NewSouth NeuroSpine, LLC
Patient Information Form

Pt # _____

Last Name:			**Social Security #:**	
First Name:	**MI:**		**Date of Birth:**	
Home Address:	**Apt #:**		**Age:**	**Sex:**
City, State, Zip:			**Home Phone #:**	
Email:			**Work Phone #:**	
Marital Status:			**Cell Phone #:**	
Race: ☐ African American ☐ Caucasian ☐ Asian ☐ Native American ☐ Other			**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic	
Emergency Contact Name:			**Phone #:**	
Primary Care Physician:			**Referring Physician:**	
Pharmacy:	**Location:**		**Phone #:**	

Accident/Injury Information:

Is your health problem due to a motor vehicle accident? ☐ Yes ☐ No	**Did you get hurt at work?** ☐ Yes ☐ No
Date of Accident/Injury:	**What state did accident/injury occur in?**

Employer Information

Employer Name:	**Adjuster Name:**
Employer Address:	**Adjuster Number:**
Emp. City/St/Zip:	**Employer Phone #:**

Primary Insurance

Subscriber Name:		**Subscriber Date of Birth:**
Plan/Policy Name:		**Plan Phone #:**
Group #:	**Subscriber ID #:**	**Relationship to Patient:**

Secondary Insurance

Subscriber Name:		**Subscriber Date of Birth:**
Plan/Policy Name:		**Plan Phone #:**
Group #:	**Subscriber ID #:**	**Relationship to Patient:**

Assignment of Insurance Benefits

☐ **I, the undersigned, certify that I (or my dependents receiving services) have insurance coverage as noted above and assign all insurance benefits otherwise payable to me for services rendered to be payable directly to NewSouth NeuroSpine, LLC (NS2).**

☐ **I understand and agree that I am financially responsible for all charges for services rendered to me (or my dependents) including those that may or may not be covered by an insurance plan in (with) which I participate.**

☐ **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 all charges.**

☐ **I understand that payment of all co-insurance, co-pays, and deductibles is preferred at the time services are rendered and that payment can be made by Visa, Mastercard, American Express, Check, Money Order, or Cash.**

☐ **I understand that if I fail to pay for my charges and NS2 refers my account to an attorney or collection agency, I am also responsible for all fees that such attorney or collection agency may charge.**

☐ **I hereby authorize NS2 to release all information necessary to secure payment for services provided.**

☐ **I authorize the use of my signature on all insurance submissions for these services.**

☐ **I authorize NS2 to release my (or my dependent's) medical records to referring, primary care, and/or treating physicians and applicable diagnostic centers.**

_____ _____

Patient or Authorized Person's Signature **Date**

NewSouth NeuroSpine, LLC
Patient History Form

Pt # _____

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Referring Physician: _____

Any medical history of chronic conditions such as Diabetes, High Blood Pressure/Cholesterol? □ Yes □ No

If Yes, please list here: _____

Are you □ Right Handed □ Left Handed?

Have you been diagnosed with any of the following:

Staph Infection □ Yes □ No

MRSA □ Yes □ No

Hepatitis □ Yes □ No Type? _____

HIV □ Yes □ No

Have you ever had a problem with anesthesia? □ Yes □ No

Have any family members had a problem with anesthesia? □ Yes □ No

If yes, please explain what kind of problems were encountered?

_____

_____

Hospitalizations/Surgeries			
Year	Name of Treating Hospital	Reason for Hospitalization/Surgery	Outcomes

Please list any food/drug or environmental allergies: _____

Please list any intolerance/adverse reaction to medication: _____

Current Medications						
Name of Medication	Dosage	How Often		Name of Medication	Dosage	How Often

What is your reason for your visit today? _____

How long have you had this problem? # of _____ □ Days □ Months □ Years

Has the problem gotten □ worse □ better □ stayed the same since the onset?

Did you sustain an injury? □ Yes □ No

If yes, how were you injured? □ Work □ Auto □ Other _____

Please explain how and when you were injured in full detail: _____

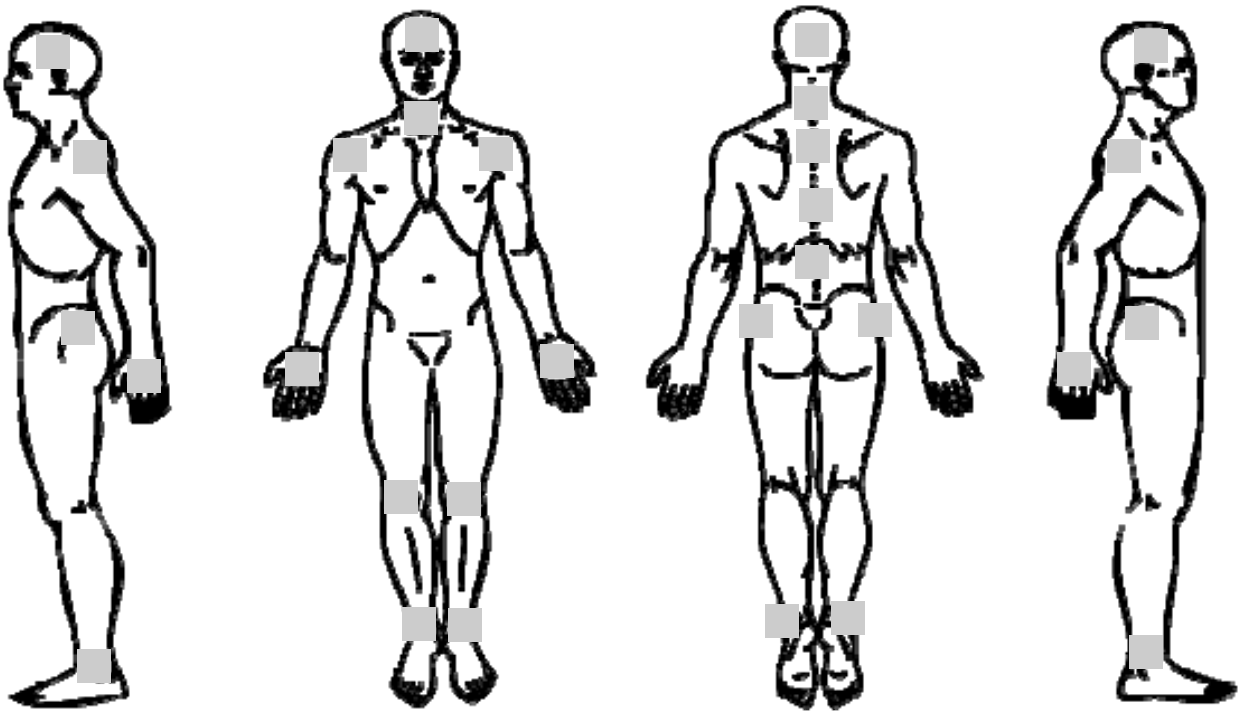
NewSouth NeuroSpine, LLC
Pain Diagram

Pt # _____

Name: _____ Date: _____

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 x	# # # # #
- - - - -	o o o o o	^ ^ ^ ^ ^	x x x x x	# # # # #
- - - - -	o o o o o	^ ^ ^ ^ ^	x 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

NewSouth NeuroSpine, LLC
Medical & Work History Form

Pt # _____

Name: _____ Date: _____

Family Medical History

Please put an (X) in the column below to indicate if a family member was diagnosed with any of these conditions or diseases:

Relationship	Year Deceased	Cancer	Type?	Heart Disease	Heart Attack	Stroke	Diabetes
Mother							
Father							
Sister(s)							
Brother(s)							
Grandmother							
Grandfather							

Other Medical History

Are you pregnant or trying to get pregnant? □ Yes □ No

Do you use any type of tobacco products? □ Yes □ No If Yes, what type? _____
Number of □ packs □ cigars □ canned products _____ □ Daily □ Weekly How many years? _____

Would you be interested in quitting? □ Yes □ No

Have you ever used tobacco products? □ Yes □ No If Yes, what type? _____
Number of □ packs □ cigars □ canned products _____ □ Daily □ Weekly How long ago? _____

Do you drink alcoholic beverages? □ Yes □ No If Yes, what type? _____
Number of drinks and type per day? _____ How many years? _____

Do you have a history of alchohol abuse? □ Yes □ No

Do you have a history of drug abuse? □ Yes □ No

Have you ever had cortisone or steroids? □ Yes □ No If Yes, were there side effects? □ Yes □ No
Please list side effects experienced: _____

Have you ever had local anesthetic? □ Yes □ No If Yes, were there side effects? □ Yes □ No
Please list side effects experienced: _____

Work History

Employer: _____ Length of employment: _____

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

Are you currently working? □ Yes □ No If Yes, □ Full duty □ Modified duty?

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

Do you have an attorney for this problem? □ Yes □ No
If Yes, please list Attorney Name and Phone Number: _____

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

NewSouth NeuroSpine, LLC

Review of Systems Form

Pt # _____

Name: _____ Date: _____

Please check if you currently have, or have had in the past, problems related to the areas indicated.

CONSTITUTIONAL SYMPTOMS				
Good general health 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
Chronix sinus problems 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
Adbominal 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 ☐ Non-Insulin	☐	NO	☐	YES
Excessive thirst or urination	☐	NO	☐	YES
Heat or cold intolerance	☐	NO	☐	YES
Skin becoming more dry	☐	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
Other known food/drug/environmental allergies:				

Reviewed by: _____ Date: _____

NewSouth NeuroSpine, LLC
HIPAA Authorization Form

Pt # _____

HIPAA Authorization for Release of Information

NewSouth NeuroSpine, LLC 2470 Flowood Drive 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 Number: _____

Please send the information to:

NewSouth NeuroSpine
2470 Flowood Drive
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 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 writingto 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 provie authority to sign on behalf of someone other than myself and may be required to provide proof of identity at the time of signature.

_____ _____

Patient Signature/Patient Representative Signature Date

(Form MUST be completed BEFORE signing)

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

Patient Representative Name (Please PRINT): _____

Relationship to the Patient: _____

(NS)² NewSouth NeuroSpine, LLC
Practice Policies

Please read the following Practice Policies and sign below.

I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and other co-insurance, 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 to be paid directly to NewSouth NeuroSpine, LLC (NS2). By signing below I confirm that the information I have provided is accurate, complete, and true; that I am either the patient or I 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. I understand that payment can be made by Visa, Mastercard, American Express, Money Order, Check or Cash. 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 collection fees that an outside attorney or collection agency may charge. 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 incovenient 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 the 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 unenforeable provision as may be legal, valid, and enforceable.

Patient Signature/Patient Representative Signature	Date
Witness Signature	Date

For Representative of the Patient (if applicable)

If signed by a representative on behalf of the patient, please complete the following:

Patient Representative Name (Please PRINT): _____

Relationship to the Patient (Parent, Guardian, etc.): _____

Patient Representative Signature: _____

NewSouth NeuroSpine, LLC

Pt # _____

Statement of Patient Rights Receipt

I acknowledge that I was provided with NewSouth NeuroSpine's Statement of Patient Rights.

Patient Name (Please PRINT): _____ Patient Date of Birth: _____

Patient Signature: _____

Notice of Privacy Practices Receipt

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

Patient Signature: _____

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.

Complete the information below to grant permission for verbal communication to these family and/or friends.

Name	Relationship	Phone Number	Appointment Dates and Times Only	Treatments, Test Results, Medical Conditions, Clinical Information Only		Financial or Insurance Information Only	No Limitations
			☐	☐	*With Limitations ☐	☐	☐
			☐	☐	*With Limitations ☐	☐	☐
			☐	☐	*With Limitations ☐	☐	☐
			☐	☐	*With Limitations ☐	☐	☐
			☐	☐	*With Limitations ☐	☐	☐

*If With Limitations is selected, please specify the limitations below:

_____

_____

_____

Release of information under this document is limited to verbal discussions with my Healthcare 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: _____ to _____.
From Date End Date

If no dates are indicated, this form will remain in effect for an unlimited 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 Signature: _____ Date: _____