We ask that new patients **arrive 30 minutes prior to your appointment** so that all paperwork can be completed before your appointment time. Established patients are asked to arrive 15 minutes prior to their appointment to complete paperwork. Out of consideration for all our patients, **if you arrive late for an appointment**, you may not be seen. If an appointment is available at a later time and at the provider's discretion, you may be able to be worked in. We are happy to try to accommodate you, but it may be necessary for you to reschedule.

****PLEASE BRING THE FOLLOWING INFORMATION TO YOUR NEW PATIENT APPOINTMENT****

*****Insurance card(s)
*Photo ID (drivers license)
*List of current medications, including herbs, vitamins and over-the-counter pills
*Completed new patient paperwork, but DO NOT sign or date forms until your visit.
*Any imaging you've had done in the last year. That would include x-rays, MRIs, CTs, bone scans, or nerve conduction studies.
If you had imaging at any other facility, we ask that you pick up a disc and report to bring to your visit with you.

CO-PAYMENTS, CO-INSURANCE OR ANY OUTSTANDING BALANCES WILL BE DUE AT THE TIME OF SERVICE AS REQUIRED BY OUR INSURANCE PLAN.

SOUTHEASTERN
SPINE & NEUROSURGERY

Patient name: _____
Date of birth: _____

FINANCIAL POLICY

Our objective is to provide you with the highest quality healthcare in the most cost-effective manner. However, the ability of Southeastern Spine & Neurosurgery to achieve this depends greatly on your understanding of our financial policy and of your financial responsibilities. If you have medical insurance, we will file a claim on your behalf. We do this as a courtesy to our patients and to honor agreements with insurers who have contracts with Southeastern Spine & Neurosurgery.

Medicare Patients

As a participating provider of Medicare Part B (physician services), Southeastern Spine & Neurosurgery will only collect your Medicare co-insurance, co-pays and deductible and any charges for services rendered but not covered by Medicare. These amounts due from you are expected at the time services are rendered. All other reimbursement will be received directly from Medicare.

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services. If you have a Medicare product that requires a co-pay, you will be responsible for the co-pay at the time services are rendered.

Commercial Insurance Patients

Please remember that your insurance contract is between you and your insurer. If your insurance company pays only a portion of your claim or reduces benefits based on your contract, you are responsible for these balances. Referrals are the responsibility of the patient. Referral forms and insurance cards should be presented when you check in. If you change insurers between appointments, it is your responsibility to notify us of the new information prior to your appointment to ensure our acceptance of the new plan.

Co-pays, deductibles and co-insurance are due at time of service.

HMO/Managed Care Insurance Patients

Many HMO/Managed Care plans require a referral. If a referral is required, it is your responsibility to obtain the referral prior to each appointment. Unauthorized services will be the financial responsibility of the patient. Co-pays, deductibles and co-insurance are due at time of service.

Patients with no insurance

Patient with no insurance are required to pay at time of service. If special financial arrangements are deemed necessary, you are responsible for making these arrangements prior to services being rendered. **NOTE:** All balances that are a result of hospitalization or a procedure are due within 30 days from the date of your first statement. If you are unable to pay, you should contact the business office immediately to discuss your options.

I understand the financial requirements described above and agree to abide by the requirements. In the event that I fail to pay this account, I agree to pay any and all collection costs up to and including collection agency fees and attorney fees.

Patient/Guarantor Signature **Date**

We accept cash, checks, Visa, Mastercard, Discover and American Express

PATIENT HISTORY: PLEASE COMPLETE ENTIRE FORM (COMPLETE IN BLACK INK ONLY)

PATIENT NAME:_____ DOS: _____

Date of birth:_____ Age at this visit: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with or experienced the following? CHECK YES OR NO TO EACH ITEM

ALLERGIC/IMMUNOLOGIC:

Yes No

___ ___ Seasonal/Environmental allergies
___ ___ Contact dermatitis
___ ___ HIV/Immunosuppresive Disorders

CARDIOVASCULAR:

Yes No

___ ___ Irregular heartbeat
___ ___ High blood pressure
___ ___ Congestive heart failure
___ ___ Mitral valve prolapse
___ ___ Varicose veins
___ ___ Heart disease
___ ___ Heart murmur
___ ___ Heart attack
___ ___ Pacemaker
___ ___ Implantable defibrillator
___ ___ Peripheral vascular disease
___ ___ AV shunt for dialysis Rt Lt

HEMATOLOGIC/LYMPHATIC:

___ ___ Bleeding disorder
___ ___ Blood clots in lungs or legs
___ ___ Cancer
Type: _____
___ ___ Clotting disorder
___ ___ Previous transfusions
___ ___ Anemia

RENAL/GU:

___ ___ Kidney disease impairment
___ ___ Dialysis
___ ___ Kidney stones
___ ___ Prostate problems
___ ___ Frequent urinary tract infection

MUSCULOSKELETAL:

Yes No

___ ___ Previous fractures
___ ___ Previous muscle/tendon injury
___ ___ Osteoarthritis
___ ___ Rheumatoid arthritis
___ ___ Scleroderma
___ ___ Fibromyalgia
___ ___ Lupus
___ ___ Scoliosis

INTEGUMENTARY/SKIN:

___ ___ Eczema
___ ___ Psoriasis
___ ___ Tattoos
___ ___ Body Piercing

METABOLIC/ENDOCRINE:

___ ___ Irregular menstrual cycle
___ ___ Diabetes - ___Insulin ___Non-insuln
___ ___ Hypoglycemia
___ ___ Gout
___ ___ Hypothyroidism
___ ___ Hyperthyroidism
___ ___ Hyperparathyroidism
___ ___ Hashimotos goiter
___ ___ Paget's disease

PSYCHOLOGIC:

___ ___ Depression
___ ___ Anxiety disorder

EYES/EARS:

Yes No

___ ___ Deafness Rt Lt
___ ___ Hard of hearing/hearing aid
___ ___ Cataracts
___ ___ Glaucoma
___ ___ Blindness
___ ___ Glasses
___ ___ Contacts

NEUROLOGIC:

___ ___ Alzheimer's disease
___ ___ Parkinson's disease
___ ___ Stroke
___ ___ Seizure disorder

PULMONARY:

___ ___ Asthma
___ ___ Bronchitis
___ ___ Emphysema
___ ___ TB or exposure

GASTROENTEROLOGIC:

___ ___ Gastric reflux
___ ___ Ulcer disease
___ ___ Irritable bowel syndrome
___ ___ Crohn's or ulcerative colitis
___ ___ Hiatal hernia
___ ___ Cirrhosis
___ ___ Hepatitis A B C

Other _____

REVIEW OF SYSTEMS:

Are you experiencing any of the following? CHECK YES or NO TO EACH ITEM

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Increased energy	___	___	Recent onset of high blood pressure	___	___	Tingling	___	___	Blurred vision
___	___	Decreased energy	___	___	Cold extremities	___	___	Muscle pain with any activity or rest	___	___	Shortness of breath
___	___	Recent weight loss	___	___	Joint swelling	___	___	Back pain	___	___	Chronic cough
___	___	Recent weight gain	___	___	Joint pain	___	___	Rashes	___	___	Problems breathing
___	___	Generalized weakness	___	___	Numbness	___	___	Headaches	___	___	Diarrhea
___	___	Fever for unknown reason	___	___	Burning on urination	___	___	Increased urinary frequency	___	___	Constipation
___	___	Poor bladder control							___	___	Depression

Other:

_____

_____

PATIENT NAME:_____ DOB:_____ DOS:_____

Family Physician/Primary Care Provider: _____
Specialist:_____
_____

PAST SURGICAL HISTORY: (Please list ALL previous surgeries)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

FAMILY HISTORY – IMMEDIATE FAMILY – NOT PATIENT

History of ( ) Heart disease ( ) Heart attack ( ) Lung disease ( ) Diabetes ( ) Rheumatoid arthritis ( ) Cancer
( ) Stroke ( ) TB ( ) Anesthesia complication ( ) Blood clots in lungs or legs
( ) Patient adopted – no history available ( ) Other: _____

SOCIAL HISTORY:

Marital status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

Available assistance and support:

Do you live in: ( ) House/apartment ( ) Assisted living ( ) Residential care home ( ) Other: _____
Number of dependent children _____

Do you currently use: Tobacco ( )Yes ( ) No ( ) Rarely ( ) Occasionally ( ) Regularly _____ packs per day
Alcohol ( )Yes ( ) No ( ) Rarely ( ) Occasionally ( ) Regularly _____ drinks per day
Recreational drugs: ( ) Yes ( ) No Explain: _____
IV drugs: ( ) Yes ( ) No Date last used: _____

PREVIOUS DIAGNOSTIC STUDIES: Did you bring them with you? ( ) Yes ( ) No

Test done (i.e., MRI, CT scan, etc.)	Date performed	Facility (i.e., Memorial, Chattanooga Outpatient Center)	Films/Reports
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY PHYSICIAN/PRIMARY CARE PROVIDER: _____
REFERRING PHYSICIAN: _____
SPECIALIST:_____
_____

PLEASE SIGN BELOW

The information provided by me on this form is true and accurate to the best of my knowledge.

Patient: _____ Date: _____

Nurse/MA Initials: _____ Date: _____ Provider Signature: _____ Date: _____

SOUTHEASTERN
SPINE & NEUROSURGERY

LIST OF CURRENT MEDICATIONS/DOSAGES

PATIENT NAME: _____ **DOB:** _____

NAME	DOSAGE	TIMES PER DAY

IF NO KNOWN DRUG/FOOD ALLERGIES, CIRCLE: N/A

1) _____

2) _____

3) _____

4) _____

5) _____

PATIENT SIGNATURE:_____

DATE: _____

SOUTHEASTERN
SPINE & NEUROSURGERY

Date: _____

Name: (First) (Middle) (Last)

Date of Birth: Sex: Race:

Social Security Number: Marital Status:

Address City: State: Zip Code:

Employer: Address: City: State: Zip Code:

Phone: Extension:

Contact Information:

Home phone: Work phone: Mobile:

Email address:

Emergency Contact Person: Phone: Relationship:

Insurance Information:

Primary Plan:	Secondary Plan:
Group/Employer:	Group/Employer:
Insured Name:	Insured Name:
Insured DOB:	Insured DOB:
Relation to Patient: Copay: $	Relation to Patient: Copay: $

Authorization:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, attorney's fees, court costs, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: Date:

SOUTHEASTERN
SPINE & NEUROSURGERY

SOUTHEASTERN SPINE & NEUROSURGERY MEDICATION AGREEMENT

1. I understand that I need to give 24 hrs notice when requesting a refill on any medication. Walk-in requests for medication or appointments will not be accepted.
2. I agree to take all medication exactly as instructed. I am not allowed to change the dosage or time schedule without speaking to my provider first.
3. I understand that no medication will be changed or called in after hours or on the weekend.
4. I understand that a follow-up visit may be required from my provider in order to obtain a refill and I must keep all recommended appointments.
5. I understand that Urine Drug Screens will be required at my provider's discretion as long as I am receiving opioid medication. I understand that my medication may be stopped or changed at the provider's discretion, based upon the results of the Drug Screen or the TN prescription monitoring data base.
6. Southeastern Spine & Neurosurgery will not refill lost or stolen medication. **These are your responsibility once you leave our office.**
7. I will not trace, sell or give away the medications that are prescribed for me. I will also not take any medication that is prescribed to someone else.
8. I am aware that while I am on medications that treat my pain, I am prohibited from driving or using heavy machinery. I understand that driving while taking opioid medication could result in a DUI change.
9. I understand that verbal abuse and argumentative behavior towards the staff will not be tolerated and could result in discharge from the practice.
10. I will not use multiple pharmacies when filling my prescriptions.
    The pharmacy I use is: _____ Phone#: _____
11. The following are conditions for immediate discharge from the practice:
    a. Obtaining opioid prescriptions from other physicians while receiving medications from our providers.
    b. Altering or forging a prescription in any way. This is a felony and will be reported.
    c. Non-compliance with any of the above statements.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICIES, AND I UNDERSTAND THAT IF I DO NOT SIGN, MY PHYSICIAN MAY REFUSE TO PRESCRIBE PAIN MEDICATIONS TO ME.

NAME:_____DATE:_____

PATIENT SIGNATURE:_____

DR. JAY JOLLEY
DR. DAVID WILES
REBECCA PAYNE, FNP-BC
NATHAN WOODY, ARNP, CNP
JESSICA SCOTT, PAC

SOUTHEASTERN
SPINE & NEUROSURGERY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last name:	First name:	SSN:	Date of birth:
Phone:	Address:	Date:	

AUTHORIZATION INFORMATION

I, _____ request and authorize Southeastern Spine & Neurosurgery to ☐ request ☐ release the information noted below from my medical records to:

☐ Medical Provider ☐ Parent/Guardian ☐ Myself ☐ Other_____

Recipient:	Address:

Phone:	Fax:	Email:

☐ Fax to number above ☐ Mail to address above ☐ Email to address above ☐ Picked up by patient

INFORMATION TO BE RELEASED (select one)

☐ All medical records to include all chart entries, diagnostics, test results and reports

☐ All records related to visits on the following date(s)_____

☐ All records related to the following diagnosis/symptoms_____

☐ All records **EXCEPT**_____

☐ All medical records **EXCEPT**_____

☐ Immunization records only

☐ Test results only from the following date(s)_____

☐ Other_____

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine & Neurosurgery. This does not constitute blanket permissions for release of such information for an infinite period of time, but is limited to this instance only.

I agree that a copy of this release, electronic or faxed submission of this release shall be valid as this original release. I understand that if I authorized Southeastern Spine & Neurosurgery to fax or email the information, that there are inherent privacy risks with these methods.

_____ _____

Patient signature Date

FOR OFFICE USE ONLY

Copied: Initial _____ Date:_____ SENT: Mailed Picked-up Faxed Emailed

Initial:_____ Date:_____

SOUTHEASTERN
SPINE & NEUROSURGERY

Disclosure of Protected Health Information

According to our policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

Do we have permission to leave messages on your voicemail? Yes No

Do we have permission to discuss medical information with a family member? Yes No *If yes, please list below.

Emergency contact name: Relationship: _____

Phone: Alternate Phone:

Alternate contact name: Relationship: _____

Phone: Alternate Phone:

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine & Neurosurgery to release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services. Third Party Administrators, and/or Workers' Compensation (or its' agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine & Neurosurgery to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine & Neurosurgery to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits made on my behalf to Southeastern Spine & Neurosurgery. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature_____ Date_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I hereby acknowledge receipt of Southeastern Spine & Neurosurgery, PLLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DPS may use and disclose my protected health information.

By signing below, I acknowledge that I understand that Southeastern Spine & Neurosurgery, PLLC has reserved the right to change its privacy practices that are described in the Notice of Privacy Practices. By signing below, I acknowledge that I also understand that any revisions to the Notice of Privacy Practices will be provided to me or made available to me.

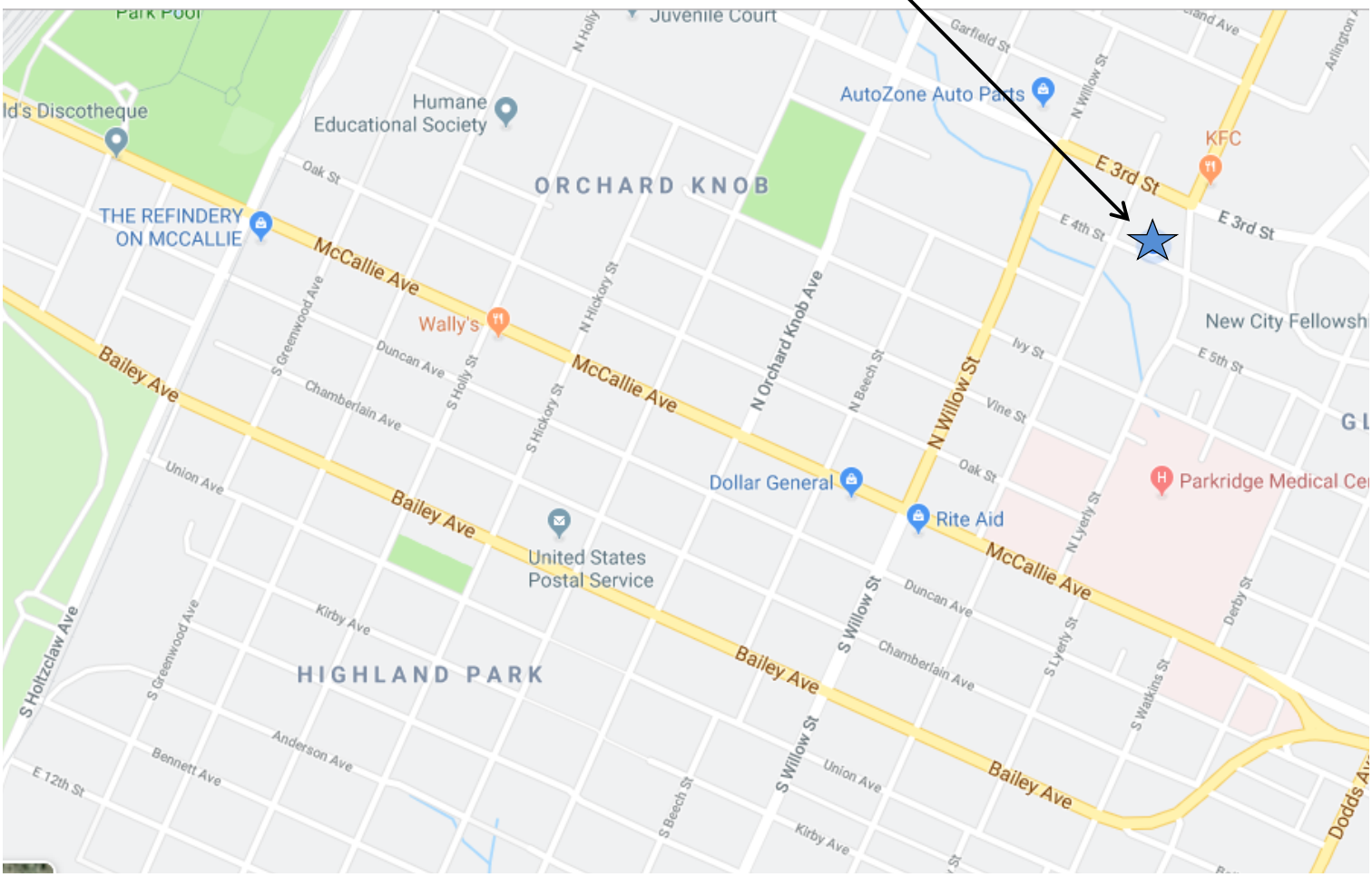
_____
Signature

_____
Print Name

_____
Date

If you are not the patient, please specify your relationship to the patient: _____

SOUTHEASTERN SPINE AND NEUROSURGERY
281 N. LYERLY ST. SUITE 300



www.GoogleMaps.com

Southeastern Spine & Neurosurgery
281 N. Lyerly Street
Chattanooga, TN 37404
Phone: (423) 693-2175

FROM HIXSON/AMNICOLA

1. Take 153 S. to Amnicola Hwy exit.
2. Follow Amnicola to Wilcox and turn left.
3. Turn right onto Dodson Avenue
4. Stay straight to go on N. Lyerly.
5. Southeastern Spine & Neurosurgery is on your right.

FROM NASHVILLE

1. Take I-24 E to Central Ave. Exit, 180A
2. Take 23rd St. to Rossville Blvd.
3. Turn left onto South Willow St.
4. Turn right onto East 3rd St.
5. Turn right onto N. Lyerly St.
6. Southeastern Spine & Neurosurgery is on your right.

FROM ATLANTA

1. Take I-75 N to -24 W split.
2. Take I-24 W to Belvoir/Germantown Ave., exit 183A.
3. Turn right onto Belvoir Ave.
4. At light, turn left onto Brainerd Rd.
5. Follow through Brainerd/McCallie tunnels.
6. Veer slight right onto McCallie.
7. Turn right onto N. Lyerly.
8. Southeastern Spine & Neurosurgery is on your left.

FROM I-27

1. Take I-27 to 4th St.
2. 4th St. turns into 3rd, just before Erlanger Hospital.
3. Follow 3rd St.
4. Turn right onto N. Lyerly.
5. Southeastern Spine & Neurosurgery is on your right.

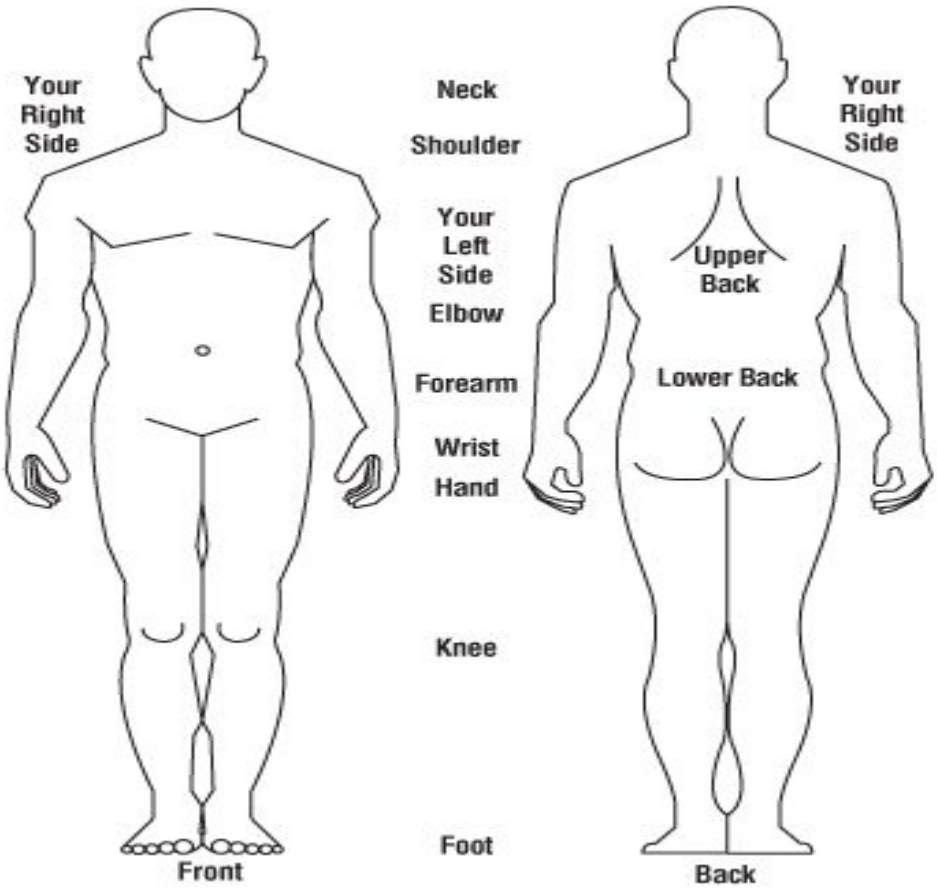
SOUTHEASTERN
SPINE & NEUROSURGERY

PAIN DRAWING/SCALE

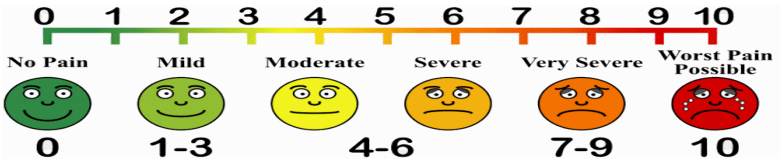
If you are experiencing pain and/or discomfort, please complete this form.

1) Mark the areas on your body where you feel the described sensation using the symbols below. Please include all affected areas.

Ache or stabbing XXX "Pins & needles" or burning === Numbness 000



2) How intense or severe does this discomfort feel?
Indicate the severity of your pain with a number on the scales below between 0 and 10.



_____

Patient signature /Date

SOUTHEASTERN
SPINE & NEUROSURGERY

Oswestry Disability Index (ODI) version 2.1a

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life.

Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 - Pain intensity

- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- (0) I can look after myself normally without causing extra pain.
- (1) I can look after myself normally but it is very painful.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self-care.
- (5) I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

- (0) I can lift heavy weights without extra pain.
- (1) I can lift heavy weights but it gives extra pain.
- (2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

Section 4 - Walking

- (0) Pain does not prevent me walking any distance.
- (1) Pain prevents me walking more than one mile.
- (2) Pain prevents me walking more than a quarter of a mile.
- (3) Pain prevents me walking more than 100 yards.
- (4) I can only walk using a stick or crutches.
- (5) I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting for more than 1 hour.
- (3) Pain prevents me from sitting for more than half an hour.
- (4) Pain prevents me from sitting for more than 10 minutes.
- (5) Pain prevents me from sitting at all.

Section 6 - Standing

- (0) I can stand as long as I want without extra pain.
- (1) I can stand as long as I want but it gives me extra pain.
- (2) Pain prevents me from standing for more than 1 hour.
- (3) Pain prevents me from standing for more than half an hour.
- (4) Pain prevents me from standing for more than 10 minutes.
- (5) Pain prevents me from standing at all.

Section 7 - Sleeping

- (0) My sleep is never disturbed by pain.
- (1) My sleep is occasionally disturbed by pain.
- (2) Because of pain I have less than 6 hours sleep.
- (3) Because of pain I have less than 4 hours sleep.
- (4) Because of pain I have less than 2 hours sleep.
- (5) Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- (0) My sex life is normal and causes no extra pain.
- (1) My sex life is normal but causes some extra pain.
- (2) My sex life is nearly normal but is very painful.
- (3) My sex life is severely restricted by pain.
- (4) My sex life is nearly absent because of pain.
- (5) Pain prevents any sex life at all.

Section 9 - Social life

- (0) My social life is normal and causes me no extra pain.
- (1) My social life is normal but increases the degree of pain.
- (2) Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- (3) Pain has restricted my social life and I do not go out as often.
- (4) Pain has restricted social life to my home.
- (5) I have no social life because of pain.

Section 10 - Travelling

- (0) I can travel anywhere without pain.
- (1) I can travel anywhere but it gives extra pain.
- (2) Pain is bad but I manage journeys over two hours.
- (3) Pain restricts me to journeys of less than one hour.
- (4) Pain restricts me to short necessary journeys under 30 minutes.
- (5) Pain prevents me from travelling except to receive treatment

Total Score=

Your ODI = %

ODI % = Total score/5 x Number of questions answered x 100