PETERSEN NEUROSPINE
THE CENTER FOR SPINAL HEALTH

PLEASE COMPLETE ALL ENTRIES

PATIENT NAME: _____ ADDRESS: _____

HOME PHONE: _____CELL PHONE: _____ CITY, STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PATIENT SSN: _____ SEX: _____ MARITAL STATUS: _____

RACE: _____ PRIMARY LANGUAGE: _____ ETHINCTY: ▫ Hispanic/Latino ▫ Not Hispanic/Latino

PATIENT EMPLOYER: _____ OCCUPATION: _____

PRIMARY DOCTOR: _____ PHONE #: _____

SPOUSE NAME: _____ PHONE: _____ DATE OF BIRTH: _____

EMAIL ADDRESS: _____

PHARMACY NAME: _____CITY/STATE: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

SUBSCRIBERS NAME: _____ DOB: _____ ☐ SELF ☐SPOUSE ☐ PARENT ☐ GUARDIAN

ID# _____ GROUP# _____ SS#: _____

SECONDARY INSURANCE NAME: _____

SUBSCRIBERS NAME: _____ DOB: _____ ☐ SELF ☐ SPOUSE ☐ PARENT ☐GUARDIAN

ID# _____ GROUP# _____ SS#: _____

IN CASE OF EMERGENCY

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

Please list any additional person(s) that we may release information to:

_____ _____ _____

CONSENT FOR EPRESCIBE PROGRAM

BY SIGNING THIS CONSENT FORM, YOU ARE AGREEING THAT YOUR PROVIDER AT PETERSEN NEUROSPINE. LLC. MAY REQUEST AND USE YOUR PRESCRIPTION MEDICATION HISTORY FROM OTHER HEATHCARE PROVIDERS AND OR THIRD-PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES.

ASSIGNMENT AND RELEASE

I HERBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND I AM FINANCIALLY RESPOSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESSING OF THIS CLAIM AND ALL FUTURE CLAIMS. IF MY ACCOUNT IS SENT TO COLLECTION AGENCY, I AGREE TO PAY ALL COLLECTION AND ATTORNEY FEES.

SIGNATURE: _____ DATE: _____

THE BELOW CONSENT IS FOR X-RAY SERVICES RECOMMEND BY PETERSEN NEUROSPINE, PLLC.

Clark & Hirsch Neurosurgery & Spine

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

CONSENT FOR TREATMENT: I, undersigned, consent to the care and treatment by the attending physicians, associates, or assistants of Clark & Hirsch Neurosurgery & Spine, PC.

Patient: _____ Date _____

Person other than patient/relationship _____

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT: In Consideration of all services and supplies provided by Clark & Hirsch Neurosurgery & Spine, PC I understand and agree that I have full responsibility to pay Clark & Hirsch Neurosurgery & Spine, PC and understand the charges not covered by my insurance remain my responsibility and assign insurance benefits to Clark & Hirsch Neurosurgery & Spine, PC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Clark & Hirsch Neurosurgery & Spine, PC to fees of any collection agency, which may be based on percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts. I agree for Clark & Hirsch Neurosurgery & Spine, PC to coordinate my care, service my account or to collect monies I may owe, Clark & Hirsch Neurosurgery & Spine, PC and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Clark & Hirsch Neurosurgery & Spine, PC may also contact me by sending text messages or emails, using any email address I provide. Methods of contacting may include prerecorded or artificial voice messages and or use automatic dialing devices, as applicable.

Notice of Privacy Practices Receipt: I have received the Notice of Privacy Practices provided by Clark & Hirsch Neurosurgery & Spine, PC.

Patient Signature _____

Person other than patient/relationship _____

PETERSEN NEUROSPINE
THE CENTER FOR SPINAL HEALTH

Patient History Questionnaire

Name:_____ DOB:_____ Date:_____

Do you have a diagnosis or symptoms with any of the following?

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot
- ☐ Cancer
- ☐ Chest Pain
- ☐ Colitis
- ☐ Compression fracture
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Fatigue
- ☐ Fever
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Joint Pain
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraine/HA
- ☐ Polio
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Sickle Cell Disease
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Weight Change

Anything else important:_____

Please list any previous surgeries:

_____

_____

PLEASE LIST YOUR DAILY MEDICATIONS	

Please list your allergies:

_____

_____

Has anyone in your family had (check all that apply):

- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Bleeding problems
- ☐ Cancer (please specify): _____
- ☐ Scoliosis
- ☐ Hip/Spine Fracture
- ☐ Spine Surgery

Do you currently use any tobacco products? _____

If yes, amount per day? _____

How long have you used tobacco products? (years): _____

Do you drink alcohol? NEVER SOCIALLY DAILY

Patient or guardian signature: _____

Physician Signature: _____ Date: _____

PETERSEN NEUROSPINE
THE CENTER FOR SPINAL HEALTH

Patient Name:_____ Date: _____

DOB: _____

1. Who referred you here? _____
2. Occupation? _____
3. Allergies? _____
4. When did your pain start? _____
5. What were you doing when your pain started?
6. Please mark your level of pain on the below diagram: (0 = no pain; 10 = worst pain)

Neck Pain:

0 5 10

Arm Pain:

Left:

0 5 10

Right:

0 5 10

Back Pain:

0 5 10

Leg Pain:

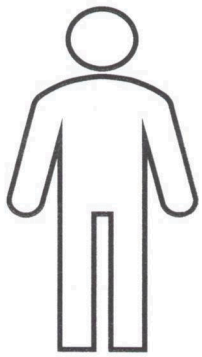
Left:

0 5 10

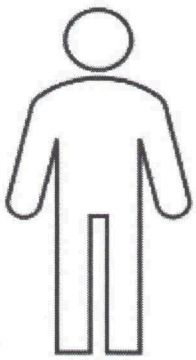
Right:

0 5 10

8. Have you had any treatment to date?
   Medicine: _____
   Brace: _____
   Physical Therapy: _____
   Manipulation: _____
9. Have you ever had epidurals/blocks? YES or NO
   If so, when was the last?
10. Any previous work injury to your neck or back? YES or NO
11. Did you require any restrictions to your work due to your injury? YES or NO
12. Have you ever had an MRI or CT scan for you current problem? YES or NO
    If yes, when and where? _____



FRONT



BACK

Place an "X" on the picture where you have pain

Place "O" on the picture where you have numbness and tingling.

Petersen Neurospine, LLC
251-225-4151

Patient's Name:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you received at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your records to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or service. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For Example: We may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. The uses and disclosures are necessary to run the Practice and ensure that all our patients receive quality care. We may disclose information to doctors, nurses, technicians, medical students and other Practice personnel for review and learning purposes. For example: we may review you record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE: This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as employees, staff and other Practice personnel, POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; ant to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment of your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following right regarding medical information we maintain about you:

Right to a paper copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a limit on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of you care, like a family member or friend. ***We are not required to agree to you request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosure to Health Plan. You have the right to restrict disclosure of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosure. You have the right to request an "accounting of disclosures." This is a list of disclosures we made of medical information about you. To Request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current cotiuve in the Practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Humans Services. To file a complaint with the Practice, contact Bendt Petersen, Privacy Officer, 251-607-6117, 6701 Airport Blvd Building D, Suite 100, Mobile AL 36608. All complaints must be submitted in writing. ***You will not be penalized for filing a complaint.***

OTHER USES OF MEDCIAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient or Patient's Personal Representative **DATE**

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting Petersen Neurospine, PLLC for your specialty care. When you schedule with us, we set our appointments so that each patient receives the appropriate amount of time to be seen by our physician and staff. Therefore, it is imperative that you keep your scheduled appointment and arrive on time.

As a courtesy, and to assist with a helpful reminder to patients, Petersen Neurospine, PLLC sends email reminders of your scheduled appointment. When time allows, reminder calls are done as a courtesy as well. If you are unable to make your scheduled appointment, please contact our office so that we may reschedule you and accommodate those patients who are waiting to schedule with the physician.

Therefore, Petersen Neurospine, PLLC has implemented the following policy:

- **EFFECTIVE FEBRUARY 1, 2022,** new **AND** established patients who fail to cancel or reschedule their appointment with at least a 24-hour notice, will be assessed a **$50** "no show charge" to your account.

- This "no show charge" is not reimbursable by your insurance company. You will be billed directly.

Our office understands that unforeseen circumstances occur, and you may not be able to keep your scheduled appointment with our office. If this does occur, please contact our office, and speak with the Office Manager as those issues will be handled separately.

You may contact Petersen Neurospine, PLLC 24 hours a day, 7 days a week by calling 251-607-6117. If it is outside of our business hours of Monday-Thursday 8:00 am to 5:00pm and Friday 8:00am to 12:00pm, please leave a message. Messages left are acceptable notifications of the need to cancel your appointment.

I have read and understand the "appointment cancellation/no show policy" for Petersen Neurospine, PLLC. I understand that I must notify Petersen Neurospine, PLLC within 24 hours of my scheduled appointment to cancel or reschedule, or I will be billed a $50 no-show charge directly, as my insurance company will not reimburse this charge.

Sign: _____ Date: _____

Patient Name: _____