NEW YORK SPINE INSTITUTE

Medical solutions for spine disorders

ALEXANDRE B. DEMOURA, MD PC

PATIENT DEMOGRAPHIC

NAME: _____ DATE: ____/____/____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PLEASE PROVIDE YOUR EMAIL ADDRESS: _____

PHONE: (HOME) _____ (CELL) _____ HEIGHT _____ WEIGHT _____

S.S.# _____ SEX: ☐ M / F ☐ D.O.B:. _____ AGE: _____

RACE: _____ ETHNICITY: _____ PERFERRED LANGUAGE: _____

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ PARTNER

ALLERGIES TO MEDICATION: _____

OTHER MEDICAL ISSUES: _____

ARE YOU CURRENTLY WORKING? ☐ YES ☐ NO ☐ LIMITED DUTY: _____

DO YOU HAVE AN ATTORNEY? ☐ YES ☐ NO ATTORNEY: _____

ATTORNEY PHONE #: _____ ATTORNEY EMAIL: _____

WHERE DID INJURY OCCUR: WORK: _____ CAR ACCIDENT: _____ OTHER _____

HOW DID INJURY/ILLNESS OCCUR? _____

EMERGENCY CONTACT NAME: _____ TEL# _____

ADDRESS _____

PRIMARY CARE PHYSICIAN'S NAME: _____ TEL# _____

ADDRESS _____

PLEASE INDICATE BELOW HOW YOU WERE REFERRED TO OUR OFFICE:

DOCTOR: _____ PHONE # (____) ____-_____

ATTORNEY: _____ PHONE # (____) ____-_____

BY PATIENT: _____ INTERNET/MAGAZINE AD/OTHER _____

Pharmacy Name: _____

Address: _____ Tel: _____

INSURANCE INFORMATION

(Please fill out in entirety)

PRIMARY INSURANCE/GUARANTOR

Insurance Carrier Name: _____

Member ID #: _____

Policy Holders Name: _____ Relationship to Patient: _____

Policy Holders Occupation_____

Policy Holders Employer: _____

SECONDARY INSURANCE:

Insurance Carrier Name: _____Ins. Telephone #: _____

Member ID #: _____Group #: _____

Policy Holders Name: _____Policy Holders Date of Birth: _____

Please provide the front desk with a copy of ALL your insurance cards

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I understand that "**The NEW YORK SPINE INSTITUTE"** is participating only with the following insurance:

- **MEDICARE**
- **WORKERS COMPENSATION**
- **NO FAULT**

All other **NEW YORK SPINE INSTITUTE** providers, including **MRI**, Pain Management, Physical Therapy, Chiropractic and X-ray **DO NOT** participate with any insurance companies other than **MEDICARE.**

I understand that if my insurance is not listed above, I will be utilizing my **OUT-OF-NETWORK** benefits for services rendered by the New York Spine Institute.

I understand it is the policy of the New York Spine Institute to accept my insurance payments as payment in full, and I will only be held responsible for my deductible, co-payment and co-insurance. **The New York Spine Institute** will accept the percentage paid by the insurance after the deductible met.

I understand that if my insurance does not provide **OUT-OF-NETWORK** benefits, I will be responsible for payment, in full unless other arrangements have been made with the billing department.

I, _____, understand that I may receive the payment(s) directly from my insurance carrier for services rendered to me at New York Spine Institute. In such event, I will immediately forward such payment(s) to New York Spine Institute. If I fail to do so, I will remain responsible for the payment(s) in full. Payments turned over in excess of thirty (30) days of receipt of payment(s) from the insurance carrier will be subject to monthly finance charges of 1.5%. I acknowledge that New York Spine Institute may seek remedies in recovering payment(s) for services rendered.

X_____ _____/_____/_____

SIGNATURE DATE

PATIENT CONSENT FORM

Patient's Name: _____

I, the undersigned, do hereby authorize New York Spine Institute to provide me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic X-Rays or Magnetic Resonance Imaging, Physical Therapy or Chiropractic services, the administration and/or injection of medications and pharmaceutical products, including, but not limited to tripper point injections, and the drawing of blood (the "Procedure(s)"), as in the judgment of personnel and/or physicians of New York Spine Institute deems necessary.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at New York Spine Institute. I understand that the Procedure(s) and any other treatment that I may receive appear indicated by the diagnostic and/or clinical observations performed by New York Spine. I attest that a medical staff member of New York Spine has explained to me the nature of the recommended Procedure(s), the purpose of and need for the recommended Procedure(s), the possible risks and complications of the recommended Procedure(s) and the alternatives, if any, to the recommended Procedure(s). I understand all explanations given to me and give this consent voluntarily. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of New York Spine Institute.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Relationship to Patient Date

I declare that I have personally explained the above information to the patient or the patient representative.

_____ _____

Provider's Signature Date

FOR FEMALE PATIENTS ONLY:

I understand that in the course of my treatment I may have x-rays or other diagnostic tests. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Relationship to Patient Date

Alexandre B. Demoura, M.D., P.C d/b/a New York Spine Institute

Patient Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which describes your rights and the Provider's legal duties with respect to the use and/or disclosure of your protected health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of Alexandre B. De Moura, M.D., P.C. d/b/a New York Spine Institutes of Privacy Practices which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information.

_____ _____

Patient/Designated Representative Signature Print Name

_____ _____

If designated representative, relationship to patient Date

FOR PROVIDER USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices. We were unable to obtain such acknowledgment, however, because:

- Treatment was rendered in an emergency treatment situation. Efforts will be made to obtain the acknowledgment as soon as reasonable practicable after the emergency.
- We were unable to effectively communicate with the patient: Reason:
- Patient refused to sign: Reason Given:
- Other (please specify):

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Patient Agreement for Controlled Substances

1. **Interdisciplinary Treatment;** I, _____ agree to actively participate in all aspects of my treatment, as recommended by Dr. Deborah Mottahedeh, D.O or any physician employed by The New York Spine Institute, including psychological testing and therapy, follow-up, physical therapy, occupational therapy, chemical substance evaluation. If I fail to do so, I understand my treatment at The New York Spine Institute may be terminated.

2. **Lifestyle;** I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal, and that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits, specifically involving exercise, weight control and the use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

3. **Physical tolerance and addiction;** I have been fully informed by my physician about the physical dependence on medications. I understand that if I have been on a medication for several weeks or more, I will become physically dependent on certain medications. When I stop such medication, I must do so slowly, and under the supervision of my physician to minimize withdrawal symptoms. I know that some persons may develop psychological dependence (addiction) to a medication.

4. **Effects of medications;** I understand the side effects of the medications may include dizziness, sleeplessness, severe sweating and altered consciousness. I understand that my ability to drive and/or operate heavy machinery may be affected, and I will not perform potentially hazardous tasks before understanding how I will be affected by the medication. I understand that his may cause injury to me or others.

   (***Males Only)*** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(***Females Only)*** I am aware that chronic opioid use has been associated with low levels of sex hormones and may lead to decrease in fertility. If I plan to become pregnant or believe that I am pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always possibility that my child will have a birth defect while I am taking an opioid.

5. **Obtaining controlled substances** from physicians only at New York Spine Institute; I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medication from my doctors at New York Spine Institute. I am not to obtain controlled substances from other physicians, friends or family members. The only exception is if it is prescribed while I am admitted in a hospital.

6. **Taking medications as prescribed;** I will not increase, alter or stop my dose of controlled substance medication without approval of a New York Spine Institute physician. If I overuse my medication and run out of medication early, I will experience increased in pain and go through withdrawal, also known as abstinence syndrome. Withdrawal is a severe Flu-like syndrome caused by sudden cessation of opioids.

7. **Storage of medications;** I will make sure to store all prescribed controlled substances in a safe location away from the reach of children and pets, and under lock and key to avoid possible theft.

8. **Lost or stolen medication;** I am responsible for my controlled substances medications. If the prescriptions is lost, misplaced or stolen, I understand that it will **NOT** be replaced. We do not accept police reports or any other reports as proof.

9. **Sharing medication;** I understand that is strictly prohibited to share my medication with other individuals. Medications are to be taken only by the patient for which they were prescribed.

10. **"Street Drugs";** I will not take any "street" drugs. I understand that taking any non-prescription drugs may be grounds for expulsion from Dr. Mottahedeh, D.O and any other physician employed by New York Spine Institute.

11. **Drug Testing;** I will submit to urine and/or saliva drug testing on a random basis, as required by New York Spine Institute physicians, nurses and/or physician assistant. If illicit substances or evidence of mind-altering medications not prescribed by New York Spine Institute physicians are found in my urine or saliva or expected levels of prescribed drugs are not found, all controlled substance prescriptions will be discontinued at the discretion of the physicians at New York Spine Institute.

12. **Appointments;** I understand that refills of my controlled substances will be given only during a scheduled appointment. Patients must attend their appointments in order to be assessed for the need to continue taking the medication. Prescriptions will only be handed to the patient for whom they are intended. Prescriptions will not be mailed to patients of called in by phone to pharmacies.

13. **Discharge from New York Spine Institute;** I understand that violating the above conditions may result in discontinuation of my prescribed controlled substances and discharge from New York Spine Institute. In addition, this information may be disclosed to other individuals involved in my care, such as my primary care physician and local medical facilities.

14. **Authorization for information;** By signing this form, I am authorizing New York Spine Institute to call my other physicians, pharmacy and/or insurance company top verify compliance with these guidelines. I will tell my doctor about all other medicines and treatment that I am receiving.

15. **Pharmacy;** I shall only be using one dedicated pharmacy to fill all my prescriptions for all controlled substances prescribed to me and this information will be readily available to all physicians, nurses, physician assistant and other paramedical staff at New York Spine Institute.

My signature below indicates that I have read and understand the above guidelines.

Patient Name (PRINT): _____

Signature: _____

Pharmacy Name: _____

Address: _____

Telephone: _____ **Fax:** _____

PATIENTS SUBJECTIVE COMPLAINTS QUESTIONNAIRE

Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes/No ☐

If yes, how/when: _____

_____

(PLEASE INDICATE WITH AN "**X**" FOR YES)

	NUMBNESS/TINGLING		**SWELLING**
	PAIN		**WEAKNESS**
	STIFFNESS		**DIZZINESS**
	SWAYING/TILTING		**DIFFICULTY WALKING**
	FAINTNESS		**LOSS OF BALANCE**
	DOUBLE VISION		**RINGING IN THE EARS**
	HEADACHES		**CHEST PAINS**
	OTHER		

(TYPE/NATURE OF INJURY, PLEASE INDICATE WITH AN "**X**" FOR YES)

	ABRASION		**INFECTIOUS DISEASE**
	AMPUTATION		**INHALATION EXPOSURE**
	AVULSION		**LACERATION**
	BITE		**BURN**
	NEEDLE STICK		**POISONING/TOXIC EFFECTS**
	CONTUSION/HEMATOMA		**DISLOCATION**
	HERNIA		**SPRAIN/STRAIN**
	FRACTURE		**PUNCTURE WOUND**
	OTHER		

ARE YOUR SYMPTOMS AFFECTED OR BROUGHT ON BY ANY OF THE FOLLOWING?

☐ CHANGE IN POSITION
☐ RAPID HEAD MOVEMENT
☐ STANDING UP
☐ WALKING IN DARK OR DIMLY LIT ROOM
☐ WALKING ON UNEVEN SURFACES
☐ TRAVELING IN A CAR, AIRPLANE OR BOAT

☐ CLIMBING STAIRS OR LADDER
☐ COUGHING, SNEEZING, STRAINING
☐ WATCHING MOVING OBJECTS
☐ SMOKING
☐ ALCOHOL
☐ CERTAIN MEDICATIONS _____

DO YOU REQUIRE EYE GLASSES? ☐ YES / NO ☐
DO YOU REQUIRE A HEARING AID? ☐ YES / NO ☐
DO YOU USE A CANE AND/OR WALKER? ☐ YES/ NO ☐

PLEASE LIST CURRENT MEDICATIONS

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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HISTORY

Must be filled out in entirety

PATIENT NAME: _____

DATE OF THE ACCIDENT: _____/_____/_____

CHIEF COMPLAINT: _____

WHERE IS PAIN? ( ) NECK ( ) BACK ( ) OTHER _____

HOW AND WHERE WERE YOU INJURED? _____

DESCRIBE: _____

_____

ANY PRIOR MOTOR VEHICLE ACCIDENTS? ( ) YES ( ) NO

PRIOR HISTORY OF NECK OR BACK PAIN? ( ) YES ( ) NO

TREATMENTS YOU HAVE RECEIVED TO DATE:
( ) PHYSICAL THERAPY
( ) CHIROPRACTIC CARE
( ) ACCUPUNCTURE
( ) EPIDURAL INJECTIONS
( ) TRIGGER POINT INJECTION
( ) DIAGNOSTIC IMAGING

ANY OTHER MEDICAL PROBLEMS? _____

OCCUPATION & EMPLOYER NAME: _____

SOCIAL HISTORY: SMOKE? ( ) NO ( ) YES, HOW MUCH? _____

DRINK? ( ) NO ( ) YES, HOW MUCH? _____

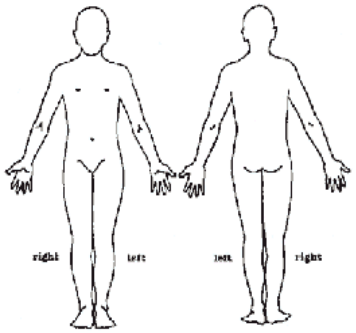
LIST ANY OPERATIONS AND/OR HOSPITALIZATIONS (WITH DATES) _____

_____

ANY RADIOLOGY TESTING? _____

_____

ANY KNOWN ALLERGIES? _____



PAIN DRAWING & SCALE REVIEW