Date: ____________________ CAROLINA NeuroSurgery & Spine MRN: ___________________

First Name: ____________________________ Middle Initial: _______ Last Name: __________________________________

Street Address: ____ City/State/Zip_____________________________________

Home Phone: (___)_________________ Cell/Other: (___)_________________ Email: _______________________________

Sex: ☐M ☐F Date of Birth: ____/____/_____ Primary Language: ________________ Marital Status: _________________

Employer: __________________________________ Address/Phone: ____

Spouse/Responsible Party/Contact Name: _______________________________________ Relationship: _________________

Date of birth: ____/____/_____ Address: ____ Phone: (___)_________________

Doctor to see you today: ________________ Referring Doctor: _________________ Primary Care Doctor: ________________

AGE: ______ PRESENT HEIGHT: ____ ft. ______in. WEIGHT: ______lbs OCCUPATION: _______________________

☐ RIGHT-HANDED? ☐ LEFT-HANDED? DO YOU SMOKE? ☐ Yes, _______ pack/day for _______ yrs. ☐ No

DRINK ALCOHOL? ☐ No ☐ socially ☐ daily ANY HISTORY OF SUBSTANCE ABUSE? ☐ Yes ☐ No

MEDICAL HISTORY

☐ HIGH BLOOD PRESSURE ☐ HEART ATTACKS ☐ LUNG DISEASE (*asthma, COPD, emphysema, etc*)

☐ DIABETES ☐ GASTROINTESTINAL SYMPTOMS (*including peptic ulcer disease, hiatal hernia*) ☐ STROKE

☐ CANCER/TUMORS (*where*) __________________________ ☐ OTHER ____

LIST ALL PREVIOUS OPERATIONS:

DATE: _____________PROCEDURE: ________________________________ PHYSICIAN: _________________________

DATE: _____________PROCEDURE: ________________________________ PHYSICIAN: _________________________

DATE: _____________PROCEDURE: ________________________________ PHYSICIAN: _________________________

ARE YOU ALLERGIC TO ANY MEDICAITONS?

Name of Medication	Reaction
1	
2	
3	

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Name of Medication	Dosage	Frequency	Reason for Taking
1			
2			
3			
4			
5			
6			
7			
8			

Pharmacy Name: _____________________________ Location: _____________________ Phone: (___)_________________

FAMILY HISTORY

MOTHER-AGE ______ HEALTH STATUS ________________ ILLNESSES ______________________________________

FATHER-AGE ______ HEALTH STATUS ________________ ILLNESSES ______________________________________

MEDICAL PROBLEMS IN FAMILY? *(such as diabetes, high blood pressure, neurological disease)* ____________________

____

Have you or anyone in your family been operated on by a physician in this practice? ☐ Yes ☐ No

EXPLAIN IN DETAIL WHAT YOU ARE BEING SEEN FOR TODAY

CHIEF COMPLAINT/SYMPTOMS: ____

DATE SYMPTOMS/PAIN STARTED: _______________ WHAT STARTED THE PAIN? ____________________________

HAVING PAIN IN: ☐ ARM(s) ☐ NECK ☐ LEG(s) ☐ BACK WHAT RELIEVES THE PAIN? ___________________

PAIN LEVEL TODAY ON SCALE OF 0 - 10 (10 = SEVERE, 0 = NO PAIN) ______________

HAS THE PAIN GOTTEN WORSE RECENTLY? HOW? ____

☐ WEAKNESS *(where)* _______________________ ☐ NUMBNESS OR TINGLING (*where*) _________________________

☐ HEADACHES ☐ LOSS OF CONTROL OF BOWEL OR BLADDER (*explain*) _________________________________

☐ COVULSIONS OR SEIZURES ☐ LOSS OF CONSCIOUSNESS ☐ OTHER ___________________________________

RECENT WEIGHT GAIN OR LOSS? ☐ No ☐ Yes (*explain*) ____

REVIEW OF SYSTEMS - Please check the items below if you have had them in the last 6 months

☐ Fever
☐ Night sweats
☐ Infections
☐ Glaucoma
☐ Cataracts
☐ Hearing loss
☐ Ringing in ears
☐ Balance disturbance
☐ Nosebleeds
☐ Inability to smell
☐ Sinus problems
☐ Sore throat
☐ Mouth sores
☐ Chronic cough
☐ Shortness of breath
☐ Bronchitis
☐ Pneumonia

☐ Chest pain/angina
☐ Irregular pulse
☐ Heart murmur
☐ High cholesterol
☐ Swelling in feet or hands
☐ Leg pain while walking
☐ Nausea
☐ Vomiting
☐ Ulcers or gastritis
☐ Liver disease
☐ Jaundice
☐ Abdominal pain
☐ Urinary tract infections
☐ Painful urination
☐ Blood in urine
☐ Difficulty starting or stopping stream

☐ Kidney stones
☐ Endometriosis (females)
☐ Arthritis
☐ Neck pain
☐ Arm weakness
☐ Leg weakness
☐ Back pain
☐ Arm pain
☐ Leg pain
☐ Joint pain or swelling
☐ Skin disease
☐ Breast pain, tenderness, or swelling
☐ Nipple discharge
☐ Disorientation
☐ Difficulty with speech
☐ Double or blurred vision

☐ Coordination in arms and/or legs
☐ Anxiety
☐ Depression
☐ Other psychiatric disorder/treatment
☐ Thyroid disease
☐ Excessive thirst
☐ Anemia
☐ Hemophilia
☐ Bleeding tendencies
☐ Swollen glands/lymph nodes
☐ Food allergies
☐ Inhalant (nasal) allergies
☐ Immunologic disorders

Please explain any checked items: ____

____

All of the information provided is accurate to the best of my knowledge.

____ _______________

Patient/Representative Signature Date

CAROLINA
NeuroSurgery & Spine
ASSOCIATES

Authorization to Discuss Protected Health Information (PHI)

Name ____ Date of Birth ____/____/_____ MRN _____________

PLEASE CHOOSE ONE OF THE OPTIONS BELOW

☐ **I DO NOT** give permission for my protected health information (PHI) to be discussed with anyone other than myself.

OR

☐ **I DO** give Carolina Neurosurgery & Spine Associates authorization to **discuss** my protected health information (PHI) with the individual(s) I have indicated below:

Name	DOB	Relationship	Appointments	Billing/ Financials	Medical Records
1.	___/___/____		☐Yes ☐ No	☐Yes ☐No	☐Yes ☐No
2.	___/___/____		☐Yes ☐ No	☐Yes ☐No	☐Yes ☐No
3.	___/___/____		☐Yes ☐ No	☐Yes ☐No	☐Yes ☐No

***Appointments – c**onfirm any appointment date, time and/or location, reason for visit, and authorization to schedule or cancel visits
***Billing/Financial -** account balance, itemized statements, change billing information, make a payment, etc.
***Medical Record -** includes but is not limited to appointment date and time, verbal disclosure of entire record set including information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral /mental health services, treatment for alcohol/ drug abuse and other conditions.

During emergent and/or extreme situations CNSA may not have access to this authorization, but will make all reasonable efforts to protect your PHI when discussing your care. Please allow up to 5 business days from the date of receipt by CNSA to update your PHI Disclosure information.

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information (PHI) to be disclosed in this document by sending written notification to CNSA. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective moving forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment is not conditional on this document.

I understand that requests for my PHI from any entity other than the individual(s) listed above may require the completion of a separate authorization form as required by Federal and/or State law or as a compliance policy of Carolina Neurosurgery & Spine Associates.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_______________________________________ _______________________
Patient / Authorized Representative Signature Date

_______________________________________ _______________________
Printed name of Authorized Representative Relationship

CAROLINA NeuroSurgery & Spine ASSOCIATES

SUMMARY NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT OF RECEIPT:
Under federal law, Carolina Neurosurgery & Spine Associates, P.A. ("CNSA") is required to protect the privacy of certain parts of your protected health information ('"PHI"') we hold in our files. CNSA is required to give you a notice (referred to as our "Notice of Privacy Practices") of our legal duties and privacy practices concerning the permitted uses and disclosures of your PHI and your rights regarding our use and disclosure of your PHI. You have the legal right to review our Notice of Privacy Practices before you sign the consent and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change and you may obtain a copy of the revised notices by accessing our website (www.cnsa.com) or contacting CNSA's Privacy Officer. You have a right to request us to restrict how we use and disclose your PHI for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement with you. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI on reliance on your consent. By signing this form you are granting consent to CNSA to use and disclose your PHI for the purposes of treatment, payment, and health care operations.

FINANCIAL POLICY:
Unless prior arrangements have been made, by either yourself or your insurance carrier, full payment is due at time of service. For your convenience, we accept Visa, MasterCard, and Discover. If you have Medicare coverage, you will receive a statement after Medicare has processed and paid your claim. We will bill plans with which we have a prior agreement and will collect required co-payments at the time of service. If your health plan determines a service to be "not covered", you will be responsible for complete payment or remaining balance upon receipt of a statement from our office. If you are covered by an insurance plan with which we DO NOT have an agreement, we will prepare and send a claim to your insurer who will send the payment directly to you. Therefore, charges for your care and treatment will be due at the time of service. Our office will also bill your health plan for all services we provide in the hospital and payment of any balance is due upon receipt of a statement from our office. Co-payments are due at the time of service. As stated in our contract with your insurance company, we are not permitted to bill you for these services. Failure to pay these co-payments may result in your account being turned over to an outside collection agency. This action will not compromise your medical care. Authorization from insurance companies may be required in order to receive full benefit coverage and must be received by our office prior to your visit. If you are not sure if authorization is required for your plan, please contact your insurance company. Failure to provide CNSA with proper authorization may result in delay or rescheduling your appointment, and makes you responsible for payment for all services related to your visit.

PAIN MEDICATION & PRESCRIPTION POLICY:
CNSA specializes in both surgical intervention and pain management services. For surgical patients, CNSA can only provide pain medication to relieve pain prior to surgery and for a predetermined period of time to assist with recovery from surgery, wherein the amount of medication will be gradually reduced to help the patient avoid dependency of the drug. Although our surgeons may provide pain medication for short-term management of acute flare-ups, they will not provide long-term pain management services. If surgery is not required or if long-term pain management is required, you will be referred back to your primary care physician or to a pain management specialist. For both our surgical and pain management patients, pain medication is to be taken as prescribed. Patients are not to increase medication dosages without consulting their physician at CNSA. Improper use of medications can lead to the termination of the physician-patient relationship. In order to carefully review all patient records, we require a 48-hour advanced notice for prescription refills, which cannot be filled in the evening, on weekends, or on holidays. Refill requests can only be accepted during regular office hours. Since individual physician’s office hours may vary, please check with our staff to ensure you are aware of your physician’s office hours.

NO SHOW POLICY:
CNSA understands that situations arise in which you must cancel your appointment. We request that if you must cancel your appointment that you provide at least 24 hour notice. This will improve access to your providers by allowing other patients to be scheduled in your appointment time. When cancellations are made with less than 24 hour notice, we are unable to offer that time to other patients. Patients who cancel with less than 24 hour notice will be considered a “No Show” and may be subject to a $50 rescheduling fee and possibly dismissed from the practice. The rescheduling fee is the sole responsibility of the patient and must be paid in full before an appointment will be rescheduled. We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellations and no show fees should be directed to the Office Manager.

I hereby acknowledge that I have been provided the Summary Notice of Privacy Practices and a copy of the Notice of Privacy Practices. I have read and understand the Financial Policy set forth by CNSA, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice. I have read, understand, and agree to the above stated Pain Medication & Prescription Policy and No Show Policy.

Name of Patient (please print): ______________________________ MRN: ______________

Signature of Patient/Responsible Party: ______________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________