PATIENT HISTORY QUESTIONNAIRE
(HISTORIAL DEL PACIENTE)

Patient Name (Nombre):_____
(Last Name) (First Name)

Address(Direccion): _____

City(Ciudad): _____State (Estado) _____Zip(Codigo Postal)_____

Home Phone (teléfono de casa)_____ Work Phone(teléfono del trabajo) _____

Sex: (Sexo) M/F Date of Birth (Fecha de Nacimiento):_____ S.S # (Seguro Social)_____

Nature of Accident: (Accidente) ☐ Automobile (Auto) ☐ Slip & Fall (Caida) ☐ Work Related (Trabajo) ☐ Other (Otro)

Date Of Accident: (Fecha de Accidente)_____

Insurance Name:_____ Phone(Telefono):_____

Address (Direccion):_____

Claim # (Numero de Reclaimo): _____ Policy # (Numero de Poliza):_____

Attorney's Name:_____ Attorney's Phone #_____
(Nombre de Abogado) (Telefono de Abogado)

Attorney's address/ (Direccion):_____

Health Insurance (Plan Medico): _____ Phone(Telefono) _____

Address (Direccion):_____

Subscriber ID#_____ Group # _____
(abonado carné de identidad) (número de grupo)

BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE FOR PROFESSIONAL SERVICE RENDERED, AND I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE TO THE DOCTOR. I HEREBY AUTHORIZE THE ATTENDING DOCTOR TO RELEASE ANY INFORMATION CONCERNING MY EXAMINATION OR TREATMENT MAY BE NECESSARY OF EITHER MEDICARE CARE, LEGAL DOCUMENTATION, OR PROCESSING APPLICATION FOR FINANCIAL BENEFITS.

BENEFICIOS

YO AUTHORIZE PAGO DIRECTO A ESTA OFICINA POR SERVICOS PROFECIONALS RECIVIDOS. SOY PERSONALMENTE RSPONBIBLE POR SERVICOS MEDICOS NO PAGADOS, AUTORIZE A EL DOCTOR A REVELAR CUALQUIE INFORMATION QUE ONSIERNA MI CONSULTA O TRATAMIENTO RESIVIDOS YA SEA A MI SEGURO, ABOGADO, OTROS MEDICOS.

Patient's Signature:_____ Date:_____
(Fiema del Paciente) (Dia)

Gaurduan:_____ Date:_____
(Tutor) (Dia)

IRREVOCABLE ASSIGNMENT OF BENEFITS

I/ ME/ MY, _____(*patient*), the insured and/or beneficiary of the policy of _____ _____ (*pip carrier*) insurance providing medical benefits to me, do hereby authorize you, _____(*pip carrier*) to pay directly to **Coastal Spine,** (hereinafter referred to as "CS"), medical benefits due to me under the terms of the applicable policy(s) issued by your company(s). Payment is authorized upon receipt of the itemized statement for services rendered. This insurance policy was in full force and effect at the time services were rendered. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me the insured. A photocopy of this assignment shall be valid as the original.

I authorize "CS", to obtain legal counsel by and through any law firm of their choosing and to enter legal (PIP Arbitrations) or other action to collect such sums due it, should sums not be paid correctly or within the legally prescribed time period. I do hereby promise full and complete cooperation with "CS's" legal counsel, including attending any type of Insurance Medical Exam (IME), Deposition, Arbitration or Court Proceeding. I understand that should I fail to cooperate with my insurance company's request, those of "CS" legal counsel, I may be held personally responsible to "CS" for any expense not covered by this assignment / letter of protection (hereinafter referred to as an "LOP") and/or expensed not recovered due to my failure to cooperate.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The undersigned hereby consents and authorizes the release of any and all medical records, reports, films, etc., directly to **"**CS**"** and/or their designated legal counsel, directly from _____(*Dr Office*) or any and all hospitals, diagnostic facilities or physicians that have rendered medical treatment, diagnostic testing or any type of medical service to the undersigned as a patient.

AUTHORIZATION TO RELEASE INFORMATION

_____(*PIP Co*) is hereby authorized to release to "CS", and/or their designated legal counsel, all or any part of my medical record, billing information, insurance policy information, EOB's and any information contained in my PIP file.

FINANCIAL RESPONSIBILITY

I hereby acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by "CS". I hereby agree to immediately forward said check(s) to "CS" upon receipt of same. It is understood and agreed that should I receive benefit checks and fail to forward any benefit checks to "CS", "CS" does maintain the right to request checks from me and initiate any and all collection efforts against me. If such action is taken by "CS", I agree to be responsible for any and all benefit checks received, plus any and all reasonable collection cost incurred including, but not limited to attorney fees, interest, expert fees and court cost.

Date:_____ **Patients Signature:_____**

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

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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

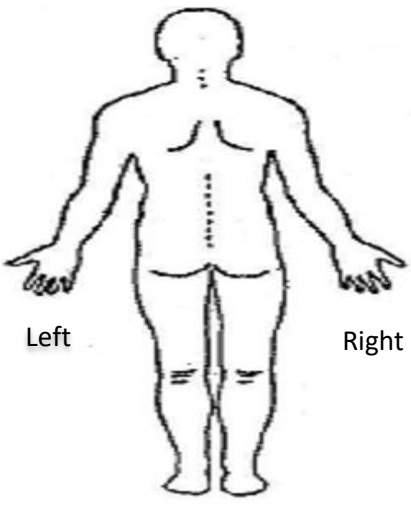
MEDICATIONS: Include Over the Counter Vitamins

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

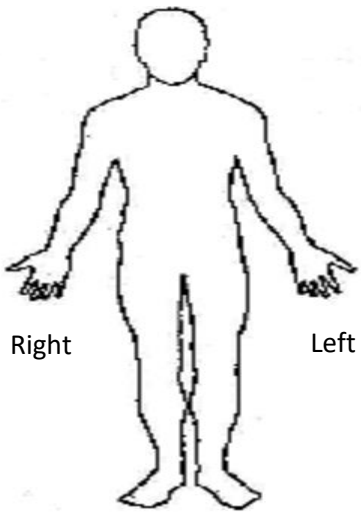
Draw using the following abbreviations where your pain is:

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

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

Review of Systems: Please Circle

Headache	Dizziness	Memory Loss
Numbness	Blurriness	Deafness
Ringing	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	

Other: _____

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

_____ _____

Patient Signature Date

Reviewed by Dr._____ Date: _____

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.

REVOCATION
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

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 cancelation 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

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

CoastalSpine
A SPINE CENTER OF EXCELLENCE

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*

(Please Print Name)

(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) _____
_____
_____
_____