Name:
DOB:
Chart:
Age:
Date:

Southern BRAIN & SPINE

RECORD RELEASE AUTHORITY

I, Erx Test Patient, hereby authorize Southern Brain & Spine to release such information as necessary and proper for completion of insurance claims, liability or compensation reports on me as deemed fit and proper. I, Erx Test Patient, do also authorize communication, either written or verbal, about my medical condition to the party referring me for neurosurgical evaluation.

I do understand that this release remains in effect until terminated by patient or legal guardian, in writing. A photocopy of this can be considered as valid as an original.

Records to be released to the following:

Primary Care Physician: _____

Treating Physician(s): _____

_____

Referring Physician: _____

Worker's Comp. Carrier: _____

Attorney: _____

Family Member / Other: _____

X _____ _____

Patient Signature or Legal Representative **Date**

_____

SBS Employee / Witness

Name:
DOB:
Chart:
Age:
Date:

Southern BRAIN & SPINE

NOTICE FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PRIVACY NOTICE
Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: Southern Brain & Spine ("Clinic") is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of Clinic. Personal health information may be disclosed to the government or other third party payers for the purpose of obtaining payment for services provided. Clinic may also use personal health information to carry out Clinic day to day operations such as scheduling, quality review and appointment reminders. You agree that Southern Brian & Spine may request and use your prescription drug history from other healthcare providers and third party pharmacy benefit payors for treatment purposes. A list of other examples of disclosures can be obtained from the Privacy Officer upon request.

Required Authorization: Clinic will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.

Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45CFR Parts 160 and 164 (the "Privacy Regulations"), Clinic has adopted privacy policies regarding usage of patient's personal health information. Clinic is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patient's right to privacy.

Additional Information: For additional information regarding Clinic's privacy policy for a copy of this notice, please contact our Privacy Officer. Clinic reserves the right to change this Notice and to make the revised and changed notice effective for medical information that Clinic already has about you, as well as any information Clinic receives in the future. We will post a copy of the current notice in Clinic. The notice will contain the effective date.

The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Patient Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

Southern BRAIN & SPINE

PERSONAL MEDICAL HISTORY (CONFIDENTIAL)

NAME _____
DOB _____ AGE _____ SEX: _____
ADDRESS _____
CITY _____ STATE/ZIP _____
SOCIAL SECURITY # _____
HOME PHONE _____
CELL PHONE _____
WORK PHONE _____
EMAIL _____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED

EMPLOYMENT STATUS:
EMPLOYED / RETIRED / UNEMPLOYED / OTHER:
OCCUPATION/EMPLOYER ADDRESS _____

I AM CURRENTLY TAKING AN ANTICOAGULANT:
COUMADIN ASPIRIN PLAVIX BLOOD THINNER
NONE

I HAVE TAKEN STEROIDS/CORTISONE IN THE PAST SIX MONTHS YES / NO

I AM: RIGHT HANDED LEFT HANDED

INJURY RELATED TO: MOTOR VEHICLE / JOB
OTHER: _____

DATE OF INJURY _____

I AM BEING REPRESENTED BY AN ATTORNEY? YES / NO

ALLERGIC REACTION, INCLUDING RASH OR FAINTING, TO ANY OF THE FOLLOWING DRUGS:
NONE PENICILLIN SULFA ANTIBIOTICS _____
CODEINE DEMEROL MORPHINE ASPIRIN DARVON
DARVOCET VICODIN LORCET PERCODAN / PERCOCET
IODINE OR OTHER XRAY CONTRAST DYES DIURETICS
ANTICONVULSANTS (DILANTIN, PHENOBARBITAL, TEGRETOL, DEPAKOTE)
NONSTEROIDAL ANTI INFLAMMATORY DRUGS LATEX ALLERGY
OTHER DRUG / FOOD ALLERGIES _____

EMERGENCY CONTACT _____
EMERGENCY CONTACT PHONE _____
REFERRAL FROM _____
PRIMARY CARE PHYSICIAN _____
SEND MEDICAL REPORT TO ABOVE DR YES / NO

I HAVE SEEN THIS DOCTOR IN THE PAST:
DR. MANISH SINGH DR. JUSTIN LUNDGREN DR. RAND VOORHIES
DR. EVERETT ROBERT DR. NAJEEB THOMAS NONE
DR. KEVIN MARTINEZ DR. DERRICK UMANSKY

I AM BEING SEEN TODAY FOR _____

I HAVE BEEN TREATED WITH THE FOLLOWING:
PHYSICAL / OCCUPATIONAL THERAPY CHIROPRACTOR BRACING
PAIN MANAGEMENT SPINAL INJECTION NONE
OTHER _____

I HAVE BEEN TESTED WITH THE FOLLOWING:
XRAYS CT SCAN MRI MYELOGRAM
EMG / NERVE CONDUCTION STUDY NONE
OTHER _____

I HAVE HAD THE PAST MEDICAL ISSUES:
NONE HEART DISEASE HYPERTENSION (HIGH-BP) PNEUMONIA ASTHMA
HAY FEVER TUBERCULOSIS OR POSITIVE SKIN TEST ANEMIA
BLEEDING TENDENCIES HISTORY OF BLOOD TRANSFUSION
CHRONIC LUNG DISEASE SKIN PROBLEMS HIATAL HERNIA
PEPTIC ULCER COLON PROBLEMS KIDNEY PROBLEMS
LIVER DISEASE HEPATITIS / JAUNDICE SLEEP APNEA GOUT
SPINE PROBLEMS / DISC RUPTURE PSYCHIATRIC PROBLEMS THYROID
GERD NEUROLOGICAL DISEASE BACK PAIN NECK PAIN
HEAD INJURY / CONCUSSION HIV / AIDS CANCER / TYPE: _____
DIABETES OTHER _____

I HAVE HAD THE PAST SURGICAL PROCEDURES:
NONE GALL BLADDER COLON SURGERY BREAST SURGERY
HEART SURGERY HYSTERECTOMY PROSTATE CARPAL TUNNEL
TONSILS / ADENOIDS C-SECTION APPENDECTOMY KNEE SURGERY
BLOOD VESSEL SURGERY HEMORRHOIDECTOMY HERNIA REPAIR
SPINAL SURGERY _____ OTHER _____

Name:
DOB:
Chart:
Age:
Date:

Southern BRAIN & SPINE

REVIEW OF CURRENT PROBLEMS OF NEUROLOGICAL SYSTEM:

NONE

HEADACHES	LOSS OF HEARING / TINNITUS
MEMORY LOSS	LOSS OF TASTE
CONFUSION	PERSONALITY CHANGES
LOSS OF SMELL	SPEECH PROBLEMS
NIGHT SWEATS	HOARSENESS / VOICE CHANGES
FAINTING / SYNCOPE	WALKING / GAIT DIFFICULTY
VERTIGO / DIZZINESS	SEIZURES / EPILEPSY
RECENT FEVER / CHILLS	VISION CHANGES / HEARING DISORDERS

DO YOU FEEL THAT YOU ARE TENSE OR HIGH STRUNG PERSON? YES / NO

DO YOU FEEL THAT HOME OR WORK IS UNPLEASANT? YES / NO

DO YOU HAVE DIFFICULTY MAKING UP YOUR MIND? YES / NO

DO YOU HAVE PERIODS OF DEPRESSION OR MELANCHOLY? YES / NO

DO YOU HAVE PERSISTANT FEARS? YES / NO

ARE YOU INCLINED TO WORRY EXCESSIVELY? YES / NO

ARE YOU EASILY IRRITATED OR UPSET? YES / NO

ARE YOUR FEELINGS EASILY HURT? YES / NO

ARE EMOTIONAL PROBLEMS IMPORTANT IN YOUR PRESENT ILLNESS? YES / NO

HAVE YOU HAD THE PNEUMONIA VACCINE? YES / NO

GENERAL REVIEW OF CURRENT PROBLEMS:

NONE

RECENT BLEEDING PROBLEMS	CHANGE IN APPETITE
CHRONIC SORE THROAT	WEIGHT LOSS
CHRONIC COUGH / ASTHMA	BLADDER/URINARY SYMPTOMS
SHORTNESS OF BREATH	CHRONIC SKIN PROBLEMS
CHRONIC FATIGUE/TIREDNESS	JOINT PROBLEMS
STOMACH/INTESTINAL PROBLEMS	CHANGE IN BOWEL HABITS
DEPRESSION	HIGH BLOOD PRESSURE / CHEST PAIN / IRREGULAR HEART BEAT
DIABETES	
INFECTION	LOSS OF SENSATION
UROLOGIC PROBLEMS	

HEIGHT: _____ WEIGHT: _____

DO YOU SMOKE, VAPE, OR USE MARIJUANA YES / NO

IF YES, HOW OFTEN AND APPROXIMATE YEAR YOU STARTED

_____

DO YOU USE ALCOHOL? YES / NO

HOW OFTEN? _____

FAMILY HISTORY: ☐ UNKNOWN

	FATHER	MOTHER	SIBLING	NONE
HEART DISEASE				
CANCER				
DIABETES				
BLEEDING				
TB				
HYPERTENSION				
STROKE				
SEIZURE/ EPILEPSY				
MIGRAINE				
KIDNEY DISEASE				

You and any one attending the appointment with you are not permitted to audio or video record any portion of your visit to Southern Brain & Spine ("SBS") without the expressed written consent of SBS.

Please silence all electronics before entering the exam room.

_____
Patient Signature / Date

PATIENT or GUARANTOR SIGNATURE _____ **DATE** _____

The above is true and correct to the best of my knowledge.

PHYSICIAN SIGNATURE _____ **DATE** _____

I have reviewed the history with the patient.

Name:
DOB:
Chart:
Age:
Date:

Southern BRAIN & SPINE

FINANCIAL RESPONSIBILITY

I acknowledge that I have been given a copy of my rights and protections against surprise medical bills

1. Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier. If you have obtained health insurance, your insurer may pay some or all of those charges on your behalf, depending upon the coverage purchases. Pre-authorization by your health plan is not necessarily a guarantee of payment. Plans review the claim to determine eligibility and benefits for the services before payment is made.

2. Each health plan establishes its own rules and definitions of what is medically necessary of reimbursement by the plan and what is excluded from coverage. This may not be consistent with your expectations or reimbursement from prior visits and may not have been communicated to us or to you before your services are rendered. Accordingly, your health plan may or may not pay for all services you receive.

3. Your insurance company may also determine that your plan requirements were not met or that an approved service provider was not used. You are welcome to receive care or testing but you will be financially responsible if your health plan reduces or denies benefits because the provider you see is not a participating provider.

4. We will submit a claim on your behalf and advise if your health plan determines some or all of your care or testing is not eligible for coverage. You are financially responsible for charges your health plan determines are not covered.

5. If your insurance carrier has not responded to a claim within 45 days, we reserve the right to formally transfer all associated liability for the claim to you. Failure to promptly resolve this balance may result in third party collection and/or legal procedures to be taken.

6. Unless arrangements have been made in advance, **co-payments, co-insurance, and any outstanding balances are expected at the time of service.**

7. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.

8. Any check returned from the bank will result in an additional $39 charge that will appear on your account.

9. You are responsible for notifying our office of any change in name, address, phone, of insurance information.

PATIENT or GUARANTOR SIGNATURE _____ **DATE** _____

The above is true and correct to the best of my knowledge and I understand my financial responsibility.

Name:
DOB:
Chart:
Age:
Date:

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital, you are protected from surprise billing or balance billing

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing. "This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out of-network providers and facilities directly.
- Your health plan generally must:
  - o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - o Cover emergency services by out-of-network providers.
  - o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - o Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Southern Brain & Spine billing department at 504-454-0141 or CMS at 1-800-985-3059 or visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Name:
DOB:
Chart:
Age:
Date:

Southern Brain & Spine, LLC.
NECK, BACK, and other SPINAL PROBLEMS
McGILL PAIN QUESTIONNAIRE, PAIN DRAWING, and PROLO SCORE
(Functional Self-Assessment)

Name:

Patient #:

PLEASE COMPLETE THIS FORM AT EACH VISIT:

Date:

IN ORDER TO HELP US UNDERSTAND YOUR PAIN, PLEASE CHECK A BOX FOR EACH ROW LISTED BELOW

	NONE	MILD	MODERATE	SEVERE
THROBBING				
SHOOTING				
STABBING				
SHARP				
CRAMPING				
GNAWING				
HOT - BURNING				
ACHING				
HEAVY				
TENDER				
SPLITTING				
TIRING - EXHAUSTING				
SICKENING				
FEARFUL				
PUNISHING - CRUEL				

10

0 No Pain	1	2	3	4	5	6	7	8	9	Pain as Bad as you can imagine

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES HOW BAD YOUR PAIN IS ON AVERAGE FOR YOUR **SPINE PAIN** (NECK, MID-BACK, or LOW-BACK PAIN)

10

0 No Pain	1	2	3	4	5	6	7	8	9	Pain as Bad as you can imagine

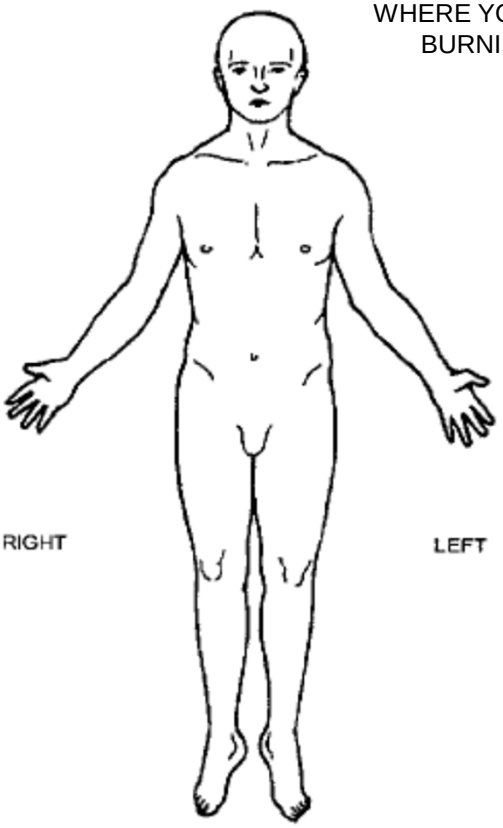
PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES HOW BAD YOUR PAIN IS ON AVERAGE FOR YOUR **EXTREMITY** (ARM and HAND, and/or LEG and FOOT)

Rand M Voorhies, MD
9/06/06

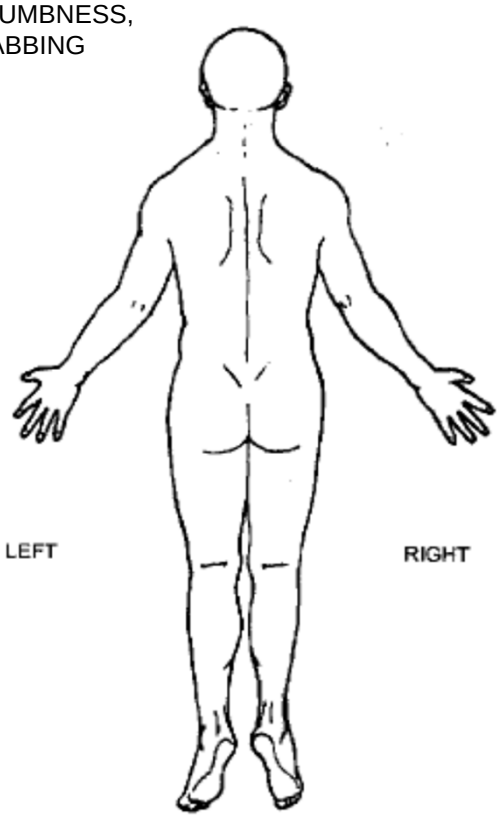
BC

Name:
DOB:
Chart:
Age:
Date:

PLEASE MARK THE AREAS OF YOUR BODY
WHERE YOU ARE FEELING PAIN, NUMBNESS,
BURNING, THROBBING, OR STABBING



Please Use These Symbols:
PAIN XXXX
NUMBNESS 0000
BURNING ////
THROBBING ####
STABBING >>>>



Check the box that most closely describes your ACTIVITY

- ❑ COMPLETE INVALID (confined to the home)
- ❑ NO GAINFUL OCCUPATION (including no housework and no retirement or leisure activities)
- ❑ ABLE TO WORK BUT NOT AT YOUR PREVIOUS JOB (nor do the same types of housework or take part in all of your previous recreational activities or pastimes)
- ❑ WORKING AT PREVIOUS JOB BUT ON A PART-TIME OR LIGHT DUTY STATUS (same kind of housework or retirement activities as before, but reduced in the amount of time and effort)
- ❑ ABLE TO WORK AT PREVIOUS JOB (or do other things) WITH NO RESTRICTIONS OF ANY KIND)

Check the box that most closely describes your PAIN

- ❑ SEVERE PAIN (cannot do anything somebody has to help you day to day)
- ❑ MODERATE LEVEL OF PAIN (able to take care of yourself without help, but can't do anything else)
- ❑ LOW LEVEL OF PAIN (able to do everything except sports, physically demanding leisure activities, or heavy housework)
- ❑ NO PAIN NOW, BUT YOU HAVE HAD ONE OR MORE SPELLS OF PAIN RECENTLY
- ❑ COMPLETE RECOVERY, NO PAIN, ABLE TO PERFORM PREVIOUS SPORTS ACTIVITIES

Patient Signature _____ Date _____

BC

Name:
DOB:
Chart:
Age:
Date:

MEDICATIONS LIST FORM

Please list all prescription and over the counter medications, vitamins and natural supplements.			
Medication Name	*Strength*	*Dosage (How you take the meds)*	*Reason you take this drug*

You MUST provide the below info:

Pharmacy Name and Address	Pharmacy Phone Number