

PATIENT INFORMATION

PATIENT'S NAME	SOCIAL SECURITY #	DOB	SEX	HOME PHONE #
				CELL PHONE #
STREET ADDRESS			CITY/STATE ZIP	
PREFERRED METHOD OF CONTACT CHECK ONE:	E-MAIL	HOME	CELL	OTHER
EMPLOYMENT or STUDENT STATUS	OCCUPATION	HOW LONG	WORK PHONE #	
PATIENT'S EMPLOYER		EMPLOYER'S ADDRESS		
EMERGENCY CONTACT OUTSIDE YOUR HOME		EMERGENCY CONTACT PHONE #	RELATIONSHIP OF CONTACT	
SPOUSE'S NAME or GUARDIAN (if patient is a minor)		SOCIAL SECURITY #	DOB	
SPOUSE or GUARDIANS EMPLOYER NAME			EMPLOYER'S PHONE #	
EMPLOYER'S ADDRESS				
REFERRING PHYSICIAN OR COMPANY	ADDRESS		PHONE #	
FAMILY DOCTOR	ADDRESS		PHONE #	
PHARMACY NAME	PHARMACY ADDRESS	PHARMACY PHONE #		
PRIMARY INSURANCE COMPANY	NAME OF INSURED & DOB	RELATIONSHIP TO PATIENT		
POLICY #	GROUP #	INSURED'S EMPLOYER		
SECONDARY INSURANCE COMPANY	NAME OF INSURED & DOB	RELATIONSHIP TO PATIENT		
POLICY #	GROUP #	INSURED'S EMPLOYER		

NO-SHOW POLICY: EFFECTIVE 7/1/06 THERE WILL BE A \$20.00 NO-SHOW/LATE CANCELLATION FEE. APPOINTMENTS MUST BE CANCELLED BY 3:00 PM OF THE PREVIOUS DAY OR BY 3:00 PM ON FRIDAY FOR A MONDAY APPOINTMENT. THE PATIENT/GUARDIAN WILL BE RESPONSIBLE FOR THIS FEE. IT WILL NOT BE BILLED TO YOUR INSURANCE COMPANY.

IS YOUR ILLNESS/INJURY DUE TO A WORK RELATED INCIDENT?

IF SO, PLEASE ANSWER THE QUESTIONS BELOW:

ACCIDENT LOCATION	DATE OF INJURY	DATE LAST WORKED
HOW WERE YOU INJURED?		
WORK COMP CARRIER	WORK COMP CARRIER ADDRESS	
ATTORNEY'S NAME	ATTORNEY'S ADDRESS	ATTORNEY'S PHONE #

IS YOUR ILLNESS/INJURY DUE TO AN AUTO ACCIDENT?

IF SO, PLEASE ANSWER THE QUESTIONS BELOW:

DATE OF ACCIDENT	ACCIDENT LOCATION	FAULT OF ANOTHER PARTY Y/N
HOW WERE YOU INJURED?		INSURANCE CARRIER
NAME OF INSURED	POLICY #	CLAIM #
ATTORNEY'S NAME	ATTORNEY'S ADDRESS	ATTORNEY'S PHONE #

SURGICAL HISTORY

	YES	NO	WHEN		YES	NO	WHEN
DISK RUPTURE (NECK)				UTERUS REMOVED			
DISK RUPTURE (BACK)				BLADDER SURGERY			
BRAIN SURGERY				KIDNEY SURGERY			
NECK ARTERY SURGERY				HEMORRHOIDS			
BLOOD VESSEL SURGERY				EYE SURGERY			
LEG/ARM SURGERY				HIP SURGERY			
HEART SURGERY				LUNG SURGERY			
GALLBLADDER SURGERY				TONSIL			
COLON SURGERY				APPENDIX			
PROSTATE SURGERY				HERNIA REPAIR			
TUBAL LIGATION				OTHER:			

DO YOU "CURRENTLY" HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES	NO		YES	NO
ANEMIA			LUNG DISEASE		
BLEEDING DISORDERS			PAINFUL JOINTS		
CANCER			POOR APPETITE		
DIABETES			PROSTATE PROBLEMS		
GOUT			PSYCHIATRIC CARE		
HEADACHES/MIGRAINES			SEIZURES		
HEART DISEASE			STOMACH ULCERS		
HIGH BLOOD PRESSURE			STROKE		
IRRITABLE BOWEL			THYROID DISEASE		
KIDNEY DISEASE			WEIGHT GAIN		
KIDNEY STONES			WEIGHT LOSS		
LIVER DISEASE			OTHER:		

IN THE "PAST" HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES	NO		YES	NO
ANEMIA			LUNG DISEASE		
BLEEDING DISORDERS			PAINFUL JOINTS		
CANCER			POOR APPETITE		
DIABETES			PROSTATE PROBLEMS		
GOUT			PSYCHIATRIC CARE		
HEADACHES/MIGRAINES			SEIZURES		
HEART DISEASE			STOMACH ULCERS		
HIGH BLOOD PRESSURE			STROKE		
IRRITABLE BOWEL			THYROID DISEASE		
KIDNEY DISEASE			WEIGHT GAIN		
KIDNEY STONES			WEIGHT LOSS		
LIVER DISEASE			OTHER:		

PATIENT HISTORY

	YES	NO				
LEFT HANDED			WEIGHT			
RIGHT HANDED			HEIGHT			
WEAR GLASSES			BLOOD PRESSURE			
WEAR CONTACTS						
ALLERGIES:						

SOCIAL HISTORY

DO YOU SMOKE? _____

IF SO, HOW MANY PACKS PER DAY? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? _____

YES _____ NO _____

DO YOU USE RECREATIONAL DRUGS? _____

YES _____ NO _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? _____

YES _____ NO _____

DO YOU KNOW OR HAVE YOU EVER HAD ANY KNOWN HIV RISKS? _____

YES _____ NO _____

ARE YOU: SINGLE _____

MARRIED _____

DIVORCED _____

SEPARATED _____

WIDOWED _____

NUMBER OF LIVING CHILDREN _____

FAMILY HISTORY

	ALIVE	DECEASED	AGE AT DEATH	KNOWN MEDICAL PROBLEMS
MOTHER				
FATHER				
BROTHER(S) AND/OR SISTERS(S)				

TREATMENT FOR MY CURRENT PROBLEM HAS INCLUDED:

PLAN X-RAYS	
MRI	
CT SCAN	
EMG/NCV	
BONE SCAN	
BONE DENSITY	
STRENGTHENING EXERCISES	
STRETCHING EXERCISES	
EPIDURAL STEROID INJECTION	
LIMITING ACTIVITIES	
PART TIME WORK	
STOPPING WORK	
BED REST	
NO TREATMENT TO DATE	

HOT/COLD PACKS	
ELECTRIC STIM	
MYOSTIM	
MASSAGE	
POOL THERAPY	
STATIONARY BIKE	
MYELOGRAM	
ULTRASOUND	
CHIROPRACTOR	
ANTI-INFLAMMATORY MEDS	
MUSCLE RELAXANTS	
PAIN MEDICATION	
OTHER:	

NOTICE OF PRIVACY PRACTICES

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign this authorization, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we do not use or disclose your information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances.

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the practice administrator. You may also send a written complaint to the U.S. Department of Health and Human Services.

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Signature

Date

Account Number

NEURO-SPINE SOLUTIONS, P.C.
240 MEDICAL PARK BLVD., STE 2700
BRISTOL, TN 37620

CONSENT FOR TREATMENT

1. GENERAL CONSENT FOR TREATMENT AND TEST:

I consent to treatment by Morgan P. Lorio, M.D., F.A.C.S. or John Testerman, M.D. and staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical care. I understand that state law requires physicians to report certain communicable diseases to the health department.

2. RELEASE FROM LIABILITY FOR LEAVING AGAINST MEDICAL ADVICE:

I agree that if I leave a physician's office against the advice of my physician, Morgan P. Lorio, M.D., F.A.C.S. or John Testerman, M.D., the personnel, and my physician(s) are released from responsibility or liability for any injuries or damages, which may result from my leaving against medical advice.

3. AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize Morgan P. Lorio, M.D. F.A.C.S. or John Testerman, M.D. and any physician(s) involved in my care to disclose and release my medical information (which may include alcohol/drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization, which is or may be liable/responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

4. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:

For and in consideration on services rendered and to be rendered by Morgan P. Lorio, M.D. F.A.C.S. or John Testerman, M.D., I hereby guarantee payment for all charges incurred for the account of the above named patient. I understand and agree that payment for such services shall be due at the time of service. I authorize and direct any person, firm, or corporation, including but not limited to insurance companies or attorney's representing that patient, or any other party for such services to assign proceeds of any payment for services rendered to said patient directly to Morgan P. Lorio, M.D. F.A.C.S. or John Testerman, M.D.. Accepting assignment of said benefits, the provider does not relinquish the right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in the hands of a collector or attorney for collection. I will pay reasonable collection fees and attorney fees, interest, court costs, and other collection expenses.

I HAVE READ AND UNDERSTAND THIS DOCUMENT IN ITS ENTIRETY AND AGREE TO ITS TERMS.

PATIENT/AUTHORIZED PARTY

RELATIONSHIP

DATE

WITNESS

NEURO-SPINE SOLUTIONS, P.C.
240 MEDICAL PARK BLVD., STE 2700
BRISTOL, TN 37620

FINANCIAL AGREEMENT

Payment for office services is due at the time services are rendered unless arrangements have been approved in advance by our office staff. We accept cash, personal checks, and credit cards. Balances greater than 30 days will incur a finance charge of 1.5% of the unpaid balance. There is a return check fee of \$30.00 for each returned check.

AUTOMOBILE ACCIDENT PATIENTS: We do not hold for litigation. We do ask that payment be made prior to services.

Patients with medical insurance must realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance covered by each carrier.
3. Not all services are a covered benefit in all contracts. Insurance companies can select services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of services rendered.

I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

Signature _____ Date _____

I hereby authorize the above physician to release information concerning my case history and treatment, examination, or hospitalization, which I received, including copies of hospital and medical records to include drug, alcohol, and psychiatric information if applicable. I hereby release you, your organization, or others from liability or damage that may result from furnishing information requested above. This authorization shall remain in effect until withdrawn by me in writing.

Signature _____ Date _____

I hereby assign and direct you to pay without further notice from me, to the above physician such amount as may be payable to me for medical and or surgical treatment. I understand that I am responsible for all charges not covered by this authorization.

Signature _____ Date _____

MEDICARE PATIENTS: I authorize any holder of medical or other information about me to be released to the social security administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of benefits to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature _____ Date _____

Neuro-Spine Solutions, P.C.
Pain Medication Policy

1. No pain medications will be prescribed to a new patient on their first visit.
2. Pain medications will only be prescribed to patients who are deemed surgical. Pain medications will only be provided during the postoperative period. Any patient that does not meet those criteria will need to obtain all pain medications from their primary care doctor.
3. Medications are written for a specific amount of days and no medication will be filled prior to the due date. NO EXCEPTIONS.
4. Medications that have been lost, stolen, or misplaced will not be replaced or refilled prior to next due date. Written prescriptions that have not been filled yet will not be replaced either. NO EXCEPTIONS
5. If you are taking any medication (narcotic/controlled substance, muscle relaxers, tranquilizers, etc....) in which the manufacturer of the drug recommends against any activity (driving, operating machinery, consuming other medications or alcohol, etc...) we cannot recommend that you act against their recommendations and will assume no liability if you choose to do so.
6. Narcotics will not be called in. A prescription must be picked up or mailed. If you choose to have your prescriptions mailed to you; we will be unable to replace in the event they do not reach your address. It will not be refilled until next due date.
7. Refills must be obtained by calling them in 3-5 days prior to due date. Medications will not be refilled on a walk-in basis. You are responsible for obtaining verification from our office staff that your prescription is ready to be picked up. Do not call until the day they are due. They will not be ready until then.
8. Patients may be terminated from the practice, with 30 days notice, for non-compliance in the taking of their medication.
9. Altering or forging a prescription of any kind will result in immediate termination from the practice. This is a felony and will be reported to authorities.
10. Random drug screening/pill counts will be performed on all patients who receive narcotic medications. If requested while you are in office, it must be done immediately. If you are called to come in for testing, you will need to be at our office on same business day prior to 5:00 with your medications in the bottle they were dispensed. Failure to comply with this

policy or inconsistent results will be grounds for immediate termination from our practice. There will be no exceptions to this policy.

11. We require that medications be filled through one pharmacy only. Please provide us with the pharmacy you wish to use in the provided space. If at any time you wish to change pharmacies you will need to notify our office prior to doing so.

Pharmacy Name _____

Phone _____

12. If you are referred to Pain Management and are released/fired by that physician, it is that physician's obligation to make sure you follow through with another pain management provider or your primary care physician. Under no circumstance will we resume writing for medications. Please do not call this office requesting same.

13. You are required to notify this office of all pain medications you are taking from any provider in this or any other office. We will not write pain medication if they are being obtained from another provider.

This policy is to ensure that potentially addictive medications are properly used, administered and monitored. We appreciate your cooperation.

I have read and understand the above policy. By signing below, I agree to abide by all terms of this policy.

Patient Signature

Date

Patient Name(Printed)

Neuro-Spine Solutions, PC
240 Medical Park Blvd., Ste 2700
Bristol, TN 37620
423-844-0501

Telephone Number/Medical Information Release

This form is required under HIPAA privacy regulations to authorize where/how we may contact you and to whom we can release information about you.

I, the undersigned, give my permission to Neuro Spine Solutions, PC to contact me at the following locations by circling the answer that applies.

- 1. yes no Home telephone number _____
- 2. yes no Cell telephone number _____
- 3. yes no Work telephone number _____
- 4. yes no Okay to leave a message on Answering Machine/Voice Mail?*

*All four of the above questions must be answered. If you do not have a cell phone, answering machine or work number circle the "no" box.

If for some reason Neuro Spine Solutions, PC need to relay my protected medical information (i.e., procedures, test results, lab results, billing issues, etc.) you can either leave a message with or discuss the information with the following individuals.

- 1. _____
Name Telephone
- 2. _____
Name Telephone
- 3. _____
Name Telephone
- 4. _____
Name Telephone

Parent or Guardian (print)

Signature

Date