NewSouth NeuroSpine **PATIENT INFORMATION** **Pt#**

Last Name:		**Social Security #:**	
First Name:	MI:	**Date of Birth:**	
Home Address1:		**Age:**	Sex:
Apt/Suite #:		**Home Phone#:**	
City, State, Zip:		**Work Phone#:**	
Email:		**Cell Phone#**:	
Marital status: Married Single Divorced Widowed		**Referring Physician:**	
Pharmacy:	**Location:**	**Phone#:**	

Race: African American ☐ Caucasian ☐ Asian ☐ Native American ☐ Other ☐ **Ethnicity:** Hispanic ☐ Non-Hispanic ☐

Is your health problem due to a motor vehicle accident? Yes No Did you get hurt at work? Yes No

Date of Wreck: _____ Date of Injury:_____ State of Wreck/Injury:_____

EMPLOYER INFORMATION

Employer Name:	**Adjusters Name/number:**
Employer Address:	**Emp. City/St/Zip:**
Employer Suite #:	**Employer Phone#:**

EMGERGENCY CONTACT INFORMATION: In case of emergency who should be notified?

Name:	**Tel#**

PRIMARY INSURANCE

Plan/Policy Name:	**Group #:**
Plan Tel#:	**Subscriber DOB**:
Subscriber Name: «SubscriberName»	**Subscriber ID/Policy #:**

Relationship to Patient: ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other

SECONDARY INSURANCE

Plan/Policy Name:	Group #:
Plan Tel#:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy #:

Relationship to Patient: ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, certify that I (or my dependents have insurance coverage as noted above and assign all insurance benefits, otherwise payable to me for services rendered, be payable directly to NewSouth NeuroSpine, LLC(NS2). I understand that I am financially responsible for all charges whether they are paid by any insurance plan I participate in. I agree to be personally responsible for the payment of all charges for services rendered to me (or if I am the guarantor of payment, the services rendered on behalf of the individual for whom I have assumed financial responsibility). I understand that while others may also, be responsible for paying these charges by virtue of an express or implied agreement, or otherwise, I am responsible for paying for all charges. I understand that payment of all co-insurance, co-pays and deductibles is preferred at the time services are rendered and that interest will not begin to accrue on my outstanding account balance prior to 30 days after the payment due date. I understand that payment can be paid by [Visa, MasterCard, Check, Cash]. Accounts not paid within the specified payment terms are subject to a Finance Charge at an annual percentage rate of ten percent (10%) per annum, which corresponds to a monthly periodic rate of 0.8333%. Further, I understand that if I fail to pay for my charges and NS2 refers my account to an outside attorney or collection agency, I am also responsible for all collections fees that an outside attorney or collection agency may charge to collect the charges I owe. I hereby authorize NS2 to release all information necessary to secure payment for services they provide me (or my dependents). I authorize the use of my signature on all insurance submissions. I authorize NS2 to release my (or my dependents) medical records to my referring, primary and treating physicians and diagnostic centers.

Patient or authorized person's signature: _____ Date: «CurrentDate»

(NS)² NewSouth NeuroSpine Patient History

Name_____ Date_____
Age_____ Height: _____Weight: _____ Referring Physician: _____
Any other Medical History: (ex: Diabetes, high blood pressure…) _____
_____
_____
_____

Are you Right Handed or Left Handed? Right / Left **Staph infection?** Yes / No **Diagnosed with MRSA**? Yes / No
Diagnosed with Hepatitis A, B or C? Yes / No Which type?_____ Diagnosed with HIV? Yes / No

Have you ever had a problem with anesthesia? Yes / No Has any family member had a problem with anesthesia? Yes / No
If yes, what kind of problems with anesthesia?_____
_____

Hospitalizations/Surgeries

Year	**Hospital Treating**		**Reason for Hospitalzation/surgery & Outcomes**

Allergies: _____
Intolerance to any medications: _____
Please list all medications you are currently taking:

Current Medications	Dose	How often	Medications	Dose	How often

What is your reason for your visit today?
_____
_____
_____

How long have you had this problem?_____days/months/years Has it gotten worse/better/stayed the same since onset? Y/N

Did you sustain an injury? Yes / NO

If yes, how were you injured? At work? Yes or NO Automobile Accident? Yes or No
Please explained how you were injured in full detail
_____

$(NS)^2$ **Name:** _____

Family Medical History:

Please put a (x) in the column if you Family has had?

	Year Deceased	Cancer	Heart disease	Heart Attack	Stroke	Diabetes
Mother						
Father						
sister						
brothers						
Grandmother						
Grandfather						

Other Medical History:

Are you pregnant? Yes / No
Do you use any type of tobacco products? Yes / No What type?_____Packs per day?_____ How many years?___
Have you ever used tobacco products? Yes/No What kind of tobacco products?_____ Packs per day_____
Interesting in quiting? Yes / No
Do you drink alcoholic beverages? Yes / No Drinks per day? _____ How many years? _____
Do you have a history of drug abuse? Yes / No
Do you have a history of alcohol abuse? Yes / No
Have you ever had cortisone or steroids? Yes / No Side effects? _____
Have you ever had local anesthetic? Yes / No Side effects?_____

Social:

Employer: _____ Length of employment: _____

Job Position: _____ Were you injured on the job? Yes / No

Are you currently working? Yes / No Full duty or Light duty? _____

If you are not working when was your last day of work? _____

Do you have an attorney for this problem? Yes NO Attorney Name/Number:_____

If this is a workers' compensation case, has your case been controverted? Yes / No

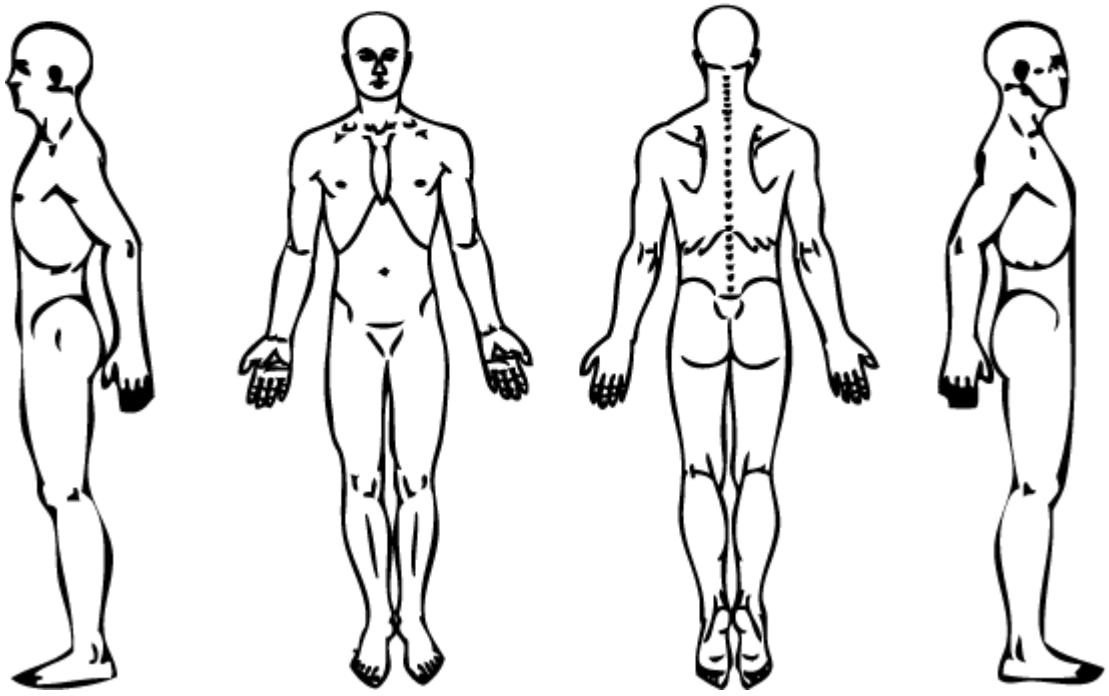
$(NS)^2$ **Name:** _____

Please fill out the pain diagram below.

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



LEFT FRONT BACK RIGHT

Please rate the severity of your pain:

Currently: No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

At its worst: No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

At its best: No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

$(NS)^2$ **Name:** _____

Review of Systems

Please check if you have/had problems related to the areas indicated.

CONSTITUTIONAL SYMPTOMS

Good general heath lately……..	☐ No	☐ Yes
Recent weight change……	☐ No	☐ Yes
Fever……...	☐ No	☐ Yes
Fatigue……	☐ No	☐ Yes
Headaches……..	☐ No	☐ Yes

EYES

Eye disease or injury……	☐ No	☐ Yes
Wear glasses/contact lenses……...	☐ No	☐ Yes
Blurred or double vision……	☐ No	☐ Yes
Glaucoma……	☐ No	☐ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing……..	☐ No	☐ Yes
Earaches or drainage……	☐ No	☐ Yes
Chronic sinus problem or rhinitis……	☐ No	☐ Yes
Nose Bleeds……	☐ No	☐ Yes
Mouth sores……	☐ No	☐ Yes
Bleeding gums……	☐ No	☐ Yes
Sore throat or voice change……	☐ No	☐ Yes
Swollen glands in neck……...	☐ No	☐ Yes

CARDIOVASCULAR

Heart Trouble…….	☐ No	☐ Yes
Chest pain……..	☐ No	☐ Yes
Palpitation……..	☐ No	☐ Yes
Shortness of breath with walking/lying flat…...	☐ No	☐ Yes
Swelling of feet, ankles, or hands……...	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs……	☐ No	☐ Yes
Spitting up blood……	☐ No	☐ Yes
Shortness of breath…….	☐ No	☐ Yes
Asthma or wheezing……	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite……..	☐ No	☐ Yes
Change in bowel movements…….	☐ No	☐ Yes
Nausea or vomiting……	☐ No	☐ Yes
Frequent diarrhea……	☐ No	☐ Yes
Painful bowel movements or constipation…	☐ No	☐ Yes
Rectal bleeding or blood in stool……	☐ No	☐ Yes
Abdominal pain…….	☐ No	☐ Yes
Bowel Incontinence……	☐ No	☐ Yes

GENITOURINARY

Frequent urination……..	☐ No	☐ Yes
Burning or painful urination……..	☐ No	☐ Yes
Blood in urine……	☐ No	☐ Yes
Change in force of stream when urinating.	☐ No	☐ Yes
Incontinence……	☐ No	☐ Yes
Kidney stones…….	☐ No	☐ Yes
Sexual difficulty…….	☐ No	☐ Yes

Other: _____

MUSCULOSKELETAL

Joint Pain……..	☐ No	☐ Yes
Joint stiffness or swelling……..	☐ No	☐ Yes
Weakness of muscle or joints……	☐ No	☐ Yes
Muscle pain or cramps……..	☐ No	☐ Yes
Back Pain……..	☐ No	☐ Yes
Cold extremities……	☐ No	☐ Yes
Difficulty in walking…….	☐ No	☐ Yes

INTEGUMENTARY (skin, breast)

Rash or Itching……	☐ No	☐ Yes
Change in Skin Color……	☐ No	☐ Yes
Change in Hair or Nails…….	☐ No	☐ Yes
Varicose veins……	☐ No	☐ Yes
Breast Pain…….	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches……	☐ No	☐ Yes
Light headed or dizzy……	☐ No	☐ Yes
Convulsions or seizures……	☐ No	☐ Yes
Numbness or tingling sensations……..	☐ No	☐ Yes
Tremors…….	☐ No	☐ Yes
Paralysis……	☐ No	☐ Yes
Stroke……	☐ No	☐ Yes
Head Injury……	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion…….	☐ No	☐ Yes
Nervousness……	☐ No	☐ Yes
Depression……	☐ No	☐ Yes
Insomnia……	☐ No	☐ Yes

ENDOCRINE

Glandular or hormone problem…….	☐ No	☐ Yes
Thyroid disease…….	☐ No	☐ Yes
Diabetes (insulin or non-insulin circle)……	☐ No	☐ Yes
Excessive thirst or urination……	☐ No	☐ Yes
Heat or cold intolerance……	☐ No	☐ Yes
Skin becoming dryer……	☐ No	☐ Yes

HEMATOLOGIC/LYMPHATIC

Bleeding problems; bruising…….	☐ No	☐ Yes
Anemia……	☐ No	☐ Yes
Phlebitis…….	☐ No	☐ Yes
Past transfusion…….	☐ No	☐ Yes
Enlarged glands…….	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction……..	☐ No	☐ Yes
Penicillin or other antibiotics…….	☐ No	☐ Yes
Morphine, Demerol, or other narcotics……	☐ No	☐ Yes
Novocaine, Lidocaine or other anesthetics	☐ No	☐ Yes
Aspirin or other pain remedies……..	☐ No	☐ Yes
Iodine, methiolate or other antiseptic……	☐ No	☐ Yes

Known food or other allergies: _____

Reviewed by: _____ Date: _____

HIPAA Authorization for Release of Information

NewSouth NeuroSpine, LLC 2470 Flowood Dr Flowood, MS 39232

Section A: Name and Locations

I hereby authorize the disclosure of my individually identifiable health information by **all medical sources**. I understand that this authorization is voluntary.

Patient name:_____ Date of Birth: _____

Social Security: _____

Please send the information to:
NewSouth NeuroSpine
2470 Flowood Dr
Flowood, MS 39232
Fax: _____
Phone: _____

Section B: Must be completed for all authorizations

1. Please send the: ☐ Entire medical record ☐ Last 3 years ☐ Last 5 years
2. Other Limitations (please specify, if any):_____
3. Purpose of disclosing the information: **Continuation of Care**

Section C: Patient rights and signature

I understand that my records may contain information regarding the diagnosis or treatment of all my medical conditions in the possession of the practice indicated above and may include confidential information such as that about the diagnosis or treatment of conditions such as HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or psychological conditions. I give my specific authorization for these records to be released. I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time by writing to the medical practice at the address indicated above. I understand that once the health information that I have authorized to be disclosed reaches the indicated recipient that other persons or organizations may re-disclose it, at which time it may no longer be protected under Privacy Laws. A photocopy of this authorization is to be considered as valid as the signed original document. I understand that I must provide documents to prove authority to sign on behalf of someone other than myself and may be required to provide proof of identity at the time of signature.

_____ _____/_____/_____
Signature of patient of patient's representative Date
(Form MUST be completed before signing)

THIS AUTHORIZATION IS VALID FOR FIVE (5) YEARS UNLESS ANOTHER DURATION IS SPECIFIED UNDER SECTION B (2).

Printed name of patient's representative: _____

Relationship to the patient: _____

Practice Policies

I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and other co-insurances, are my responsibility. I understand that if there are any items on this policy release that I do not understand that I can ask to meet with the office manager for clarification prior to signing this form.

I authorize my insurance benefits be paid directly to NewSouth NeuroSpine, LLC (NS2). By signing below I represent that the information I have provided is accurate, complete, and true; that I am either the patient of am duly authorized to act as an agent of the patient. I understand that I am financially responsible for all charges whether or not they are paid by any insurance plan I participate in. I agree to be personally responsible for the payment of all charges for services rendered to me (or if I am the guarantor of payment, the services rendered on behalf of the individual for whom I have assumed financial responsibility). I understand that while others may also be responsible for paying these charges by virtue of an express or implied agreement, or otherwise, I am responsible for paying for all charges. I understand that payment of all co-insurance, co-pays and deductibles is preferred at the time services are rendered and that interest will not begin to accrue on my outstanding account balance prior to 30 days after the payment due date. I understand that payment can be paid by [Visa, MasterCard, American Express, Money Order, Check,Cash]. Accounts not paid within the specified payment terms are subject to a Finance Charge at an annual percentage rate of ten percent (10%) per annum, which corresponds to a monthly periodic rate of 0.8333%. Further, I understand that if I fail to pay for my charges and NS2 refers my account to an outside attorney/ collection agency, I am also responsible for all collections fees that an outside attorney or collection agency may charge to collect the charges I owe. I understand that I am personally obligated to pay my account in full in accordance with the regular rates and terms of the office policies; and to pay all additional court costs and legal fees that may be incurred or caused by not paying this account in full or in a timely fashion.

These Terms and Conditions of Healthcare shall be governed by, and construed and enforced in accordance with, the internal substantive laws of the State of Mississippi, without respect to its conflict of laws principles. By signing below, you irrevocably submit to the jurisdiction of any state court in Rankin County, Mississippi, or any courts of the United States of America located in Rankin County, Mississippi, and agree that all suits, actions and proceedings brought by you involving NewSouth NeuroSpine, LLC, or its physicians, affiliates, subsidiaries, employees, agents, suppliers, contractors, officers, and directors shall be brought only in such courts in Rankin County, Mississippi. You irrevocably waive, to the fullest extent permitted by law, any objection which you may now or hereafter have to the laying of the venue of any such suit, action or proceeding brought in any such court, any claim that any such suit, action proceeding brought in such a court has been brought in an inconvenient forum and the right to object, with respect to any such suit, action or proceeding brought in any such court, that such court does not have jurisdiction over you. If any provision of this agreement is held to be illegal, invalid or unenforceable under present or future laws, the legality, validity or enforceability of the remaining provisions of these Terms and Conditions shall not be affected thereby, and in lieu of such illegal, invalid or unenforceable provision, there shall be added automatically as part of these Terms and Conditions a provision as similar in terms to such illegal, invalid or unenforceable provision as may be legal, valid and enforceable.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For Personal representative of the Patient (if applicable)
If signed by a representative on behalf of the patient, complete the following:
Print Name of Personal Representative: _____
Relationship to the Patient (parent, guardian, etc): _____
Signature of Personal Representative: _____

$(NS)^2$ Statement of Patient Rights Receipt

I acknowledge that I was provided with the NewSouth NeuroSpine's state of patient rights.

Print the Name of the Patient: _____

Signature of the Patient: _____

Patient's Date of Birth: «PatientDOB»

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of NewSouth NeuroSpine.

Signature of the Patient: _____

Permission For Verbal Communications

I permit NewSouth NeuroSpine, their physicians, nurses, and other personnel to discuss health information in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Name	**Phone Number**	**Relationship**
1._____	_____	_____
2. _____	_____	_____

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to_____(date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between NewSouth NeuroSpine and any of the individuals named above, I must notify NewSouth NeuroSpine by contacting the Medical Records Department.

Patient's Signature: _____ Date: _____