Carolina Sports and Spine

Please Print
First Name _____ **Middle Initial** ____ **Last Name** _____
Emergency Contact: Name: _____
Phone #: _____
Occupation: _____
Job Description: _____
_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? **Y___ N __**
IF YES, PLEASE NOTIFY THE RECEPTIONIST.

Medical Conditions: (Check all that apply)

	AIDS/HIV		Alcoholism/Drugs		Alzheimer		Anemia
	Arthritis		Blood Clots		Cancer		COPD/Asthma
	Diabetes		Depression		Heart Disease		Hepatitis
	High Blood Pressure		Hypothyroid		High Cholesterol		Kidney Disease
	Liver Disease		Mental Illness		Seizure		Sickle Cell
	Sleep Apnea		Stomach Ulcers		Stroke		
	Other (please list)						

Family History (Please list conditions that run in your family)

□**Allergies:** (Please list)

Surgical History (Please List all Surgeries and Year, especially spine surgeries)

Lumbar Spine Surgeries/Yr	Cervical Spine Surgeries/Yr	Other:

Social History: (Circle all that apply to you)

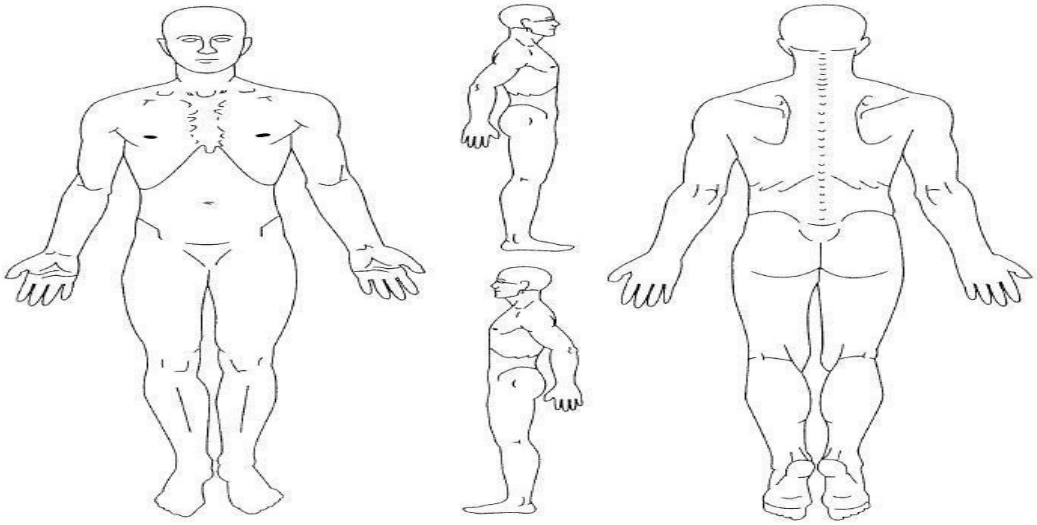
Illicit Drugs	occasional	often	never
Drink Alcohol	occasional	often	never
Cigarettes:	Less than 1 pack/a day	More than 1 pack/a day	Never

How Long_____
Bring a List of your Medications to your appointment.

Carolina Sports and Spine

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling D=Dull Ache



Height ____ft_____in Weight _____lbs

I fully acknowledge that the information provided is complete and correct to the best of my knowledge and understand that it is my responsibility to inform Carolina Sports and Spine PA, of any changes to information I have provided.

PATIENT'S NAME (Please Print): _____

PATIENT SIGNATURE: _____ **DATE:** _____

Carolina Sports and Spine

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits Carolina Sports and Spine PA or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Carolina Sports and Spine PA is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be
made directly to Carolina Sports and Spine PA, or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Carolina Sports and Spine PA , Patient Information Privacy Policy. I hereby authorize Carolina Sports and Spine PA or the physician individually to release any of my medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Carolina Sports and Spine PA representative or my physician to mail, call, or email me with communications regarding my health care, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Carolina Sports and Spine PA to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Carolina Sports and Spine PA physician or his or her designee.

HIPAA Privacy Practices
I acknowledge that I have received and /or have been given the opportunity to review Carolina Sports and Spine PA Notice of HIPAA Privacy Practices for protected health information.

PATIENT'S NAME (Please Print): _____

PATIENT SIGNATURE: _____ **DATE:** _____

Financial Policy
Carolina Sports and Spine PA, wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. Your medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Carolina Sports and Spine, PA. Please review and sign the following financial policy prior to your office visit.

CO-PAYS, DEDUCTIBLES, AND FEES – All co-pays, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered. We accept cash, check, or credit cards (VISA, MasterCard, and Debit).

INSURANCE – You must present a current insurance card at each visit. If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Carolina Sports and Spine, PA if your insurance pays the claim, at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. According to NC Statute 58-22253, insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed by Carolina Sports and Spine, PA.

Carolina Sports and Spine

MISSED APPOINTMENTS – If you are unable to make your scheduled appointment time, please contact our office at least 24 hours prior to your scheduled appointment so that another patient may fill your slot. If we do NOT receive a 24 hour or more notice of cancellation you will be billed $40 for each missed office visit appointment and $80 for each missed procedure visit. After 3 "No Shows", it will be left to the discretion of our providers to determine whether or not you will be dismissed from the care of Carolina Sports and Spine, PA.
PROMPT PAYMENT – we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety please contact our billing office to discuss payment options. If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency and we will ask you to seek your medical care from another medical office.

PATIENT'S NAME (Please Print): _____

PATIENT SIGNATURE: _____ **DATE:** _____

MEDICATION AGREEMENT

As a patient of Carolina Sports and Spine, PA, you are responsible of assuring that all prescriptions issued to you remain unaltered and appropriately filled, that your medications are properly stored and taken as directed, that you do not receive narcotic medications from outside sources, that you do not take illicit substances, that you do not lose your prescriptions. You are responsible for keeping your scheduled appointments and exhibiting courteous behavior towards the clinic staff. Failure to follow these rules may result in your dismissal from our practice.

Many of the medications that Carolina Sports and Spine, PA uses are controlled substance medications- opioids (narcotics). Several side effects or special situations may arise when using opioids. They include, but are not limited to the following: Addiction, Tolerance, Respiratory Depression and possibly Death. Narcotic Medication use is a serious matter. Never take more than the prescribed dose or give it to others.
Carolina Sports and Spine adheres to strict drug testing guidelines. Carolina Sports and Spine adheres to a **zero tolerance policy** with regard to narcotic medication compliance. You must have your pill bottles available for pill counts prior to any prescriptions being provided. If you have failed your urine drug screen either by not taking your medications as prescribed, receiving narcotic medications from multiple sources, or using illicit drugs, Carolina Sports and Spine, PA will not provide you with any more narcotic medications. CSS strongly recommends that you seek help at a qualified drug treatment center. All test results are shared with primary care physicians and referring physicians.

Narcotics will NOT be provided to patients on initial consultation.

PATIENT'S NAME (Please Print): _____

PATIENT SIGNATURE: _____ **DATE:** _____

Carolina Sports and Spine

HIPPA FORM

The notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information.

A federal regulation, known as "HIPAA Privacy Rule", requires that we provide detailed notice in writing of our privacy practices.

We have a commitment to protecting health information about you and that can be identified with you. This information is called "protected health information" or "PHI". We are required by law to
Maintain the privacy of PHI about you Provide you with the opportunity of reading the notice of privacy practices and our legal duties and concerning your privacy and PHI Comply with the terms of our Notice of Privacy Practices that is currently in effect.

The following categories describe the different ways we may use and disclose PHI:
Treatment, Payment, Health Care Operations Written authorization by law, proper government authorities, law enforcement, coroners, medical examiners, organ and tissue donation, research, judicial and administrative proceedings, to avert a serious threat to health or safety, workers' compensation, specialized government functions, disclosures required by HIPAA privacy rule, incidental disclosures, limited data set disclosures

Other uses and disclosures we can make without your written authorization for which you have the opportunity to object. Any objections should be discussed with your physician under any circumstances other than those listed above, we will ask you for your written authorization.

Your Rights Regarding PHI About You
1. You have a right to request restrictions
2. You have a right to receive Confidential Communications
3. You have a right to request a copy of your PHI
4. You have a right to request amendment to your PHI
5.You have a right to receive an accounting of disclosures
6. You have a right to receive a copy of notice:

Questions/Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the United States Department of Health and Human Services. To file a complaint with this office or if you have questions, please contact Jennifer Yap at 2524424024. We will not retaliate or take action against you for filing a complaint.

For more detailed information, please ask the medical receptionist at the front desk.

I acknowledge that I have been given the opportunity to view or was provided with a copy of the Notice of Privacy Practices. Carolina Sports and Spine, PA

PATIENT'S NAME (Please Print): _____

PATIENT SIGNATURE: _____ **DATE:** _____

HIPPA FORM

I hereby acknowledge that I have received and read the information documenting my rights as a patient and the responsibilities of Carolina Sports and Spine under the Health Insurance Portability and Accountability Act of 1996. Please list family and/or friends with whom we may discuss your medical condition, demographic information,diagnosis, and/or financial account if necessary:

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

I authorize Carolina Sports and Spine to notify me of upcoming appointments via email and/or telephone. Please initial _____

PATIENT'S NAME (Please Print): _____

PATIENT SIGNATURE: _____ **DATE:** _____