WEST AVE
Neuro Spine
AMIR S. MALIK, M.D.

PATIENT INFORMATION

Name:	DOB:	Gender: F M	Marital: M S D W (circle one)
Address:	City:	State:	Zip:
Home #:	Cell#:	Work#:	Email:
TDL#:	SS#:	Employer:	Address:
Emergency Contact Name:		Phone:	

INSURANCE INFORMATION

Primary Ins: _____
ID #: _____ Group #: _____
INSURED'S NAME: _____ DOB: _____
Employer: _____ Employer's Phone: _____
Address: _____

Secondary Ins: _____
ID #: _____ Group #: _____
INSURED'S NAME: _____ DOB: _____
Employer: _____ Employer's Phone: _____
Address: _____

REFERRAL INFORMATION

Please let us know whom we can thank for referring you to our office.

Physician ☐ Friend ☐ Insurance ☐ Patient ☐ Other ☐

Name: _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS & RELEASE AUTHORIZATION (EXCLUDING WORKER'S COMPENSATION)
I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING PRIVATE INSURANCE, TO SPINE CARE, PA. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED VALID AS ORIGINAL. I UNDERSTAND I AM FINANCIALLY REPSONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION DEEMED NECESSARY FOR MY TREATMENT TO INSURANCE COMPANY AND TO ANY OTHER MEDICAL PROVIDER TO WHOM I AM REFERRED. IN ADDITON, I UNDERSTAND THAT I AM LIABLE FOR A $25.00 CHARGE IN THE EVENT OF A MISSED/BROKEN APPOINTMENT WITHIN LESS THAN A 24HR CANCELLATION NOTICE.

Patient Signature Date

Patient Name:_____Date: _____

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SPINE SURGERY NEW PATIENT QUESTIONNAIRE

WHERE IS YOUR PAIN NOW?

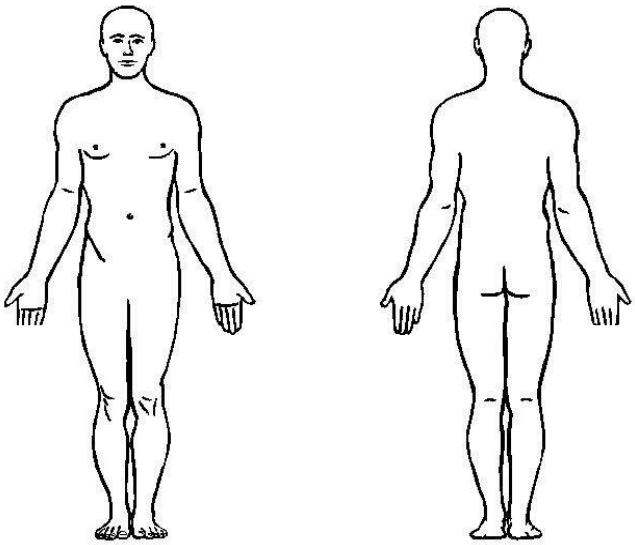
Please indicate on the table below the percentage of pain that you currently feel in your *legs, arms, neck, and back.*

Ex: back pain 50% and leg pain 50% = 100%

LEG PAIN	**%**
ARM PAIN	**%**
NECK PAIN	**%**
BACK PAIN	**%**
TOTAL	**100%**

On the diagrams below please do the following:

Place an "**X**" where you have **pain**.
Place an "**O**" where you have **numbness**.
Place a "**T**" where you have **tingling**.
Place an "**S**" where you feel **stabbing pain**.



CURRENT HISTORY

What is the main reason for your visit today? (circle one)
back pain leg pain neck pain other explain_____

How long have you had this pain?(circle one)
<2mo 2-6mos 6-12mos 1yr or > please explain _____

Have you been treated by another provider for this condition? **Yes or No**
If yes, please explain: _____

Have you had any type of treatment? *(i.e. chiropractic care, injections, physical therapy, etc)* **Yes or No**
If yes, please explain: _____

Have you had any type of diagnostic testing for this problem? *(i.e. X-RAY, BMD, CT, MRI, EMG)* **Yes or No**
If yes, please explain: _____

Patient Name:_____Date: _____

Are you taking any Anti-inflammatory medication(s): RE: Advil, Motrin, Aleve, Celebrex, etc.
If yes, please explain: _____

Are you taking any prescribed Analgesic medication(s): RE: Robaxin, Flexeril, Soma, Norco, Hydrocodone, Vicoden, etc.
If yes, please explain: _____

Have you had any Physical therapy or Occupational Therapy for your condition?
If yes, please explain: _____
Dates: _____ Frequency: _____

Do you use a brace, cane or other mobility device?
If yes, please explain: _____

Have you ever had any of the below conservative treatments:
Steroid Injections _____ Yes How many injections: _____ Dates: _____

Have you tired any lifestyle change recommendations: RE: Weight Reduction, Exercise, Quit smoking, Quit Drinking
If yes, please explain: _____

PAST MEDICAL HISTORY

Have you ever been hospitalized? **Yes or No**
If yes, please explain: _____

Have you ever had any type of surgery? **Yes or No** ***(If yes, list date, type of surgery, complications if any)***

Date	***Surgery***	***Complications***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current or Past Illnesses or Hospitalizations:

_____

_____

_____

Medications	Strength	Dosage

Patient Name:_____Date: _____

Allergies

Do you have any **known** allergies to medications? **Yes or No**

Are you allergic to Latex? **Yes or No**

If yes, please explain: _____

SOCIAL HISTORY

Do you smoke? **Yes or No**

If yes, how many packs per day? _____ **How many years?** ___Did you quit? **Yes or No**

If so when did you stop? _____

Do you use any other types of nicotine products? **Yes or No**

If yes, please explain: _____

Do you drink alcohol? **Yes or No**

If yes, how often and how much do you consume? _____

FAMILY HISTORY

Do you have a family history of the following?

Arthritis	**yes or no**	Mental Health Disorders	**yes or no**
Hypertension	**yes or no**	Blood clots/excessive-bleeding	**yes or no**
Cancer	**yes or no**	Diabetes	**yes or no**
Adverse Reaction to Anesthesia	**yes or no**	Cardiac Disorders	**yes or no**

OTHER : _____

REVIEW of SYSTEMS

Do you currently or have had problems with the following? Please explain all **"yes"** answers.

Skin	Yes or No	_____
Ears, Nose, Throat	Yes or No	_____
Cardiac/High Blood Press	Yes or No	_____
Lungs(Asthma, Infection)	Yes or No	_____
Stomach/Digestive	Yes or No	_____
Bladder/Bowel	Yes or No	_____
Diabetes	Yes or No	_____
Cancer	Yes or No	_____
Musculoskeletal	Yes or No	_____
Neurological	Yes or No	_____
Psychiatric	Yes or No	
Reproductive	Yes or No	_____
Fever/		

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by Dr. Malik or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES

Dr. Malik is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the Notice of Privacy Policies and Practices provided to you. ***PLEASE REVIEW IT CAREFULLY.***

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, Dr. Malik may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Dr. Malik agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Policies and Practices, please consult with a practice representative at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time; however, Dr. Malik requires that you must revoke this request in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the dates of your request.

CHANGES TO PRIVACY PRACTICES

Dr. Malik reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Policies and Practices. Dr. Malik will notify you of any changes of privacy practices either by mail, at your next appointment or any other pre-approved method that you request.

SIGNATURE

I have reviewed this consent form, received Notice of Privacy Policies and Practices, and given my permission to Dr. Malik to use and disclose my health information in accordance with this consent and the notice provided.

PRINT NAME_____ PATIENT REP PRINT NAME_____

PATIENT SIGNATURE_____ PATIENT REP SIGNATURE_____

DATE_____ PATIENT REP RELATIONSHIP TO PATIENT _____

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FINANCIAL POLICY STATEMENT

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. There is a service charge for returned checks.

It is the policy of Dr. Malik to bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within sixty (60) days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Your time of service receipt includes all information necessary for submitting claims to your insurance company.

Patients with an outstanding balance sixty (60) days or more overdue must make arrangements for payment prior to scheduling appointments.

IF YOU ARE ENROLLED IN A MANAGED CARE INSURANCE PLAN (i.e., HMO), you must have a referral authorization from you PCP (primary care physician) before you will be seen in our office. Retroactive referrals are not guaranteed.

PLEASE BE ADVISED THAT WE DO NOT TREAT AUTOMOBILE ACCIDENT INURIES, WORKMAN'S COMPENSATION INJURIES/CLAIMS, OR INJURIES THAT ARE INVOLED IN LITIGATION.

I HAVE READ AND UNDERSTAND DR. MALIK'S FINANCIAL POLICY. I AGREE TO ASSIGN INSURANCE BENEFITS TO THE DR. MALIK WHENEVER NECESSARY. IA SLO AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTIOIN AGENCY, IN ADDITION TO THE AMOUNT OWED, I ALSO WILL BE RESPONSIBLE FOR THE FEE CHARGED BY THE COLLECTION AGENCY FOR COSTS OF COLLECTIONS.

If my insurance company denies payment for any reason, I understand I am financially responsible for all services rendered by Dr. Malik.

I UNDERSTAND IT IS MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

PRINTED NAME _____

SIGNATURE_____ DATE_____

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CONSENT TO RELEASE INFORMATIONIORALLY TO FAMILY OR FRIENDS FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

PATIENT NAME _____

Dr. Malik has my permission to release my confidential health information to the following individuals who are involved in my care.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this permission, in writing, at any time and that disclosures made in good faith may have already occurred and that the withdrawal of permission cannot be applied retroactively.

PATIENT SIGNATURE _____ DATE _____

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DISCLOSURE OF FINANCIAL INTEREST NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Amir S. Malik, MD has financial interest in the following facilities:
   - Elite Hospital for Surgical Excellence
   - Lucenta Labs Custom Rx, LP
2. Due to the financial interest in the above facilities, Dr. Malik may receive, directly or indirectly, remuneration when services are provided at the above facilities.
3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than the facilities listed above and you have the right to use a provider other than Dr. Malik.
4. You will **NOT** be treated differently by Dr. Malik if you choose to obtain health care services at a facility other than those listed above.

If you have any questions concerning this notice, please feel free to ask Dr. Malik. We welcome you as a patient and value our relationship with you.

Patient Signature_____ **Date**_____

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NOTICE OF FEE FOR DISABILITY AND FMLA FORMS

For all disability and Family and Medical Leave Act (FMLA) forms there is a $75 fee.

If an addendum is required for your disability or FMLA forms there is an additional fee of $50.

The forms will not be completed until payment is made. After payment is received, allow 10 business days for completion.

It will be the patient's responsibility to pick and send the forms.

_____ _____

Patient Signature Date

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Balance Self-Test
Are You At Risk For Falls?

1. Have you fallen in the past year?	Yes	No
2. Do you lose your balance when standing?	Yes	No
3. Do you lose your balance when you initially get up after sitting?	Yes	No
4. Do you get dizzy, faint or have seizures?	Yes	No
5. Does it take you more than one try to get up out of a chair or out of bed?	Yes	No
6. Do you trip over your own feet or objects on the floor?	Yes	No
7. Do you take corner too sharp or bump into corners or door frames?	Yes	No
8. Do you use a walker, cane or need assistance to get around?	Yes	No
9. Do you lose your balance, feel unsteady or stagger when walking?	Yes	No
10. Have you had a recent loss of decrease in vision or hearing?	Yes	No
11. Do you have numbness or loss of sensation in your feet or legs?	Yes	No
12. Have you experienced a stroke, accident or any other health problem that may have affected your balance?	Yes	No

If you answered yes to one or more questions, you may have a balance problem.

Please ask the staff how we can help you improve your balance.

Patient name: _____

Date: _____

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Member Authorization Form for a designated Representative to Appeal a Determination

Date: _____

Member Name: _____
Member #: _____

I hereby authorize _____ to appeal determination concerning:
_____
_____
_____

On my behalf, as a designated representative, and, as part of the appeal, I hereby authorize _____ its decision letter and in connection with the processing of my appeal, to communicate with my designated representative in all aspects of the appeal. I understand that these communications may contain the following:

All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorders and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
___ Signature of Witness ___ Designated Representative (Check one)

_____
Name of Witness/Designated Representative (Please Print)

_____
Title (if on provider's staff) or Relationship to Member

Appendix 7- Waiver of Liability Statement

(Rev. 105, issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

Waiver of Liability Statement

_____ _____

Enrollee's Name Medicare/HIC number

_____ _____

Provider Dates of Service

_____

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600

_____ _____

Signature Date

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- **A. Notifier:**
- **B. Patient Name:** **C. Identification Number:**

• Advance Beneficiary Notice of Noncoverage (ABN)

- **NOTE:** If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.
Ask us any questions that you may have after you finish reading.
Choose an option below about whether to receive the **D.** _____ listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

OPTION 3. I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: