NEW PATIENT QUESTIONNAIRE

Patient First Name: _____ **Last Name**:_____

Date of Birth: _____ **Gender:** ❑Male ❑Female ❑Other:_____

Height:_____ **Weight:** _____

Cell Phone: _____ **Home Phone**: _____

Email: _____

Home Address: _____

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

Social Security #: _____

Primary Insurance Carrier: _____

Member ID:_____ Group number:_____

Second Insurance Carrier: _____

Member ID:_____ Group number:_____

Race: ❑American Indian or Alaska Native ❑Black or African American ❑Asian ❑Asian Indian ❑White ❑Other Race:_____ ❑Decline to report

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Other Race:_____ ❑Decline to report

Language: ❑English ❑Spanish ❑Mandarin ❑Vietnamese ❑Korean ❑Other:_____

Work Status: ❑ Employed ❑Not currently employed **Occupation**: _____

Emergency Contact: _____ **Relation**: _____

Phone: _____

Referring Physician: _____Practice:_____

Phone: _____ Fax:_____

Pharmacy Name: _____ **Phone:** _____

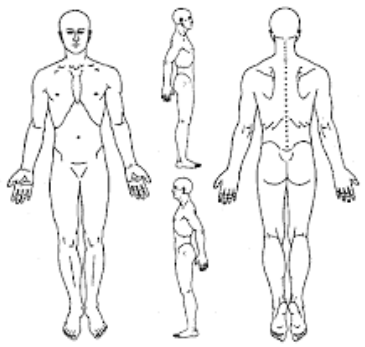
Address: _____

HISTORY OF PRESENT ILLNESS

Reason for Visit: _____ Pain (0-10): _____

WHERE IS YOUR PAIN PRIMARILY LOCATED?

(Please below & shade on diagram)



❑Head ❑Neck ❑Upper-Mid Back
❑Right Arm. ❑Left Arm ❑Mid-Back Pain
❑Lower Back ❑Abdomen ❑Pain in the Tailbone
❑Other:_____

**Is your condition related to ❑Auto Accident
❑Other Accident

MEDICATIONS

(List all current medications, doses & frequencies, including over-the-counter medications & vitamins.)

MEDICATION NAME	DOSE	FREQUENCY

Do you take any blood thinners like **COUMADIN, PLAVIX, LOVENOX** OR **ASPIRIN**? ❑YES ❑NO

ALLERGIES

Have you ever been told you were allergic to a medication? ❑YES ❑NO

ALLERGY (Medications, etc)	REACTION

ACTIVE MEDICAL PROBLEMS

(Please below any medical problem for which you are currently being treated.)

❑Arthritis ❑Asthma/COPD/Wheezing ❑Angina/Chest Pain/Heart Attack

❑Liver Disease ❑Kidney Disease/On Dialysis ❑Fainting Spells/Blackouts

❑Vision Problems ❑Diabetes ❑TIA or Stroke

❑Cancer ❑Bleeding problems ❑Seizure or Epilepsy

❑High Blood Pressure ❑Low Blood Pressure ❑Developmental Disorder

❑Migraines ❑High Cholesterol ❑Mental Illness

❑Coagulation Disorder ❑Heart disease ❑Other:_____

FAMILY HISTORY

Has anyone in your family had any of these conditions? (Please check all that apply.)

	Blood Clotting	Mental Illness	Diabetes	Heart Disease	Migraines	Hypertension
Father						
Mother						
Sibling						
Grandparent						
Child						

SURGICAL HISTORY

(List past surgeries and the dates they were performed.)

SURGERY	DATE	LOCATION

SOCIAL HISTORY

Do you currently smoke? ❑YES ❑NO If yes, for how many years? _____

If yes, how many cigarettes a day? _____

Were you ever a former smoker? ❑YES ❑NO If yes, when did you quit?_____

Do you drink alcohol? ❑ YES ❑ NO

How many drinks/day? _____

Have you ever used drugs? ❑YES ❑NO If yes, do you currently use drugs? ❑YES ❑NO

Check the ones that you have used. ❑MARIJUANA ❑COCAINE ❑METH ❑HEROIN ❑CRACK

Atlantic Advanced Spine & Neurology Institute (AASNI) Registration Form

Consent to Treatment:

I consent to medical care while I am a patient at Atlantic Advanced Spine and Neurology Institute (AASNI), as recommended by my care team. I understand that my medical care may be provided by physicians, physician assistants, nurse practitioners and other health care providers. My providers may recommend lab tests, imaging tests, procedure, operations, medicines and/or monitoring. No guarantee has been made as to the results of treatments for examination at AASNI.

Release of Medical Information:

I authorize the AASNI to release all Health Plans the medical information necessary to obtain approval for payment for my care and/or to process my claims. “Health Plan(s)” includes the Center for Medicare and Medicaid Assistance and their agents or review agencies. The term “medical information” includes, but is not limited to, information related to psychological, psychiatric, HIV/AIDS, communicable diseases, and alcohol and drug abuse diagnosis and treatment.

Assignment of Benefits:

I authorize and request payment of all Health Plan benefits directly to AASNI and authorize AASNI to submit claims and pursue all appeal rights of any claim denials, reductions, and other adverse determinations on my behalf. I further authorize and assign to AASNI the right to obtain all benefits and other relief available under my Health Plan(s) or Employment Retirement Income Security Act of 1974 (ERISA) including without limitation the right to obtain information on my health Plan(s) and the basis for claim determination.

Telemedicine (Virtual Visits):

I understand that care may be provided to me by telemedicine, which may include services via video or audio communication.
Patients are limited to a maximum of two phone calls per day. AASNI staff will return your call within 24-48 business hours depending on the urgency of the call.

Photography and Recordings:

Photography and Recordings. I understand photographs and recordings may be taken of me during my care for purposes of identification, diagnosis, and treatment. As permitted by law, I further agree that recordings or photographs may be created and used for educational, quality improvement, research and teaching purposes. If required by law, AASNI will obtain my express written consent for use or release of photographs and recordings for any other purpose.

Telephone/Email:

I authorize AASNI to communicate with me regarding services, payment for services, scheduling appointments and health care operations activities using text messages, an automatic telephone dialing system, or prerecorded voice at the telephone number(s) I provide. I understand that my calls may be monitored or recorded for any purposes. If I provide AASNI with an email address, I agree to receive email messages from AASNI. These emails may contain my health information and may not be encrypted. Unencrypted emails create potential privacy and security risks. If I do not want to receive encrypted emails, I will not provide my email address to Atlantic Advanced Spine and Neurology Institute.

Valuables:

AASNI is not responsible for the loss or theft of any patient personal items.

Notice of Non-Discrimination:

AASNI does not discriminate on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service, or any other classification protected by federal, state or local laws.

By signing this form, you understand the rules and policies set by the AASN and agree to abide by the policies and procedures.

_____ _____

Patient Printed Name Authorized Representative Printed Name

_____ _____

Patient or Authorized Representative Signature Date

This form has been electronically signed.

Atlantic Advanced Spine & Neurology Institute (AASNI) Patient Financial Policy

Thank you for choosing Atlantic Advanced Spine & Neurology Institute (AASNI) for your care. Our providers and staff are committed to the success of your medical treatment. Our goal is to provide patients with excellent medical care and exceptional customer service. Please review our financial policy listed below.

***Insurance patients**:* Patients must present valid health insurance along with a driver's license or other form of ID at the time of service. All Copay must be paid on the date of service. As a courtesy, we will file all qualifying insurance claims to the patient's medical insurance after their visit. It is the patient's responsibility to understand their own insurance plan and benefits; patients should contact their health insurance directly with questions related to their plan. After a patient's insurance has submitted payment for a claim, any remaining balance will become the patient's full responsibility and must be paid within (30) days of invoice. Please note, any claims found to be the result of a work-related injury or motor vehicle accident may not qualify to be filed with the patient's regular health insurance plan. It is the office policy to charge the patient a deposit of the Medicare rate for the visit/procedure/tests, if deductibles exceed $1,000.00 at the time of the visit. A refund check will be issued if insurance authorizes the payment

Self-Pay Patients: Self-Pay patients are required to pay in full at the time of service. Self-Pay patients are responsible for the office visit fee plus any additional services performed during the appointment. These include, but are not limited to injections, tests, et. All self-Pay patients will be informed of any additional charges prior to performance of a service.

Workers' Compensation: All charges for services incurred while treating a verified work-related injury will be billed to the patient's workers' compensation carrier. Claim information and authorization must be obtained prior to the start of treatment. If a claim is denied through the workers' compensation carrier or later found not to be the result of a work-related injury, the patient may have their claims filed with their personal medical insurance or becomes directly responsible for charges accrued. If a patient is treated for a condition that was never reported to their employer but found to be the result of a previous work-related injury, the claim will not qualify to be sent to a workers' compensation carrier. Any denied claim, even those in litigation, will become the full financial responsibility of the patient.

Motor Vehicle Accident/ Personal injury: Per company policy, we are unable to file claims related to a motor vehicle accident to a patient's health or car insurance. If a patient's condition is the result of a motor vehicle accident or collision, the patient will be financially responsible for any incurred charges. The patient will be treated as a self-pay patient, and payment will be due at time of service. If any claims submitted to a patient's medical insurance are later found to be the result of a previous or unmentioned motor vehicle accident, the patient will become fully financially responsible for any denied or retracted claims.

Missed Appointment: In the event of a cancellation, we require at least 24 hours notice prior to the scheduled appointment time. Patients not giving 24 hours's notice will incur a $30.00 missed appointment fee. If a patient has 3 missed appointments in a calendar year, AASNI reserves the right to discharge the patient from the practice.

Form Fee: All short term disability, leave of absence (FMLA), etc, forms are generally completed within 10 business days after receipt of payment. Prepayment of $50 (cash, debit, or credit) per form must be paid prior to completion.

Overdue Accounts: All overdue accounts will be sent to a collection agency and may be subject to legal action. Relevant personal and account information may be released during this action. If sent to collections, patient accounts will accrue an additional 38% charge in addition to any existing balance.

I have read the above agreement and accept the terms in cooperation with Atlantic Advanced Spine and Neurology. I understand I will be fully financially responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand this financial agreement can be amended at any time without prior notification to me, the patient. In the event of the patient being a minor, I am the legal guardian or parent of the patient, and I agree that I am responsible for all services rendered to the patient herein.

Patient Printed Name

Authorized Representative Printed Name

Patient or Authorized Representative Signature

Date

This form has been electronically signed.

Atlantic Advanced Spine & Neurology Institute (AASNI)

Medical Record Request/Release Authorization Form

Patient Name: _____

Date of Birth: _____

I authorize ***Atlantic Advanced Spine & Neurology Institute*** to request and/or release all my protected information for the purpose of review and evaluation by medical providers.

I understand the following:

A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
B. The information released in response to this authorization may be re-disclosed to other parties.
C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
D. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient / Legal Guardian Date

This form has been electronically signed.

Request From:

Facility:_____ Provider: _____

Phone number:_____ Fax number:_____

For the time frame of: All_____

Most recent one year_____

In the past 6 months_____

Others_____

TO: Atlanta Advanced Spine & Neurology Institute

Dr. Kewei Yu, MD

Phone number: 470 268 6980 ***Fax number: 888 815 1765***