



2001 Peachtree Road, NE ♦ Suite 575 ♦ Atlanta, GA 30309
Phone: (404) 350-0106 ♦ Fax: (404) 350-0176

Fax

To: _____ **From:** _____

Fax: _____ **Pages:** _____, including cover sheet

Phone: _____ **Date:** _____

Re: _____ **CC:** _____

Urgent **For Review** **Please Comment** **Please Reply** **Please Recycle**

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CONFIDENTIALLY: THE INFORMATION CONTAINED IN THIS FACSIMILE TRANSMISSION IS INTENDED FOR THE USE OF THE INDIVIDUAL TO WHOM IT IS ADDRESSED, AND MAY CONTAIN INFORMATION WHICH IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF YOU ARE NOT THE INTENDED RECIPIENT OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DESTRUCTION OR COPYING OF THE COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN ORIGINAL FACSIMILE WITHOUT RETAINING ANY COPIES TO US AT THE ABOVE ADDRESS VIA UNITED STATES POSTAL SERVICE. THANK YOU.

IF TRANSMISSION IS NOT RECEIVED PROPERLY PLEASE NOTIFY US IMMEDIATELY AT THE ABOVE NUMBER.

THANK YOU.



Thank you for selecting Atlanta Brain and Spine Care for your treatment. To help our healthcare providers with their evaluation, we request that you bring the following items with you or have the items sent to our office prior to your appointment.

❑ **Copies of Your Medical Records from Your Referring Physician**

Please complete the enclosed form and ask that your referring physician mail your medical records to our office prior to your visit. **In some situations, if we do not have these items when you arrive for your appointment, your appointment will be rescheduled.**

NOTE → If you are scheduled to see Dr. Haid and you previously saw him at Emory, you will need to contact Emory and request that your medical records are mailed to our office. You may use the enclosed form to expedite this process.

❑ **X-ray's, MRI's or CT Scans**

Please bring these items with you. Our healthcare providers need these items to diagnose your condition. In most situations, if you do not have these items when you arrive for your appointment, you will need to set up an additional appointment after the diagnostic test is performed. **In some situations, if you do not have these items when you arrive for your appointment, your appointment will be rescheduled.**

Patients are responsible for their films. Patients must obtain their films and bring them or have them shipped to our office for their appointment. If patients want their films returned, patients may either pick up their films or patients must remit a shipping and handling fee to our office prior to shipping and provide a ship to address. Our office does not store films which our providers do not anticipate needing in the future.

If the patient's physician anticipates needing the films after the appointment, the films will be filed in our office. At the time the films are no longer needed, the patient will be notified and will have thirty (30) calendar days from the date of notification to pick up the films or remit a shipping and handling fee of thirty dollars (\$30) to our office. The shipping and handling fee must be received prior to the films being shipped. The patient must provide the ship to address and the address must be within the United States. If the patient does not pick up the films or remit the shipping fee by the end of the thirty (30) day period, the films will be discarded.

If the physician sees a patient and does NOT anticipate needing the films in the future after the patient's appointment, the patient may pick up the films or ask that we ship the films to an address in the United States. The patient must provide the ship to address. If we ship the films, there will be a thirty dollar (\$30) shipping and handling fee that must be paid in advance of shipping. If the fee is not remitted, the films will be kept for thirty (30) calendar days and then discarded. The thirty day period begins with the date of the last office appointment.

❑ **New Patient Packet**

Please complete the enclosed paperwork and return it to our office at least one week prior to your appointment. **If our office does not receive this information prior to your appointment, your time at our office may be extended by at least two (2) hours and may ultimately result in you having to reschedule your appointment.** We can not sufficiently stress the importance of completing and returning the paperwork prior to your appointment date. Also remember to bring your insurance card(s) and picture identification.

We kindly ask that you provide twenty-four hours notice for appointment cancellation. If we do not receive twenty-four hours notice, you will be charged one hundred dollars (\$100).

If you have questions or concerns, please call us at (404) 350-0106. We look forward to meeting you.



PATIENT INFORMATION – PLEASE PRINT CLEARLY

PATIENT'S NAME	SOCIAL SECURITY #	BIRTHDATE	AGE
STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE #
PHYSICIAN REQUESTING VISIT:	MARITAL STATUS	DRIVER'S LICENSE #	WORK PHONE #
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		
EMPLOYER'S ADDRESS:	CITY AND STATE	ZIP CODE	
HERE TO SEE: Dr. Haid Dr. Robinson Dr. Wray Scot Fleck, PA-C Freda Wall PA-C Laura Smith, NP			
SPOUSE (OR GUARDIAN'S NAME IF MINOR)			
1.EMERGENCY CONTACT:(OTHER THAN SPOUSE)	RELATIONSHIP	PHONE #	
2.ALTERNATE CONTACT:(OTHER THAN SPOUSE)	RELATIONSHIP	PHONE #	

We require all patients to show their insurance or managed care membership card, and their driver’s license, so that we may make copies for our permanent record.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient’s account. Payment is expected at the time of service. For your convenience, we accept Visa, Mastercard, American Express, Discover, check, money order or cash. If surgery is necessary, we will ask you to remit the estimated patient responsible portion of the surgery charge at the time the surgery is scheduled.

PAYMENT AND RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize Atlanta Brain and Spine Care to furnish information concerning my present illness to third party payers. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him or her as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and or attorney fees associated with my failure to pay my debt. A photo static copy of this authorization will be valid as the original.

I hereby authorize Atlanta Brain and Spine Care to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary.

Signature of Patient or Guardian _____ Date _____



INSURANCE VERIFICATION FORM

TO THE PATIENT: THE FOLLOWING INFORMATION IS REQUIRED IN ORDER FOR THE OFFICE TO FILE YOUR INSURANCE. FAILURE TO PROVIDE COMPLETE INFORMATION MAY RESULT IN YOU BEING REQUIRED TO PAY FOR YOUR VISIT IN FULL AT THE TIME OF SERVICE.

PATIENT NAME: _____ DATE: ____/____/____

PRIMARY POLICY HOLDER INFORMATION:

NAME: _____ D.O.B: ____/____/____ S.S. # ____-____-____
 RELATIONSHIP TO PATIENT: _____
 Employed By: _____

SECONDARY POLICY HOLDER INFORMATION:

NAME: _____ D.O.B.: ____/____/____ S.S. # ____-____-____
 RELATIONSHIP TO PATIENT: _____
 Employed By: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

GROUP NO: _____
 I.D. NUMBER: _____
 EFFECTIVE DATE: _____

GROUP NO: _____
 I.D. NUMBER: _____
 EFFECTIVE DATE: _____

(EFFECTIVE DATES MUST BE GIVEN)

(EFFECTIVE DATES MUST BE GIVEN)

ARE YOU COVERED BY MEDICARE? _____
 ARE YOU COVERED BY MEDICAID? _____

MEDICARE #: _____ RAILROAD? _____
PLEASE GIVE SECRETARY A CURRENT MEDICAL ELIGIBILITY FORM.

INSURANCE COMPANY MAILING ADDRESS: _____

INSURANCE COMPANY MAILING ADDRESS: _____

PHYSICIAN'S OFFICE USE ONLY BELOW THIS LINE

CONTACT PERSON: _____ PHONE EXT.: _____

BENEFITS:

COPAY: _____

DEDUCTIBLE: _____

X-RAY: _____

LAB: _____

OUT PT SURGERY: _____

PRE-EXISTING CONDITION CLAUSE: _____

INS. VER. BY	DATE



REFERRING PHYSICIAN INFORMATION SHEET

Please complete the following information on every provider that has treated you for the condition you are being treated for today:

Physician Name: _____
Address: _____

Phone #: _____
Dates Treated: _____
Specialty: _____
Office use: NPI #: _____

Physician Name: _____
Address: _____

Phone #: _____
Dates Treated: _____
Specialty: _____
Office use: NPI #: _____

Physician Name: _____
Address: _____

Phone #: _____
Dates Treated: _____
Specialty: _____
Office use: NPI #: _____

Physician Name: _____
Address: _____

Phone #: _____
Dates Treated: _____
Specialty: _____
Office use: NPI #: _____

Physician Name: _____
Address: _____

Phone #: _____
Dates Treated: _____
Specialty: _____
Office use: NPI #: _____

Authorization to Disclose Information for Purposes Requested by Patient or Physician's Office

I, _____, hereby authorize **Atlanta Brain and Spine Care** to disclose protected health information to the aforementioned providers for medical reasons. This information may include but is not limited to letters which discuss my visit, treatment plan and progress **or** copies of office visit notes, lab reports, diagnostic reports, op notes **or** other communication such as phone calls which may be deemed necessary to provide effective communication between the various physicians involved in my healthcare.

This authorization shall be in force and effect until **[specify date or event that relates to the patient or the purpose of the use or disclosure]** _____, at which time this authorization to use or disclose this protected health information expires.



I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Privacy Officer** at **2001 Peachtree Road Suite 575, Atlanta, GA 30309**. I understand that a revocation is not effective to the extent that **Atlanta Brain and Spine Care** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Atlanta Brain and Spine Care will not condition my treatment, payment or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state or federal law.
- Refuse to sign this authorization

The use or disclosure requested under this authorization to the physicians involved in my healthcare **will not** result in direct or indirect remuneration to **Atlanta Brain and Spine Care** from a third party.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (please print)

Date of Birth

Relationship to patient (or other authority to serve)

Social Security Number

Date



Narcotics – Medication Policy

EACH PATIENT HAS SPECIFIC REQUIREMENTS FOR TREATMENT. WE WILL EVALUATE EACH PATIENT AND DETERMINE THE BEST METHOD OF TREATMENT TO INCLUDE PHYSICAL THERAPY, INJECTION THERAPY AND MEDICATIONS. TO PROVIDE THE BEST CARE IN THE MOST EFFICIENT AND TIMELY MANNER, WE ASK ALL OF OUR PATIENTS TO READ AND SIGN THE FOLLOWING CONTRACT.

- _____1. NARCOTIC/SEDATIVE MEDICATIONS **WILL NOT BE CALLED IN AFTER 5PM.**
- _____2. NARCOTIC/SEDATIVE MEDICATIONS **WILL NOT BE CALLED IN OVER THE WEEKEND.**
- _____3. REFILLS WILL NOT BE GIVEN TO PATIENTS THAT HAVE NOT BEEN SEEN RECENTLY. THIS WILL BE DETERMINED BY THE PHYSICIAN.
- _____4. REFILLS WILL NOT BE GIVEN FOR LOST OR STOLEN PRESCRIPTIONS OF NARCOTICS OR SEDATIVES.
- _____5. REQUESTS FOR MEDICATIONS MADE **AFTER NOON ON FRIDAY WILL NOT BE CALLED IN UNTIL MONDAY.**
- _____6. WHEN CALLING FOR A MEDICATION LEAVE THE PHARMACY NAME AND NUMBER AS WELL AS YOUR NUMBER. IF YOU HAVE CHANGED THE MEDICATIONS YOU ARE TAKING, WE NEED TO KNOW THOSE CHANGES.
- _____7. ONLY ONE PHYSICIAN SHOULD BE PRESCRIBING YOUR MEDICATIONS.
- _____8. MOST IMPORTANTLY: DO NOT WAIT UNTIL THE LAST MINUTE TO REQUEST MEDICATIONS. MEDICATIONS WILL BE CALLED IN AS QUICKLY AS POSSIBLE, BUT YOU SHOULD EXPECT **A 24 TO 48 HOUR PERIOD OF TIME BEFORE YOUR MEDICATION IS CALLED IN TO YOUR PHARMACY. IT IS YOUR RESPONSIBILITY TO KEEP UP WITH YOUR MEDS. DO NOT WAIT UNTIL YOU RUN OUT TO CALL FOR MEDICATIONS.**

I UNDERSTAND THE ABOVE STATEMENTS AND AGREE TO FOLLOW THEM AS STATED.

SIGNATURE _____ DATE _____



PATIENT CONSENT

I hereby give my consent for Atlanta Brain & Spine Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Atlanta Brain & Spine Care Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Brain & Spine Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Atlanta Brain & Spine Care
Privacy Officer
2001 Peachtree Road, N.E., Suite 575
Atlanta, GA 30309
(404) 350-0106

With this consent, Atlanta Brain & Spine Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Atlanta Brain & spine Care may mail to my home or alternative location any items that may assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Atlanta Brain & Spine Care may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Atlanta Brain & Spine Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Atlanta Brain & Spine Care use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or late revoke it, Atlanta Brain & spine Care may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date _____

Print Name of Patient or Legal Guardian



PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Atlanta Brain and Spine Care's Notice of Privacy Practices is located on our web site www.atlantabrainandspine.com. A copy is available in our office or you may request a copy.

I have read a copy of the Notice of Privacy Practices of ATLANTA BRIAN & SPINE CARE on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of ATLANTA BRIAN & SPINE CARE.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

**Compliance Officer
ATLANTA BRAIN & SPINE CARE
2001 Peachtree Road, N.E.
Suite 575
(404) 350-0106
(404) 350-0176 Fax**

Signature of Patient

PRINT NAME: _____

DATE: _____



Authorization to Obtain and Use or Disclose Information for Purposes Requested by Patient or Physician's Office

I, _____, hereby authorize **Atlanta Brain and Spine Care** to (check those that apply):

_____ obtain and use the following protected health information from, or

_____ disclose the following protected health information to:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

[Specifically describe the information to be obtained and used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

This protected health information is being obtained and used or disclosed for the following purposes: [List specific purposes here.]

_____ Personal Use

_____ Medical Reasons

_____ Other (please list): _____

Continued next page



This authorization shall be in force and effect until **[specify date or event that relates to the patient or the purpose of the use or disclosure]** _____, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Privacy Officer** at **2001 Peachtree Road Suite 575, Atlanta, GA 30309**. I understand that a revocation is not effective to the extent that **Atlanta Brain and Spine Care** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Atlanta Brain and Spine Care will not condition my treatment, payment or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under state or federal law.
- Refuse to sign this authorization

The use or disclosure requested under this authorization _____ **will** _____ **will not** result in direct or indirect remuneration (payment) to **Atlanta Brain and Spine Care** from a third party.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (please print)

Date of Birth

Relationship to patient (or other authority to serve)

Social Security Number

Date



PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish.

Social Security Number (SSN) _____ **Appointment Date** _____

Full Name _____ Male Female Date of Birth _____

Pharmacy Preference (INCLUDE LOCATION & PHONE NUMBER)

Name of Primary Care (Family) Physician _____ Phone Number _____

Name of Referring Physician _____ Phone Number _____

CURRENT MEDICATIONS: Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

No Yes **If yes, please list below include dosages.**

Medication Name		

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? No Yes

If yes, please list below.

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES: Are you allergic to seafood? No Yes **If yes, what reaction do you have?** _____

Are you allergic to things that touch your skin, such as latex, tape, metal? No Yes latex tape metal

PAST HEALTH HISTORY: Have you ever been DIAGNOSED with any of the following problems?

Cancer (type) _____ No Yes

What year? _____

Nose and Sinus:

Nasal Allergies No Yes

What year? _____

Heart and Blood Vessels:

High / Elevated Cholesterol No Yes

What year? _____

High Blood pressure No Yes

What year? _____

Lungs and Respiratory:

Tuberculosis No Yes

What year? _____

Stomach and Digestive:

Duodenal ulcer No Yes

What year? _____

Hepatitis No Yes What

year? _____

Stomach ulcer No Yes

What year? _____

Kidney and Gender Problems:

Renal failure No Yes

What year? _____

Are you pregnant? No Yes

Mental & Emotional:

Depression No Yes

What year? _____

Anxiety No Yes

What year? _____

Glands, Hormones, and Sugar Control:

Diabetes No Yes

What year? _____

Thyroid deficiency No Yes

What year? _____

Thyroid excess No Yes

What year? _____

Blood & Lymph Node problems:

Anemia No Yes

What year? _____

Allergies, Immune & Infectious Problems:

HIV No Yes

What year? _____

Infectious mononucleosis No Yes

What year? _____

SURGERIES AND HOSPITALIZATIONS:

Have you had problems with anesthesia (being numbed or put to sleep)?

high fever trouble with intubation (placement of breathing tube)

Have you had surgery? No Yes

If **yes**, list types and when they were done.

Have you ever been hospitalized for non-surgical reasons? No Yes

If **yes**, list types and when they were done.

FAMILY HISTORY:

Specific Anesthesia Problem Mother Father
 Brother Sister

Ears:

Hearing Loss before age 20 Mother Father
 Brother Sister

Hearing Loss after age 20 Mother Father
 Brother Sister

Nose and Sinus:

Nasal Allergies Mother Father
 Brother Sister

Heart and Blood Vessels:

Heart Disease Mother Father
 Brother Sister

High Blood Pressure Mother Father
Brother Sister

Lungs and Respiratory:

Asthma Mother Father
 Brother Sister

Lung Cancer Mother Father
 Brother Sister

Brain and Nervous:

Stroke Mother Father
 Brother Sister

Blood & Lymph Node problems:

Bleeding/clotting problem Mother Father
 Brother Sister

Other _____ Mother Father
 Brother Sister



SOCIAL HISTORY:

What is or was your occupation? _____ Check here if you are retired.

Have you ever used tobacco in any form?

No Yes

If yes, please complete the following:

Type of Tobacco	From year	To year
Cigarettes per day: _____		
Other: (list type)		

Are you exposed to second hand smoke? No Yes

Do you consume alcohol? No Yes

If yes, please complete the following:

Type of Alcohol	How Much	How often

Do you use drugs recreationally? No Yes **If yes, please list** _____

REVIEW OF SYSTEMS: Mark yes or no and CHECK any of the following ***SYMPTOMS*** you have recently had

General health problems No Yes
(fever, sleeping problems, unintentional weight loss)

Head or Face problems No Yes
(headache, face pain)

Eye problems No Yes
(blurred vision double vision, loss of vision)

Ear problems No Yes
(hearing loss, dizziness, ringing)

Mouth & Throat problems No Yes
(change in voice, snoring, sore throat, ulcers)

Neck problems No Yes
(neck masses or lumps, pain, swollen glands)

Heart or circulation problems No Yes
(blacking out or fainting, bluish discoloration of lips or fingernails, chest pain, irregular heartbeat, leg cramps, swelling of ankles)

Lung or respiratory problems No Yes
(freq non-productive cough, freq productive cough, shortness of breath, wheezing)

Stomach problems No Yes
(abdominal pain, diarrhea, heartburn, nausea, vomiting)

Bones, Joints and Muscles No Yes
(pain in back, painful joints, stiffness, swelling of joints)

Brain or Nervous system problems No Yes
(change in alertness, loss of bladder control, loss of consciousness, numbness, seizures, severe face pain, weakness)

Problems with Glands, Hormones No Yes
(feel cold all the time, feel hot when others do not, increased appetite, increased fatigue, neck has enlarged, unwanted weight change)

Problems with Blood or Lymph nodes No Yes
(bleeds excessively after injury, bruises easily)

Problems with Allergies No Yes
(food intolerances, freq sneezing, hives, post nasal drainage, severe reaction to insect bites)

What is the main reason you are seeing the doctor today? _____



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Additional Information: