PATIENT INFORMATION SHEET

PLEASE PRINT

Social Security #:_____-______-______ **Date:** ____________________

Last Name: __________________ **Suffix:** Jr, Sr, II, III **First Name:** ___________________________ **Middle Initial:** _______

Other Name: _________________ **Address:** ____

Apt. #/P.O. Box: ______________ **City:** _____________________ **State:** ___________**Zip Code:** _________-________

Home Phone: (____) _______-______ **Mobile Phone:** (____) ______-_______ **Work Phone:** (____) _______-_______

Birthdate: _____/_____/_____ **Sex:** ☐ Male ☐ Female **Religion:** ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Significant Other

Email: ___________________________________ **Birth Country:** _________________ **Preferred Language:** _______________

<u>Race</u>: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander

☐ White or Caucasian ☐ Other ☐ Declined to Answer ☐ Unknown (Multiple selections can be made)

<u>Ethnicity</u>: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Answer ☐ Unknown (Only a single selection)

Employer: ____ ☐ Full-time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Student

Employer Address: ____________________________________**City:** ____________ **State:** __________ **Zip Code:** _________

Primary Care Physician: _____________________________________**PCP Phone #:** ___________________________________

Referred By: ____**Referring Phone #:** ______________________________

Pharmacy: ______________________ **Phone:** _______________ **Address:** _________________ **City/State:** _______________

Emergency Contact: ____________________________ **Phone:** __________________________ **Relationship:** ______________

Legal Guardian: _______________________________ **Relationship:** _________________________________

Primary Insurance

Primary Insurance: _______________________________ Phone Number: __________________________________

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other Subscriber: ____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Dependent Other: _______________________

Subscribers Birthdate: _____/______/______ Insurance ID# ____

Secondary Insurance

Secondary Insurance: ______________________________ Phone Number: __________________________________

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other Subscriber: ____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Dependent Other: _______________________

Subscribers Birthdate: _____/______/______ Insurance ID# ____

PATIENT INFORMATION SHEET

PLEASE PRINT

ONLY For Worker's Compensation, Accidents, Etc.

Bill To: ______________________________ (Full Name: First, Middle, & Last)

Social Security #: _____-____-_____ Claim Type: Self ☐ Workers Comp ☐ PIP ☐ MVA ☐

Name: ______________________ Address: ______________________________

Apt. # / P.O. Box: ______________ City: ______________ State: ________ Zip code: _______-_____

Case Type: ______________ Claim #: ______________ Adjuster: ______________________

Accident or Illness Onset Date: ____/____/_____ (Month Day Year) Accident State: _____ First Dr. Visit Date: ____/____/_____ (Month Day Year)

Accident Description: ______________________________

Accident Address: ______________________________

Employer: ______________________ Employer Contact: ______________________

Employer Address: ______________________ City: ______________ State: _____ Zip code: _______

Employer Phone: (____) _____-_______ Employer Fax: (____) _____-_______

Are you on disability? Yes No If yes, for what condition: ______________________

Last Worked: ______________________

Is there any workers compensation or litigation related to your condition? Yes No

****Do you have an attorney representing you with regards to a work related injury or auto accident? *****

Yes____ No____

Attorneys Name: ______________________ **Phone:** ______________________

Address: ______________________________

PATIENT INFORMATION SHEET

PLEASE PRINT

Consent and Assignment

***** Medicare *****
I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediate or carriers any information needed for this or a related Medicare claim (Title XVIII) I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accept assignment below. I understand that I am responsible for any health insurance deductibles co-insurance (co-pays) and non-covered charges.

*****Blue Shield of Maryland*****
I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pays), and non-covered charges.

*****Legal Assignment***** (applicable to Physician Services)
The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting there from are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

*****Insurance Assignment*****
I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

*****Managed Care*****
I understand that, without an authorization/referral from my HMO/PPO/PIPA, I will be financially responsible for the charges I incur.

*****Guarantee*****
As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to SPPS and it successors and assigns, the full and complete payment due by the patient, as and when the same becomes due.

Signature: ____ Date: ____/____/_____
(Sign Here) Month Day Year

*****Signature of Patient, Responsible Party, Parent, or Legal Guardian*****

Signature: ____ Date: ____/____/_____
(Sign Here – I authorize a copy of this authorization to be used in place of the original) Month Day Year

Maryland Spine Center Patient Questionnaire

Date: _____/_____/_____

Name: ____ DOB: _____/_____/_____Age: _________

Current Height: ______________ Weight: ________________

Why are you being seen today? ____

____

Date of onset pain/injury: ____________ How did your symptoms start: □Fall □Accident □Gradual

Duration of symptoms: ____ months / years. Are the symptoms getting: □Better □Worse

The pain is principally in the: □Neck/Arms □Back/Legs □No Pain

What is the proportion of pain in the neck/back vs. arms/legs?

Neck/Arms	Back/Legs
◊ 0% arms & 100% neck	◊ 0% legs & 100% back
◊ 25% arms & 75% neck	◊ 25% legs & 75% back
◊ 50% arms & 50% neck	◊ 50% legs & 50% back
◊ 75% arms & 25% neck	◊ 75% legs & 25% back
◊ 100% arms & 0% neck	◊ 100% legs & 0% back

Do you have any numbness: □Yes □No Where: ____

Do you have any weakness: □Yes □No Where: ____

Do you have any bowel or bladder dysfunction: ____

What treatments have you received thus far for this condition?		Did it help?	
Physical Therapy:	□Yes □No	□Yes □No	
Brace:	□Yes □No	□Yes □No	
Epidural Steroid Injection:	□Yes □No	□Yes □No	Levels: _______________
Spine Surgery:	□Yes □No	□Yes □No	
Other: __________________________		□Yes □No	

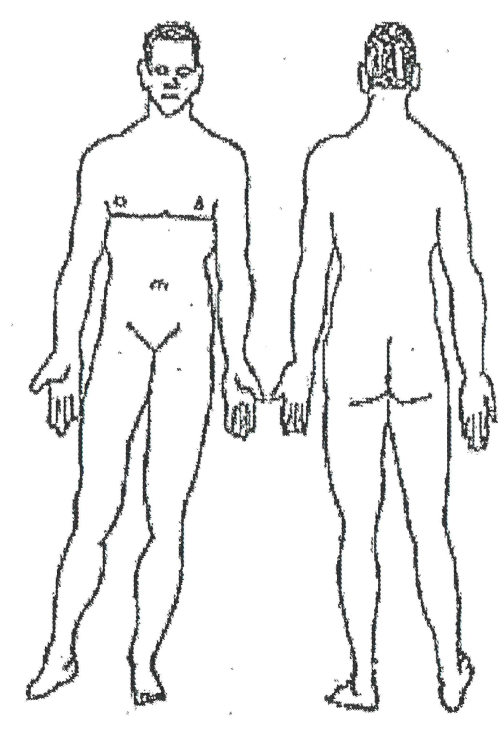
If you have had previous spine surgery, please describe below:

Date Surgeon Procedure

1. ____
2. ____
3. ____

Maryland Spine Center Patient Questionnaire

On the diagram below, please mark where you have pain:



(Please Circle)

Abnormal Bleeding	Burning on Urination	Chills
Constipation	Cough	Diarrhea
Difficulty Swallowing	Fevers	Headaches
Heartburn	Imbalance / Dizziness	Nausea
Poor Appetite	Swelling of Ankles	Undesired Weight Gain
Undesired Weight Loss	Vomiting	

CURRENT MEDICATION (dosage and name of drug, please include any OTC medication: if more than 8 please attach separate sheet with list of medication).

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Are you allergic to any medications? (List allergy and reaction)_______________________________

Social History

Do you smoke: ☐ Current ☐ Former ☐ No If yes, how many packs per day: ____, for how many years: ______

Do you use other tobacco products: ☐ Yes ☐ No Which ones: ☐ Cigars ☐ Chewing Tobacco ☐ Snuff ☐ Other

Do you drink alcoholic beverages: ☐ Yes ☐ No How much, how often: ____________________

Illicit or recreational drugs/non-prescription drugs: _______________________________

Maryland Spine Center Patient Questionnaire

PLEASE LIST ALL SURGERIES THAT YOU HAVE HAD:

SURGERY	DATE	SURGERY	DATE
1. ______		5. ______	
2. ______		6. ______	
3. ______		7. ______	
4. ______		8. ______	

PAST MEDICAL HISTORY: conditions for which you have had or are currently receiving treatment:

Please circle type / location of condition in parenthesis if applicable.

□ Anemia
□ Arthritis
□ Asthma
□ Blood clots *(Legs / Arms)*
□ Cancer (Location: ___________)
□ Coronary Artery Dis.
□ Current Chest Pain
□ Diabetes *(Non-insulin dep. / insulin dep)*
□ Emphysema
□ Gastric Reflux
□ Heart Attack
□ Heart Disease
□ Hepatitis *(treated: y / n)*
□ High Cholesterol
□ Hypertension
□ Kidney Failure
□ Liver / Pancreatic Disease
□ Other Kidney Disease
□ Peptic Ulcer
□ Positive for HIV / AIDS
□ Received Blood Trans.
□ Seizure Disorder
□ Sleep Apnea *(CPAP: yes / no)*
□ Stroke
□ Thyroid Disease
□ Tuberculosis
□ Other: ________________________________

FAMILY HISTORY: for blood relatives only: please check if any relative had any of the following:

	Living	High blood pressure	Heart disease	Diabetes	Stroke	Bleeding Problems	Cancer	Other problems: (please describe)
MOTHER	□Yes □No	□	□	□	□	□	□	
Grandmother	□Yes □No	□	□	□	□	□	□	
Grandfather	□Yes □No	□	□	□	□	□	□	
FATHER	□Yes □No	□	□	□	□	□	□	
Grandmother	□Yes □No	□	□	□	□	□	□	
Grandfather	□Yes □No	□	□	□	□	□	□	
Brother	□Yes □No	□	□	□	□	□	□	
Sister	□Yes □No	□	□	□	□	□	□	

REVIEW OF SYSTEMS:
(Please Circle)

Abnormal Bleeding
Constipation
Difficulty Swallowing
Heartburn
Poor Appetite
Undesired Weight Loss
Burning on Urination
Cough
Fevers
Imbalance / Dizziness
Swelling of Ankles
Vomiting
Chills
Diarrhea
Headaches
Nausea
Undesired Weight Gain

The Maryland Spine Center
Pain Assessment Form

If you are in physical pain or discomfort, you have the right to proper pain management. Talk to your doctor about this. Here's why:

- No one should have to live with pain or discomfort.
- There are treatments and medications that really work.
- The Doctor can't help you unless you tell them about the pain.
- Your Doctor will need to know the following about your pain:
  1. Where do you feel your pain?
  2. Is this a new pain?
  3. How does your pain feel (sharp, dull, stabbing, aching, burning, shooting, numbing, constant)?
  4. What makes your pain worse?
  5. What are you doing to currently ease your pain?

This questionnaire helps the physicians and nurses evaluate your health and plan your care. Please rate your pain on the numerical pain rating scale below by circling number from 1 -10.

No Pain
Mild Pain
Moderate

Pain
Severe Pain
Pain
Overwhelming

0 1 2 3 4 5 6 7 8 9 10

Do you want your doctor to address your pain during today's visit? ____Yes ____No

Please list any medications (with dosages) or treatments that you are using for pain relief:

____

____

____

____________________ __________

Patient Signature Date

BILLING NOTICE TO OUR PATIENTS

The Maryland Spine Center is an outpatient department of Mercy Medical Center. Accordingly, you will receive two bills for your appointments in the Center. You will receive a physician services bill from the physician group and an outpatient clinic bill from Mercy. Together, these two bills represent charges incurred during your visit to the Center and we provide this notice to help avoid confusion when you receive two separate bills.

Depending on your insurance coverage, you may be responsible for some or all of both bills. All charges are billed to the patient's insurance company to determine the amount of patient responsibility. If in doubt, please contact your insurance carrier to determine the co-pay, deductible, and/or coinsurance amounts.

Thank you.

I have read and understand this billing notice:

______________________________	__________________
Patient Name – Printed	Date of Birth
______________________________	__________________
Patient Signature	Date of Signature

Welcome to

As part of our electronic medical record (EMR) system, we invite you to be an active member in your health care and to improve the high-quality care you already receive. Through this system, you will have access to a secure website called **MyChart**.

MyChart gives you direct online access to portions of your EMR where your doctor stores your health information. Your lab results, appointment information, medications, immunizations, and more are all securely stored for quick retrieval.

MyChart shows you that same information – so you see what your doctor sees!

MyChart also provides new, convenient methods of communication with your doctor's office and ability to make secure, online payments. Renew prescriptions, send messages, schedule appointments, and pay your bill – all online.

Notice of Physicians Financial Interest

I, ___________________________________ (patient name) am aware that the following physicians (or an immediate family member) have financial ownership in the diagnostic treatment facility or in the treatment(s), goods, or services names below. I acknowledge that I have the right to obtain these services or a comparable product from another provider of my choosing. Upon request, my doctor will provide me with a list of other providers or discuss any alternative treatment options with me.

Dr. Charles Edwards, II: SurgCenter of Towson

Dr. Justin Park: SurgCenter of Towson

I have read the Notice of Physicians Financial Interest and acknowledge the above listed physician's (or the physicians immediate family member) financial interest in the facility, treatment, goods or services listed above.

____
Signature of Patient or Guardian

____
Relationship to Patient

____
Date

Permission to Discuss Health Information with Family and Friends

This form allows you to identify those family members, friends, or other persons involved in your care that you would like to give Mercy permission to talk with about your medical care. You may also identify any person(s) with whom Mercy should not share your health information.

Patient Name: ______________________________

I give permission to allow Mercy Health Services (Mercy) to verbally discuss the following health information about me:

- ☐ Scheduling/appointment information
- ☐ Medical information, including symptoms, diagnoses, medications, and treatment plan.
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ All of the above
- ☐ Other: ____

Mercy has my permission to discuss the above information with:

Name	Cell Phone	Work Phone	Relationship

I understand that:

- I do not have to sign this form, and I should only sign it if I want Mercy to be able to discuss my health information with someone.
- In certain circumstances, Mercy may speak to other individuals who are involved in my care, if permitted by law, that may not be identified on this form.
- I have the right to revoke my permission at any time, or update this form at any time by contacting: Compliance Hotline 410-576-5297; Toll free 1-855-576-5297.
- This form does not authorize releasing copies of my medical records. If you would like Mercy to share copies of your medical records with someone, you will need to fill out an Authorization form, which is available by calling your physician's practice.

Mercy is permitted to share certain health information with family, friends, and other persons (i.e., caretakers) if they are involved in your healthcare. **If there are any family members or other persons with whom Mercy should not share any of your health information, please identify those persons below:**

____

Mercy will document a restriction on your medical record for the person(s) listed above, and unless otherwise required by law, will not share information these persons.

____________________________________ ______________________

Signature of Patient/Authorized Representative Date

If other than patient, state authority to sign: ____

OFFICE NOTE: Patients may fill out and sign this form or Mercy Staff may verbally discuss the information in this form with the patient and document the patient's wishes in the medical record.