Peachtree Spine Physicians

PATIENT INFORMATION

Name:	**Date of Birth:**	
Address:	**Social Security #:**	
City:	**Sex:**	
State: Zip:	**Marital Status:**	
Home Phone #:	**Race:**	**Ethnicity:**
Cell Phone #:	**Language Spoken:**	
Email Address:	**Emergency Contact:**	
Employer:	**Emergency Phone #:**	
Work Phone #:	**Emergency Relationship:**	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security #:**
City:	**Employer:**
State: Zip:	**Employer Address:**
Home Phone #:	**Employer City:**
Work Phone #:	**Employer State:**
Cell Phone #:	**Zip:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate #:	**Certificate #:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**

ADDITIONAL INFORMATION

Primary Care Physician:	**Pharmacy Name:**
Phone:	**Phone:**
Fax:	**Fax:**
Address:	**Address:**
City:	**City:**
State: Zip:	**State: Zip:**
Complete information below, if applicable:	
Attorney Name:	**Adjuster Name:**
Phone:	**Phone:**
Address:	**Fax:**
City/State/Zip:	**Date of Injury:**

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or Peachtree Spine Physicians when they accept assignment.

Authorization to Release Medical Information: I hereby authorize Peachtree Spine Physicians to release any information necessary for my course of treatment.

ADDITIONAL INSURANCE QUESTIONS

Is the subscriber currently employed and working? YES / NO

If yes, does the company have more than 20 employees? YES / NO

Is the subscriber out on disability? YES / NO

If yes, does company have greater than 100 employees? YES / NO

Is this a Cobra policy? YES / NO

_______________________________________ ____________________

Signature (Patient or Personal Representative) Date

Peachtree Spine Physicians
Name: «PName» **Date:** «Custom1»

Reason for visit: ***(circle all that apply)***
Back pain Neck pain Mid-back pain
RT arm pain RT leg pain LT arm pain LT leg pain

Your pain has been as high as:
(none) 0 1 2 3 4 5 6 7 8 9 10 *(severe)*

Date of Injury: ____________________________

If no injury, how long have you had your pain?
_____ Days Weeks Months Years ***(circle one)***

The pain is: ***(circle all that apply)***
Continuous Occasional

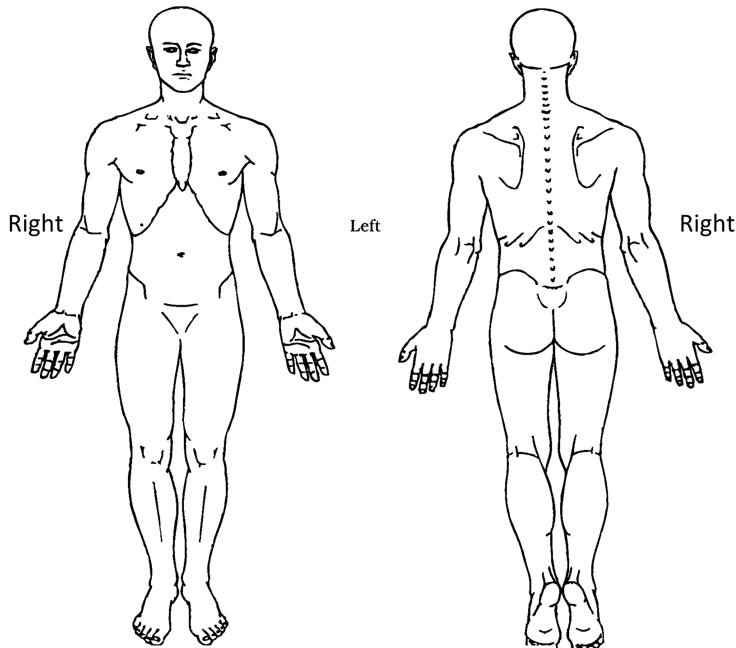
When is your pain worse? ***(circle all that apply)***
Morning Daytime Evening Night time

Describe your pain: ***(circle all that apply)***
Dull Sharp Aching Knifelike Stabbing Throbbing Shooting
Burning Like pins and needles

What makes your pain worse? ***(circle all that apply)***
Lifting Bending Lying Sitting Standing Driving
Changes in weather Walking Coughing Sneezing

What makes your pain better? ***(circle all that apply)***
Medications Bending Lying Sitting Standing
Walking Changing positions Nothing

Mark the location of your pain:



What associated symptoms do you have? ***(circle all that apply)***
Numbness Weakness Catching Giving out

Do you have any recent changes in controlling your bowels or bladder? ***(circle one)***

Yes No

Do you have any unexplained fevers above 101.5°F? ***(circle one)***

Yes No

Do you have any unexplained weight loss greater than 15 pounds? ***(circle one)***

Yes No

What treatments have you had for this problem?
(circle all that apply)

Medication Physical therapy Chiropractic Care Surgery
Epidural Steroid Injections Facet Injections Joint Injections
Trigger Point Injections Acupuncture Nothing

When started? How long done? ____________________

____

What diagnostic studies have you had for this problem?
(circle all that apply)

X-ray MRI CT Scan Myelogram Discogram Bone Scan
Bone Density Scan EMG Nothing

If symptoms are due to an injury, what type of injury did you have?
(circle all that apply)

Work related Traffic accident Lifting injury Fall injury Object fell on you Repetitive use injury

Review of Systems: **Do you currently have any of the following medical symptoms?** ***(check all that apply)***

Symptom	Yes	No
Weight Gain		
Advanced Care Plan		
Rash		
Visual Disturbances		
Sore Throat		
Cough		
Shortness of Breath		
Chest Pain		
Cold Hands/Feet		
Swelling in Legs		
Constipation		
Incontinence of Bowel		
Nausea		
Incontinence of Bladder		
Muscle Weakness		
Balance Problems		
Seizures		
Sleep Disturbance		
Feelings of Sadness		
Appetite Changes		
Abnormal Bleeding		

Allergies:

(Please list all medication allergies, and the type of reaction to the medication, including allergies to iodine, contrast dye, & shellfish.)

____
____
____
____
____
____
____
____
____

Medical History / Family History:

If you answered "Yes" to either question, please indicate what Medications, if any, you are currently prescribed

Illness ***(check all that apply)***	**You**	**Any Family Member**
History of Back Pain		
Cancer		
Heart Disease		
High Blood Pressure**		
Diabetes**		
High Blood Fats/Cholesterol		
Vein trouble/Blood Clots		
Stroke/TIA		
Asthma		
Sleep Apnea		
Lung Disease		
Esophageal Reflux/Stomach Ulcers		
Liver Disease/Hepatitis		
Kidney/Bladder Disease		
Abnormalities of Female Organs		
Abnormalities of Prostate		
Thyroid Disease		
Abnormal Bleeding		
Blood Problems(Anemia, High/Low White count)		
Joint Disease		
Anxiety/Depression/Psychiatric Illness		
History of Substance Addiction		
Skin Disease		
Other:________________________		

Surgical History: ***(circle all that apply)***

Cosmetic	Bowel	Vascular
Cancer	Lung	Kidney/Bladder
Head/Brain	Appendix	Liver/Gall Bladder
Cataract	Hernia	Prostate/Female Organs
Tonsils	Bone/Joint	Sinus/Nose
Heart	Spine	Other: _____________

Social History: **Who lives with you?** ***(circle all that apply)***

Self Spouse Family Children Child Parent(s)
Roommate Significant Other Partner Friend Caregiver
Group Home Other: ___________ Pet(s):______________

Tobacco Use: ***(circle one)*** None Smoke Chew/Dip

Alcohol Use: ***(circle one)*** Yes No

Illegal Drug Use: ***(circle one)*** Yes No

Occupational History:

What is your occupation?

____

Are you currently working? ***(circle one)*** Yes No

Medications:

(Please list ALL of your current medications, including over-the-counter medications. Please list dosages and how often you take the medication.)

NAME **DOSE** **FREQUENCY**

____
____
____
____
____
____
____
____
____
____
____
____

Pregnancy History: ***(circle one; for women only)***

Are you currently pregnant? Yes No Unknown

Please provide any other concerns or comments:

____
____
____

For Office Use Only:

F/U: ______________________________ days/weeks/months
Inj:____
MRI:____
EMG/NCS:____
PT:____
X-Ray:____
Referral to:____
Dictation#:____
E&M Code:____
ICD-9 Code:____

Weight: __________ lbs. Height: ___________in.

BP: Systolic:________ Diastolic: ________ BMI: _______

Peachtree Spine Physicians Injury Form

Patient Name: ______________________________

Was your injury work related? **Yes / No**

Please complete the appropriate area below based on your type of injury

Traffic Accident (Please circle your answers):

Location of the motor vehicle accident:

Public road Non-public road (off road, driveway, sidewalk, etc)

Type of Vehicle you were in:

Car SUV Pick-up truck Van Heavy transport vehicle (semi-truck, bus, etc) Motorcycle (2 or 3 wheeled) Bicycle No vehicle, Pedestrian

Your location in vehicle (if applicable):

Driver Front Passenger Rear Passenger

Were you wearing a seatbelt (if applicable)?

Yes No

What did you collide with?

Car SUV Pick-up truck Van

Heavy transport vehicle (semi-truck, bus, etc) Motorcycle (2 or 3 wheeled) Bicycle Pedestrian Fixed Object (guard rail, pole, etc) Nothing (overturned vehicle)

Were you injured by an airbag (if applicable)?

Yes No

Falls/Slips/Stumbles (Please circle your answers):

What did you fall from?

Level ground Stairs Ladder Roof

Stumbled into something Slip without fall

Place of fall/slip/stumble (If applicable)

Home Store Restaurant N/A

Struck By Object (Please circle your answers):

What object(s) were you struck by?

____

Place of Injury (If applicable)

Home Store Restaurant N/A

Lifting Injury (Please circle your answers):

What object were you lifting when you injured yourself?

____

Place of Lifting Injury (If applicable)

Home Store Restaurant N/A

Other Injury not Listed

(WriteHere):____

Patient Contact Information

This form is designed to make contacting you easy and done in a way that is respectful of your privacy. Please fill in the information below.

PLEASE PRINT THIS INFORMATION LEGIBLY

Your **name:** ______________________________

Your **current address:** ______________________________

____

____

Your current **home telephone** number: (   ) ______________________________

If you are unavailable, may we leave a message on your home voicemail or with someone else who answers the phone? YES NO

Do you have a **cell phone** that we may use to contact you? If so, please provide the number below:

(   ) ______________________________

May we leave a message on your cell phone or with someone else who answers? YES NO

Do you have a **work phone** number that we may use to contact you? If so, please provide the number:

(   ) ______________________________

May we leave a message on your work voicemail? YES NO

Do you have **email**? If so, please provide your email address below:

____

What are the best times and ways to reach you? ______________________________

____

Is there anything else you would like us to know about contacting you, or is there anyone you would not like for us to speak with about your care with us? ______________________________

____

____

Patient Signature Date

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

Peachtree Spine Physicians would like to assure you of your rights and responsibilities as a patient.

You have the right to:

- Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Personal & informal privacy, within the law.
- Information presented in a manner and form that you understand. You or an individual designated by you or a legally authorized person, have the right to be informed about your condition and the recommended procedures to be performed so that you can make the decision whether or not to undergo the procedure knowing the risks, benefits and alternatives. You also have the right to ask questions.
- Request information on formulating an advance directive.
- Appropriate assessment & management of pain.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns of your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Be able to participate of refuse to participate in any research without risk of compromising your right to access care, treatment and/or services.
- Know the identity & professional status of individuals providing service.
- Request a change in providers of care if other qualified providers are available.
- Request information on the financial aspects of provided services and after hour care provisions.
- Request a consultation at your own expense.

PATIENT COMPLAINT OR GRIEVANCE

Peachtree Spine Physicians will promptly review, investigate & attempt to resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, please contact the surgery center directly and ask to speak with the Clinical Coordinator at 404-843-3323. Upon notification of your complaint, we will obtain further information to resolve the issue. If we are unable to immediately resolve your issue, we will provide a written notice within 30 days that contains the name of the person responsible for conducting the investigation, the basic steps taken to investigate and resolve the grievance, the results and the date of completion.

If your feel your grievance was not resolved to your satisfaction you may contact:

GA Dept. of Community Health
Attn: Complaint Department
2 Peachtree Street, Suite 3100
Atlanta, GA 30303-3142
404-657-5726 or 1-800-878-6442
http://ors.dhr.georgia.gov/protal/site/DHR-ORS/

Medicare Ombudsman
1-800-633-4227 (1-800-Medicare)
www.medicare.gov/ombudsman/resources.asp
www.cms.hhs.gov/center/ombudsman.asp

PATIENT RESPONSIBILITIES

You are responsible for:

- Providing accurate complete information regarding your present health status (including past & present medications), past medical history.
- Inform the healthcare provider about any advance directive at (living will) at that might affect your care.
- Following the treatment plan recommended by the physician and discharge instructions provided by the nurse.
- Following the rules & regulations of the facility affecting patient care & conduct.
- Notifying the facility if unable to keep an appointment.
- Being considerate & respectful of the rights of other patients & facility personnel.
- Providing a responsible adult to transport you home after surgery & an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
- Indicating whether you clearly understand a contemplated course of action & what is expected of you.
- Your actions if you refuse treatment leave the facility against the advice of the practitioner and/or do not follow the practitioner's instructions relating to care.
- Assuring financial obligations of your health care are fulfilled as expediently as possible.

ADVANCE DIRECTIVE (Living Will)

Peachtree Spine Physicians is not an acute care facility; therefore regardless of the contents of any advanced directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures & transfer you to a hospital for further evaluation/treatment. Any information regarding current health care directives or health care power of attorney will be shared with the facility where you are transferred. If you do not have an advanced directive but would like one, we will provide one for you.

*********Check one of the Boxes Below:***********

[ ] Yes, I have an advanced directive, which I've provided, & am aware of this facility's policy regarding the honoring of this document.

[ ] Yes, I have an advanced directive, but haven't provided one to this facility.

Per your advanced directive, if no chance of survival, please select one of the following: [ ] Resuscitate [ ] Do Not Resuscitate

[ ] No, I do not have an advanced directive and do not want one.

[ ] An advanced directive has been provided to me at my request.

PHYSICIAN INVESTMENT

Peachtree Spine Physicians, ASC, LLC is wholly owned by Dr. Jeffrey Grossman, Dr. Matthew Richardson and Dr. Rayden Cody.

ACKNOWLEDGEMENT

By signing this form I acknowledge written receipt of the Patient Bill of Rights prior to the start of my procedure and had an opportunity to ask questions.

Signature: ____

«PName»

Date: ____

Peachtree Spine Physicians

Acknowledgement of Receipt of Privacy Practices

I, ____ have been given the opportunity to receive a copy of Peachtree Spine Physicians Notice of Privacy Practices.

____
Date

____
Print Name

____
Signature

OFFICE USE ONLY

On ______________________ __20____ at________ (AM/PM) we made a good faith attempt to obtain a written acknowledgement of receipt of our NPP, but acknowledgement could not be obtained because of the following reasons:

- ______ Patient refused to sign
- ______ Communication barriers prevented obtaining a receipt
- ______ An emergency prevented obtaining a receipt
- ______ Other: ____

MEDICATION AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician to comply with the law regarding pain-control medications.

I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this Agreement.

I understand that if I breach this Agreement my physician will be forced to stop prescribing these pain-control medications.

I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life and how well the medication is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will safeguard my medication from loss or theft. **Lost or stolen medications cannot be replaced.**

I agree that only one physician may prescribe pain medications. If pain medications are received from other physician practices, our clinic will be unable to prescribe pain medications thereafter.

I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours.

If your MD prescribes any narcotics, Peachtree Spine Physicians is required by law to perform random UDS (Urine Drug Screen) tests at least every 3 months to ensure compliance with state and federal laws. Failure to participate in testing or inconsistent results from testing will result in discharge from the practice.

I authorize my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my medications. I authorize my physician to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this Agreement and the medications presented for pain management.

I agree that I will use my medication as prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to follow these procedures that have been fully explained to me. All of my questions and concerns regarding my medications have been adequately answered. A copy of this Agreement has been given to me.

Nothing herein shall be deemed to alter the discretion of my physician to use his best judgment in recommending treatment and medication options.

This Agreement is entered into on this ______ day of _________________, _____________.

Patient signature: ____
«PName»

Witnessed by: ____

Physician signature: ____