



We ask that new patients **arrive 30 minutes prior to your appointment** so that all paperwork can be completed before your appointment time. Established patients are asked to arrive 15 minutes prior to their appointment to complete paperwork. Out of consideration for all our patients, **if you arrive late for an appointment**, you may not be seen. If an appointment is available at a later time and at the provider's discretion, you may be able to be worked in. We are happy to try to accommodate you, but it may be necessary for you to reschedule.

****PLEASE BRING THE FOLLOWING INFORMATION TO YOUR NEW PATIENT APPOINTMENT****

- *Insurance card(s)
- *Photo ID (drivers license)
- *List of current medications, including herbs, vitamins and over-the-counter pills
- *Completed new patient paperwork, but DO NOT sign or date forms until your visit.
- *Any imaging you've had done in the last year. That would include x-rays, MRIs, CTs, bone scans, or nerve conduction studies.
- **If you had imaging at any facility other than Chattanooga Imaging or Prime Imaging, we ask that you pick up a disc and report to bring to your visit with you.**

CO-PAYMENTS, CO-INSURANCE OR ANY OUTSTANDING BALANCES WILL BE DUE AT THE TIME OF SERVICE AS REQUIRED BY OUR INSURANCE PLAN.



NAME: (F) _____ (M) _____ (L) _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONTACT INFORMATION (PLEASE CIRCLE PREFERRED CONTACT NUMBER)

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

EMPLOYER: _____ ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMPLOYER PHONE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT PERSON NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PERSON PHONE: _____

File with _____ (Insurance Company Name)

Insured's Name: _____ Insured's Date of Birth _____

Is this visit Workers Compensation? Yes No

Is this visit Auto Accident? Yes No

State of MVA, Accident or Injury: _____ Date of injury or accident: _____

Carrier Name: _____ Attorney Name: _____

Case Manager/Adjuster: _____ Attorney Address: _____

Claims Address: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

Claim #: _____ Employer at time of injury: _____

Authorization: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine, Brain & Joint for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: _____ Date: _____



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last name:	First name:	SSN:	Date of birth:
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AUTHORIZATION INFORMATION

I request and authorize Southeastern Spine, Brain & Joint as noted below from my		<input type="checkbox"/> request	<input type="checkbox"/> release the information
medical records to:	<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Myself
	<input type="checkbox"/> Other _____		
Entity:	Address: _____		
Phone:	Fax:	Email:	
<input type="checkbox"/> Fax to number above	<input type="checkbox"/> Mail to address above	<input type="checkbox"/> Email to address above	<input type="checkbox"/> Picked up by patient

INFORMATION TO BE RELEASED (select one)

<input type="checkbox"/> All medical records to include all chart entries, diagnostics, test results and reports
<input type="checkbox"/> All records related to visits on the following date(s) _____
<input type="checkbox"/> All records related to the following diagnosis/symptoms _____
<input type="checkbox"/> All medical records EXCEPT _____
<input type="checkbox"/> Test results only from the following date(s) _____
<input type="checkbox"/> Other _____

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine, Brain & Joint. This does not constitute blanket permissions for release of such information for an infinite period of time, but is limited to this instance only.

I agree that a copy of this release, electronic or faxed submission of this release shall be valid as this original release. I understand that if I authorized Southeastern Spine, Brain & Joint to fax or email the information, that there are inherent privacy risks with these methods.

 Patient signature _____
 Date

FOR OFFICE USE ONLY

Copied: Initial _____	Date: _____	SENT: Mailed	Picked-up	Faxed	Emailed
Initial: _____	Date: _____				



PATIENT HISTORY: PLEASE COMPLETE ENTIRE FORM (COMPLETE IN BLACK INK ONLY)

Patient Name: _____

Date of Service: _____

Date of Birth: _____

Age at this visit: _____

Have you ever been diagnosed with or experienced the following? CHECK YES OR NO TO EACH ITEM

PSYCHOLOGIC:

Yes No

Anxiety disorder

Depression

CARDIOVASCULAR:

Peripheral vascular disease

Pacemaker / Implantable defibrillator

Heart disease

Heart attack

High blood pressure

Congestive heart failure

Mitral valve prolapse

NEUROLOGIC:

Parkinson's disease

Alzheimer's Disease

Stroke

Seizure Disorder

MUSCULOSKELETAL:

Yes No

Scoliosis

Osteoarthritis

Rheumatoid arthritis

Lupus

Fibromyalgia

IMMUNOLOGIC:

HIV / Immunosuppressive disorders

GASTROENTEROLOGIC:

Hepatitis A B C

Hiatal hernia

Ulcer disease

Cirrhosis

Crohn's or ulcerative colitis

METABOLIC/ENDOCRINE:

Diabetes - ___Insulin ___Non-insulin

Hypoglycemia

RENAL/GU:

Yes No

Kidney disease impairment

Prostate problems

Dialysis

Frequent urinary tract infection

Kidney stones

HEMATOLOGIC/LYMPHATIC:

Bleeding disorder

Blood clots in lungs or legs

Anemia

Cancer _____

Previous Transfusions

Clotting disorder

PULMONARY:

Emphysema

Asthma

TB or exposure

Other _____

REVIEW OF SYSTEMS:

Are you experiencing any of the following? CHECK YES OR NO TO EACH ITEM

Yes No

Recent onset high blood pressure

Muscle pain w/ activity or rest

Cold extremities

Joint swelling

Yes No

Tingling

Numbness

Back pain

Chronic cough

Yes No

Blurred vision

Problems breathing

Poor bladder control

Increased urinary frequency

Yes No

Generalized weakness

Headaches

Shortness of breath

Joint pain

Other: _____

PAST SURGICAL HISTORY: (Please list ALL previous surgeries)

PREVIOUS DIAGNOSTIC STUDIES: Did you bring them with you? Yes No

Test done (i.e., MRI, CT scan, etc.)

Date performed

Facility (i.e., Memorial, Chattanooga Outpatient Center)

PLEASE SIGN BELOW

The information provided by me on this form is true and accurate to the best of my knowledge.

Patient: _____ Date: _____

Nurse/MA Initials: _____ Date: _____ Provider Signature: _____ Date: _____



Disclosure of Protected Health Information

According to our policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

Do we have permission to leave messages on your voicemail? Yes No

Do we have permission to discuss medical information with a family member? Yes No *If yes, please list below.

Emergency contact name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Alternate contact name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine, Brain & Joint to release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services. Third Party Administrators, and/or Workers' Compensation (or its' agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine, Brain & Joint to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine, Brain & Joint to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits made on my behalf to Southeastern Spine, Brain & Joint. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature _____ Date _____



RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I hereby acknowledge receipt of Southeastern Spine, Brain & Joint, PLLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DPS may use and disclose my protected health information.

By signing below, I acknowledge that I understand that Southeastern Spine, Brain & Joint, PLLC has reserved the right to change its privacy practices that are described in the Notice of Privacy Practices. By signing below, I acknowledge that I also understand that any revisions to the Notice of Privacy Practices will be provided to me or made available to me.

Signature

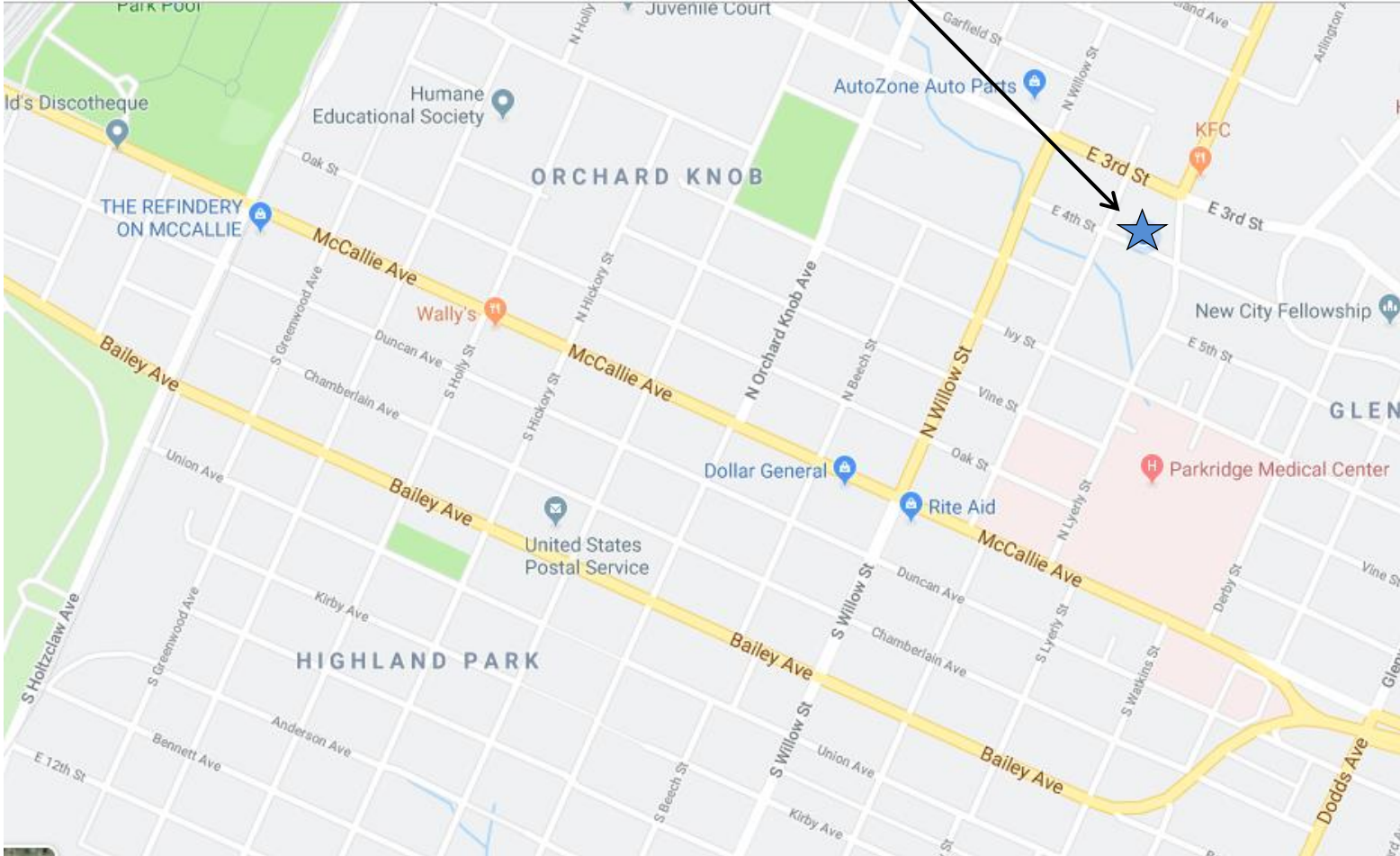
Print Name

Date

If you are not the patient, please specify your relationship to the patient: _____

SOUTHEASTERN SPINE, BRAIN & JOINT

281 N. LYERLY ST. SUITE 300



www.GoogleMaps.com



Southeastern Spine, Brain & Joint

281 N. Lyerly Street

Chattanooga, TN 37404

Phone: (423) 693-2175

FROM HIXSON/AMNICOLA

1. Take 153 S. to Amnicola Hwy exit.
2. Follow Amnicola to Wilcox and turn left.
3. Turn right onto Dodson Avenue
4. Stay straight to go on N. Lyerly.
5. Southeastern Spine, Brain & Joint is on your right.

FROM NASHVILLE

1. Take I-24 E to Central Ave. Exit, 180A
2. Take 23rd St. to Rossville Blvd.
3. Turn left onto South Willow St.
4. Turn right onto East 3rd St.
5. Turn right onto N. Lyerly St.
6. Southeastern Spine, Brain & Joint is on your right.

FROM ATLANTA

1. Take I-75 N to -24 W split.
2. Take I-24 W to Belvoir/Germantown Ave., exit 183A.
3. Turn right onto Belvoir Ave.
4. At light, turn left onto Brainerd Rd.
5. Follow through Brainerd/McCallie tunnels.
6. Veer slight right onto McCallie.
7. Turn right onto N. Lyerly.
8. Southeastern Spine, Brain & Joint is on your left.

FROM I-27

1. Take I-27 to 4th St.
2. 4th St. turns into 3rd, just before Erlanger Hospital.
3. Follow 3rd St.
4. Turn right onto N. Lyerly.
5. Southeastern Spine, Brain & Joint is on your right.



Oswestry Disability Index (ODI) version 2.1a

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life.

Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 - Pain intensity

- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- (0) I can look after myself normally without causing extra pain.
- (1) I can look after myself normally but it is very painful.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self-care.
- (5) I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

- (0) I can lift heavy weights without extra pain.
- (1) I can lift heavy weights but it gives extra pain.
- (2) Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

Section 4 - Walking

- (0) Pain does not prevent me walking any distance.
- (1) Pain prevents me walking more than one mile.
- (2) Pain prevents me walking more than a quarter of a mile.
- (3) Pain prevents me walking more than 100 yards.
- (4) I can only walk using a stick or crutches.
- (5) I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting for more than 1 hour.
- (3) Pain prevents me from sitting for more than half an hour.
- (4) Pain prevents me from sitting for more than 10 minutes.
- (5) Pain prevents me from sitting at all.

Section 6 - Standing

- (0) I can stand as long as I want without extra pain.
- (1) I can stand as long as I want but it gives me extra pain.
- (2) Pain prevents me from standing for more than 1 hour.
- (3) Pain prevents me from standing for more than half an hour.
- (4) Pain prevents me from standing for more than 10 minutes.
- (5) Pain prevents me from standing at all.

Section 7 - Sleeping

- (0) My sleep is never disturbed by pain.
- (1) My sleep is occasionally disturbed by pain.
- (2) Because of pain I have less than 6 hours sleep.
- (3) Because of pain I have less than 4 hours sleep.
- (4) Because of pain I have less than 2 hours sleep.
- (5) Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- (0) My sex life is normal and causes no extra pain.
- (1) My sex life is normal but causes some extra pain.
- (2) My sex life is nearly normal but is very painful.
- (3) My sex life is severely restricted by pain.
- (4) My sex life is nearly absent because of pain.
- (5) Pain prevents any sex life at all.

Section 9 - Social life

- (0) My social life is normal and causes me no extra pain.
- (1) My social life is normal but increases the degree of pain.
- (2) Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- (3) Pain has restricted my social life and I do not go out as often.
- (4) Pain has restricted social life to my home.
- (5) I have no social life because of pain.

Section 10 - Travelling

- (0) I can travel anywhere without pain.
- (1) I can travel anywhere but it gives extra pain.
- (2) Pain is bad but I manage journeys over two hours.
- (3) Pain restricts me to journeys of less than one hour.
- (4) Pain restricts me to short necessary journeys under 30 minutes.
- (5) Pain prevents me from travelling except to receive treatment

Total Score=

Your ODI = %

ODI % = Total score/5 x Number of questions answered x 100

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Opium Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6) : 432