NON-SURGICAL ORTHOPAEDICS, P.C.
Specializing in Spine Care & Pain Management

PATIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Cell Phone: _____

Zip: _____ Sex: ○ Male ○ Female Soc Security # _____ Date of Birth: _____ Age: _____

Email address: _____ Race: ○ Caucasian ○ Black ○ Hispanic ○ Other

Patient's Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip_____ Work Phone: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed Spouse's Name: _____ DOB _____

EMERGENCY Contact: _____ Phone: _____

Patient Primary Care Physician: _____ Phone: _____

Party responsible for account (If Work Comp or Auto provide that information)

Name: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ DOB: _____

Responsible person's employer: _____ Phone: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ Phone: _____

ID # _____ Group # _____

Additional Insurance

Subscriber Name: _____ Date of Birth: _____

Insurance Company: _____ Phone: _____

ID # _____ Group # _____

City: _____ State: _____ Zip: _____

Attorney's name (if applicable) _____ Phone: _____

Major credit card type and number: _____ Exp. Date: _____

There may be instances that your health care provider may wish to communicate some aspects of your protected health information and or account information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Non-Surgical Orthopaedics, PC cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Non-Surgical Orthopaedics, PC to communicate my information electronically. ○ Yes ○ No

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to me. I also authorize Non-Surgical Orthopaedics, P.C. (NSO) and The Center for Spine Procedures, P. C. (CSP) to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I acknowledge that I understand by the policies of the practice of NSO as read in the Practice Handbook, and will be bound by the provisions contained in the handbook, including changes to office visit ($75) or procedure ($220) no-show or late cancellation fees. I also authorize the practice to release any medical information or insurance information that requested by any physical therapy, diagnostic imaging or clinical research facility that the practice refers me to as part of my treatment.

Patient (Guardian) Signature: _____ Date: _____

NON-SURGICAL ORTHOPAEDICS, P.C.
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Patient Information Profile

Please fill in bubbles completely (example: ● Yes ○ No)

Social History

What is your marital status? ○ Married ○ Single ○ Widowed ○ Divorced
Do you have children? ○ Yes ○ No
Do you smoke? ○ Yes ○ No ○ Quit
Do you drink alcohol? ○ Yes ○ No ○ Socially
Do you have a disability? ○ Yes ○ No If Yes, Describe: _____
Do you have a drug history? ○ Yes ○ No
Employment: ○ Full time ○ Part time ○ Disability ○ Retired ○ Unemployed
Employer Name: _____

Family History

				Pertinent Family History
Father	○ Alive	○ Deceased	○ Unknown	_____
Mother	○ Alive	○ Deceased	○ Unknown	_____
Siblings	○ Alive	○ Deceased	○ Unknown	_____
Children	○ Alive	○ Deceased	○ Unknown	_____

Are you having any of these symptoms:

Fevers?	○ Yes	○ No	Wheezing?	○ Yes	○ No
Weakness?	○ Yes	○ No	Nausea?	○ Yes	○ No
Recent weight loss?	○ Yes	○ No	Heartburn?	○ Yes	○ No
Night sweats?	○ Yes	○ No	Loss of bowel control?	○ Yes	○ No
Feeling very tired?	○ Yes	○ No	Constipation?	○ Yes	○ No
Difficulty falling asleep?	○ Yes	○ No	Diarrhea?	○ Yes	○ No
Difficulty staying asleep?	○ Yes	○ No	Difficulty urinating?	○ Yes	○ No
Joint swelling?	○ Yes	○ No	Blood in your urine?	○ Yes	○ No
Joint pain?	○ Yes	○ No	Urinary urgency?	○ Yes	○ No
Joint stiffness?	○ Yes	○ No	Frequent urination?	○ Yes	○ No
Pain in your legs?	○ Yes	○ No	Loss of bladder control?	○ Yes	○ No
Pain in your arms?	○ Yes	○ No	Up at night to urinate?	○ Yes	○ No
Neck pain?	○ Yes	○ No	Anxiety?	○ Yes	○ No
General “all over” muscle pain?			Depression?	○ Yes	○ No
	○ Yes	○ No	A high level of stress?	○ Yes	○ No
Low back pain?	○ Yes	○ No	Nervousness?	○ Yes	○ No
Mid back pain?	○ Yes	○ No	Emotional Problems?	○ Yes	○ No
Difficulty walking?	○ Yes	○ No	Lack of Concentration?	○ Yes	○ No
Leg swelling?	○ Yes	○ No	Tremors?	○ Yes	○ No
Headaches?	○ Yes	○ No	Paralysis?	○ Yes	○ No
Dizziness?	○ Yes	○ No	Lack of Coordination?	○ Yes	○ No
Ringing in your ears?	○ Yes	○ No	Disorientation?	○ Yes	○ No
Chest pain?	○ Yes	○ No	Blurring of vision?	○ Yes	○ No
Shortness of breath?	○ Yes	○ No	Numbness & tingling in extremities?		
Palpitations?	○ Yes	○ No		○ Yes	○ No
Irregular Heartbeat?	○ Yes	○ No	Easy bruising?	○ Yes	○ No
High Blood Pressure?	○ Yes	○ No	Bleeding tendency?	○ Yes	○ No
Fainting?	○ Yes	○ No	Rash?	○ Yes	○ No
Cough?	○ Yes	○ No	Hives?	○ Yes	○ No
Coughing Blood?	○ Yes	○ No	Reactions to drugs?	○ Yes	○ No
Respiratory Infections?	○ Yes	○ No			

During your visit with your physician today, what two questions would you like to have answered?

1.
2.

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PATIENT INFORMATION PROFILE

Patient Name:	**Age:**	**Date:**	**Referred By:**

Payment Source (please choose one)

❒ Insurance ❒ Funding Company
❒ Workers' Comp ❒ Self pay

How did you hear about us?

❒ MD ❒ Chiropractor ❒ Friend/Family ❒ Attorney
❒ Internet ❒ TV ❒ Other _____

Were you in an accident? ○ Yes ○ **No** **(If yes, please choose):** ❒ Work ❒ Auto ❒ Sports Date of Accident: _____

List your current medications:	**List any medical conditions:**	**List allergies to medications:**

List any previous surgeries & dates:

Other professionals seen for this injury (check all that apply): ☐ MD ☐ Chiropractor ☐ Physical Therapist

Do you have an attorney? ○ Yes ○ No **Attorney Name:** _____

INJURY HISTORY

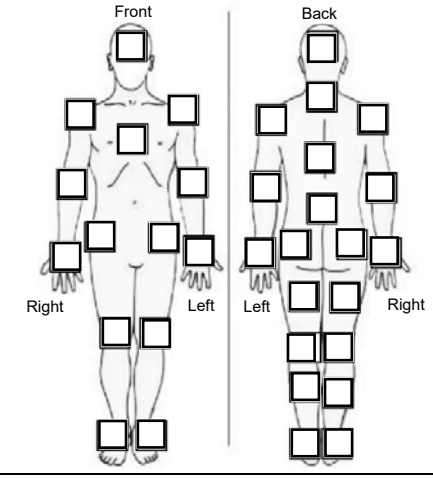
Have you had any <u>tests</u> for your current condition?
(Mark all that apply and provide approximate date, MM/YY)

☐	X-Rays	Date:
☐	MRI	Date:
☐	CT Scan	Date:
☐	CT Myelogram	Date:
☐	EMG	Date:

Have you had any <u>treatment</u> for your current condition?
(Mark all that apply and provide approximate date, MM/YY)

☐	Chiropractic	Date:
☐	Physical Therapy	Date:
☐	Injections	Date:
☐	Pain Management	Date:
☐	Massage Therapy	Date:
☐	Surgery	Date:

PAIN DIAGRAM



1. **Please mark the body diagrams where you are experiencing pain.**
2. **For each location marked, indicate in the table below, the type & intensity of your pain.**

<u>Types of pain include</u>:
• Aching • Burning • Cramps • Dull • Numbness • Shooting
• Stabbing • Stiffness • Swelling • Throbbing • Tingling • Other

<u>Pain Location</u>	**<u>Type of Pain</u>**	**<u>Pain Intensity</u>** (0 – 10)

NON-SURGICAL ORTHOPAEDICS, P.C.
Specializing in Spine Care & Pain Management

Arnold J. Weil, M.D.
Anthony R. Grasso, M.D.

Appointment Cancellation Policy

Non-Surgical Orthopaedics, P.C. requires a 24 hour notice for cancellation of appointments. We reserve the right to charge a **$75.00 fee for appointments that are cancelled without a 24 hour notice, or if a patient does not show up for their scheduled appointment.**

If the appointment was for an EMG the less than 24 hour cancellation notice fee or no show fee is $220. If the appointment was for an injection procedure in the Center for Spine Procedures, P.C., the less than 24 hour cancellation fee or no show fee is $220.

You will also be charged a $45.00 Late Fee if you are more than 15 minutes late to your appointment.

This fee is your responsibility and will not be billed to your insurance company.

It is the responsibility of you, the patient, to provide us with your current address, telephone numbers and insurance information at the time of your initial visit and any other visits thereafter. In addition, it is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan.

You are ultimately responsible for payment of services rendered from our office and copays, deductibles, co-insurances, balances, etc. must be paid prior to seeing the physician or we may have to reschedule your appointment.

Your signature below is required and is proof that you acknowledged the Appointment Cancellation Policy set in place by Non-Surgical Orthopaedics, P.C. and acknowledge that you will be responsible for payment of a cancelled or missed appointment.

_____
Print Name

_____
Patient Signature

_____
Date

Non-Surgical Orthopaedics, P.C.
Center for Spine Procedures, P.C
335 Roselane Street Marietta GA 30060
770-421-1420 Office
770-421-8055 Fax

Patient Contact Release

Dear Patient,

HIPAA law protects the use and disclosure of all patient information in their files. In order for us to contact you and remind you of appointments, discuss any financial matters or even speak with your family, we need authorization on file from you. Please review the situations below in which we use your information to contact you.

- Re-Schedule or remind you of an appointment.
- Obtain or update insurance information on file.
- Discuss or inform you of any financial arrangements, benefits, or account issues.

By signing below, you are authorizing our office the use of your medical file in order to discuss the aforementioned. In the event that you are not available to discuss these matters, you are further authorizing us the use of email, patient portal or your voicemail or answering devise to relay any of this necessary information. Please write below any other family member with which you are authorizing us to leave a message with relating to the above if you are not available. Under HIPAA law, you may change your authorization by notifying our office in writing.

Other family members we may speak with:

Name	**Relationship**	**Contact Info (Phone, Email)**

_____
Signature of Patient

_____ _____
Print Name Date

Research Intake Form

Georgia Institute for Clinical Research, LLC is the research department of Non-Surgical Orthopaedics, P.C. We work with pharmaceutical and biomedical companies to provide treatments for various conditions that are not yet available. All of our studies are of no cost to you and provide a stipend to compensate for your time and travel.

Name:_____ Today's Date:_____

Date of Birth: _____

[] Current Patient [] New Patient

Would you be interested in learning more about our current studies?
[] Yes [] No

What areas would you be interested in for current and/or future studies (please check all that apply):

[] Migraines
[] Knee Pain
[] Shoulder pain
[] High Cholesterol/Triglycerides
[] Fibromyalgia
[] Hip Pain
[] Fibromyalgia
[] Have you received the Cover 19 vaccine [ ]Yes [ ]No
[] Uncontrolled Hypertension
[] Low Back Pain/Sciatica
[] Neck Pain
[] Arthritis - Osteoarthritis and Rheumatoid Arthritis
[] Sciatica
[] Post Surgical Pain
[] Type II Diabetes
[] Other areas of Interest _____

May a Research Coordinator contact you to further discuss a study you may qualify for?

[] Yes [] No

If yes, please let us know your preferred method of contact:

[] Telephone (Please provide best contact number):_____

[] Email (Please provide best email address): _____

Thank you for taking the time to complete this form.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A copy of the Notice of Privacy Practices of Non-Surgical Orthopaedics, P.C. is provided in the lobby for my review. I am aware that I can obtain a copy of this Notice at any time.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be provided in the main waiting room area of Non-Surgical Orthopaedics, P.C.

I also understand that if I have any questions with regard to this Notice of Privacy Practices, I may contact in writing the Practice Administrator at the following address:

Non-Surgical Orthopaedics, P.C.
335 Roselane Street
Marietta, GA 30060

770-421-8055 (fax)
jennifer@lowbackpain.com (email)

_____
Signature of Patient

_____
Print Name

_____
Date:

Medical Records Release Form

Date: _____

Patient's Name: _____

Patient's SSN: _____

Patient's DOB: _____ (MM/DD/YYYY)

Patient's Phone #: _____

I, _____, authorize the release of all of my health records (including all electronically prescribed prescriptions, records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). I request they be sent to:

Non-Surgical Orthopaedics, PC
335 Roselane Street
Marietta, GA 30060
Phone 770-421-1420
Fax 770-421-8055 ATTN: Medical Records

There is no expiration date for this authorization unless noted and initialed below:

Expiration date: _____ Patient Initials _____

I understand that I have the right to revoke this authorization at any time. I must do so by writing Non-Surgical Orthopaedics, P.C. The revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Patient / Guardian Signature Date

_____
Relationship, if not patient

NON-SURGICAL ORTHOPAEDICS, P.C.
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Pain Management Agreement

Patient Agreement for Controlled Substance Prescriptions:

Controlled Substance medications (narcotics, tranquilizers, and barbiturates) can be an important part of the treatment of chronic pain when other options such as surgery, therapy, and injections have failed or are not warranted. I n such cases, careful monitoring of the dosage and administration frequency is essential to control pain and avoid adverse effects. The patient understands there is a potential risk of addiction, abuse, misuse and mental impairment due to the medication(s). The patient further understands that the medication may cause drowsiness. and they should avoid driving or operating heavy machinery while on the medication.

If controlled substances are prescribed as part of the treatment plan, this agreement shall go into effect. Accordingly, I agree to comply with the following statements:

1. I am solely responsible for my specific controlled substance medication. If the prescription is lost, stolen or taken more frequently than prescribed, it will not be replaced without an examination by the physician. A follow up appointment will be made “as available” to assess the situation. Medications will NOT be refilled for “missed” appointments.
2. I have no prior history of or treatment for drug abuse, misuse, diversion, or addiction.
3. I will not accept or request or utilize any controlled (or illegal) substance medications from ANY other facility, physician or individual while I am receiving medications from Non-Surgical Orthopaedics, P.C., without the knowledge of and written approval of my physician.
4. Under no circumstances will I increase the dosage or frequency of medications without approval from my physician. This change will be documented in my medical record.
5. I understand that calls for refills or changes of medications will be accepted ONLY between the hours of 8:00 am to 3:00pm, Monday through Friday. Under NO circumstances will refills or changes be made after hours, on weekends, or on holidays.
6. In understand refills will not be made if I "run out early" or on an "emergency" basis. I am responsible for the proper dosage, administration, and monitoring of the amount of medication.
7. Should my physician feel that such is warranted, I agree to undergo random drug testing through the administration of a urine drug screen. I understand that I am responsible for the cost of this test.
8. Should my physician feel that circumstances warrant an investigation, I formally authorize Non-Surgical Orthopaedics, P.C. to communicate with any pharmacy or physician to determine whether a similar medication has been filled in my name, or for any other reason.
9. I understand there will be no change in medication or prescription un less the unused portion of the original prescription is accounted for at our facility.
10. I understand that I may be required to fill the prescription or medication at a pharmacy designated by the practice.
11. I understand and accept the inherent risks of addiction, substance abuse, and potential side effects or hazards associated with the use of narcotic medications or other controlled substances, and my physician has discussed them with me.

I understand that if I violate any of the conditions above, my participation in the Pain Management Program can be terminated immediately , and my action may be reported to the Drug Enforcement Agency, other physicians, and pharmacies.

Name:_____ Signature:_____

Witness:_____ Date:_____

Medications and Dosage: _____**ALL NARCOTICS**_____

335 Roselane Street NW • Marietta, GA 30060 • (o) 770.421.1420 • (f) 770.421.8055
www.lowbackpain.com

Print Form | Clear Form | Save Form | Submit Form