Virginia Spine Specialists
Minimally Invasive Spine Care

Mudit Sharma, MD, FAANS, FACS
Board Certified Neurosurgeon

Dave Pope, PA-C
Physician Assistant

PATIENT REGISTRATION & CONSENT

PATIENT INFORMATION:

Name: _____
DOB: _____ **Age:** _____
Male: _____ **Female:** ____
Single: ___ **Married:** ___ **Divorced:** ____ **Widow:** _____
Address: _____
_____
Home #: _____
Mobile #: _____
SSN: _____
Email Address: _____
Race: _____
Ethnicity: _____
Language: _____

INSURANCE INFORMATION:

Primary Insurance: _____
Policy Number: _____
Policy Holder: □ **Self** □ **Other**
If Other, policy holder name: _____
DOB: _____ **SSN:** _____
Secondary Insurance: _____
Policy Number: _____
Policy Holder: □ **Self** □ **Other**
If Other, policy holder name: _____
DOB: _____ **SSN:** _____
Did this injury occur at work? □ **YES** □ **NO**
Did this injury result from an accident? □ **YES** □ **NO**
If YES, do you have an active claim? □ **YES** □ **NO**

EMPLOYMENT INFORMATION:

Job Status: □ **FT** □ **PT** □ **Student** □ **Retired**
Employer: _____
Work #: _____

PHARMACY INFORMATION:

Pharmacy Name: _____
Pharmacy Phone: _____
Pharmacy Address: _____

PRIMARY CARE PROVIDER:

Name: _____
Phone: _____
Fax: _____

REFERRING PROVIDER:

Name: _____
Phone: _____
Fax: _____

EMERGENCY CONTACT #1

Contact Name: _____
Phone #: _____
Relationship: _____

EMERGENCY CONTACT #2

Contact Name: _____
Phone #: _____
Relationship: _____

Signature on File/ Consent for treatment: By signing below, I agree to the following: I allow Virginia Spine Specialists to participate in the treatment of my health. **I understand Virginia Spine Specialists will NOT manage my pain medication.** I authorize the release of this information to my insurance company. I understand I am responsible for my account. I authorize my doctor to act as my agent in helping me to obtain payment from the insurance. I authorize payment directly to Virginia Spine Specialists.

_____ _____
Patient/Responsible Party Signature Today's Date

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RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICE

I acknowledge that I have been offered a copy of Virginia Spine Specialists Notice of Privacy Practices, I understand that a copy can also be found on our website **www.VASpines.com**. I have also had the opportunity to ask questions and receive explanations regarding this policy.

_____ _____

Patient/Responsible Party Signature Today's Date

CONSENT TO USE / DISCLOSE HEALTH INFORMATION

We understand the importance of being able to communicate or share certain pieces of health-related information to your family members or spouses. The HIPAA Privacy Act requires that must obtain permission from you before we can share any health-related information which includes: Appointments, Insurance/Account billing, and treatment related information as well. If you would like for us to be able to share certain pieces of this information, please make sure you list their names below and designate their relationship to you and check the boxes applicable. **You may opt out of this consent by checking the box at the end of this page.**

I hereby give my permission to the person (s) listed below to authorize treatment and to receive information about my care.

1. _____ (First and Last name required)

Relationship □ Spouse □ Family Member _____ □ Guardian □ Other: _____

2. _____ (First and Last name required)

Relationship □ Spouse □ Family Member _____ □ Guardian □ Other: _____

APPOINTMENT MESSAGES

□ Home □ Office □ Cell

□ Person □ Mail □ E-Mail

MEDICAL MESSAGES

□ Home □ Office □ Cell

□ Person □ Mail □ E-Mail

_____ _____

Patient/Responsible Party Signature Today's Date

ONLY CHECK IF YOU DO NOT WANT YOUR INFORMATION SHARED

□ **I DO NOT WANT MY INFORMATION SHARED WITH ANYONE** **Initials:** _____

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FINANCIAL POLICY

- I hereby authorize my insurance benefits to be paid directly to the physician and/or physician group for which I am financially responsible for all charges. I also consent to the release and re-disclosure of my medical record to enable or facilitate the payment, collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. If at any point you change insurance, or your insurance policy terminates or cancels coverage, you will be fully responsible for all charges that are not subject to being refiled with any new insurance provided. Most insurance(s) have timely filing requirements that if they are not met, we are not able to rebill those services. **If we are unable to refile your claims, you will be fully responsible for all charges.**
- Fees for services, along with unpaid deductibles and co-payments, **are due at the time of treatment**.
- Upon requesting medical records, there will be a $0.50 charge per page up to 50 pages and $0.25 thereafter.
- For FMLA or Short-Term disability documents that need to be completed there will be a processing fee of $20.00 per occurrence.

Initials: _____

CANCELLATION POLICY

- I understand that it is my responsibility to contact the office if I must cancel or reschedule an appointment within a timely manner.
- **Office Visit appointment not cancelled within (48) business hours will be charged $30.00 cancellation fee. This fee is NOT billable to your insurance carrier.**
- **Surgical Scheduled appointments not cancelled within (72) business hours will be charged $150.00 cancellation fee. This fee is NOT billable to your insurance carrier.**
- **If you must cancel or reschedule your appointment, we ask that you contact us directly at 571-921-4877, (Monday-Thursday 8:00am-4:00pm and Friday from 8:00-2:00pm)**

Initials: _____

REFERRAL POLICY

- I understand that if my insurance carrier requires a written **Insurance Referral** from my Primary Care Physician, I am responsible for obtaining the insurance referral prior to being seen in our office and prior to being treated by our providers. If an **Insurance Referral** has not been obtained before my appointment, I will be asked to sign a **Waiver Form** acknowledging that if the referral is not able to be obtained timely, I will be financially responsible for the charges incurred that can range from $300-$600 for a **Self-Pay** new patient visit.

Initials: _____

_____ _____

Patient/Responsible Party Signature Today's Date

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HEALTH HISTORY

Dear patient: To better understand your health status, please complete below.

Patient Last Name:					**Date of Birth: _____/_____/_____**
Patient First Name:					**Height: Weight:**
Reason for visit:					
Date of Injury or onset of problem:			**Date of most recent episode (Flare Up):**		
Are you currently taking medications for this? ☐ Yes ☐ No					
Have you or any blood relative had an of the following:	Yes:	No:	Who:	Year:	Doctors Notes: (Please do not write in this area)
Allergies, Hay Fever					
Anemia					
Alcoholism					
Arthritis					
Asthma					
Bleeding Problems					
Blood Transfusion					
Birth Defects					
Cancer					
COPD (Pulmonary)					
Diabetes					
Emphysema					
Epilepsy or Seizures					
Gallstones					
Glaucoma					
Heart Trouble					
Hepatitis					
HIV					
Hypertension					
Mental Illness					
Migraine Headaches					
Reflux/GERD					
Rheumatic Fever					
Stroke					
Suicide					
Thyroid Disease					
Tuberculosis					
Ulcer					
Venereal Disease					
Other					

ALLERGIES: (If NONE, please indicate "NKA")	
NAME OF DRUG / ITEM	**REACTION**

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YOUR HEALTHCARE PROVIDERS

(If more please continue reverse side of this sheet)

SPECIALTY	NAME	PHONE NUMBER
Primary Care		
Pain Management		
Cardiologist		
Vascular		
Pulmonologist		
Neurologist		

MEDICATIONS

(If more please continue reverse side of this sheet)

MEDICATION NAME	DOSE	PRESCRIBING DOCTOR	LAST DATE TAKEN

SURGICAL HISTORY

(If more please continue reverse side of this sheet)

NAME OF SURGERY	DATE	PERFORMING DOCTOR

Have you ever had a problem with general anesthesia? ☐ YES ☐ NO

If YES - Please explain:

SOCIAL HISTORY

CHECK YES OR NO:	YES	NO	ANSWERS:
Do you Smoke?			# Pack/Day:
Do you Chew tobacco?			#
Have you ever smoked in the past?			Stop Date:
Do you use "Street" Drugs?			
Do you eat at least 3 meals a day?			
Any diet preferences or restrictions?			Type:
Number of caffeine drinks a day?			
Number of alcoholic drinks a day?			
Do you exercise regularly?			Days/Week:
What exercise (s) do you do?			
What are your hobbies?			
Do you have children?			How many: Male: Female:
Civil status:	☐ Single ☐ Married ☐ Divorced ☐ Widow		

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TREATMENT HISTORY

Please complete to the best of your knowledge, this information is required by your health plan

TREATMENT	DURATION & DATES	WHERE WAS IT PERFORMED?
Physical Therapy		
Chiropractic Care		
Acupuncture		
Epidural Injections (ESI)		
Trigger Point Injections		
Facet Injections		
Massage		

Have you had any of the following studies for this problem? Please write the most recent dates for each:

STUDY	DATE (S)	BODY REGION STUDIED	WHERE WAS IT PERFORMED?
X- Rays			
MRI			
CT			
EMG			
Myelogram			
Bone Density			

SELF PAIN ASSESSMENT

How bad is your pain now? Please circle the appropriate number below:

NO PAIN 1 2 3 4 5 6 7 8 9 10 **WORST POSSIBLE PAIN**

Is the above level of pain ⇨ □ ON MEDICATION □ WITHOUT MEDICATION?

1) When did your present level of pain start? _____
2) Are you able to work? YES / NO If no, last day of work _____
3) What reduces this pain? (check all that apply) □ Lying Down □ Sitting □ Walking □ Muscle Relaxants
   □ Heat □ Ice □ Physical Therapy □ NSAIDS □ Pain Medications □ Nothing
4) What activities make your pain worse?) □ Exercise (during) □ Exercise(after) □ Coughing □ Sneezing
   □ Bending forward □ Bending Backward □ No apparent cause
5) What medications have you tried in the past for the pain? _____

   _____ _____ _____
6) Are you still using the above medications? □ YES □ NO
7) Are you under the care of a pain management doctor? □ YES □ NO

   (If YES, who?) _____

(Doctor Name & Location)

_____ _____

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REVIEW OF SYSTEMS

(please **circle** symptoms or history you have experienced or check "NONE" for each section if applicable)

***Constitutional/General*:** Easy Fatigued, Unexplained Fevers, Insomnia (trouble sleeping), Loss of Appetite, Easy Bruising, Weight Loss, Weight Gain, **NONE**
Musculoskeletal: Joint Pain, Joint Stiffness, Morning Stiffness, Joint Surgery, Joint Swelling, Leg Cramps, Muscle Cramps, Osteoarthritis, Rheumatoid Arthritis, Scoliosis, Sjogren's Syndrome, Lupus, Back pain, **NONE**
Neurology: Head Injury, Mini-Stroke (TIA), Stroke Headache, Learning Disabilities, Loss of Balance, Loss of Feeling in Legs, Loss of Feelings on One Side, Memory Loss/Seizures, Tremors, Vertigo, Weakness in Arms, Weakness in Legs, **NONE**
Heart/Lungs: Chest Pain, High Blood Pressure, Heart Attack, Congestive Heart Failure, Dizziness, Irregular Heartbeat (palpitations), Leg Edema, Blood clots (DVT), Shortness of breath, Cough, Sputum, Wheezing, **NONE**
Endocrine: Diabetes, Excessive Swelling, Excessive Thirst, Excessive Urination, Thyroid Disease, Hormonal Disease, Heat Intolerance, **NONE**
Head/Neck: Change in Vision, Double Vision, Drooping eyelid, Light Intolerance, Loss of Hearing, Loss of Smell, Loss of Vision, Trouble Swallowing, Sore throat, Change in Voice, Nose Bleeds, Ringing in Ears, **NONE**
Gastrointestinal: Abdominal Pain, Bleeding from Bowel, Blood in Stool, Change in Bowel Habits, Constipation, Cirrhosis of Liver, Colitis, Diarrhea, Reflux (GERD), Heartburn, Hepatitis, Hiatal Hernia, Irritable Bowel Syndrome (IBS), Nausea, Vomiting, **NONE**
Blood/Immune System: HIV Exposure, Persistent Infection(s), Abnormal Bleeding, Abnormal Bruising, Anemia, Enlarged Lymph Nodes, **NONE**
Female: Frequent Yeast Infections, Breast Cancer, Breast Fibrocystic Disease, Post-Menopausal, Abnormal Vaginal Discharge, Heavy or Painful Periods, Infertility, Diminished Sex drive, **NONE**
Male: Difficulty Urinating, Difficulty with Erection, Diminished Sex drive, **NONE**
Psychology: Currently receiving Counseling, Eating Disorder, High Stress Level, Depression, Suicidal Thoughts, Mania, Psychosis, Psychiatric Hospitalization, **NONE**

MARK THE AREA YOU ARE HAVING **PAIN**

WITH AN X

MARK THE AREA YOU ARE HAVING **NUMBNESS AND TINGLING**

WITH AN O