NEUROSURGICAL AND SPINE ASSOCIATES OF OKLAHOMA, PC

REGISTRATION FORM

(Please Print)

Today's date:	**Family Physician:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Race:	Ethnicity:	Preferred Language:			

Street address:	Social Security no.:	Home phone /Cell #: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members/Friends seen here:

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Please indicate primary insurance	❑ Medicare	❑ Blue Cross	❑ Aetna	❑ Tricare	❑ Other

Subscriber's name:	**Subscriber's SS #:**	**Birth date**: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	**Subscriber's name**:	**Subscriber's Birth Date:** / /	**Subscriber's SS#:**
Insurance Group no.:	Insurance Policy no.:	Patient's relationship to subscriber:	❑ Self ❑ Spouse
		❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neurosurgical and Spine Associates of Oklahoma or insurance company to release any information required to process my claims. I also consent to review of my prescription history.

Patient/Guardian signature ______________________ ***Date*** ______________

PERSONAL HEALTH HISTORY

SYMPTOMS FOR WHICH YOU ARE HERE TODAY (DESCRIBE WHAT YOU ARE FEELING AND WHERE)		
HOW LONG?	**Injured at work?**	**What makes symptoms better?**
WHAT WORSENS SYMPTOMS?		
HOW HAVE YOU TREATED SYMPTOMS?		

Have you had any of these tests in the last 6 months (specify dates and where)?	☐ XRays	☐ CT
	☐ MRI	☐ Myelogram
	☐ EMG	☐ Bone density
ARE YOU CLAUSTROPHOBIC? ☐Yes ☐ No	**Do you take calcium?** ☐ Yes ☐ No	

PAST SURGERIES		
Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ Yes	☐ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

***Please list your Pharmacy*_____________________________*Address*___________________________*Phone #*______________________**

Name of Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name of Drug:	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)	
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)	
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)	
	☐ Yes	☐ No
Caffeine	# of cups/cans per day?	
	☐ Yes	☐ No
Alcohol	What kind?	How often?

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day				
	☐ # of years	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	Do you currently use recreational or street drugs?	☐ Or year quit			
Personal Safety	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No

OTHER PROBLEMS

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	
☐ Clotting Disorder	☐ Headaches	
☐ Osteoporosis	☐ Seizure Disorder	
☐ Hypertension	☐ Heart Disease	
☐ Diabetes	☐ Arthritis	

Family History

	Living	Healthy	Heart Disease	Diabetes	Hypertension	Stroke	High Cholesterol	Breast Cancer	Colon Cancer	Lung Cancer	Melanoma	Ovarian Cancer	Cancer	Osteoporosis	Asthma	Kidney Disease	Thyroid Disease	Liver Disease	Respiratory Disease	Depression	Anemia	Other
Father	Y / N																					
Mother	Y / N																					
Sister	Y / N																					
Sister	Y / N																					
Sister	Y / N																					
Brother	Y / N																					
Brother	Y / N																					

NEUROSURGICAL AND SPINE ASSOCIATES OF OKLAHOMA, PC

Patient Name: ____

1. Is this a work related injury?

   ____No ____Yes If yes, date of injury ____/ ____/ ____
   If yes, please provide the following information:

   Employer Name: ____________________
   Employer Address: ____________________
   Employer Phone: ____________________
   Work Comp Carrier: ____________________
   Work Comp Address: ____________________
   Work Comp Phone: ____________________
   Work Comp Contact: ____________________
   Work Comp Claim #: ____________________

2. Is your condition related to a motor vehicle accident (motorcycle, automobile, etc.?)

   ____No ____Yes If yes, date of injury ____/ ____/ ____

   If yes, please provide the following information:

   #1 Auto Ins Name: ____________________
   Address: ____________________
   Phone: ____________________
   Policy/Claim #: ____________________

   #2 Auto Ins Name: ____________________
   Address: ____________________
   Phone: ____________________
   Policy/Claim #: ____________________

3. If yes to any of the above, have you obtained a lawyer on your behalf?

   ____No ____Yes

   If yes, please provide the following:

   Lawyer Name: ____________________
   Address: ____________________
   Phone: ____________________

   I agree the above statements are accurate and true.

____

Patient Signature **Date**

REVIEW OF SYSTEMS

Patient Name: ____ Date: ______________________

GENERAL		GASTROINTESTINAL	
Anxiety		Constipation	
Appetite Changes		Diarrhea	
Easily Fatigued		Liver disease	
Fever/Chills		Rectal bleeding	
Night Sweats		Ulcers	
Weight Change		Vomiting	
OPHTHALMOLOGY		**INFECTIONS / HEMATOLOGY**	
Blurring of vision		Hepatitis A/B/C	
Double vision		AIDS / HIV exposure	
Loss of vison		**MUSCULOSKELETAL**	
ENT / RESPIRATORY		Arthritis	
Asthma		Back pain with motion	
Chronic Bronchitis		Frequent bone fractures	
COPD		Muscle wasting and fatigue	
Difficulty swallowing		Neck pain with motion	
Emphysema		Pain/stiffness in arms, wrists or hands	
Excessive snoring		Pain/stiffness in legs, knees or feet	
Frequent sinus infections		**UROLOGY**	
Hearing loss		Incontinence	
Ringing in ears		Kidney disease	
Productive cough		Pain with urination	
Sleep Apnea		Sex disease	
Shortness of breath		**NEUROLOGICAL**	
Wheezing		Fainting/Blackouts	
ENDOCRINE		Headaches with vomiting	
Diabetes		Loss of arm / leg function	
Thyroid Imbalance		Loss of eye / ear function	
CARDIOVASCULAR		Memory loss	
Chest pain with exertion		Recent loss of bowel / bladder control	
Chest pain with rest		Seizures	
High/Low Blood Pressure		Stroke	
Irregular Heart Beat		Tremors	
Pacemaker		**PSYCHIATRIC**	
Shortness of Breath		Anxiety	
		Depression	
		Mood swings	
		Suicidal thoughts	

Neurosurgical and Spine Associates of Oklahoma, PC

DISCLOSURE NOTICE

Dr. Qualls Stevens or members of his family have financial relationships with the companies listed below. These relationships include; however, are not limited to hospital investments, ownership, fees for medical directorship and stock investments. It is our priority to provide our patients exceptional care and our referrals are based on the best possible care for our patients. If you do not want to use the services rendered by these businesses, please inform us and we will make alternate plans for referral and/or these services, when at all possible.

1. Healthcare Partners Investments, LLC/Community Hospital
2. Picadilly Distributors, LLC
3. Ameria Property Management, LLC

I have read and understand the above Disclosure Notice on this ________day of _____________, 20___

Signed:____

NEUROSURGICAL AND SPINE ASSOCIATES OF OKLAHOMA, PC
8 SW 89th Street Ste 100
Oklahoma City, OK 73139

Notice of Privacy Practices (HIPAA) Signature Form

This signature page is in reference to the forms entitles:

1. Notice of Privacy Practices (HIPAA)

If you did not receive these documents, or have misplaced them, please ask for another copy. This signature page is in reference to the Federal HIPAA Privacy Regulations requirements.

This undersigned certifies that he/she has received a copy of the **Notice of Privacy Practices (HIPAA),** and is the client, or is duly authorized by the client as the client's representative. If a more detailed verbal explanation is needed, in addition to the one you received, please request one now and we would be pleased to assist you.

____ _______________________________________

Patient Signature (or Patient's Representative) **Date**

HIPAA RELEASE

I,____, intend for any person named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following person (Family, Friends, etc):

___________________________________ ______________________ ____________________________

Name Relationship Phone Number

___________________________________ ______________________ ____________________________

Name Relationship Phone Number

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to any agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

This authority given to any named person shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to any named person may be subject to redisclosure by a named person herein has no expiration date and shall expire only in the event that I revoke this HIPPA Release in writing and deliver it to my health-care provider. There are not exceptions to my right to revoke this HIPAA Release.

____

Patient Signature

Neurosurgical & Spine Associates of Oklahoma, PC

Financial Policy

Thank you for choosing Neurosurgical & Spine Associates of Oklahoma for your healthcare needs. We are committed to delivering outstanding medical care. The following is a statement of our policy which we require you to read and sign prior to any treatment.

Payment of any co-pays, deductibles and other fees are due at the time of service. Please be prepared to make payment on the day you visit the office. Any remaining balance on your account after the insurance company has paid your claim is due upon receipt of a statement from our office.

If your insurance requires you to obtain a primary care physician (PCP) referral for appointments with a specialist, you will be required to do so prior to your visit. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. If the authorization is not received, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Your insurance is a contract between you (the subscriber), your employer and the insurance company. We are not a party to that contract. Should your insurance fail to pay, for any reason, you are responsible for the balance. We will transfer liability of the claim to you if your insurance does not properly pay within 45 days. We expect you to be interactive and responsible for communicating with your insurance carrier on any open claims.

Failure to give 24 hour notice of cancellation of an appointment or not showing up for an appointment can result in a charge of $75 to your account. This charge cannot be billed to your insurance company and will be your responsibility. Failure to pay this fee will be treated according to our policy on unpaid balances.

If you are scheduled for surgery, you will be required to pay any deductibles, co-ins, co-pays or any non covered services prior to your scheduled surgery date.

If a check is returned for insufficient funds, or if a payment has been stopped, you will be charged a $35.00 fee in addition to the amount of the check. You will be required to pick up the check within 10 days and to pay the debt with cash or credit card.

There will be a fee of $40 to fill out forms--FMLA, Disability, etc....
Please allow 7-10 business days for forms to be completed.

If you need to have medical records copied, you will need to sign a medical release form. There will be a fee of $1.00 for the first page and .50 cents for each additional page not to exceed $25.00. Please allow 7-10 business days for forms to be completed.

I have read and understand the above Financial Policy and agree to the conditions listed.

____

Patient Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the patient, certify that the information on this form is true to the best of knowledge I hereby authorize the release of all applicable medical information including, without limitation, copies attending, referral and/or follow-up physicians and such other health care practitioners or organizations with/which will be providing subsequent monitoring, care or treatment in connection with care provided by any Neurosurgical and Spine Associates of Oklahoma employee. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize Neurosurgical and Spine Associates of Oklahoma to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to the physician and/or clinic. I further agree that a photocopy of this document is to be considered as valid as an original

____

Patient Signature **Date**

Patient Name:____ Date:_________________________

NEUROSURGICAL & SPINE ASSOCIATES OF OKLAHOMA, PC

QUALLS STEVENS, DO

8 SW 89th ST, SUITE 100

OKLAHOMA CITY, OK. 73130

PHONE 405-455-3322 FAX 405-606-4668

CONTROLLED SUBSTANCE/NARCOTIC PRESCRIPTION CONTRACT

Controlled substance medication (narcotics, opioids, tranquilizers, barbiturates) can be very useful to treat some painful conditions, but have high potential for misuse and abuse and are, therefore, closely controlled and monitored by the government. If used excessively, the medications can cause adverse effects such as impaired judgment, vomiting, constipation, lethargy and even death.

To ensure that the medications are used properly to treat pain, each patient must agree to follow the instructions below. Patients, who do not abide by the instructions and conditions of this contract and / or the treatment plan, will be terminated from the practice.

Please read this contract thoroughly as it is a condition of your treatment. Your signature will be required.

1. I am responsible for my narcotic medications. If the prescription or the medication itself is lost, misplaced, stolen, or if I use my medication at a greater rate than prescribed, I will be without for a period of time. I understand that early refills are not given.
2. Forging or altering a narcotic prescription or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated and I will be reported to the authorities. (DEA, Police, etc.)
3. I understand that refills of narcotic medication will be made only during my regularly scheduled appointment. Refills for controlled substances will not be provided during non- office hours, holiday, or weekends. The answering service will not contact the doctor after hours regarding refills.
4. Excessive phone calls requesting increased dosages or frequency is viewed as drug seeking behavior. Changes in medication will not be made without an office visit.
5. I will not request or accept narcotic medication from any other physician or individual while I am receiving such medications from this office, unless it is administered to me by a physician in an emergency room or hospital. If narcotic medication is prescribed by an emergency room physician, I will inform this office. In addition to being illegal to obtain narcotic prescriptions from multiple physicians, it may endanger my health. Any violation of this policy will be reported to the authorities and all physicians involved in my care.
6. I understand that I will be asked to submit to a drug test which will screen for illegal drug use and for the narcotics which I am being prescribed. These drug screens will be given at my initial visit and for every refill I request. They may also be given randomly. If I refuse the test at any given time, I understand that I have chosen not to continue by treatment with Dr. Stevens and my treatment with him will be discontinued immediately. In addition, should the results display any violation set forth in this contract, my treatment with Dr. Stevens may be immediately discontinued.
7. I understand that Dr. Stevens and/or his staff are able to pull my narcotic record from the Oklahoma Bureau of Narcotics secured web-site. This web-site tracks all narcotics I have received and details which doctor prescribed the narcotic and at what pharmacy they were filled.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I UNDERSTAND, AND AGREE, THAT IF I VIOLATE ANY OF THE ABOVE INSTRUCTIONS AND CONDITIONS, MY ENTIRE TREATMENT MAY BE TERMINATED. IF I DECLINE TO TAKE A URINE TEST, MY ENTIRE TREATMENT WILL BE TERMINATED. ANY VIOLATION OF THE CONTRACT OR COUNSELING RECEIVED REGARDING VIOLATIONS WILL REMAIN A PART OF MY PERMANENT MEDICAL RECORD. THIS CONTRACT WILL REMAIN ENFORCED DURING THE ENTIRE COURSE OF MY TREATEMENT PLAN.

_______________________________________ _________________________________

Patient's Signature Date