Spine, Pain & Rehabilitation Center
OF COLORADO

Gin-Ming Hsu, M.D.
Aubrey Deegan PA-C
Board Certified in Physical Medicine & Rehabilitation,
Pain Management and Spinal Cord Injury Medicine

Patient Name:_____ Date of Birth_____

New Patient Packet Questionnaire

Pain History

Tell us why you are here today (please circle) Pain medication/other options

When did the pain start? _____

What is the cause of your pain? (please circle) Trauma/Fall/Motor Vehicle Accident/Unknown

Where is your pain located on your body _____

What side is your pain located on (please circle) right/left/both
Is one side worse than the other? Yes/No
If yes, please specify: Left greater than right/Right greater than left

Describe character of your pain: Stabbing/Burning/Throbbing/Numbness/Tingling

If you have neck pain does it radiate into the arms? Yes/No

If you have low back pain, does it radiate into the legs? Yes/No

What is the least pain you have from on a scale of 0 to 10? _____

What is the greatest pain you have on a scale of 0 to 10? _____

How long does your pain last? Consistent/Intermittent
Does your pain last: A few hours/All day/Varies

Is sleep affected by your pain? Yes/No

What makes your pain worse? Activity/Bending/Lifting/Twisting/Other_____

What makes your pain better? Medications/Rest/Repositioning/Other_____

Do you have bowel or bladder incontinence? Yes/No
If yes, please explain: _____

If you were injured, briefly describe your injury: (ground level fall/rear ended car accident):_____
_____

List any physicians (primary care/specialists) you have seen for your pain and explain any treatment plans: _____

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Have you received any imaging for your pain? If no, write N/A

Date	Type of Image i.e., X-ray, CT, MRI	Facility Name

Have you had any surgeries? If no, write N/A

Date	Type of surgery	Facility Name

Have you had any non-surgical procedures for your pain? If no, write N/A

Date	Type of Procedure i.e., Nerve Block, Epidural Injection	Facility Name

Please list any medications taken in the ***PAST***. If no, write N/A

Name of Medication	Dose (mg)	Frequency i.e., Once a Day	Stop Date

Please list any current medications you are ***CURRENTLY*** taking. If no, write N/A

Name of Medication	Dose (mg)	Frequency i.e., Once a Day	Start Date

Pleas list any other therapies or treatments not mentioned above to treat your pain. If no, write N/A

Type of therapy i.e., PT, Massage, Chiropractic	Frequency	Duration i.e., how many weeks or months	Facility

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Patient Demographics Information Sheet

Welcome to Spine, Pain and Rehabilitation Center of Colorado (SPARCC)

Please complete this entire form. ***The details requested in this form are requirements of the new Healthcare Reform Act. Your cooperation is appreciated***

Name _____

Last First Middle

Address _____City _____State _____Zip _____

Contact Info (Circle preferred phone contact):

Home Phone: _____Work Phone: _____

Cell Phone: _____ E-mail: _____

Date of Birth: _____ Gender: F/M Social Security #: _____

Preferred Language: English/Spanish/Other: _____

Race (circle one): African American, Alaskan Native, American Indian, Asian, Caucasian, Hispanic, Pacific Islander, Other Race

Ethnicity (circle one or add) (i.e. cultural background: American (US), Asian, Chinese, Indian, Latin American, Mexican, Middle Eastern, North American Indian, Vietnamese, Other) _____

Your Pharmacy: _____Address:_____

Phone #: _____

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Patient Demographics Information Sheet

Insurance Information

Primary Insurance: _____ ID #:_____

Group #: _____ Policy Holder: _____

Address: _____

Phone Number: _____ Effective Date: _____

Secondary Insurance: _____ ID#:_____

Group #: _____ Policy Holder: _____

Address: _____

I understand that I am financially responsible for all charges not covered by my insurance for services rendered on my behalf. I authorize SPARCC to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that non-payment of any charges due from me may affect future appointments. All information provided above is accurate and truthful.

Signature _____ Date _____

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Please tell us if you are: ☐Right Handed ☐Left Handed

Review of Systems

Please check if you have experienced any of the following in the last three months:

☐Fatigue ☐Weight Gain ☐Weight Loss ☐Chest pain ☐Shortness of Breath
☐Abdominal Pain ☐Painful Urination ☐Rash ☐Seizures ☐Easy bruising
☐Seasonal Allergies ☐Depression

Past Medical History

☐Heart Problems: Coronary Artery disease, heart attack, atrial fibrillation (circle one)
other:_____
☐High Blood Pressure
☐Diabetes: Type I, Type II
☐Cancer: (Specify):_____
Other Major Medical Problems:_____
_____

Please list all Past Surgeries. Write N/A if this does not apply

Surgery Preformed	Date	Facility

Family Medical History

Mother: ☐Coronary Artery Disease ☐High blood pressure ☐Diabetes ☐Cancer (type:_____)
Father: ☐Coronary Artery Disease ☐High blood pressure ☐Diabetes ☐Cancer (type:_____)
Sister(s): ☐Coronary Artery Disease ☐High blood pressure ☐Diabetes ☐Cancer (type:_____)
Brother(s): ☐Coronary Artery Disease ☐High blood pressure ☐Diabetes ☐Cancer (type:_____)
Any other major family medical problems?
_____
_____

Allergies

Allergies to ☐Latex ☐Iodine ☐Contrast (used in medical imaging tests)
Allergies to Medications? ☐No Known Drug Allergies
if Yes, please list: _____

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Social History

Marital status? Single/Married/Widowed/Divorced/Domestic Partner (circle one)
Spouse/Partner's Name: _____
Number of children:_____ Names/Ages:_____

Currently working? Unemployed/Part Time/Full Time (circle one)
Occupation: _____Employer:_____
Unemployed Since:_____
Disability: What was the date of your disability? _____
Reason for disability? _____
Retired: What date? _____Occupation at retirement? _____

Lifestyle

Do you use tobacco? Y/N cigarettes/cigars/pipe/chewing tobacco (circle one)
☐Never smoked
Past smoker Y/N Quit date?_____
Current smoker: For how many years?_____ How many per day?_____

Do you use marijuana? Y/N recreational/medical (circle one)
Do you drink alcohol? Y/N How much? _____
☐Never drank alcohol
Past alcohol use Y/N Quit date?_____
Current alcohol use: Liquor/Beer/Wine (circle)
How often: Occasional/Social/Regular
_____times/week ____times/month____times/year

History of addiction? Y/N Prior/Current (circle one)
alcohol/drug:(specify):_____
Have you been in a drug or alcohol rehab program? Y/N
When: _____Reason? drug/alcohol: (specify): _____
History of use of illegal/street drugs? Y/N
Any prior arrest or convictions for illegal drug use? Y/N (Specify): _____
_____

Mental Health History

Mental Health History: Y/N ☐Depression ☐ Anxiety
Other Major Mental Health History_____
_____
_____

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Practice Policy and Procedures

Spine, Pain and Rehabilitation Center of Colorado is dedicated to providing you with you with the best possible medical care. We are also committed to extending this same level of service to our business and financial policies. It is crucial that you understand these policies, especially in view of our ongoing changes in the health care industry. These changes may affect you in the services that are covered by your insurance carrier or in the services that are determined by insurance to be due and payable directly by you.

No Insurance: Payment will be due at the time of service.

I have read and agree to the above statement (initial)_____

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles, and non-covered services received. If you are unable to pay your balance in full, we require that 50% of the balance be paid at the time of service and prior arrangements be made with our Billing Office or Clinic Coordinator before your next scheduled appointment.

For your convenience we accept cash, checks, credit cards (Visa, MasterCard and American Express), and money orders. Payments are also accepted by phone.

I have read and agree to the above statement (initial)_____

Balances Due Policy
Your insurance company will notify both you and our office with an Explanation of Benefits (EOB) if there is a balance due that is your responsibility. Balances over 30 days will incur a 2% interest charge per month.

I have read and agree to the above statement (initial) _____

Co-Pay Policy
Per Insurance law and regulations, all patients are expected to pay their co-pay at the time of the office visit. Most insurance companies have co-payments that are a flat fee per visit. That is a portion of the cost at the time the service is rendered. We do not bill for co-payments. It is your responsibility to inform the receptionist if you do not have the means to pay your co-payment and your appointment will be rescheduled.

I have read and agree to the above statement (initial) _____

Returned Check Fee: There will be a charge assessed of $25.00 for all returned checks. In addition to the returned check fee, the full check amount will have to be paid in cash before any future appointments can be scheduled.

I have read and agree to the above statement (initial)_____

Collections: If your balance becomes delinquent and is sent to collections, you may be subject to dismissal from the practice.

I have read and agree to the above statement (initial)_____

Cancellation / No Show / Reschedule Policy: Our policy requires that if you need to cancel or reschedule your appointment that you at least provide our office 24 hour notice (not including weekends and holidays). Failure to show up for your appointment or failure to cancel or reschedule your appointment will result in a $50.00 fee. Failure to show up for your procedure will result in a $100.00 fee. This fee must be paid before any future appointments can be rescheduled. Please be advised that three or more no shows can result in termination from the practice.

I have read and agree to the above statement (initial)_____

Disability, FMLA, Insurance Forms: There will be a charge of $200.00 per hour for the completion of medical forms. Payment is due prior to the doctor completing the requested forms. Please allow 7-10 days for the completion of these forms.

I have read and agree to the above statement (initial)_____

Prescription Refill Policy
You must call four (4) business days (i.e., Monday to Friday, not including weekends) prior to needing your medication refills. You will be provided an instruction sheet that will remind you of the information required for your refill.

I have read and agree to the above statement (initial) _____

_____

Print Name

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Notice of Privacy Practices

Spine, Pain and Rehabilitation Center of Colorado (SPARCC) will comply with all new requirements and Patient Rights as granted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and in accordance with city, state and federal laws and regulations.

HIPAA provides patients with specific rights related to their protected health information (PHI):

1. The right to inspect their PHI and to obtain a copy of it;
2. The right to request an amendment to their PHI;
3. The right to an Accounting of Disclosure made by SPARCC;
4. The right to request restrictions on the uses and disclosures of their PHI made by SPARCC;
5. The right to request that SPARCC communicate with them about their PHI at an alternative location (i.e., at work instead of at home) or via alternative means (i.e., mail only); and
6. The right to receive a paper copy of SPARCC's Notice of Privacy Practices, including a description of any limitations to the specific right. In addition, some of the rights require action on the part of the patient before SPARCC can respond.

If you have any questions concerning any of your rights, please as us for a copy of our written "HIPAA Privacy Notice" or speak to our Office Manager who can explain how SPARCC processes work in accommodating your rights.

I have read and understand the above statements regarding my PHI and HIPAA privacy rights. I also understand that I have access by request to an extended version of my privacy notice per request.

_____

Print Name

_____ _____

Signature *Date*

The practice reserves the right to change the terms of Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains.

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Patient Release of Information

Patient Name: _____DOB _____

Address: _____

TO:

_____

Fax: _____

I have been a patient at your facility or I am the patient's authorized representative.
I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I, _____ hereby authorized _____

To release to: FAX **303-282-4407**

Please fax the following:

_____ Allergy list
_____ Hospital documents (H&P, OP Note, Discharge Summary)
_____ Lab Results
_____ Radiology Results (x-ray, CT, MRI, ect.)
_____ Office Notes
_____ Medication Notes
_____ Other (specify)_____
From (Date)_____To:_____
Reason for Request: Continuing treatment _____ Other_____

I understand that this authorization is subject to revocation at any time, except to extent that the above named facility has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may re-disclose.

_____
Patient or Representative Signature Date

_____
Witness Date

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Designation of Individuals who are Involved in My Payment or Treatment Decisions

In order to comply with federal privacy laws, Spine, Pain and Rehabilitation Center of Colorado (SPARCC) may provide limited information about you to individuals who may be involved in your treatment or payment decisions unless you object to share this information.

SPARCC requests you list on this form the people you authorize to receive your health information **(e.g., family members or others ho accompany you to appointments or who call the Clinic on your behalf).** Please provide the full name of these individual s in the lines below, the relationship to you, and whether they are involved in decisions related to your treatment and/or payment. You do not need to list yourself if you are the patient.

I authorize SPARCC to disclose information related to my treatment or payment obligations to the people listed below.

Individual's Full Name (Please Print)	**Relationship to Patient**	**Involved in Payment (Check if Yes)**	**Involved in Treatment (Check if Yes)**

This information will be presumed valid and SPARCC may rely on it until you have notified SPARCC in writing of any changes to this form. Notification of a change in the above information provided by you should be sent to Spine, Pain and Rehabilitation Center of Colorado, 2480 S Downing St. Suite 210 Denver CO 80210.

_____ _____

Full Patient Name (print) *Legal Representative (print) if applicable*