PATIENT NAME	PATIENT DATE OF BIRTH	TODAY'S DATE

INJURY INFORMATION			
	CIRCLE ONE:		
ARE YOU HERE TODAY FOR AN INJURY?	YES NO	DATE OF INJURY	
ARE YOU HERE TODAY FOR A WORK-RELATED INJURY?	YES NO	TYPE OF INJURY	
ARE YOU HERE TODAY FOR A MOTOR VEHICLE INJURY?	YES NO		
DO YOU HAVE A WORKER'S COMPENSATION CLAIM?	YES NO	IF YES, PLEASE LIST CARRIER INFORMATION:	
DO YOU INTEND TO FILE A WORKER'S COMPENSATION CLAIM? OR ARE YOU APPEALING A WC DENIAL?	YES NO		

CARRIER:	CARRIERS CLAIM #:	TWICC #:
CARRIER ADDRESS:		ADJUSTER:
TREATING PHYSICIAN:		EMPLOYER AT THE TIME OF INJURY:
TREATING PHYSICIAN ADDRESS:		PHONE #:
IS AN ATTORNEY INVOLVED IN YOUR CASE? YES NO		IF YES, PLEASE LIST INFORMATION:
ATTORNEY NAME:	ATTORNEY PHONE #:	
ATTORNEY ADDRESS:		

CONSENT FOR TREATMENT

Please initial each section indicating you have read, accept and understand the information. Please sign below

_____	I voluntarily consent to receive medical and healthcare services provided by Precision Spine Care (PSC), including doctors, assistants, and other healthcare providers such as Nurse Practitioners (NP) or Physician Assistant (PA) as deemed necessary. I understand that medical services provided by PSC might include diagnostic procedures, examinations, and/or treatment. I acknowledge that no warranty or guarantee has been made to me as a result or cure of any treatments.
_____	I acknowledge that a NP/PA may provide medical services that are within his or her scope of training, education, and experience, in collaboration with and under the supervision of a medical doctor. PSC believes that this collaborative approach helps provide exceptional healthcare. NP/PA are permitted to perform minor procedures, assess, diagnose, and treat. I consent to services rendered to me by PSC staff, Medical Doctors, NP and/or PA, and I understand that I may request to see a Medical Doctor at any time. This request may require rescheduling my appointment.
_____	I understand that this consent to treatment will remain valid and in effect while under the care of Precision Spine Care, unless revoked by me in writing. I understand that it is my right to refuse treatment and my responsibility to inform my caregiver of that choice.

By signing below, I confirm that I have read, acknowledge, and consent to the all of the above.

Patient or Legal Representative Signature	Date	Printed Name
x		
Witness Signature	**Date**	**Printed Name**
x		

PATIENT NAME	PATIENT DATE OF BIRTH	TODAY'S DATE

PATIENT FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
Please initial each section indicating you have read, accept and understand the information. Please sign below

_____	I understand that I, as the patient, or patient's responsible party, am ultimately responsible for services rendered by PSC, the physicians, and providers. I will honor the physician's office payment policy. If unable to pay in full at the time of service, the office may ask others of my creditworthiness. I agree to pay all expenses related to collection efforts, whether by collection agency and/or attorney and any returned check fees or similar.
_____	I understand that insurance coverage is not a guarantee of payment. All estimates of patient portions are true estimates and actual balances owed, may vary. I understand that it is my responsibility to comply with the pre-certification requirements and PCP referral requirements of my insurance. I will notify PSC if my insurance has a required, preferred laboratory or other ancillary service providers prior to service. I understand that payment is expected at time of service.
_____	If I have provided Medicare as a payment source for my treatment, I certify that the information provided by me with regards to Medicare payments is accurate. I assign Medicare benefits payable for physician and provider services to the physician and provider. I am responsible for any health deductibles and co-insurance.
_____	If I have provided insurance information or Worker's Compensation information as a payment source for my treatment, I certify that the information provided by me with regards to insurance coverage is accurate. I irrevocably assign and transfer benefits payable for physician and provider services to the physician and provider offices for all services provided. I am responsible for any health deductibles, co-payments, and co-insurance.
_____	I understand that PSC reserves the right to reschedule or cancel my appointment if I am more than 15 minutes late and that PSC reserves the right to charge an administrative cancellation fee up to $150 for any appointments not kept (no-shows) or cancelled with less than 24 hours notice.

PSC PHYSICIANS INVESTED IN YOUR FUTURE:
Industry and Facility Relationships

Our physicians have invested in cutting-edge advancements in patient care options through research programs, new technologies and the development of new medical products and devices that improve patient care. The surgeons and pain management physicians work with companies to help create and improve products and they are sometimes compensated for their intellectual efforts and their time; this is a standard industry practice and must be disclosed. They participate as consultants, serve on advisory boards and on Board of Directors. Their compensation may include various forms including, but not limited to consulting fees and royalty interest payments. Some of the products or devices may be used in your medical treatment; however, the decision to use a specific device is made based upon what is in your best medical interest. PSC patients have the option to choose their preferred health care facility or provider.

Should you have any questions about a company, product, or your physician's relationship with a potential company, please feel free to ask your physician. The following is a current list of companies with whom one or more PSC Physicians has a financial interest:

LDR Spine	Flexuspine	Zimmer Spine	Exxatech, Inc	St. Jude Medical, Inc.	Stim Wave
Bone Buddies	Wenzel Spine	SI Bone, Inc	RTI Surgical	Suture Concepts	Vertos
Medtronic, Inc.	Boston Scientific	Apex Biologics	Nevro	Stryker Spine	Texas Spine and Joint Hospital

By signing below, I confirm that I have read, acknowledge, and consent to all of the above.

Patient or Legal Representative Signature	**Date**	**Printed Name**
x		
Witness Signature	**Date**	**Printed Name**
x		

Patient Name	Patient Date of Birth	Today's Date

NOTICE OF PRIVACY PRACTICES, RELEASE OF INFORMATION AND HIPAA COMPLIANCE
Please initial each section indicating you have read, accept, and understand the information. Please sign below

_____	I understand that PSC is required by federal and state laws to maintain the privacy of my protected health information and to notify me of any changes to the Privacy Practice. I acknowledge that PSC has offered me with a written copy of the Notice of Privacy Practices, and I **ACCEPTED / DECLINED** a copy. (Please circle one). I have been afforded the opportunity to read the NPP and ask questions.
_____	I hereby give PSC permission to send a copy of my medical records for continuing professional care to my referring physicians, my insurance company, workers compensation carrier and/or my attorney if applicable. I understand that it is the policy of PSC to restrict access to my Protected Health Information as required by law and that those records will only be accessed by parties or disclosed to parties that have a legitimate need under their job duties (such as insurance processing, etc). I release PSC and affiliates from any liability for the release of this information, which includes disclosures of blood tests, HIV tests, and other diseases, indefinitely.
_____	I authorize Precision Spine Care to share the following Protected Health Information with the individual(s) listed below. PSC may routinely request an update to this information; however, I understand it is my responsibility to notify PSC in writing should this authorization change at any time in the future. This list is not exhaustive, and my information may be shared with other individuals or entities as needed for my care or as authorized by me on other forms. ☐ Clinic and Physician Staff Documentation ☐ Laboratory and Diagnostic Imaging Results ☐ Sensitive Information (Mental Health, STD, etc.) ☐ Medications ☐ **All Medical Records** **Authorized recipient: _____ Relationship: _____** **Authorized recipient: _____ Relationship: _____** **Authorized recipient: _____ Relationship: _____**
_____	PSC may transmit my health information electronically with healthcare providers to facilitate my care. I understand that if I wish to revoke the option, I may request the form to do so. I authorize PSC to transmit my prescriptions electronically to the designated pharmacy of my choice and to retrieve a record of my prescription history and maintain this history in my health record.
_____	Confidential patient information **MAY / MAY NOT** (please circle one) be left on my voicemail or answering machine.
_____	I authorize PSC to send me appointment reminders via automated SMS text messages, phone calls and emails, and I understand messaging fees may be applied by my carrier. I authorize PSC and third-party collection agents to utilize all contact information I have provided in efforts to communicate with me regarding my account and owed balances, in compliance with state and Federal laws. I agree to be contacted through text, phone, mail and/or email and will notify in writing should this authorization be revoked. I understand that I can opt-out and will do so if desired.

By signing below, I confirm that I have read, acknowledge, and consent to the above.

Patient or Legal Representative Signature	Date	Printed Name
x		
Witness Signature	**Date**	**Printed Name**
x		

Patient Name	Patient Date of Birth	Today's Date

Medical History

- ☐ Anemia
- ☐ Anesthetic Complications
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cardiac Arrhythmia
- ☐ Cardiovascular Disorder
- ☐ Carpal Tunnel Syndrome
- ☐ Cerebral Atherosclerosis
- ☐ Cataract
- ☐ COPD
- ☐ Intervertebral Disc Degeneration
- ☐ _____
- ☐ CPAP dependency
- ☐ Diabetes
- ☐ Depression
- ☐ Hypercholesterolemia
- ☐ Fibromyalgia
- ☐ Bladder Disorder
- ☐ Migraine
- ☐ Emphysema
- ☐ Hypertension
- ☐ Gastrointestinal Disorder
- ☐ Gout
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Hepatitis / Liver Disease
- ☐ Peripheral Nerve Disease
- ☐ _____
- ☐ Seizure Disorder
- ☐ Herniated Intervertebral Disc
- ☐ Kidney Disorder
- ☐ Meningitis
- ☐ Tremor
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ History of Pneumonia
- ☐ Psychiatric Disorder
- ☐ Lupus
- ☐ Thyroid Disease
- ☐ Tumor
- ☐ Chronic UTI
- ☐ Claustrophobic
- ☐ _____
- ☐ _____

Surgical History

- ☐ Aneurysm Clipping
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthrodesis
- ☐ Arthroscopy
- ☐ Cardiac Surgery
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cerebral Shunt
- ☐ Cervical Spine Surgery
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Coronary Artery Bypass Grafting
- ☐ _____
- ☐ Defibrillator
- ☐ Eye / Ear Implants
- ☐ Gastric Bypass
- ☐ Heart Valve / Stent
- ☐ Hemorrhoidectomy
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Replacement
- ☐ Kyphoplasty
- ☐ Laminectomy
- ☐ LASIK
- ☐ Lumbar Spine Surgery
- ☐ Microdiscectomy
- ☐ Mastectomy
- ☐ _____
- ☐ ORIF
- ☐ Pacemaker
- ☐ Prostatectomy
- ☐ Shoulder Replacement
- ☐ SI Fusion
- ☐ Small Bowel Resection
- ☐ Spinal Cord Stimulator
- ☐ Spinal Infusion Pump
- ☐ Other Pump: _____
- ☐ Thoracic Spine Surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Cancer Treatment – Type: _____
- ☐ Metal in Body – Location: _____
- ☐ _____

Family History

- ☐ Aneurysm
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ _____
- ☐ Heart Disease/Attack
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraine
- ☐ _____
- ☐ Seizure Disorder
- ☐ Stomach / Colon Disorders
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ _____

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Social History

Alcohol Use: ☐ Yes ☐ No ☐ How Often? _____

Tobacco Use: ☐ Never ☐ Smoke ☐ Chewing ☐ Vape ☐ How Often? _____

Additional Medical History

Are You Right or Left-Handed? ☐ Left ☐ Right

Have You Received the Flu Vaccine This Year? ☐ Yes ☐ No If No, Why? _____

If You Are Over the Age 65, Have You Received A Pneumonia Vaccine? ☐ Yes ☐ No If No, Why? _____

If You Are Female Between 50-74, Have You Had A Mammogram in The Last 2 Years? ☐ Yes ☐ No When _____

If You Are Between 50-75, Have You Had A Colonoscopy Performed in The Last 10 Years? ☐ Yes ☐ No When _____

Have You Received the Covid-19 Vaccine? ☐ Yes ☐ No Date of Dosage 1st _____ 2nd _____ Brand _____

Allergies

Allergies to the following? ☐ Latex ☐ Iodine or Shellfish ☐ Dye ☐ Sulfa ☐ Lidocaine ☐ Steroids

Please list any medications you are allergic to and type of reaction.

1. _____ Reaction _____ 2. _____ Reaction _____

3. _____ Reaction _____ 4. _____ Reaction _____

Medications

Do you take any of the following medications?

☐ Vitamin E ☐ Coumadin ☐ Heparin ☐ Plavix ☐ Effient ☐ Aspirin ☐ Eliquis ☐ Pradaxa ☐ Fish Oil

List any other medications/dosage/frequency currently taken, including over the counter/herbal/diet supplements, aspirin, or aspirin products and non-steroidal anti-inflammatories.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

11. _____ 12. _____

13. _____ 14. _____

15. _____ 16. _____

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Pain Identification

Please rate your pain according to the scale below:

No Pain		Low		Moderate		Intense			Unbearable	
0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐	10☐

Pain Level now: _____ Lowest pain level in last month: _____ Highest pain level in last month: _____

Indicate the location of the pain you are experiencing on the drawing below. Describe the type of pain you are feeling.