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it causes extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help but manage most of my personal care
- ❑ I need help every day in most aspects of self-care
- ❑ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it gives extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ❑ I can lift very light weights
- ❑ I cannot lift or carry anything at all

Section 4: Walking

- ❑ Pain does not prevent me walking any distance
- ❑ Pain prevents me from walking more than 2 kilometres
- ❑ Pain prevents me from walking more than 1 kilometre
- ❑ Pain prevents me from walking more than 500 metres
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time

Section 5: Sitting

- ❑ I can sit in any chair as long as I like
- ❑ I can only sit in my favourite chair as long as I like
- ❑ Pain prevents me sitting more than one hour
- ❑ Pain prevents me from sitting more than 30 minutes
- ❑ Pain prevents me from sitting more than 10 minutes
- ❑ Pain prevents me from sitting at all

Section 6: Standing

- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing for more than 3 minutes
- ❑ Pain prevents me from standing for more than 10 minutes
- ❑ Pain prevents me from standing at all

Section 7: Sleeping

- ❑ My sleep is never disturbed by pain
- ❑ My sleep is occasionally disturbed by pain
- ❑ Because of pain I have less than 6 hours sleep
- ❑ Because of pain I have less than 4 hours sleep
- ❑ Because of pain I have less than 2 hours sleep
- ❑ Pain prevents me from sleeping at all

Section 8: Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain
- ❑ My sex life is normal but causes some extra pain
- ❑ My sex life is nearly normal but is very painful
- ❑ My sex life is severely restricted by pain
- ❑ My sex life is nearly absent because of pain
- ❑ Pain prevents any sex life at all

Section 9: Social life

- ❑ My social life is normal and gives me no extra pain
- ❑ My social life is normal but increases the degree of pain
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sports
- ❑ Pain has restricted my social life and I do not go out as often
- ❑ Pain has restricted my social life to my home
- ❑ I have no social life because of pain

Section 10: Travelling

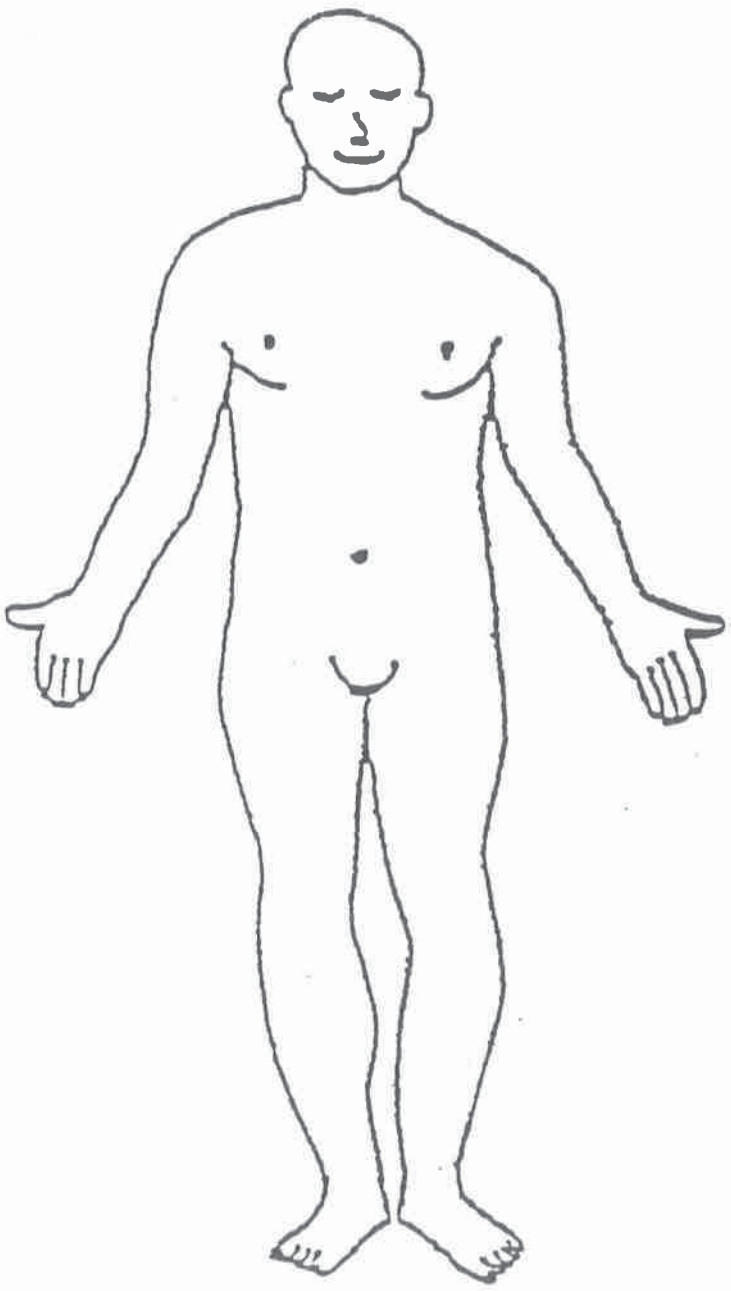
- ❑ I can travel anywhere without pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ Pain is bad but I manage journeys over two hours
- ❑ Pain restricts me to journeys of less than one hour
- ❑ Pain restricts me to short necessary journeys under 30 minutes
- ❑ Pain prevents me from travelling except to receive treatment

Use the body diagram below to indicate the location of any of the 5 sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

= = = = = =	Numbness
O O O O O	Pins and needles
X X X X X	Burning Pain
/ / / / / / / / /	Stabbing Pain
^ ^ ^ ^ ^ ^	Aching Pain

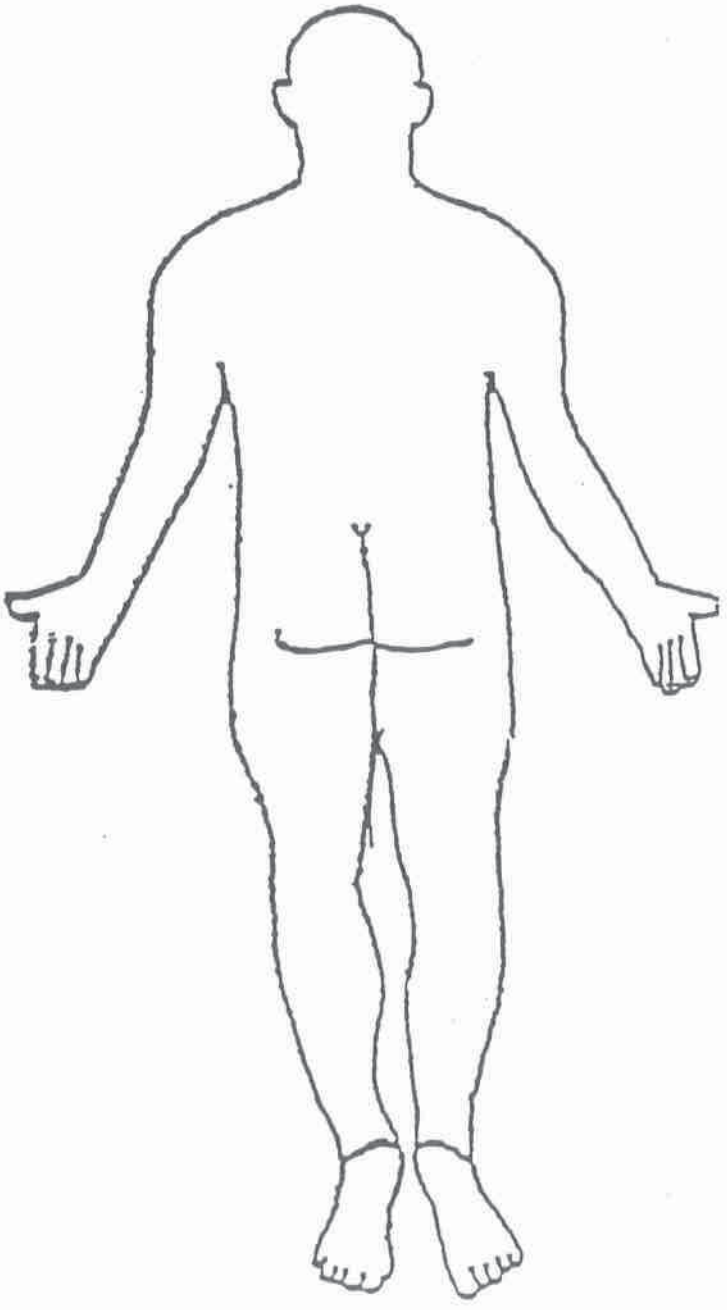
FRONT

Right Left



BACK

Left Right



(1) Who referred you to us?

_____

(2) Who is your primary care physician?

_____

(3) Briefly describe the details of your injury or the initial onset of your symptoms:

_____

_____

_____

(4) How long have the symptoms been present?

_____

(5) Please provide the following information:
If this was a work injury or a motor vehicle accident: _____
Please briefly describe the accident/injury: _____

_____

_____

Were you taken to the hospital? Yes No

Were you hospitalized? Yes No

What physicians (or other) healthcare professionals who have treated you for this injury to date?

_____

(6) How would you compare your pain ratio (circle one)

FOR BACK AND LEG PAIN ONLY
1 = 100% back pain and 0% leg pain
2 = 75% back pain and 25% leg pain
3 = 50% back pain and 50% leg pain
4 = 25% back pain and 75% leg pain
5 = 0% back pain and 100% leg pain

FOR NECK AND ARM PAIN ONLY
1 = 100% neck pain and 0% arm pain
2 = 75% neck pain and 25% arm pain
3 = 50% neck pain and 50% arm pain
4 = 25% neck pain and 75% arm pain
5 = 0% neck pain and 100% arm pain

(7) Put a check mark next to the activities which change the nature of your pain:

		Aggravates	Relieves
1.	Sitting	_____	_____
2.	Standing	_____	_____
3.	Rising from sitting	_____	_____
4.	Leaning forward (Brushing teeth)	_____	_____
5.	Walking	_____	_____
6.	Lying on your side	_____	_____
7.	Lying on your back	_____	_____
8.	Lying on your stomach	_____	_____
9.	Driving	_____	_____
10.	Coughing/sneezing	_____	_____
11.	Bending forward	_____	_____

(8) Please circle the number that best applies to your usual level of pain.
0 = No pain
10 = Pain as bad as it can be

0 1 2 3 4 5 6 7 8 9 10

(9) What makes your pain better?

_____

_____

(10) What makes your pain worse?

_____

_____

(11) Circle the tests that have been performed thus far:
X-ray CT-Scan Myelogram MRI EMG Bone Density Study
If so, when ? _____

(12) Circle the treatment that you have had so far:
Back Brace Nerve Block Physical Therapy Chiropractic
TENS Unit
Other: _____

(13) Have you had any previous neck or back problems or surgeries? Describe:

_____

_____

(14) List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

(15) List any medications you currently take: _____

_____

(16) Do you have allergies to any medications? YES NO
If YES, list the medications: _____

(17) Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
Eyes (poor vision, eye pain, tearing, redness, etc.)			
General / constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)			
Ears, nose, throat (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
Cardiovascular (high bp, racing pulse, etc.)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
Genital, kidney, bladder (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
Females are you pregnant? Nursing?			
Muscles, bones, joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood / lymph (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
Allergic / immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

(18) Social History
Have you ever had a blood transfusion? .....YES NO

Do you drink alcohol .....YES NO If YES, how much? _____

Do you presently smoke?...YES NO If YES, how many packs per day?_____
How many years? _____

Are you a past smoker?.....YES NO If YES, how many packs per day?_____
How many years? _____

(19) Family History of: (Please Circle)

1- Arthritis	5- Diabetes	9- Tuberculosis
2- Back Pain	6- Glaucoma	10- Other Inheritable Diseases
3- Neck Pain	7- Cancer	11- Blood Transfusion - yes or no
4- Hypertension	8- Stroke	

Other _____

_____

_____

(20) Are you (circle one)

1- Unemployed	2- Employed	3- Homemaker
4- Student	5- Retired	

(21) If you selected "1" or "2", please answer the following questions:

1- If you have been off work this year, how much time have you lost?

1- Unknown	2- About 1 day
3- About 3 days	4- About a week
5- About 1 month	6- About 3 months
7- About 6 months	8- About 6 months to a year

(22) To help us better understand the physical stresses during your work day, please tell us what type of job you do.

Job Description:

_____

_____

Employer:

_____

(23) If you want to make any additional comments please do so below and on the back of this page.

_____

Patient Signature_____ **Date**_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the Southeastern Spine Institute Notice of Privacy Practices

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

For Southeastern Spine Institute use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Southeastern Spine Institute's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record

FINANCIAL POLICY FOR PATIENT CARE SERVICES

Patients are responsible for the payment of all services provided by the Southeastern Spine Institute. After your visit, if the physician decides that further services are needed such as a procedure or surgery, we will call your insurance company to verify coverage. **Copays, coinsurance or deductibles must be paid prior to services rendered.** For any unpaid balances, we send three statements, after which we may turn your account over to our attorney.

Uninsured & Self Pay: Uninsured or self pay patients may be required to make payment at the time of service or prior to the provision of any procedures. However, a financial counselor will discuss with you ways you can meet your obligation.

Workers Compensation: If your case is authorized by your employer/workers compensation carrier, we will bill the carrier.

Pending Workers Compensation: If your case is pending authorization, we will file your health insurance, and we will require you to sign a subrogation form.

Motor Vehicle Accident or other Liability: If you are the victim of an accident and are filing claims against a third party, you may file a claim with your health insurance or pursue the third party on the advice of your attorney. If you do not have an attorney, **and** you do not have health insurance, we may ask you to review your circumstances with one of our financial counselors before your first appointment. **If you choose to use your health insurance, we require you to sign a subrogation form, and pay all copays, deductibles, and coinsurance amounts at the time of or prior to service**. If you sign a waiver providing that we be paid from funds at settlement, no payment is required at the time of service. However, we reserve the right to file a claim with your health insurance, based on our attorney's recommendation.

Special Note to Medicare and Medicaid beneficiaries: If your illness is a result of or benefits are payable by a third party, Medicare and Federal regulations require us to attempt to collect our fees from the third party. Medicare and Medicaid are always the payor of last resort.

Our Physicians will not discuss payment with you. Please do not discuss financial issues with them.

I understand the above financial policy and my responsibility.

Signature:_____ Date:_____

Print Name:_____

THE SOUTHEASTERN SPINE INSTITUTE

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

Authorization to be Paid: The undersigned authorizes Southeastern Spine Institute to contact, furnish and discuss with insurance companies all medical and financial information pertaining to the medical services that may be required to be paid or collected for the care received. The undersigned irrevocably assigns and transfers to Southeastern Spine Institute all rights and interest in benefits that the patient may have under any policy of insurance including all medical, third party liability, automobile coverage, workers' compensation benefits, or any other insurance or benefits. The undersigned directs that any such insurance company or payer make payment of such benefits directly to the Southeastern Spine Institute. By signing below, the undersigned agrees to be financially responsible for amounts not covered by insurance.

Third Party Liability Cases: If the patient's illness is a result of an accident, The undersigned understands that he/she has the option to request Southeastern Spine institute to bill Health Insurance or pursue payment from the auto or accident insurance of the person responsible for the accident. I**n accord with federal regulations**, Southeastern Spine, will file claims for Medicare or Medicaid beneficiaries whose illness is a result of an accident caused by a third party or whose claims may be paid by a third party, only as a last resort. In all cases, Southeastern Spine reserves the right to file claims to health insurance on the advice of our attorney. If Southeastern Spine is asked to bill health insurance, the undersigned understands that the patient is responsible for paying all deductibles and co-pays at the time of service.

Please Initial One of the Below:

YES: _____: I herby request that the Southeastern Spine Institute pursue payment of my medical bills from the auto or accident insurance of the person responsible for the accident instead of billing my health insurance.

NO: _____: I hereby request that the Southeastern Spine Institute bill my Health Insurance. I acknowledge that in this case, I am responsible for remitting payment of all insurance deductibles and co-payments at the time of service or before service is provided.

Please Initial Below:

_____ I have received a copy of the Practice's **Notice of Privacy Practices.**

_____I authorize Southeastern Spine Institute to provide me reasonable and proper medical care.

Signature of Patient or Responsible Party _____ Date _____

HEALTH INSURANCE SUBROGATION & ACCIDENT FORM

Patient Name: _____ Date: _____

Health Insurance Company: _____ Policy #: _____

You are requesting health care services related to an accident, and your health insurance company may not accept responsibility until you notify them of the accident details.

Do you have an attorney representing you in this matter? Yes No

Attorney name, address and phone number:

NAME _____
Street or PO _____
City, State Zip _____
Telephone _____

Please answer the following questions:

Date of accident: _____

Type of accident (circle one) Workers Comp Motor Vehicle Other

WORKERS COMPENSATION (complete the following) :

Have you filed a claim? Yes No

Has it been accepted and authorized: Yes No

(if yes) name of insurance carrier: _____

Phone number: _____ W/C case manager/adjuster name: _____

Authorized by: _____ claim #: _____

MOTOR VEHICLE/OTHER (complete the following):

Please provide the name, address and phone number of the person causing the injury:

NAME _____
Street or PO _____
city, State Zip _____
Telephone _____

Provide the name, address and phone number of the insured's (person who caused the accident) insurance company:

NAME _____
Street or PO _____
city, State Zip _____
Telephone _____

Provide the name, address and phone number of your automobile insurance company:

NAME _____
Street or PO _____
city, State Zip _____
Telephone _____

Please provide the following information:

Location of accident _____

_____

_____

Did another person cause the accident? Yes No

Were you driving or a passenger? Driver Passenger

Do you have a copy of the accident report? Yes No

Please briefly describe the accident _____

_____

_____

_____

_____

I agree that the above information is correct and I understand that this information will be sent to my insurance company so that they may determine their responsibility.

_____

Signature Date

Southeastern Spine Institute
1106 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464

Request for Protected Health Information

Date: _____ Patient: _____

I authorize **Southeastern Spine Institute** to receive my medical information from your office, and other medical facilities for the purposes of continuity of care.

This signed PHI Form authorizes SSI to request and receive the following medical information:

- **Operative Reports (Spine Surgeries)** **Other_____**
- **Progress Notes**
- **MRI/X-ray Reports**
- **Bone Scans**
- **EMG's**
- **Labs**
- **Any records relating to spine care treatment within the last year.**

This authorization is valid for 12 months from the date of signature unless otherwise specified below:

____ Continuing Care * Patient Authorization is not required for continued patient care*

Date of Expiration: _____

_____ _____

Name of Patient or Personal Representative/Relationship to Patient (Print) Date of Birth

_____

Signature of Patient or Personal Representative Date

Office Use Only:

SSI Internal Staff Requestor: _____ Date Requested: _____

Please fax records to fax number: _____ Date Received: _____

This form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 164.508 (c). HIPAA electronic medical records privacy rules allow health care providers to use or disclose patient health information, such as diagnostic images, laboratory tests, diagnoses, and other medical information for treatment purposes without the patient's authorization.

Physician/Patient Disclosure of Ownership
in
Southeastern Spine Institute Ambulatory Surgery Center, LLC

During the course of your physician/patient relationship with _____ ("Physician"), the Physician may at a future time refer you to Southeastern Spine Institute Ambulatory Surgery Center, LLC ("ASC"). The ASC is an ambulatory surgery center separate from Southeastern Spine Institute ("SSI"). The address of the ASC is Suite 100, 1106 Chuck Dawley Boulevard, Mt. Pleasant, SC 29464. The medical office of SSI is located just above the ASC at Suite 200, 1106 Chuck Dawley Boulevard, Mt. Pleasant.

In connection with any referral to the ASC, you are hereby advised that the Physician has an investment interest in the ASC.

You have the right and option to obtain the health care items and services for which the Physician may refer you to the ASC at any other ambulatory surgery center or hospital that provides ambulatory surgery procedures. Facilities in the Mt. Pleasant area that provide ambulatory surgery procedures include East Cooper Regional Medical Center.

By signing below you acknowledge you have received, reviewed and understand this Physician/Patient Disclosure of Ownership Form. Further, by signing below you acknowledge that should you be referred to the ASC, your signature below evidences your informed decision to decline the option to have the ambulatory procedure performed at one the above identified facilities, or any other unnamed facilities. Lastly, you further acknowledge by signing below that you signed the Physician/Patient Ownership Disclosure Form prior to the Physician's referral of you to the ASC.

Date: _____, 20_____

_____
Signature of Patient

_____
Printed Name of Patient

Authorization for Release of Medical Information to Family Members or Caregivers

Southeastern Spine Institute

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Street City, State Zip

The following individuals (s) are authorized to obtain my medical information/records and prescriptions:

Name:_____

Telephone:_____

Relationship to patient:_____

Name:_____

Telephone:_____

Relationship to patient:_____

I understand that is authorization can be revoked at any time by providing written notification along with my signature.

_____ _____
Patient Signature or Personal Representative Date
