SOUTH SHORE NEUROSPINE

Stephen H. Johnson, MD, FACS
Jason P. Rahal, MD
Katharine Bills-Woods, PA-C
Megan Lee, PA-C

851 Main Street, Suite 6
South Weymouth MA 02190
781-331-0250/F 781-340-0506
ww.ssneuro.com

Dear Patient:

Welcome to South Shore NeuroSpine. Please bring the following with you to your appointment:

- Insurance cards – Primary and/or Secondary Insurances.
- Co-payment. We accept cash, check, Visa, MasterCard and debit cards.
- MRI or other imaging studies CDs.
- Completed Medical History and Registration forms.
- Worker's Compensation insurance information if applicable.
- Personal Injury Protection (PIP) exhaust letter if applicable.
- Photo ID.

***IMPORTANT* You MUST bring your MRI CDs to this appointment or your visit will be RESCHEDULED. If you had your MRI or other imaging studies performed at South Shore Hospital, you DO NOT need to bring the CDs to the office as we have access to these studies through the hospital electronic medical records system.**

Please call your Primary Care Provider to obtain an **INSURANCE REFERRAL** if needed to comply with your insurance plan.

Plan to arrive 30 minutes before your scheduled appointment time to complete additional health care forms.

If you need to reschedule or cancel your appointment, please call within 48 hours so that others may benefit from this appointment. You may be asked to reschedule your appointment if you arrive late.

We look forward to providing your medical care. If you have any questions, please call our office.

Sincerely,
South Shore NeuroSpine

DIRECTIONS:

From the South: Travel North on Route 3 to Exit 16 – Route 18 South.
Go to the third traffic light and turn right on Columbian Street.
Parking lot is immediately on the left.

From the North: Travel South on Route 3 to Exit 16B – Route 18 South.
Go to the third traffic light and turn right on Columbian Street.
Parking lot is immediately on the left.

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First Name: _____ **MI** ____ **Last Name:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone Home: _____ **Work:** _____ **Cell:** _____

Email Address: _____ **Marital Status: SINGLE MARRIED DIVORCED WIDOWED**

Emergency Phone: _____ **Contact Name/Relationship**: _____

Gender: M F **Date of Birth:** _____ **Social Security Number:** _____

Primary Care Provider: _____

Referring Provider IF different from Primary Care Provider: _____

FINANCIAL RESPONSIBILITY

Account (Circle): Insurance Worker's Comp MVA **Relationship: SELF SPOUSE MOTHER FATHER**

Financial Responsible Party Name If Not Self: _____ **DOB:** _____

Financial Responsible Party Address and Telephone IF DIFFERENT FROM ABOVE:

Address _____ **Phone:** _____

PRIMARY Insurance Carrier Plan Name: _____

Your Relationship to Subscriber (Circle): SELF SPOUSE MOTHER FATHER

Subscriber's Name: _____ **DOB:** _____ **Gender: M F**

Subscriber's Employer: _____

Policy ID: _____ **COPAY:** _____

SECONDARY Insurance Carrier Plan Name: _____

Your Relationship to Subscriber (Circle): SELF SPOUSE MOTHER FATHER

Subscriber's Name: _____ **DOB:** _____ **Gender: M F**

Subscriber's Employer: _____

Policy ID: _____ **COPAY:** _____

I authorize the release of all medical information necessary to process insurance claims for my services.
I also authorize payment of medical benefits directly to Coastal Medical Associates.

_____ _____
Patient Signature Date

_____
Printed Name

SOUTH SHORE NEUROSPINE

Patient Medical History - Please Complete This Form Accurately As It Will Become Part of Your Medical Record

NAME _____ **AGE** _____ **DOB** _____ **TODAY'S DATE** _____

Known Drug Allergies: Circle if NONE or LIST: _____

Are you taking a blood thinner (circle)? NO YES, If YES please circle which Blood Thinners you are currently taking:

ASPIRIN COUMADIN PLAVIX XARELTO ELIQUIS NSAIDS OTHER:_____

Current Medications and Doses: _____

_____

Preferred Pharmacy: _____ **City/Town:**_____ **Phone #:**_____

Medical History: Are you being treated for any of the issues below. Check all that apply:

___ AIDS
___ Anemia
___ Aneurysm – Type _____
___ Asthma
___ Bowel/Bladder Problems
___ Brain Tumor
___ Cancer – Type _____
___ Cerebrovascular Disease
___ CPAP
___ Depression
___ Diabetes – Type _____
___ Gastric Reflux
___ Heart Disease
___ Hepatitis – Type _____
___ High Blood Pressure
___ Kidney Problems
___ Lung Disease
___ Migraine Headaches
___ Osteoporosis
___ Sudden Weight Loss/Gain
___ Other _____

Surgical History:

Heart surgery (circle)? NO YES Type: _____ Date: _____ MD: _____
Spine surgery (circle)? NO YES Type: _____ Date: _____ MD: _____
Brain surgery (circle)? NO YES Type: _____ Date: _____ MD: _____

Family History – Circle ALL that apply:

Anesthesia Complications: Mother Father Sibling(s)
Bleeding Disorders: Mother Father Sibling(s)
Cancer: Mother Father Sibling(s)
Cerebrovascular Disease: Mother Father Sibling(s)
Diabetes: Mother Father Sibling(s)
Heart Disease: Mother Father Sibling(s)
Spinal Disorders: Mother Father Sibling(s)
Stroke: Mother Father Sibling(s)

Social History:
What Pain Relievers are you on and how long: _____
Alcohol Consumption:
___ Do not drink. ___ Drink: Alcohol Beer Wine Occasional Daily Weekly # ___
___ Active alcoholic. ___ Recovering alcoholic. Date stopped drinking _____
Smoking Status:
___ Never smoked ___ Former Smoker Stopped _____ Smoke: Occasional Daily Weekly # ___ per _____
Drug Use:
___ Recreational and/or Narcotic Drug Never Occasional Daily Weekly Type: _____

Review of Systems – Circle ALL that apply:

Constitutional: night sweats, weight loss, weight gain, abnormal bleeding
Head and Neck: dizziness, headaches, changes in vision, ringing in ears, difficulty with speech
Pulmonary: shortness of breath, difficulty breathing
Cardiovascular: chest pain, palpitations
Genitourinary: urinary urgency, incontinence, discharge, painful urination
Gastrointestinal: abdominal pain, nausea, vomiting, diarrhea, constipation
Musculoskeletal: joint pain, stiffness, swelling
Neurologic: poor memory, arm weakness, leg weakness
Psychiatric: anxiety, depression

Please estimate your: Height _____ Weight _____

Job Title: _____

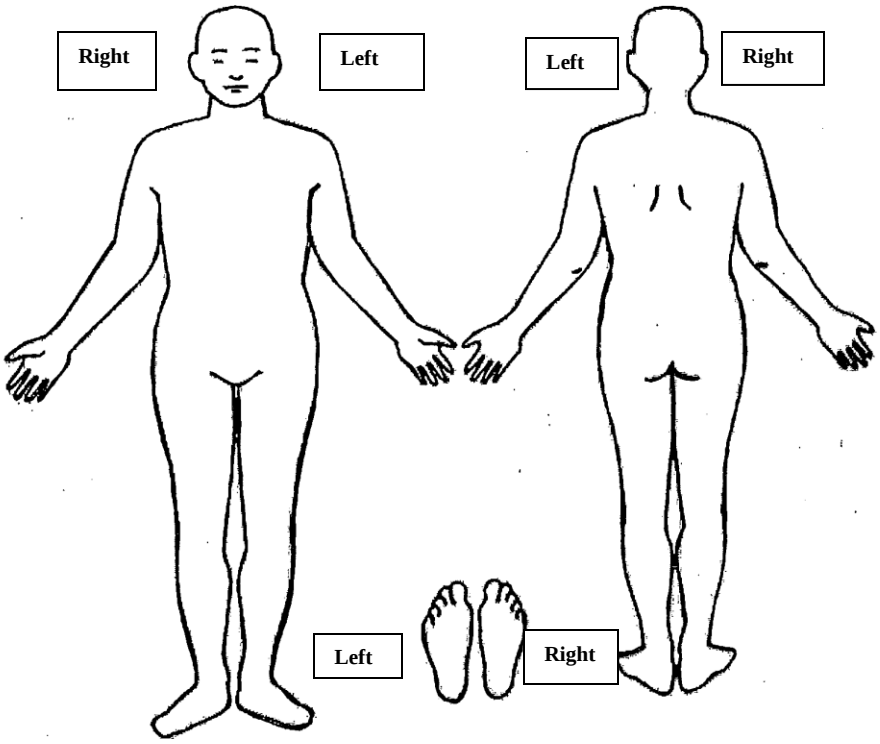
Are you currently working (circle): YES NO If NO, How long have you been Out of Work: _____

Patient Signature: _____ **Date:** _____ **Provider:** _____ **Date:** _____

SOUTH SHORE NEUROSPINE

Name _____

Pain Chart DOB _____

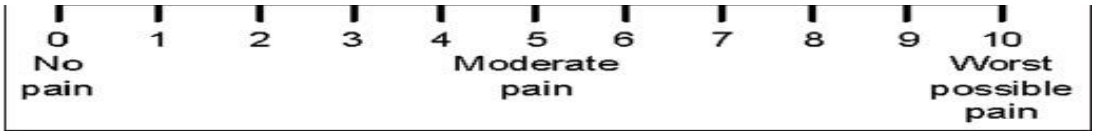


Please indicate where you feel the pain/sensation; you may use the symbols below for description.

NNN dull/aching pain	== numbness	/// stabbing/cutting
XXX burning	::: pins and needles	*SSS* muscular cramps

DATE: _____

PAIN INTENSITY: _____ / 10



What is your current Pain Level? Please **CIRCLE** above.

Printed Name _____ Date: _____

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PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

By signing this form, I give my permission to the person(s) listed to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	**Name of Individual and Relationship to Patient**	**Comments/Instructions** (May pick up meds, may disclose test results, share scheduling info)	**Patient/Guardian Initials**

THE PROVIDERS AND STAFF HAVE MY PERMISSION TO: (Please check all that apply)

□ Leave message at home with my spouse or with: _____

Relationship: _____

□ Leave message on cell phone. Number: _____

□ Leave message on voicemail. Number: _____

_____ _____
Patient Signature Date

_____
Printed Name

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OFFICE POLICIES

Welcome to South Shore NeuroSpine (SSNS). In our continuing effort to provide you with the best medical care, we ask that you familiarize yourself with the following office policies. This document must be signed by you and will be kept in your chart. If it is determined that you need further testing or a procedure, our staff will make the necessary arrangements. It is imperative that you follow through with the treatment plan that was agreed upon. If, for any reason, you decide not to comply with the scheduled test or procedure, it is your responsibility to call our office and inform us of any such decision. When all scheduled tests have been completed, your provider will go over the results with you at your scheduled follow-up visit. If you are not going to, or have not kept your follow-up appointment and have not heard from the doctor after the tenth day following completion of all testing, you must call our office to discuss each and every one of the results with the provider who ordered them. Often, when a patient begins to feel better, they decide they do not need to come back for scheduled follow-up care. We strongly advise against this. We cannot stress enough the importance of complete compliance with follow-up care. You and your provider together will decide when it is in your best interest to discontinue or change your treatment plan.

As part of our Office Policy, your relationship with our practice may be terminated for reasons of treatment noncompliance, follow-up noncompliance, office policy noncompliance and/or verbal abuse.

NOTICE REGARDING HMO AND INSURANCE COMPANY REFERRALS

If you have an HMO or insurance carrier that requires a referral in order to be seen by a specialist, it is **your responsibility** to ask your primary care provider to provide you or our office with that referral prior to your appointment in our office. **If you do not have a referral in place, you may be financially responsible for the visit.**

PATIENT'S FINANCIAL RESPONSIBILITY

South Shore NeuroSpine (SSNS) will process all billing matters for medical services rendered by SSNS. We will file claims for services with your insurance company on your behalf. If you have made prior arrangements to establish a Self Pay account, we will bill you directly. We will obtain authorizations for surgical services, in advance, from your insurance carrier. It is your shared responsibility to also contact your insurance carrier to confirm that the prescribed services are covered by your plan. In the rare event that authorized procedures are later denied for payment by your insurance carrier, we will attempt to resolve the matter on your behalf. If your insurance carrier denies reimbursement after our unsuccessful attempt to resolve the claim, you will be responsible for all balances due.

It is your personal responsibility at the time of your visit to pay all co-pays, deductibles and co-insurance. Outstanding balances that are due after your claim has been processed by your insurance carrier, or if your claim is denied by your insurance carrier, will be billed to you. We will issue invoices and statements to you identifying all amounts due from you that are not covered by your insurance carrier. Payment of any amount invoiced must be received within thirty (30) days of invoicing. In the event of financial hardship, eligible patients may make arrangements to set up a payment plan for balances due, by contacting SSNS upon receipt of an invoice. Eligibility for a payment plan and arrangements regarding payment will be determined at the sole discretion of SSNS. Failure to comply may result in your invoice being forwarded to a collection agency.

CANCELLATION POLICY

We request that you contact our office to cancel your appointment at least 24 hours in advance. Our answering service is available 24 hours a day, 7 days a week and will take your cancellation notice.

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

This authorizes the providers of South Shore NeuroSpine (SSNS), to release to any hospital and all medical attendants involved in my care, full and complete reports and information that may be requested by and/or to any of those entities. This authorization also includes examination and/or release of all hospital or office records, MRI films/CDs, x-ray films/CDs, tests, test results, and any other written documentation related to my medical care. Additionally, South Shore NeuroSpine is authorized to release any and all information compiled by them relevant to my continued medical care that may be requested of them after services have been provided. Unless specifically terminated, this consent will extend for an unlimited period of time while the below signed individual is under the care of South Shore NeuroSpine. A photocopy of this authorization may be accepted with the same authority as the original.

_____ _____

Patient Signature Date

_____

Printed Name

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Prescription Medication Policy

Requests for refills of prescribed medications must be phoned in during office hours which are:

Monday through Thursday 9 AM to 4 PM

No prescriptions will be refilled or ordered outside of normal office hours or on weekends.

We will NOT routinely prescribe narcotic pain relievers at the time of initial consultation. The decision to prescribe is left to the discretion of your provider. Your referring physician should manage all pain medication until the time that a treatment plan has been recommended by the providers in this office.

We will not provide chronic prescription medicines to patients who have been referred to us on those medications. Those prescriptions will remain the responsibility of the referring provider or the prior prescribing provider.

In the event surgery is planned, this office will provide post-operative pain management. Narcotic pain management in the post-operative period is usually limited to 2 – 4 weeks after surgery. **If narcotic medications are given, you will be required to sign our pain management contract.**

The Department of Public Health, pharmacies and insurance companies monitor patient use of narcotic pain medications and contact the prescribing physician(s) if a patient is receiving narcotic pain medication from more than one physician. If this office receives notification, from any source, that a patient is receiving narcotic pain medication from more than one physician, prescribing of such medication by this office will be immediately suspended.

Under no circumstances will narcotic pain medication be prescribed beyond a 90-day period. If narcotic pain management is required beyond 90 days, then a referral to a Chronic Pain Specialist will be made and your care will be returned to your primary care physician.

In the event of suspected or documented narcotic abuse, further prescriptions of narcotic pain medications will not be made and the patient may be discharged from care.

If a patient has not been seen in this office during the preceding 3 months, no prescriptions will be "called-in" to the pharmacy without re-assessment of the patient.

You are responsible to report any and all side effects from the medication(s) you are taking as soon as possible. If we are unavailable, please contact your PCP.

IF YOU REQUEST A PRESCRIPTION REFILL BY TELEPHONE, THE PROVIDER MUST REVIEW YOUR CHART PRIOR TO CONTACTING THE PHARMACIST. THEREFORE, YOUR REQUEST MAY NOT BE PROCESSED IMMEDIATELY. IT IS THE POLICY OF THIS OFFICE TO COMPLETE ALL LEGITIMATE REQUESTS WITHIN 48 BUSINESS HOURS. THEREFORE, REQUESTS MADE ON FRIDAYS OR HOLIDAYS MAY NOT BE COMPLETED UNTIL THE FOLLOWING WEEK. WE WILL NOT PROCESS WALK-IN REQUESTS FOR PRESCRIPTION REFILLS. IT IS YOUR RESPONSIBILITY TO PLAN ACCORDINGLY.

_____ _____
Patient Signature Date

_____
Printed Patient Name