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:

AUTHORIZATION INFORMATION

I request and authorize Southeastern Spine, Brain & Joint to noted below ☐ request ☐ release the information from my medical records to:

☐ Medical Provider ☐ Parent/Guardian ☐ Myself ☐ Other_____

Entity:	Address:

Phone:	Fax:	Email:

☐ Fax to number above ☐ Mail to address above ☐ Email to address above ☐ Picked up by patient

INFORMATION TO BE RELEASED (select one)

☐ All medical records to include all chart entries, diagnostics, test results and reports

☐ All records related to visits on the following date(s)_____

☐ All records related to the following diagnosis/symptoms_____

☐ All medical records **EXCEPT**_____

☐ Test results only from the following date(s)_____

☐ 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:_____

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 & Neurosurgery 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 & Neurosurgery. 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 MEDICATION AGREEMENT

1. I understand that I need to give 24 hrs notice when requesting a refill on any medication. Walk-in requests for medication or appointments will not be accepted.
2. I agree to take all medication exactly as instructed. I am not allowed to change the dosage or time schedule without speaking to my provider first.
3. I understand that no medication will be changed or called in after hours or on the weekend.
4. I understand that a follow-up visit may be required from my provider in order to obtain a refill and I must keep all recommended appointments.
5. I understand that Urine Drug Screens will be required at my provider's discretion as long as I am receiving opioid medication. I understand that my medication may be stopped or changed at the provider's discretion, based upon the results of the Drug Screen or the TN prescription monitoring data base.
6. Southeastern Spine, Brain & Joint will not refill lost or stolen medication. **These are your responsibility once you leave our office.**
7. I will not trace, sell or give away the medications that are prescribed for me. I will also not take any medication that is prescribed to someone else.
8. I am aware that while I am on medications that treat my pain, I am prohibited from driving or using heavy machinery. I understand that driving while taking opioid medication could result in a DUI change.
9. I understand that verbal abuse and argumentative behavior towards the staff will not be tolerated and could result in discharge from the practice.
10. I will not use multiple pharmacies when filling my prescriptions.
    The pharmacy I use is: _____ Phone#: _____
11. The following are conditions for immediate discharge from the practice:
    a. Obtaining opioid prescriptions from other physicians while receiving medications from our providers.
    b. Altering or forging a prescription in any way. This is a felony and will be reported.
    c. Non-compliance with any of the above statements.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICIES, AND I UNDERSTAND THAT IF I DO NOT SIGN, MY PHYSICIAN MAY REFUSE TO PRESCRIBE PAIN MEDICATIONS TO ME.

NAME:_____DATE:_____

PATIENT SIGNATURE:_____

DR. JAY JOLLEY
DR. DAVID WILES
DR. MATTHEW BERNARD
REBECCA PAYNE, FNP-BC
NATHAN WOODY, ARNP, CNP
JESSICA SCOTT, PAC
MARY HUBBARD, MSN, APRN, FNP-C

SOUTHEASTERN SPINE • BRAIN • JOINT

Oswestry Neck Disability Questionnaire

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

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.

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 causes extra pain.
- 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 need help every day in all aspects of self-care.

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

Section 4 – Reading
- 0 I can read as much as I want to with no pain.
- 1 I can read as much as I want to with slight pain.
- 2 I can read as much as I want to with moderate pain.
- 3 I cannot read as much as I want to because of moderate pain in my neck.
- 4 I can hardly read at all because of severe pain.
- 5 I cannot read at all.

Section 5 – Headaches
- 0 I have no headaches at all.
- 1 I have slight headaches that come infrequently.
- 2 I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- 4 I have severe headaches which come frequently.
- 5 I have a headache almost all the time.

Section 6 – Concentration
- 0 I can concentrate fully when I want to with no difficulty.
- 1 I can concentrate fully when I want to with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating when I want to.
- 3 I have a lot of difficulty in concentrating when I want to.
- 4 I have a great deal of difficulty in concentrating when I want to.
- 5 I cannot concentrate at all.

Section 7 – Work
- 0 I can do as much work as I want to.
- 1 I can do my usual work, but no more.
- 2 I can do most of my usual work, but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

Section 8 – Driving
- 0 I can drive my car without neck pain.
- 1 I can drive my car as long as I want with slight pain.
- 2 I can drive my car as long as I want with moderate pain.
- 3 I cannot drive my car as long as I want because of moderate pain.
- 4 I can hardly drive at all because of severe pain.
- 5 I cannot drive my car at all.

Section 9 – Sleeping
- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hr sleepless).
- 2 My sleep is mildly disturbed (1-2 hrs sleepless).
- 3 My sleep is moderately disturbed(2-3 hrs sleepless).
- 4 My sleep is greatly disturbed (3-5 hrs sleepless).
- 5 My sleep is completely disturbed (5-7 hrs sleepless).

Section 10 – Recreation
- 0 I am able to engage in my recreation activities with no neck pain.
- 1 I am able to engage in all my recreation activities with some pain in my neck.
- 2 I am able to engage in most, but not all, of my usual activities because of my neck pain.
- 3 I am able to engage in a few of my usual recreation activities because of my neck pain.
- 4 I can hardly do any recreation activities because of pain in my neck.
- 5 I cannot do recreation activities at all.

TOTAL: _____

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

Sex (circle one): Female Male

Mark appropriate box beside each question	Yes	No
Do you have a *family history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Do you have a *personal history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Are you between 16—45 years old?		
Do you have a history of preadolescent sexual abuse?		
Do you have a personal history of ADD, OCD, bipolar, schizophrenia		
Do you have a personal history of depression?		
Scoring totals		

**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.

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction. Adapted for use by Southeastern Spine, Brain & Joint.

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