NEW ENGLAND SPORT AND SPINE
PATIENT REGISTRATION FORM

PATIENT NAME:_____ DATE:_____

STREET ADDRESS:_____

CITY_____ STATE_____ ZIP CODE_____

TELEPHONE NO:_____ SEX:_____ DATE OF BIRTH_____

SSN : _____ WORK PHONE NO: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY:_____

EMERGENCY CONTACT NAME AND PHONE NO.: _____

PREFERED PHARMACY:_____

INSURANCE INFORMATION

Is this a worker's compensation injury? □ yes □ no □ I don't know
If yes, please ask the receptionist for worker's compensation claim form which must be completed.

Is this a personal injury or automobile accident claim? □ yes □ no □ I don't know
If yes, do you have an attorney? □ yes □ no Please complete the auto/liability claim form, which is available from the receptionist.

1) PRIMARY HEALTH INSURANCE PLAN NAME:_____

INSURANCE ID#:_____ GROUP ID#:_____

SUBSCRIBER'S NAME (if different than patient) _____

SUBSCRIBER'S SS# _____ DOB: _____

2) SECONDARY INSURANCE PLAN NAME:_____

INSURANCE ID#:_____ GROUP ID#:_____

SUBSCRIBER'S NAME (if different than patient) _____

SUBSCRIBER'S SS# _____ DOB: _____

This section only needs to be filled out if patient is under the age of 18

MOTHER'S NAME: _____ FATHER'S NAME: _____

STREET ADDRESS:_____ STREET ADDRESS: _____

City, State, ZIP: _____ City, State, ZIP: _____

SS#: _____ DOB:_____ SS#: _____ DOB:_____

NEW ENGLAND SPORT AND SPINE FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

_____ Patient with Insurance: You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered "not medically necessary" by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

_____ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet with our billing specialist.

_____ Worker's Compensation Patient: As a Worker's Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Please be sure to inform the office personnel that injury resulted during employment. Your health insurance information will also be obtained as we may bill your health insurance company in the event that your worker's compensation claim is controverted (disputed). You will then be responsible for the patient portion of your health insurance plan (i.e. deductible, copay, coinsurance amounts). The patient is ultimately responsible for the balance due.

_____ Personal injury (accident): If you are a personal injury/automobile accident patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing. If statements are to be sent to your attorney instead of to an insurance company, a lien must be signed by your attorney guaranteeing payment for services rendered.

_____ Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any noncovered services.

_____ Patient without proof of Insurance: If you do not have evidence of health insurance, or complete information regarding your worker's compensation claim or personal injury claim at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

_____ Non-participating provider: We do not participate with _____
If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

GUARANTEE OF PAYMENT
Please initial each section on the line provided.

_____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

_____ I have been advised that if my health insurance carrier/HMO/Medicaid/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

_____ I authorize payment of benefits from my insurance carriers directly to New England Sport And Spine. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying New England Sport And Spine].

_____ I understand that two missed or cancelled appointments (with less than a 24 hour notice) in a twelve month period will require a $100 re-instatement fee before I can make any additional appointments. I also understand this is a one-time privilege. Any repeat offenses will make me subject to dismissal from the practice.

_____ Minor Patients only:
The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

PAYMENT IS REQUIRED AT TIME OF SERVICE
THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS
For your convenience, we also accept VISA and MasterCard.

I have read and understand my financial responsibilities as outlined in both pages of this New England Sport and Spine Financial Policy document.

X_____ _____
Patient's signature Date

_____
Patient's Printed Name

_____ _____
Printed name of person signing on behalf of patient Relationship to patient

NEW ENGLAND SPORT AND SPINE CONSENT FORM / PRIVACY NOTICE
Please initial each section on the line provided.

_____ Consent for Treatment:
I consent to diagnostic procedures and medical care as necessary in the judgement of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____ Medical Release Authorization:
With my consent, New England Sport and Spine may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION
PLEASE REVIEW IT CAREFULLY
To review the more comprehensive version of this notice or if you have any questions please call the office at (207) 622-4500.

The effective date of this notice is APRIL 14, 2003

New England Sport and Spine is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy
At New England Sport and Spine your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure
Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

HealthInfoNet: We participate in HealthInfoNet, the statewide health information exchange (HIE) designated by the State of Maine. The HIE is a secure computer system for health care providers to view and share your important health information to support treatment and continuity of care. For example, if you are admitted to a health care facility not affiliated with ours, health care providers there will be able to see important health information held in our electronic medical record systems.

Your record in the HIE includes medicines (prescriptions), lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included are identifiers such as your full name, birth date and social security number. All information contained in the HIE is kept private and used in accordance with applicable state and federal laws and regulations. The information is accessible to participating providers to support treatment and healthcare operations such as mandated disease reporting to the Maine Centers for Disease Control and Prevention.

You do not have to participate in the HIE to receive care. For more information about HealthInfoNet and your choices regarding participation, visit www.hinfonet.org or call toll-free 1-866-592-4352.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

_____ Consent for Contact:
With my consent, New England Sport and Spine may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

_____ Consent for text message and/or email contact:
With my consent, New England Sport and Spine may send lab and appointment reminder messages to my through a text message to my cellular phone or email address.
My cell phone number is: _____ Email: _____

Practice Duties – Regarding your health care information
New England Sport and Spine is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

New England Sport and Spine is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights – Regarding their health care information
The patient has the right to request the practice to restrict use and disclosure of protected health information. New England Sport and Spine is not required to agree to the requested restrictions.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to New England Sport and Spine's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, New England Sport and Spine may decline to provide treatment to me.

X_____ _____
Patient's signature **Date**

_____
Patient's Printed Name

_____ _____
Printed name of person signing on behalf of patient **Relationship to patient**

NEW ENGLAND SPORT AND SPINE
CONSENT FOR IMMUNODEFICIENCY VIRUS (HIV) TESTING
FOLLOWING AN ACCIDENTAL EXPOSURE

(To be completed at the NESS office or after communication with provider)

After discussion with _____, I have voluntarily decided to have a sample of my blood drawn for the purpose of having the blood sample tested for the presence of antibodies to the Human Immunodeficiency Virus (HIV). The reason for this testing is that I may have been accidentally exposed to HIV.

I have been informed that HIV has been identified as the causative agent Acquires Immunodeficiency Syndrome (AIDS), and that person infected with HIV may transmit the virus to others. I have also been informed that evidence to date suggests that transmission of the virus takes place only through sexual contact with an affected person, exposure to blood r other bodily fluids (such as through use of contaminated needles), or from an infected mother to her infant or fetus during pregnancy or birth. However, I have also been informed that there is much that is not known about HIV and about it potential for transmitting o for causing AIDS.

I have been informed that the test for HIV is generally accurate. Even so, I understand that a small percentage of individuals tested will have a "false positive" test result, more likely in the early stages of the infection. For that reason, a negative HIV antibody test result does not guarantee that I am not infected with HIV.

_____ has informed me of the risks and benefits associated with the performance of this test. Importantly, a true positive test will indicate that I am at risk for developing AIDS in the future. Among the risks that are generally associated with obtaining a blood specimen are minor bleeding, swelling, or discomfort at the site from which the blood specimen is obtained.

Understanding all this information, I hereby agree to this test in an entirely voluntary fashion. I have not been coerced or induced in any way to have this test performed. There will be no charge to me for this test. I will be informed of my test results. My test results will be maintained in strict confidence in accordance with Maine Law.

NEITHER THE FACT NOR THE RESULTS OF THIS TEST WILL APPEAR IN MY MEDICAL RECORD

DATE:_____ EMPLOYEE SIGNATURE:_____

WITNESS:_____

Initial Visit Patient Questionnaire

Name: _____ Date: _____
DOB: _____ Primary Care Provider: _____
Referring Provider: _____

What brings you here for your visit today?_____

Please tell us more about your pain.

Location of pain	Describe (sharp, dull, shooting, throbbing, aching…)
i.e. Right side of low back	**intermittent; sharp and shooting**

When did the pain begin? _____
Was the onset of pain: (check one) □ sudden or □ gradual?

Trauma history: Have you ever had a significant traumatic injury? □ no □ yes If yes, when? _____
Please give details of injury: _____
_____

Is the pain the result of a work-related injury? □ yes □ no □ unknown
Is the pain the result of an automobile or personal injury claim? □ yes □ no □ unknown

If you have **headaches**, <u>how many days per month</u> have you had them during the past 3 months?
□ 0-5 □ 6-10 □ 11-15 □ 16-20 □ 21-25 □ 26-30 □ more than one a day
Do you have any other symptoms before or during a headache? _____
What brings on, or triggers your headaches? _____

Please circle the **<u>ONE</u>** number on the line below that describes the overall amount of pain you are experiencing <u>today</u>:
no pain ----------worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle the **<u>ONE</u>** number on the line below that describes the <u>worst</u> your pain has been in the last month:
no pain ----------worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle the **<u>ONE</u>** number on the line below that describes the <u>least</u> your pain has been in the last month:
no pain ----------worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Is your pain worse (check the box that <u>best</u> applies):

	at night		in the morning		end of shift/day		hot, humid days
	no difference day or night		wet/cloudy days		cold days		certain time of year

Please circle the number on the line below that describes your ability to sleep at night:

didn't sleep----------fell asleep immediately

a wink **0 1 2 3 4 5 6 7 8 9 10** and slept all night

Check the box that best describes your emotional health (check ONE):

	Happy/cheerful		Optimistic		Anxious		Worried
	Angry		Depressed		Suicidal		Compulsive
	Indifferent		Hopeless		Frustrated		Panicked
	Other (please explain):						

Check the activities that increase your pain

	Getting out of bed		Lifting		Prolonged standing		Sitting
	Bending backwards		Exercising		Leaning forwards		Reaching up
	Lying on back or side		Twisting		Straining		Reaching over
	Coughing/sneezing		Walking		Going downstairs		Long car rides
	Looking up or sideways		Running		Computer work		

What makes your pain better? _____

Can you do the following activities <u>without help</u>?

	YES	**NO**		**YES**	**NO**
Eating			Getting dressed		
Bathing			Get up from the bed or a chair		
Using the toilet					

What tests/treatments have you had for your current problem? **Where?**

_____ _____

_____ _____

Please look at the following Quality of Life Scale and <u>circle ONE number</u> between 0 and 10 that best describes your current level of function.

0	Stay in bed all day; feel hopeless and helpless about life
1	Stay in bed at least half the day; have no contact with outside world
2	Get out of bed but don't get dressed; stay at home all day
3	Get dressed in the morning; minimal activities at home; contact with friends via phone or email
4	Do simple chores around the house; minimal activities outside of home two days a week
5	Struggle but fulfill daily home responsibilities; no outside activity; not able to work/volunteer
6	Work/volunteer limited hours; take part in limited social activities on weekends
7	Work/volunteer for a few hours daily; can be active at least 5 hours a day; can make plans to do simple activities on weekends
8	Work/volunteer for at least 6 hours daily; have energy to make plans for one evening social activity during the week; active on weekends
9	Work/volunteer/be active 8 hours daily; take part in family life; outside social activities limited
10	Go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life

Past Medical History: Please check any conditions you have or have had in the past:

	AIDS/HIV positive		Alcoholism		Anemia		Anorexia
	Appendicitis		Arthritis		Asthma		Bleeding disorders
	Blood clots		Cancer		Diabetes		Drug dependency
	Emphysema		Epilepsy/seizures		Glaucoma		Goiter
	Osteoporosis		Gout		Heart disease		High cholesterol
	High blood pressure		Kidney disease		Liver disease/Hepatitis		Migraines
	Prostate problems		Psychiatric care		Acid reflux (GERD)		Stomach ulcers
	Stroke		Thyroid problems		Irritable Bowel		Depression

Comments: _____
_____

Past Surgical History: Please list all surgeries you have had and the approximate year:
_____
_____
_____
_____
_____
_____
_____
_____

Medications: Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: Are you allergic to any medications/substances? □ no □ yes: _____

Social History: Do you smoke or chew tobacco? □ no □ yes _____ packs per day for _____ years
Did you <u>ever</u> smoke or chew tobacco? □ no □ yes When did you quit? _____
Alcohol intake: □ never □ rare □ occasional; Average number of drinks per day: _____
Do you currently, or have you <u>ever</u> used recreational drugs? □ no □ yes

Occupation (current or previous): _____
Are you working: □ Full-time □ Part-time □ Retired □ Disabled through Social Security, year: _____
□ Not working currently because of pain

Family History: Have your relatives had any of the following medical problems?

Blood Relative	Arthritis	Migraines	Cancer	Joint Problems	Osteoporosis
Mother					
Father					
Brother/Sister					
Children					
Grandparents					

Review of Systems: Please check any problems you are **now having** or have had **repeatedly** in the last month

	Fatigue		Fever		Weight Change		Weakness
	Headaches		Dizziness		Head injury		Confusion
	Vision changes		Hearing Loss		Ear aches		Sinus trouble
	Trouble swallowing		Jaw pain		Chest pain/pressure		Shortness of breath
	Rapid heart beat		Irregular heart beat		Calf pain with walking		Swelling of ankles
	Blood clots		Chronic cough		Coughing up blood		Wheezing
	Poor appetite		Heartburn/Indigestion		Belly pain		Diarrhea
	Constipation		Rectal bleeding		Nausea/vomiting		Poor bowel control
	Painful urination		Poor bladder control		Difficulty urinating		Rash/Hives
	Painful/swollen joints		Back pain		Arm or leg pain		Difficulty walking
	Convulsions/seizures		Numbness/tingling		Weakness arms/legs		Difficulty sleeping
	Depression		Anxiety		Excess thirst/urination		Easy bruising/bleeding
	Other (please describe)						

Comments:_____
_____

For women: Date of last menstrual period: _____
History of irregular or painful periods? □ no □ yes

What is your goal for today's visit? _____

You authorize the release of office notes to your primary care physician and referring physician by signing here: _____
Patient Signature

Reviewed by: _____ Date: _____