THE GATES HAND CENTER

A Division of Neuroscience and Spine Associates, PL

HEALTH HISTORY FORM

Patient Name:		Date of Birth:	Today's Date:
Height:	Weight:	Which hand do you use most often? (Circle one) RIGHT LEFT BOTH	
What brings you to see Dr. Gates today?		How long have symptoms been present? Or list date your symptoms started.	

Please rate your pain on a scale of 0 to 10 (check box below)

☐ 0 No Pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 Moderate Pain	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst Possible Pain

What **over-the-counter** medications have you taken for the pain?

Did this help your pain? (Circle one)

Yes No Somewhat N/A

Please list the name of physicians you are currently under the care of:	
Medical Doctor/Internist	
Cardiologist	
Pain Management Specialist	
Rheumatologist	
Pulmonologist	

ACCIDENT/INJURY FORM

Dear Patient or Guarantor,

Your insurance contract provides benefits that may need to be coordinated with other medical insurance which you may be covered under. The primary carrier will pay first when there is more than one insurance company. In order for us to expedite your claim process, the following information must be completed.

Is the reason for your visit due to an accident or injury? **Yes** or **No**

Date of Accident or Injury: _____/_____/_____

Where did this accident or injury occur?	
□ Work	□ Auto Accident
□ Sports	□ School
□ Home	□ Business
□ Other:	

What were you doing to cause the injury? Or how did this injury occur?	
□ Lifting	□ Pulling
□ Falling	□ Pushing
□ Reaching	□ Hit by object
□ Other:	

How did this accident or injury occur? (Be as specific as possible):

_____

_____

Were you evaluated at a hospital emergency room, urgent care facility, or another physician's office prior to your appointment today? **Yes** or **No** (If **yes**, please list where you were seen):

_____

I have completed this questionnaire to the best of my ability, and carefully reviewed its contents. Any unanswered questions indicate they do not apply.

Patient or Guardian Signature: _____ Date: _____/_____/_____

ALLERGIES	
□ No Known Drug Allergies	
Name of medication or food	Reaction (rash, swelling, upset stomach, etc.)

MEDICATIONS:		
• Please list your medications and vitamins you are currently taking. Include the dosage and how often you take it each day; you may provide a copy of your medication list to our staff. • Include ALL blood thinning medications you are currently taking, for example: Baby aspirin, Coumadin or Plavix.		
Medication Name	**Dosage**	**How often you take it**

FAMILY MEDICAL HISTORY: *Check all the conditions that apply to members of your family*								
	MOTHER	FATHER	SON	DAUGHTER	GRANDFATHER	GRANDMOTHER	BROTHER	SISTER
Heart Disease	□	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Cancer (include type)	□	□	□	□	□	□	□	□
Lung Disease	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□
Blood Clots	□	□	□	□	□	□	□	□
□ No family members with medical conditions					□ I'm adopted			

PAST AND CURRENT MEDICAL HISTORY

Please check ALL conditions that you have been diagnosed with:

❑ I HAVE NO PAST OR CURRENT MEDICAL CONDITIONS

❑ High blood pressure	❑ Lung Disease	❑ Kidney Disease
❑ High cholesterol	❑ Asthma	❑ Kidney Stones
❑ Stroke	❑ Emphysema	❑ Hepatitis (type) _____
❑ Heart Attack	❑ COPD	❑ HIV/AIDS
❑ Heart Disease	❑ Epilepsy (Seizure Disorder)	❑ Colitis
❑ Bleeding Disorder	❑ Neuropathy	❑ Thyroid Disease
❑ Atrial Fibrillation	❑ Pulmonary Embolism	❑ Rheumatoid Arthritis
❑ Blood Clots	❑ Sleep Apnea	❑ Psoriatic Arthritis
❑ Congestive Heart Failure	❑ Ulcers	❑ Gout
❑ Cancer: type_____	❑ Diabetes: Type 1 *or* Type 2	❑ Osteoporosis

❑ Other conditions I have that are not listed:

_____

_____

SURGICAL HISTORY: ***You may also provide a list of your surgical history to our staff***	
Surgical Procedure (Include body part, **left** or **right**)	Approximate **Date** of Surgery
□ **CHECK THIS BOX IF YOU HAVE NEVER HAD SURGERY BEFORE**	
Do you have a pacemaker, heart stents, or aneurysm clips? Yes No	

Please answer these questions about your health and feelings. Read each question carefully and circle your best answer.				
		Yes	Maybe	No
1.	I give up too easily	2	1	0
2.	I have difficulty concentrating	2	1	0
3.	I am comfortable being around people	0	1	2
	DURING THE PAST WEEK How much trouble have you had with:	None	Some	A Lot
4.	Sleeping	0	1	2
5.	Getting tired easily	0	1	2
6.	Feeling depressed or sad	0	1	2
7.	Nervousness	0	1	2

_____*Add the scores next to each of the blanks you checked. A total of 5 or greater may indicate depression or anxiety. Consult your primary care provider for further evaluation.

Please list dates for the following questions below to the best of your ability

Have you had the Flu vaccine this year? **Yes** **No** _____/_____/_____

Have you had the Pneumonia vaccine this year? **Yes** **No** _____/_____/_____

When was your last colonoscopy? _____/_____/_____

Women: When was your last mammogram? _____/_____/_____

Do you have any hobbies? _____

Do you smoke cigarettes? If yes, how many packs per day?	□ Yes _____ □ No □ Former Smoker (Quit date: _____)
Do you smoke cigars? If yes, how many cigars per day?	□ Yes _____ □ No
Do you drink alcohol? If yes, how many drinks per day?	□ Yes _____ □ No □ Socially

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PATIENT INFORMATION

Patient: **First Name** **Middle** **Last** **Age** **Date of Birth**

Preferred Name/Nickname:	**Social Security Number:**	**Marital Status: (Please Circle One)** Single Married Divorced Unmarried Widowed
Primary Language Spoken: (Please Circle One) English Spanish Chinese German Creole Hindi French Other _____	**Ethnicity: (Please Circle One)** Not Hispanic or Latino Hispanic/Latino **Gender:** Male Female Other	**Race: (Please Circle One)** White Black Asian Native American Other _____

Local Mailing Address: **City** **State** **Zip Code**

Out of Town Mailing Address: **Dates: _____ to _____ (Example: March to October)**

Home Phone Number	**Out of Town Phone Number**	**Cell Phone Number**
Email Address		
Occupation	**Employer**	**Employer Phone Number**
Emergency Contact	**Relationship**	**Phone Number**

Who referred you to our office? ❑ **Dr.** ❑ **Other**

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Pharmacy Name:		**Pharmacy <u>Phone Number</u>**	
Is this a liability case? ❑ **YES** ❑ **NO**		**Name of Attorney:**	
If an accident, Where did it happen? ❑ **Home** ❑ **Work** ❑ **Other**_____	**Date of Injury:**	**How did injury/accident occur? (Please give details)**	
<u>INSURANCE INFORMATION</u>			
Person responsible for payment	**Primary Insurance Company (Please have your card ready to be copied)**		
Policy Holder's Name	**Insurance Company's Address**		
Policy Holder's Date of Birth:	**Guarantor (If patient is a minor):** **Social Security Number of Guarantor:**		
Policy Holder's Employer	**Policy #**	**Group #**	**Guarantor's Date of Birth:**

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. You are responsible for bills and services rendered in this office and payment is required for all services <u>at the time that they are rendered</u>, unless prior arrangements have been made.

As a courtesy, our office will file the appropriate insurance for you. *However*, you are required to pay any unmet deductible, non-covered services and co-payments. If we are forced to pursue collection against you for payment of our service, you will be liable for all costs and expenses incurred by such collection efforts including, without limitation, reasonable attorney's fees.

I give permission to release information relating to my medical treatment to my insurance company in order to process my claim for services and authorize payment of medical benefits to myself or party who accepts assignment. My signature below signifies my understanding of this policy, and acceptance of the terms stated herein.

Signature_____ Date_____

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THANK YOU FOR ENTRUSTING YOUR ORTHOPAEDIC NEEDS TO DR. GATES AND DR. ALSAMKARI. WE ARE COMMITTED TO PROVIDING YOU THE BEST POSSIBLE CARE AND VALUE YOUR PATRONAGE.

PLEASE REVIEW OUR OFFICE FINANCIAL POLICIES:
PAYMENT IS DUE AT TIME SERVICES ARE RENDERED. WE ACCEPT: CASH, CHECKS, AND MASTERCARD, VISA AND DISCOVER CARDS.

IF YOU HAVE MEDICAL INSURANCE YOU SHOULD REALIZE THAT:

1.) **YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.**
2.) NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER**. IT IS YOUR RESPONSIBLLITY TO KNOW YOUR CONTRACT.**

PARTICIPATING INSURANCE PLANS:
We participate in many insurance plans. As a courtesy to our patients, we will file your insurance claim to the primary insurance company. WE DO NOT FILE TO ANY SECONDARY INSURANCE. All charges are your responsibility. All co-pays and deductibles will be collected at time of service.

MEDICARE:
At this time, we accept Medicare assignment. If your secondary insurance is not set-up as a "MEDIGAP" or AUTOMATIC CROSSOVER, we will collect the 20% at time of service. As a courtesy, we will file the secondary insurance claim for your reimbursement.

AUTO INSURANCE AND NON-PARTICIPATING INSURANCE PLANS:
PAYMENT IN FULL IS REQUIRED. We will file claims as a courtesy for patient's reimbursement.

OTHER CHARGES:
SURGERY CANCELLATION POLICY:
A fee of $250.00 will be charged if cancellation for a scheduled procedure is received with less than 48 hour notice.

OFFICE CANCELLATION & NO SHOW POLICY:
A fee of $50.00 will be charged if cancellation for a scheduled office visit is received with less than 24 hours notice from the appointment time.

Additional charges:

$50.00 for returned checks
$10.00 charge for x-ray copies due at time of pick up.
$5.00/page for form completion and a $10 minimum fee for review of CD's and excess record review that requires additional time by the provider.
$250.00 FOR LONG TERM DISABILITY FORM COMPLETION.

_____

Signature Date

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NASA NEUROSCIENCE & SPINE ASSOCIATES

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I,_____, understand that as part of my health care, Neuroscience & Spine Associates originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes;
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Neuroscience & Spine Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164 506 of the Code of Federal Regulations.

I further understand that Neuroscience & Spine Associates reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should Neuroscience & Spine Associates change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use of disclosure of my health information:_____

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and ( )accept / ( )decline (check one) the terms of this consent.

Patient / Responsible Party Signature:_____ **Date:**_____

Patient's Name (Printed): _____

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MEDICAL RECORDS RELEASE / REQUEST

I, DOB Patient #

(Print patient's name)

Phone:_____ Fax: _____

herein give permission to *Neuroscience & Spine Associates*

***1660 Medical Blvd, Ste 200, Naples, FL 34110 P 239.449.7937 / F 877.793.1399* to Release my Records to:**

Name:_____

Address:_____

Phone: _____ Fax:_____

OR Request my Records From:

Name:_____

Address: _____

Phone: _____Fax:_____

A copy of the (*) COMPLETE MEDICAL* RECORD OR choose of the following:

Dates of Service: *From*_____ to _____

( ) Progress Notes / Consultation Reports ( )Lab Report(s) ( ) X-Ray / MRI Report(s)

( ) MRI Discs or X-Ray Discs ( ) EEG/EMG Reports ( ) Medication List / Medication Allergies

( ) Surgical Procedures / Biopsy Report(s) ( ) Other: _____

For the purpose of: Personal Use _____ Insurance _____ Continuing Care _____ Legal _____ Other: _____

Please initial to allow the designated facility to disclose information protected under federal law relative to:

_____ drug and/or alcohol treatment

_____ psychiatric care

_____ diagnosis or information specific to HIV, AIDS

_____ Sickle Cell Anemia

I wish to allow the following person(s) access to my medical records:

Name: _____Relationship: _____

Name:_____Relationship: _____

This authorization will expire 2 (two) years following the last date of service. After this date, Neuroscience and Spine Associates can no longer use or disclose patient records without a new authorization form. I have read this authorization and understand what information will be used or disclosed, by Neuroscience and Spine Associates PL.I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth. The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Neuroscience and Spine Associates, P.L. must receive the revocation in writing and must include:

** The patient's name, address, and patient number, if applicable. * The effective date of this authorization, and the recipients of the protected health information according to this authorization, * The patient's desire to revoke this authorization, the date of the revocation, and the patient's signature.* All revocations must be sent to:

Neuroscience and Spine Associates, P.L. Attn: Medical Records 1660 Medical Blvd. Ste. 200 Naples, FL. 34110

Revocations are not effective until received by Medical Records. I fully understand and accept the terms of this authorization.

Patient or Authorized Personal Representative: _____ Date:_____

Personal Representative Description: _____