The Advanced Spine Center

** REQUIRED TO COMPLETE

PATIENT INFORMATION:

LAST NAME**	FIRST NAME**	MI	DATE OF BIRTH**	AGE	SOCIAL SECURITY #
STREET ADDRESS/ P.O. BOX**		CITY**	STATE**	ZIP**	
HOME PHONE	WORK PHONE	CELL PHONE**	SEX** ☐M ☐F	MARITAL STATUS** ☐M ☐W ☐S ☐D ☐CU	
EMAIL ADDRESS**	PHONE # TO BEST CONTACT YOU: ☐Home ☐Work ☐Cell	ETHNICITY** ☐ **Latino/Hispanic** ☐**Other** ☐**Not Reported/Refused**			
PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER**			RACE**		
REFERRING PHYSICIAN, ADDRESS & PHONE NUMBER**			LANGUAGE**		

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME**	FIRST NAME**	MI	DATE OF BIRTH**	SOCIAL SECURITY #	
STREET ADDRESS/ P.O. BOX**		CITY**	STATE**	ZIP**	
EMAIL ADDRESS**	HOME PHONE	WORK PHONE	CELL PHONE**		
EMPLOYER**	EMPLOYER STREET ADDRESS**		CITY**	ZIP**	

EMERGENCY CONTACT:

NAME**	PHONE**	RELATIONSHIP**
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE**	EFFECTIVE DATE**	POLICY HOLDER NAME**	SEX** ☐M ☐F	POLICY HOLDER BIRTHDATE**
POLICY NUMBER**	GROUP NUMBER	RELATIONSHIP TO PATIENT** ☐Self ☐Spouse ☐Parent ☐Child ☐Other		CO-PAY AMOUNT
EMPLOYER**	EMPLOYER STREET ADDRESS**		CITY**	ZIP**

SECONDARY INSURANCE:

PRIMARY INSURANCE**	EFFECTIVE DATE**	POLICY HOLDER NAME**	SEX** ☐M ☐F	POLICY HOLDER BIRTHDATE**
POLICY NUMBER**	GROUP NUMBER	RELATIONSHIP TO PATIENT** ☐Self ☐Spouse ☐Parent ☐Child ☐Other		CO-PAY AMOUNT

PHYSICIAN TREATING YOU TODAY:	REFERRED BY:

IS THIS INJURY/ACCIDENT RELATED TO: ☐ WORK ☐ MOTOR VEHICLE ☐ SCHOOL ☐ OTHER	
DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I the undersigned give my authorization to treat and assign directly to Advanced Spinal Care & Associates LLC "dba: The Advance Spine Center", all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature of patient or patient's representative**

Date**

The Advanced Spine Center

160 E. Hanover Avenue, Suite 201
Morristown, NJ 07960

333 Mount Hope Avenue, Suite 140
Rockaway, NJ 07866

720 US 202/206 North, Bldg. 2
Bridgewater, NJ 08807

Mailing Address: P.O. Box 2266, Morristown, NJ 07962 Phone (973) 538-0900 Fax (973) 538-0909

PATIENT FINANCIAL RESPONSIBILITY, CONSENT & ASSIGNMENT OF BENEFITS FORM

(Revised November 15, 2017)

Date: _____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. As a courtesy, Advanced Spinal Care & Associates LLC "dba: The Advanced Spine Center" agrees to accept the ALLOWABLE amount determined by my insurance carrier for all claims processed properly. For participating insurance plans, I understand that I am responsible for referrals, authorizations and/or any specific requirements to the plan. Information on participation status is available upon request. Also I understand that I am responsible for payment of any co-payment, coinsurance and/or deductible applied against claims submitted whether for in-network or out-of-network benefits. I further understand that it is my responsibility to assure all claims are processed by my carrier and to appeal any claim determined by The Advanced Spine Center to be paid unfairly or inequitable as determined by usual payment received from other carriers for similar services. I also agree to remit payment at the time of the visit or upon receipt of bill for coinsurance / deductible.

I understand that I am financially responsible to The Advanced Spine Center for any charges not covered by health care benefits. It is my responsibility to promptly notify The Advanced Spine Center of any changes in my health care coverage and any other personal or contact information provided to the practice. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by The Advanced Spine Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for professional services received. Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without being paid in full is subject to immediate collection process. Services that are transferred to collection status shall accrue interest at the rate of 1% per month or the maximum rate allowable by law, whichever is less, on any outstanding balance calculated from the date payment was originally due. In the event that payment is not timely made, I understand that The advanced Spine Center may retain an attorney to assist in the collection process; and that I shall be financially responsible for any and all cost and fees incurred by The Advanced Spine Center in collecting or attempting to collect any amounts due and owing, including but not be limited to reasonable attorney fees, costs, and expenses whether or not a lawsuit has been filed. A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds.

_____
Initials

Assignment of Benefits/Consent to Treat

I hereby give my authorization to treat and assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to The Advanced Spine Center, including but not limited to, my right to appeal and sue for reimbursement and benefits. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to The Advanced Spine Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I understand and agree that should my insurance carrier(s), including medicare, private insurance and any other health/medical plan, issue payment direct to me instead of The Advanced Spine Center, all such payments shall be expressly held in trust by me for the benefit of The Advanced Spine Center; and I shall immediately endorse and tender said payment over to The Advanced Spine Center.

I hereby assign my rights, title and interest under the medical expense section and/or PIP section of my insurance policy to The Advanced Spine Center to bring a lawsuit or arbitration against my insurance carrier(s). This allows The Advanced Spine Center to retain an attorney of their choice to filing litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against my insurance carrier, or any other company, against which I may proceed for medical expense benefits. Unless revoked, this assignment is valid for all administrative and judicial reviews under the Patient Protection and Affordable Care Act, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

_____
Initials

Charles A. Gatto, M.D.
Spine Surgery

Jason Lowenstein, M.D.
Pediatric/Adult Scoliosis
Spine Surgery

George S. Naseef, M.D.
Spine Surgery

Authorization to Release Information

I hereby authorize The Advanced Spine Center to: (1) release any information necessary to insurance carriers, their employees and/or agents, regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, including but not limited to filing arbitration/litigation in The Advanced Spine Center's name on my behalf; and (3) allow a photocopy of my signature to be used to process insurance claims.

I further authorize The Advanced Spine Center to release my medical records and/or information regarding my care to the following **friend** or **family member**:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The above authorizations will remain in effect until revoked by me in writing. Any revocation has prospective effect only. I have requested medical services from The Advanced Spine Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I have been informed whether my services will be reimbursed at an out-of-network level. I knowingly, voluntarily and specifically select The Advanced Spine Center as my medical provider.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Name Patient/Responsibility

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, PRINT NAME, by marking [√] (or [x]) and signing below, agree to:

☒ representation by Advanced Spinal Care & Associates, LLC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☒ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

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HIPAA AUTHORIZATION AND ESIGNATURE CONSENT DISCLOSURE

I understand that I (patient), or an authorized representative, must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alphanumeric date (e.g., January 1, 2006) unless the signature is on file. I understand that in lieu of signing the claim, that I may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements" (see. Rev. 10540, 06-11-21)[1] I understand that the authorization is effective indefinitely unless I, or my representative revokes this arrangement. **Note: I understand that this can be a "Signature on File" and/or computer generated.**

I understand that my healthcare plan is required: 1) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care; 2) be comprehensive, requiring minimal augmentation by paper or other communications; and 3) provide for timely acknowledgment response. I understand this also includes but is not limited to status reporting that supports a transparent claims and denial management process (including adjudication and appeals), describing all data elements (including reason and remark codes) in unambiguous terms. (see. Section 1104 ACA)

I understand and acknowledge that the Provider has, to the extent feasible and appropriate, verified eligibility, obtained preauthorization, and informed me of my financial responsibility for specific service(s) prior to or at the point of care consistent the Health Information Technology for Economic and Clinical Health Act. Pub. L. No. 111-5, 1234 Stat. 226 and the Department of Health and Human Services Regulations, 45 C.F.R. § 160 et seq. (collectively, "HIPAA").

I certify that I knowingly, voluntarily, and specifically agreed to the use of my signature on all my insurance and/or employee health care benefit claims submission(s) consistent with the regulations explained to me within this **HIPAA Authorization and Electronic Signature Consent Disclosure**. This includes signatures in compliance with the E-Sign Act and Uniform Electronic Transactions Act. A photocopy, computer generated, or any other reproduction of this signature and assignment/authorization is to be considered valid, and the same as if it was the original.

This form is intended to protect patients from surprise medical bills and increase transparency by requiring certain health care facilities and insurers to disclose certain required information.

Patient Name	Patient Date of Birth	Date

Patient/Authorized Rep Name *(printed)*	Patient/Authorized Rep Signature

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OUT-OF-NETWORK ("OON") SURPRISE BILL PROTECTION DISCLOSURE

DISCLOSURE(S) TO COVERED PERSON(S) REGARDING OUT-OF-NETWORK TREATMENT

Please read carefully before you sign

I certify that I have insurance and/or employee health care benefits coverage which provides both In-Network (INET) and/or Out of Network (ONET) benefits. I certify that I have been informed that the referenced Provider organization and/or its associated Providers are Out-of-Network (ONET) as required under the Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L. 2018, c. 32 ("Act").

I understand and acknowledge that the Act was to limit a covered person's financial responsibility to the network level cost-sharing as applied to the allowed amount/charge when inadvertent and/or involuntary services are rendered by Providers who are not members of a managed care network (i.e., PPO Network).

I understand and acknowledge that "a covered person's cost-sharing liability under the Act is based upon the application of network cost-sharing, not a network level reimbursement amount." (Bulletin NO. 18-14) The transparency and claims processing provisions apply to all carriers operating in New Jersey consistent with the Administrative Simplification provisions mandated under numerous State and Federal healthcare regulations as detailed within this disclosure/notification.

I understand and acknowledge that the Provider has, to the extent feasible and appropriate, verified eligibility, obtained preauthorization, and informed me of my financial responsibility for specific service(s) prior to or at the point of care consistent the Health Information Technology for Economic and Clinical Health Act. Pub. L. No. 111-5, 1234 Stat. 226 and the Department of Health and Human Services Regulations, 45 C.F.R. § 160 et seq. (collectively, "HIPAA").

I certify that I knowingly, voluntarily, and specifically selected the referenced ONET Provider(s) with full knowledge that the provider is ONET with respect to my health benefits plan and consent to the treatment plan the Provider may recommend.

I authorize the use of my signature on all my insurance and/or employee health care benefit claims processing including but not limited to, requesting data, verifying eligibility, adjudication and appeals consistent with section 1104(b)(2) of the Affordable Care Act. This includes signatures in compliance with the E-Sign Act and Uniform Electronic Transactions Act.[1] A photocopy, computer generated, or any other reproduction of this signature and assignment/authorization is to be considered valid, and the same as if it was the original.

I have read this express assignment/authorization and it has been explained to me prior to the Provider submitting my healthcare claims for reimbursement.

Patient Name	Patient Date of Birth	Date

Patient/Authorized Rep Name *(printed)*	Patient/Authorized Rep Signature

Patient Name: _____
Date of Birth: _____
Member ID: _____
Subscriber Employer: _____

HITECH RECORDS REQUEST

Dear Records Custodian:

I write this letter to **Formally Request** an electronic copy of all medical records related to the referenced claim(s) to be sent to the Provider referenced below:

Provider_Group
Provider EDI Department
666 Main Ave, Unit 18
Towaco, NJ 07082-6616
Email: curesactsupport@providerehi.com

The HIPAA Privacy Rule gives individuals the right to access, upon request, the medical and health information (protected health information or PHI) about them in one or more designated record sets[1] maintained by or for the individuals' health care providers and health plans (HIPAA covered entities). [45 CFR 164.524]

Importantly, The Health Information Technology for Economic and Clinical Health Act (HITECH Act), 42 U.S.C.A.§17935(e)(1), and its implementing regulations, 45 CFR 164.524(c)(3), provides that "if requested by an individual, a covered entity must transmit the copy of protected health information directly to another person designated by the individual." Further, please note that the HITECH Act requires you to provide the requested records within thirty (30) days of receiving this request. 45 CFR 164.524(b)(2).

If any of the records are available only as paper copies, and have never been made into an electronic format, please identify each such record. Pursuant to the HITECH ACT, your entity may only charge a fee that "shall not be greater than the entity's labor costs in responding to the request for the copy". 42 U.S.C.A. §17935(e)(2). Notably, the HITECH Act preempts any contrary provisions for state law regarding incurred costs for making copies of paper medical records.

The HITECH Act and its regulations do not allow you to bill for paper copies when an electronic copy has been requested. Please understand that I have authorized the referenced Provider to file complaints with the Department of Health and Human Services (HHS) if the Plan/Payer and/or agents acting on their behalf violate the law by either improperly applying the paper medical records copying charge rate for electronic records and/or fail to provide the requested records within the required timeframe.

I authorize the Plan/Payer and/or agent(s) acting on their behalf to communicate directly with the referenced Provider regarding all issues related to this request, including authorization and the time frame for providing electronic copies of all my medical records related to the referenced claim(s) consistent with State and Federal regulations.

Please know that your cooperation, effort, and time are appreciated.

Sincerely,

_____
Patient Signature

cc: The Advanced Spine Center

[1] Designated record sets include medical records, billing records, payment and claims records, health plan enrollment records, case management records, as well as other records used, in whole or in part, by or for a covered entity to make decisions about individuals [45 CFR 164.501]

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Informed Consent Agreement for Treatment of Intractable Pain with Narcotics (Opioid Analgesics)

I understand that I have a right to comprehensive pain management but, due to the nature of the medications, I would like to enter into a treatment agreement because I would like to prevent chemical dependency as a result of the intake of these medications. I understand that failure to follow any of these agreed statements might result in my physician not providing ongoing care for me.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my day-to-day functioning. I understand that daily use of a narcotic increases' certain risks, which include but are not limited to:

- Addiction
- Nausea, vomiting and constipation.
- Impaired judgment, sleepiness, and confusion.
- Allergic reactions, overdose, and fatal complications
- Breathing problems
- Dizziness
- Impaired ability to operate machines or drive motor vehicles
- Development of tolerance
- Abstinence syndrome (withdrawal) if the medication is stopped abruptly

I agree to the following guidelines:

1. I will take this medication as prescribed by my provider. I will not vary the dosage or interval without authorization from my physician.
2. I will submit to random urine or blood tests if requested by my physician to assess my compliance, and/or to test for the presence of mood altering /illicit/addicting drugs in my system. If I am found to be non-compliant, or if I test Positive for other substance physicians of The Advanced Spine Center will not continue to treat me.
3. I will obtain all my prescriptions for pain medications through my physician and will fill all my prescriptions at _____Pharmacy. In an acute emergency another provider may prescribe medications for me. If this occurs, I will notify The Advanced Spine Center within a week of such an ER visit.
4. I am responsible to make sure that I do not run out of my medications on weekends or holidays, because abrupt discontinuation of these medications may cause severe withdrawal syndrome.
5. Due to the potential for misuse, I know that I will be unable to obtain early refills or replacement of lost or stolen medication. Refills will only be made during regular office hours Monday through Thursday and require 72 hours to process.
6. I agree to see my physicians for on-going case management and will schedule and keep my regular appointments as long as I am taking this narcotic medication.
7. If I do not follow these guidelines, I understand that my treatment may be terminated.

I have discussed the risks, benefits, and alternatives to narcotic treatment with The Advanced Spine Center. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

_____ _____ _____

Patient Signature Date Provider Signature

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Prescription Policy and Refill Request Procedures

Please call 3 business days before your medication is due to be refilled. This will allow us ample time to fulfill your request.

1. Please call the office at (973) 538-0900 between the hours of 9:00am and 4:00 pm Monday – Thursday and Fridays 9:00 – 12:00 Noon.
2. All refills called in after 2:00 pm **will not be** addressed until the next business day.
3. Please give all relevant information whether speaking to a person or leaving a message:
    A. First and last name and your date of birth
    B. Phone number where you can be reached
    C. Name of the medication and dosage information
    D. Pharmacy name and number

    Please be advised that you are to only use 1 pharmacy to fill your medications.
4. Any medications that need to be handwritten may be picked up in the Cedar Knolls office on Fridays. **Prescriptions will NOT be mailed. A valid ID required for pickup.**
5. All patients must have a follow-up appointment scheduled with the doctor within **90 days** when receiving Schedule II narcotics as mandated by New Jersey State Law. All others must have a follow up appointment scheduled as mandated by the doctor.
6. **You may NOT receive narcotics from multiple physicians.**
7. You must take the medication as prescribed by the doctor. You may **NOT** vary the dosage without authorization from the doctor.
8. **Any unauthorized alterations or modifications to a prescription are cause for immediate discharge from the practice.**

    Please note that you are responsible to make sure that you DO NOT run out of your medications on weekends or holidays.

I hereby understand and will comply with the above set refill request and prescription policy. Any violation of the above set rules will result in the immediate cessation of services provided to you by Advanced Spinal Care & Associates LLC ("The Advanced Spine Center".

Pharmacy Name: _____ Pharmacy Phone #: _____

Sign: _____ Date: _____

Doctors Initials: _____

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Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment: In order to be respectful of the medical needs of other patients, please be courteous and call The Advanced Spine Center promptly if you are unable to show up for an appointment. This time will be reallocated to someone who needs treatment. If it is necessary to cancel your scheduled appointment, New Patient's require at least 48 hours advance notice and Established follow-up patients require at least 24 hours advance notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment: To cancel appointments, please call (973) 538-0900. If you do not reach a Patient Advocate, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment within our policy timeframe.

- New Patient cancellation: $150 fee will be billed to your account.
- Follow-Up cancellation: $50 fee will be billed to your account.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- New Patient cancellation: $150 fee will be billed to your account.
- Follow-Up cancellation: $50 fee will be billed to your account.

NOTE: This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. You will never be charged for a cancellation if it is made more than 48 hours in advance of your scheduled appointment time. Thank you for providing our office and our patients with this courtesy. I have read, understand, and agree to abide by the policy above:

Print Name: _____

_____ _____

Signature of Patient (or Responsible Party) Date

Charles A. Gatto, M.D.

NAME: _____ DATE: _____

MRN#: _____ AGE: _____

Please describe your problem: _____

_____

_____

_____

_____

When did this problem start?(approx): _____
Have you had unexpected weight loss?:_____
Does the pain wake you from sleep?:_____
How far can you walk?(city blocks):_____

Was there an injury?: _____
Did this injury result in a lawsuit?: _____
Is your bladder/urine function normal?: _____
Is your bowel/feces control normal?_____

PHYSICIAN ONLY:

Rad Pain- _____

N/P- _____

Weakness- _____

B/B / N/P to A/G- _____

Gait/Bal/Fine Motor Skills- _____

_____

Meds- _____

PT / Chiropractic- _____

Injections- _____

Surgeries- _____

Studies- _____

_____

PE- _____

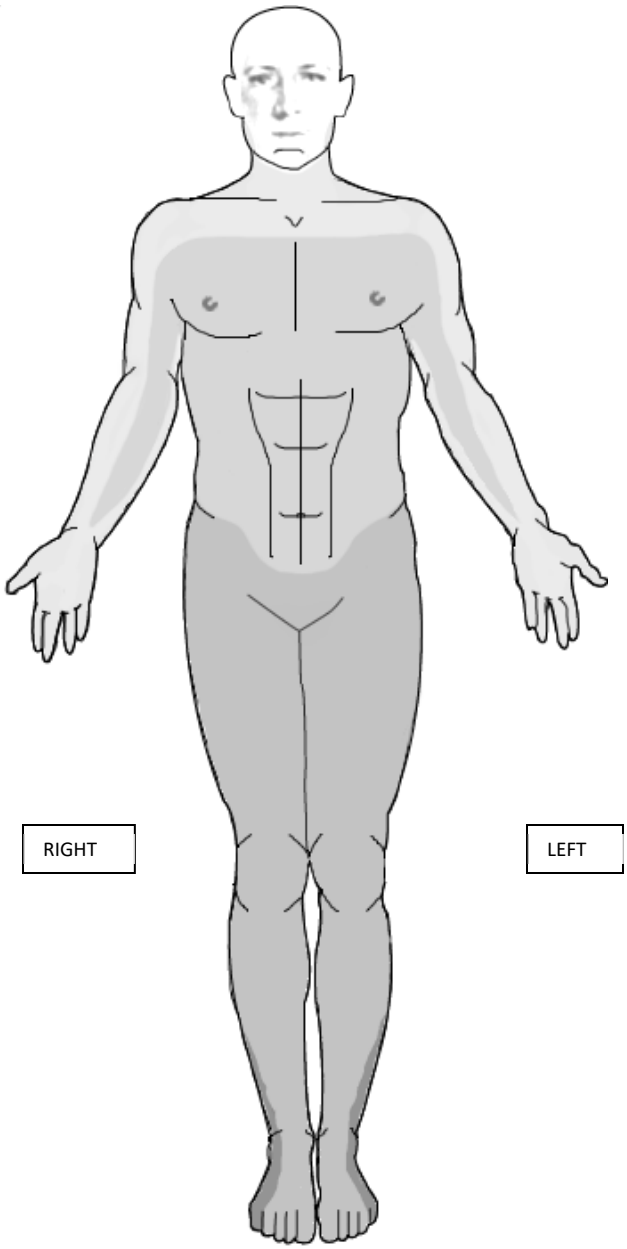
Assessment- _____

Plan: _____

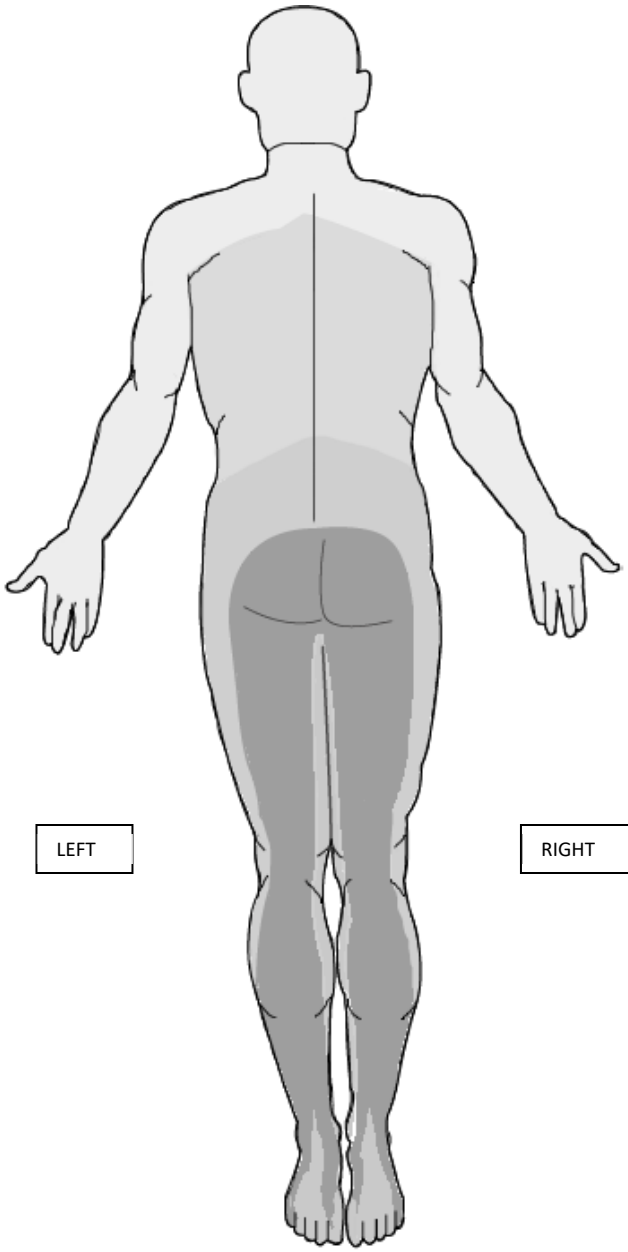
WHERE IS YOUR PAIN NOW?

Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN xxxx BURNING ++++ TINGLING - - - NUMBNESS oooo



FRONT



BACK

My number one problem is:

____ back/neck pain ____ arm/leg pain ____ numbness/tingling ____ weakness

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

GENERAL SYMPTONS: (CURRENTLY OR WITHIN THE LAST YEAR)

- ☐ CHILLS/SWEATS
- ☐ FEVER
- ☐ DIZZINESS
- ☐ HEADACHES
- ☐ RINGING IN EARS
- ☐ BLOOD IN URINE
- ☐ PAINFUL URINATION
- ☐ BLADDER/URINE ACCIDENTS
- ☐ BOWEL/FECAL ACCIDENTS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ INSOMNIA
- ☐ LOSS OF APPETITE
- ☐ LOSS OF WEIGHT
- ☐ HIVES
- ☐ RASH
- ☐ ITCHING
- ☐ SORES
- ☐ EASY BRUISING
- ☐ STOMACH PAIN
- ☐ EXTREME THIRST
- ☐ NAUSEA
- ☐ BLOATING/GAS
- ☐ VOMITING BLOOD

MEN:

- ☐ ERECTILE DIFFICULTIES
- ☐ PENILE SORES
- ☐ PAINFUL INTERCOURSE

WOMEN:

- ☐ MENOPAUSE
- ☐ IRREGULAR MENSES
- ☐ PAINFUL INTERCOURSE

GENERAL CONDITIONS: (NOW OR IN THE PAST)

- ☐ CANCER
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ RHEUMATOID DZ
- ☐ STROKE
- ☐ SEIZURES
- ☐ EMPHYSEMA
- ☐ ASTHMA
- ☐ GOUT
- ☐ STOMACH ULCERS
- ☐ BLEEDING DISORDER
- ☐ ANEMIA
- ☐ ANOREXIA/BULIMIA
- ☐ DEPRESSION
- ☐ PSYCHIATRIC CARE
- ☐ ALCOHOLISM
- ☐ DRUG DEPEND.
- ☐ SERIOUS INFEC.
- ☐ SEX. TRANS. DZ
- ☐ AIDS/HIV

PAST MEDICAL HISTORY: (PROBLEMS/CONDITIONS/DISEASES THAT YOU HAVE OR HAVE HAD IN THE PAST)

- ☐ HEART PROBLEMS _____
- ☐ LUNG _____
- ☐ KIDNEY _____
- ☐ LIVER _____
- ☐ NEUROLOGIC _____
- ☐ RHEUMATOID _____
- ☐ BOWEL _____
- ☐ THYROID _____
- ☐ GENITO-URINARY _____

ANTECEDENT HISTORY: (IF YES: PLEASE DESCRIBE AND GIVE DATES)

PRIOR WORKER'S COMPENSATION INJURIES: ☐ YES / ☐ NO _____

_____

PRIOR MOTOR VEHICLE ACCIDENTS: ☐ YES / ☐ NO _____

_____

PRIOR SYMPTOMS/STUDIES/TREATMENTS/CHIROPRACTOR VISITS: ☐ YES / ☐ NO _____

_____

PAST SURGICAL HISTORY:

SURGERY	DATE	SURGERY	DATE

MEDICATIONS: (CURRENTLY)

NAME DOSAGE NAME DOSAGE

_____

_____

_____

_____

_____

_____

_____

PHARMACY NAME: _____ STREET: _____ TOWN: _____

ALLERGIES: (ESPECIALLY TO MEDICATION)

MEDICATION REACTION MEDICATION REACTION

_____

_____

_____

ARE YOU ALLERGIC TO: ❑ LATEX ❑ NICKEL ❑ NONE

SOCIAL HABITS:

DO YOU SMOKE? ❑_____ HOW MUCH PER DAY? _____

DO YOU DRINK ALCOHOL? ❑_____ HOW MUCH/HOW OFTEN? _____

DO YOU USE OTHER DRUGS? ❑_____ 3RD WORLD COUNTRY TRAVEL? _____

FAMILY HISTORY:

ARE YOU MARRIED? ❑_____

HOW MANY CHILDREN DO YOU HAVE? _____ AGES: _____

DO ANY FAMILY MEMBERS HAVE OR HAVE HAD ANY SIGNIFICANT MEDICAL PROBLEMS? _____

_____

OCCUPATIONAL HISTORY:

DO YOU CURRENTLY WORK? ❑_____ OCCUPATION: _____

WHO REFERRED YOU TO OUR OFFICE?_____

WHO IS YOUR GENERAL PHYSICIAN? _____

TOWN: _____

***** WOMEN: IF YOU MAY BE PREGNANT BE SURE TO TELL THE DOCTOR OR THE TECHNICIAN PRIOR TO ANY X-RAYS. *****

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT'S SIGNATURE: _____ PHYSICIAN'S SIGNATURE: _____