

**Coastal Spine Initial Visit Form:**

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Sex: (Circle) M / F Marital Status: \_\_\_\_\_ Primary Language: (Circle) English | Spanish | Other \_\_\_\_\_

Race: (Circle) Caucasian | Hispanic | Asian | African American | Other: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Street: \_\_\_\_\_ City: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ City: \_\_\_\_\_

Pain Management Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Chiropractor Name: \_\_\_\_\_ City: \_\_\_\_\_

**Do you have any allergies? If yes, please list them:** \_\_\_\_\_

**Medical History: (Circle)** Heart Attack | Pacemaker | Stroke | COPD | Hypertension | Diabetes | A-Fib | Clots | Infection | Cholesterol | Thyroid | Embolism | Cancer | Other: \_\_\_\_\_

**Surgical History: Type and Date**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Family History: (Circle)** Heart Attack | Stroke | COPD | Hypertension | Diabetes | A-Fib | Clots | Infection | Cholesterol | Thyroid | Embolism | Cancer | Other: \_\_\_\_\_

**Social History:** List any Recreational Drugs you are taking? \_\_\_\_\_

**Smoke:** (Circle) Y / N # of \_\_\_\_\_ packs per Day | Week | Month **Alcohol:** (Circle) Y / N # of \_\_\_\_\_ drinks per Day | Week | Month

- 1. Is your pain the result of a: (Circle) Fall | Injury on the job | Motor Vehicle Accident | Other: \_\_\_\_\_
- 2. Is there a lawsuit pending related to your injury? (Circle) Y / N Attorney Name and Firm: \_\_\_\_\_
- 3. Did you have a history of neck pain prior to this injury or accident? (Circle) Y / N
- 4. If yes, what treatment have you had? \_\_\_\_\_
- 5. Did you have a history of low back pain prior to this injury or accident? (Circle) Y / N
- 6. If yes, what treatment have you had? \_\_\_\_\_
- 7. Which of the following describes you currently? (Circle) Working | Not Working | Unemployed | Retired | Disabled | Student
- 8. What is your Employer's Name, Address and Phone Number: \_\_\_\_\_
- 9. Job requires: (Circle) Lifting Y / N Standing Y / N Sitting Y / N
- 10. How long can you Sit? \_\_\_\_\_ Stand? \_\_\_\_\_ Walk? \_\_\_\_\_
- 11. What medicine for your pain has failed? \_\_\_\_\_
- 12. Circle what you are seeing us for: Neck | Back | Right Leg | Left Leg | Right Arm | Left Arm
- 13. Do you have weakness? (Circle) Y / N If yes, where? \_\_\_\_\_ Numbness Y / N If yes, where? \_\_\_\_\_
- 14. Have you lost control over your bowel or bladder? (Circle) Y / N
- 15. What testing/treatment have you had? (Circle) MRI | CT | X-Rays | EMG | Bone Scan | Chiropractor | Bracing | TENS Unit
- 16. Have you had Physical Therapy? (Circle) Y / N Did it help? Y / N # of Weeks \_\_\_\_\_ Location? \_\_\_\_\_
- 17. Have you had an Epidural? (Circle) Y / N How many? \_\_\_\_\_ Did it help? Y / N By whom? \_\_\_\_\_

**PLEASE FILL OUT THE BELOW IF YOU WERE INVOLVED IN AN AUTO ACCIDENT ONLY:**

- 1. (Circle) if you were the *Driver* or *Passenger*? Where you wearing a seat belt? Y / N Did the police come to the scene? Y / N
- 2. Did the airbags deploy? Y / N What was the date of accident? \_\_\_\_\_
- 3. Did the ambulance come to the scene? Y / N If yes, what hospital and city did you go to? \_\_\_\_\_
- 4. Did they perform any imaging? Y / N If yes, what testing did you have? \_\_\_\_\_

**EVERYONE PLEASE SIGN ONE OF THE BELOW FOLLOWING STATEMENTS:**

- 1 This injury is **NOT** related to an auto accident, work injury or slip and fall. There is no litigation pending regarding this injury.

\_\_\_\_\_  
Patient Signature Date

- 2 This injury **IS** related to an auto accident, work injury, or slip and fall. *I have provided Coastal Spine, P.C. with all claim and litigation information pertaining to this injury.*

\_\_\_\_\_  
Patient Signature Date

**MEDICATIONS: Include Over the Counter Vitamins**

	Name	Dose	Amount	Frequency
Ex.	Lipitor	40mg	1	Twice a day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Draw using the following abbreviations where your pain is:

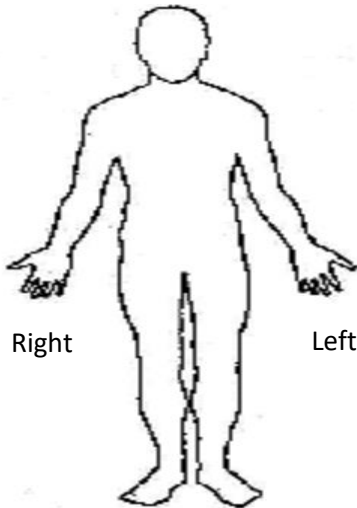
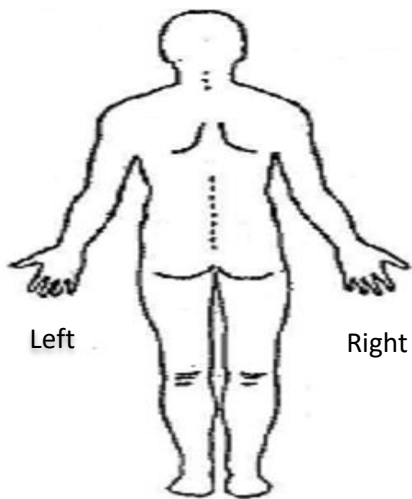
- |             |                      |
|-------------|----------------------|
| Ache = A    | Pins and Needles = P |
| Burning = B | Stabbing = S         |
| Numb = N    | Other = O            |

**Review of Systems: Please Circle**

- |                     |                      |              |
|---------------------|----------------------|--------------|
| Headache            | Dizziness            | Memory Loss  |
| Numbness            | Blurriness           | Deafness     |
| Ringling            | Chest Pain           | Weakness     |
| Rapid Beat          | Edema                | Diarrhea     |
| Weight Loss         | Cough Blood          | Cough        |
| Weight Gain         | Urinary Burning      |              |
| Wheezing            | MRSA                 | Insomnia     |
| Constipation        | Incontinence         | Arthritis    |
| Depression          | Bleeding Bowel       | AIDS/HIV     |
| Anxiety             | Fatigue              | Transfusions |
| Hepatitis           | Bladder Incontinence |              |
| Shortness of Breath | Swallowing Issues    |              |

Back

Front



Circle your pain level on a scale of 1 to 10.  
10 being unbearable, or the worst imaginable, pain.

1 2 3 4 5 6 7 8 9 10

I consent that all the above is accurate to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Reviewed by Dr. \_\_\_\_\_

Date: \_\_\_\_\_

Other: \_\_\_\_\_



## Consent for Treatment/Financial Responsibility

### RELEASE OF INFORMATION

I authorize Coastal Spine, P.C. to release or disclose to any insurance company, governmental agency, managed care organization or any other entity or person who may be required to pay all or part of the costs of my treatment, all medical records or other information from Coastal Spine, P.C. records relating to my identity, diagnosis, prognosis and treatment. I understand that the specific type of information to be disclosed may include, but is not limited to diagnosis, discharge summary, history and physical, progress notes, doctors' orders, laboratory, operative and/or radiology reports, nurses' notes, consultations. The purpose of this disclosure is to enable Coastal Spine, P.C. to secure payment of my physician bill from such insurance companies, governmental agencies, managed care organizations or other entities that may be required to pay on my behalf. I authorize Coastal Spine, P.C. to release my medical record information to any physician or caregiver participating in my care while I am being treated at Coastal Spine, P.C. and to any physician or caregiver involved in my continuing care. For Worker's Compensation, I give consent to release to my employer all medical records or other information from Coastal Spine, P.C. records relating to my identity, diagnosis, prognosis and treatment (including follow-up visits and related additional treatment or related testing) for any employment-related testing/injury/illness.

### REVOCACTION

This consent is subject to revocation (withdrawal) at any time except to the extent that Coastal Spine, P.C. has released or disclosed information because I have signed this consent. If I do not revoke this consent in writing, it will terminate one year from date of signature. I understand that this consent shall operate as a complete release of liability to Coastal Spine, P.C., its trustees, officers, employees and agents for the release of the information authorized to be released on this form.

### DISCLOSURE OF FINANCIAL INTEREST

**As per the Principles of Medical Ethics of the American Medical Association (H-140.984), the physicians at Coastal Spine, P.C. are required to inform their patients that they do hold a financial interest in Radiology services provided at Coastal Spine, P.C. The physicians may also have financial interest in other services such as monitoring services, Fellowship Surgical Center and various device companies that may be used in your treatment.**

**I acknowledge the receipt of the Coastal Spine, P.C. privacy policy, and I am aware that the privacy policy is available at the front desk for review.**

**PATIENT SIGNATURE:** \_\_\_\_\_

**PERSON SIGNING ON PATIENT'S BEHALF:** \_\_\_\_\_

### CONSENT FOR TREATMENT

I authorize the medical staff, employees and contracted healthcare providers of Coastal Spine, P.C. to provide necessary medical treatment to me, including routine laboratory tests, diagnostic procedures and medical care. Physician, nursing or other healthcare personnel who are in training may be observing and participating in my care under the supervision of Coastal Spine, P.C. and I hereby give my consent to such observations and/or participation.

### ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I acknowledge that I have been provided with a copy of Coastal Spine, P.C.'s Assignment of Benefits and Financial Responsibilities form, which is effective as of today's date.

**PATIENT SIGNATURE:** \_\_\_\_\_

\_\_\_\_\_  
**DATE**



## **INFORMATION FOR HEALTH BENEFIT PLANS**

### **Please Keep For Your Records:**

Coastal Spine, P.C., participates in the following health benefits plans:

- Amerihealth Administrators
- Independence Administrators
- Independence Blue Cross
- Independence Personal Choice
- Keystone Health Plan East
- QualCare
- Medicare

## **FACILITY AFFILIATIONS**

Coastal Spine, P.C. is affiliated with the following health care facilities:

- Fellowship Surgical Center
- Jefferson Health System
- Virtua Health System
- Capital Health System



## **Narcotic Agreement Policy**

**Please read the following carefully!!!**

In the best interest of your health and well-being, medications will be given by one of our Physicians only under the following circumstances:

1. You agree to notify the physicians at CoastalSpine of all pain medications and narcotics that you are receiving from other physicians.
2. If you are currently and regularly seen every 3 months in the care of one of our physicians, OR
3. You are scheduled and awaiting your surgery or injection, OR
4. You have had surgery or injections in the past 3 months.  
*Surgical Patients:* 3 months POST OP physicians will no longer prescribe
5. Agree to submit to a urine drug screen prior to starting and episodically during prescribing of narcotic pain medications. Urine screens can be requested at any time.

Also, please be aware that all of our Physicians rotate coverage on evenings and weekends. As such, it is impossible for your physician to recall all the details of the medication dispensed to you;

- **Contact our PRESCRIPTION-LINE at (856) 222-4444, press prompt 3 and leave your prescription information, at least 2-3 days prior to running out. You need to contact us during regular business hours (Monday-Friday) between the hours of 9 a.m. and 4:30 p.m. excluding holidays so a physician can review your chart and prescribe the appropriate medication(s). Prescriptions will only be refilled until your next upcoming appointment.**
- Please allow **2 business days (48 hours) for all prescription refills.**
- Prescriptions can be picked up between the hours 9am – 4:30pm
- Continuous cancellation of appointments may ultimately lead to no prescriptions and a discharge from the practice.

**Under No Circumstances can the Physician On-Call (Evenings or Weekends), phone in prescription medications. No Exceptions!! All calls must be made the following business day.**

**Please note: No further prescriptions will be given to any patients if our office is notified of tampering or altering of any prescriptions. NO EXCEPTIONS!!**

Please be reminded there is video surveillance in the building.

If our physicians feel that you do not require further surgery or injections; but you are suffering from a painful alignment, be assured that we will direct you to the best Pain Management physicians that are available, to help you cope with your condition.

**By signing below, I state that I have read, understood and will abide by this policy during my treatment here at CoastalSpine.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



Authorization for Health Information Disclosure
4000 Church Road, Mount Laurel, NJ 08054
Phone: (856) 222-4444 Fax: (856) 222-4733

PATIENT INFORMATION

Patient Name: Date of Birth: Phone:
Street Address: City: State: Zip Code:

REQUESTOR/RECIPIENT INFORMATION

I give permission to disclose the following information from my health records to Coastal Spine. Any information listed below that is not checked off may not be released. I give consent for the following information to be released.

I give permission for CoastalSpine to disclose the following information from my health records. Any information listed below that is not checked off may not be released. I give consent for the following information to be released.

(Please circle)

- Complete Health Record History and Physical Examinations Consultations Reports Progress Notes
Imaging Reports/ Imaging Films Discharge Summary Laboratory Results Billing Statements

I also give my consent for messages from CoastalSpine to be released to:

- Spouse /Other Name: Phone:
Child Name: Phone:
Attorney Name: Phone: Fax: Address:
Doctor Name: Phone: Fax: Address:
Voice Mails Name: Phone:
Other

Specify dates of treatment (or date ranges) if applicable:

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the above named health care provider/health plan authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary and is not a condition of treatment, payment, enrollment or eligibility for benefits. I understand that if I have any questions about disclosure of my health information, I may contact the healthcare provider/health plan listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

Signature of Patient or Authorized Representative Date
Description of Representative's Authority (witness signature required) Signature of Witness

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE

# ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

**Purpose:** This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices. \* You have the right to refuse to sign this document\*

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(Please Print Name)

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(Signature)

Date: \_\_\_\_\_

## Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but the acknowledgement could not be obtained because:

- The patient or individual refused to sign this document
- Communications conflicts prohibit us from obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) \_\_\_\_\_

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