GEORGIA SPINE
& Orthopedics

DEMOGRAPHIC INFORMATION:

First Name: _____ MI: _____ Last Name: _____

SSN: _____ DOB: _____

Address: _____

City _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph:_____

Work Ph: _____ E- Mail :_____

Occupation: _____ Employer: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

PHARMACY INFORMATION

Pharmacy Name:
Address/City:
Phone:

REFERRING PHYSICIAN/PRIMARY CARE PHYSICIAN

Referring Physician Name:	Phone:
Primary Care Physician Name:	Phone:

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION *NOTE: Dr. Jeshuran and/or staff cannot speak to anyone, even immediate family members regarding your visit(s) unless their name is listed on this form.*

I, _____, authorize Dr. Winston Jeshuran and staff to use and/or disclose my health information relating to my treatment/diagnosis to any healthcare provider involved in my current treatment/diagnosis. In addition, I authorize the following individual(s) complete access to my health information and account records:

_____ _____

NAME RELATIONSHIP

INSURANCE INFORMATION:

Primary Insurance: _____	**Secondary Insurance**: _____
Insured's Name: _____	Insured's Name: _____
Insured's DOB: _____	Insured's DOB: _____
Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other	Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other
SS# of Insured: _____	SS# of Insured: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Effective Date: _____	Effective Date: _____
Copay : _____	Copay: _____

Do you have Medicare PART B? Yes, or No - ID # _____Eff. Date_____

Workers Compensation:

W/C Insurance Company:	Adjusters Name:	Phone:
Address/City/State	ID #	Fax No.:

Were you injured on the job? Yes or No * Date of Accident _____

Please note that Dr. Jeshuran does NOT file to auto policies unless medical coverage is provided. Your health insurance policy will be billed and it is the responsibility of the patient to handle auto policy reimbursement to the insurance company. Dr. Jeshuran must approve your visit if you do not have regular medical insurance and are being seen due to an accident. We do NOT accept liens from attorneys.

Attorney: _____ Contact: _____

Authorization Form (please sign and date each authorization)

Medical Information Release Authorization

I hereby authorize Georgia Spine & Orthopedics LLC and its employees to furnish to any representative of any insurance company with whom I have coverage, to my referring physician, my family physician, my attorney, or to any court, any and all information that Dr. Jeshuran, or his employees have or may hereafter have, either written or oral, pertaining to or in any matter connected with any disability, injury, illness, ailment, medical and/or personal history, treatment, examination, consultation, and operation, either past or present and to furnish these companies, my attorney, or to any court upon request, copies of my medical records, charts, and reports pertaining thereto; I further agree that no person, firm, or corporation shall be held liable in any matter to furnishing or having furnished such information.

_____ _____

Signature Date

Assignment of Insurance Benefits to Physician

For value received, I hereby transfer, assign and set over to Georgia Spine & Orthopedics LLC all insurance benefits of every kind and description for basic, surgical and/or major medical coverage. I understand and agree that I am responsible for any balance due after the insurance company pays.

Signature Date

Patient Financial Responsibility

I will be responsible to Georgia Spine & Orthopedics LLC for all amounts and balances incurred on my account. I further authorize the sending of my medical records and bills to my attorney or insurance company, and in the event of recovery by trial or settlement to allow my attorney or insurance company to pay directly to Georgia Spine & Orthopedics LLC. an amount sufficient to cover these bills and to deduct the same from any recovery which may be due me. I recognize that not withstanding any anticipated recovery or insurance reimbursement that I continue to be fully and completely responsible for all amounts in my patient account and will remit timely payment without delay.

Signature Date

Medication History Authorization

I give Georgia Spine & Orthopedics LLC permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed/divulged as part of my medical record release. □ Yes □ No

Signature Date

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PATIENT CONSENT FORM- PATIENT CONSENT TO USE/DISCLOSE HEALTH CARE INFORMATION

PATIENT'S NAME: _____

DOB: _____

ACKNOWLDEGEMENT OF PRIVACY NOTICES (HIPPA) AND DISCLOSURE INFORMATION

I understand that the patient's health information is private and confidential. I understand that Georgia Spine & Orthopedics, LLC work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health operations. In general, there will be no other uses of and disclosures unless I permit.

Georgia Spine & Orthopedics, LLC have a detailed document titled, "Notices of Privacy Practices", in which it contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the notice before signing this agreement.

My signature below indicates that I have been given the chance to review a current copy of Georgia Spine & Orthopedics LLC "Notice of Privacy Practices". My signature means that I agree to allow Georgia Spine & Orthopedics LLC to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____

Patient Signature or Legally Authorized Individual Signature Date

Authorization for Release of Medical Records
(To obtain records from another Professional Medical Facility)

I, _____, authorize the following protected health information released from the medical record of (place your name/info below):

_____

Last Name First MI

_____

Street Address

_____

City State Zip Code

_____

Patient's DOB SSN

Medical Records Released to:

Georgia Spine & Orthopedics
310 Hospital Drive, Suite 210
Macon, Georgia 31217
Phone: 478- 787-6255
Fax: 478-812-8700

I understand that this authorization is valid unless I notify Georgia Spine & Orthopedics otherwise. I may revoke this authorization in writing at any time except to the extent that Georgia Spine & Orthopedics has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Georgia Spine & Orthopedics to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I understand that I may be billed per the fee schedule for medical records with the exception of records directly released from Georgia Spine & Orthopedics to another professional medical facility. This information will be requested in a promptly manner according to the standards of Georgia Spine & Orthopedics provided all information has been supplied to Georgia Spine & Orthopedics correctly.

_____

SIGNATURE OF PATIENT DATE
PARENT/LEGAL GUARDIAN

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Patient Medical History Information

Patient Name: _____ Date of Birth:_____ Today's Date:_____

What is the reason for today's visit? _____

Medications

*Please list all of your current medication, including both prescription and "over-the-counter" medication or check the box that applies. (If you need more room, please use the back of this page.)

□ No Medication □Medication List

Allergies

*Please list all allergies and reactions or check the box for none: □ No Known Drug Allergies

Allergies	Reactions

*Have you ever had a reaction to Iodine, shellfish or contrast dye? □yes □no

Past Medical History

*Please check any of the following medical problems you have had or presently have or check the box for none: □No Medical Problems

□ AIDS/HIV	□ Dialysis	□ Liver Disease	□ Ulcer
□ Anemia	□ DVT/Phlebitis/PE	□ Migraine Headaches	□ Blood Clotting
□ Arthritis	□ Fibromyalgia	□ Neurologic Problems	
□ Asthma	□ GERD	□ Osteoporosis	□ Other:
□ Bleeding Problems	□ GI Bleed	□ Respiratory Problems	□ Other:
□ Cancer	□ Heart Disease	□ Seizures	□ Other:
□ COPD	□ High Blood Pressure	□ Stroke	□ Other:
□ Depression	□ Hepatitis Type: ___	□ Thyroid Disease	□ Other:
□ Diabetes	□ Head Injury	□ Kidney Disease	

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Patient Medical History Information

Surgical History

*Please list all surgeries and hospitalizations:

Date	Procedure/Illness	Physician

Family History

*Please check below if you have a family history of any of the following or check box:

□Unknown/Adopted

	Brother	Sister	Mother	Father	grandmother	grandfather	aunt	uncle
diabetes								
cancer								
Heart disease								
stroke								
hypertension								
migraines								
Other:								

Social History

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □Domestic Partner

Hand Dominance: □Right □Left □Bilateral

Exercise Level: □None □Occasional □Moderate □Heavy

Are you currently employed: □ Yes □ No Employer: _____ Occupation: _____

If you are not working, has pain or an injury forced you to stop working? □ Yes □ No

Is this a work-related injury? □ Yes □ No

Smoking Status: □ Never Smoker □ Former Smoker □ Current Every Day Smoker How Much: _____

Illicit Drugs: _____ Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy

Are you pregnant: □ Yes □ No

If you were injured, is litigation ongoing? □ Yes □ No

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Patient Medical History Information

Review of Systems

*Please check the boxes that currently apply to the patient:

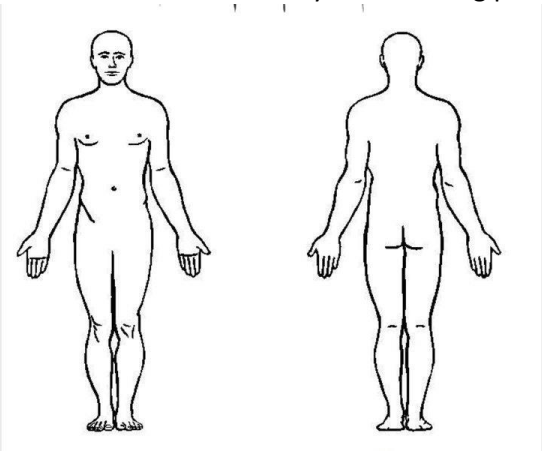
□ Rapid weight gain	□ Tremors	□ Diarrhea
□ Rapid weight loss	□ Nose/Sinus Problem	□ Vision Changes
□ Fever	□ Dizziness	□ Swollen Glands
□ Fatigue	□ Irregular Heartbeat	□ Difficulty Urinating
□ Numbness/Tingling	□ Chest Pain	□ Shortness of Breath
□ Weakness	□ Cough	□ Cough with blood
□ Headaches	□ Hearing Loss	□ Night Sweats
□ Seizures	□ Vomiting	□ Rash
□ Memory Loss	□ Abdominal Pain	□ Itching/Hives

Height: _____ Weight:_____

Symptoms

Please describe your reason for today's visit: _____
When did symptoms begin or injury occur:_____
Are your symptoms related to an injury? □ Yes □ No Have you had this problem before? □ Yes □ No
Have you seen anyone else for this problem? □ Yes □ No Who? _____

*Mark areas below where you are having pain with an **X** and numbness/tingling with an **O.**



Please rate your pain NOW:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Ever

Please rate your pain AT ITS WORSE:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Ever

Pain is: □ Constant □ Intermittent
□ Burning □ Sharp □ Stinging □ Dull □ Throbbing □ Aching
□ Equal of both sides □ Only or worse on the right side □ Only or worse on the left side

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Patient Medical History Information

Symptoms continued

Makes Pain Worse:		**Makes Pain Better:**	
□ All Activity	□ Twisting	□ Nothing	□ Standing
□ Sitting	□ Coughing	□ Lying Down	□ Walking
□ Standing	□ Sneezing	□ Ice	□ Twisting
□ Walking	□ Lying Down	□ Heat	□ Bending Forward
□ Wakes from sleep	□ Nothing	□ Activity	□ Resting
□ Lifting	□ Other:	□ Exercise	□ Other:
□ Bending	□ Physical Activity	□ Sitting	□ Changing position

Have you had: □ Inability to urinate □ Loss of balance while walking
□ Arm or leg weakness □ Falls

Are your symptoms getting: □ Better □ Worse □ Staying the Same

Current Work Status: □ Out of Work □ Light Duty □ Full Duty □ Retired

What tests have you had for this problem? □ CT Scan □ X Rays □ MRI
□ Diskogram □ Myelogram □ Emg □ Blood Work
□ Other: _____Where/When did you have this done? _____

Have you tried any of the following?

Treatments	**Relief** (Check One)		
Physical Therapy	□ Yes	□ No	□Temporary
Home Exercise Program	□ Yes	□ No	□Temporary
Chiropractor	□ Yes	□ No	□Temporary
Acupuncture	□ Yes	□ No	□Temporary
Over the counter Medications	□ Yes	□ No	□Temporary
Prescription Medications	□ Yes	□ No	□Temporary
Ice	□ Yes	□ No	□Temporary
Heat	□ Yes	□ No	□Temporary
Assistive devices (walker, cane, etc.)	□ Yes	□ No	□Temporary
Brace, Cast, Splint, or Sling	□ Yes	□ No	□Temporary
Nerve Stimulation Therapy	□ Yes	□ No	□Temporary
Injections: What kind? _____	□ Yes	□ No	□Temporary

Patient/Personal Representative Signature _____ Date _____

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You have agreed to receive narcotics for the treatment of your pain. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this contract below. If you have any questions regarding this information or our office policy regarding the prescribing of narcotics, please ask for clarification.

I, _____,
understand that:
Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and increase my function. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.
I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal, and the possibility that the medicine will not provide complete relief. The misuse and/or overuse of narcotic medication can result in serious health risks including respiratory depression or even death.
This medication will be strictly monitored, and all my prescriptions should be filled at the same pharmacy. Should the need arise to change pharmacies our office must be informed. The pharmacy that I have selected is:
Pharmacy : _____
Phone: _____
I **cannot** receive this medication by phone. I will not call the office to have a prescription called in. Early refill request will not be honored.
I will take the narcotic medication **only as prescribed**. Any changes **must** first be discussed and agreed upon with Georgia Spine & Orthopedics.
Medications **will not** be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or have access to them.
I agree that only Georgia Spine & Orthopedics will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than Georgia Spine & Orthopedics. I will instruct my other physicians to confer with Georgia Spine & Orthopedics for any changes or need for additional narcotic medications of **any kind**. If it is brought to the attention of Georgia Spine & Orthopedics that other providers are prescribing medications for

me, Georgia spine & Orthopedics reserves the right to discontinue prescribing medications and/or discharge me from the practice.
I understand that I may ask Georgia Spine & Orthopedics and/or my pharmacist questions about my medication and treatment.
I will inform Georgia Spine & Orthopedics of any changes to my medical condition, any changes in any prescription and/or over-the-counter medication that I take and of any adverse effects that I may experience from any of the medications that I take.
I agree to tell Georgia Spine & Orthopedics my complete and honest personal drug/medication usage and history.
I will not use any illegal "street drugs" while receiving medications from Georgia Spine & Orthopedics.
I will communicate fully and honestly with Georgia Spine & Orthopedics about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
Routine blood work and random drug screens may be a part of my treatment plan. I agree to have them done on the day requested.
Georgia Spine & Orthopedics has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.
If the responsible legal authorities have questions concerning my treatment all confidentiality is waived, and these authorities may be given full unrestricted access to my records.
It is a felony to obtain narcotic medications under false pretenses. This could include getting medications from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way.
I understand that narcotic medications will be stopped immediately if any of the following occurs:

- I trade, sell, or misuse the medication
- Georgia Spine & Orthopedics find that I have broken any part of this contract
- I do not go for a blood or urine test when asked
- My blood or urine test shows the presence of medications that Georgia Spine & Ortho is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- I get narcotics from sources other than Georgia Spine & Orthopedics
- Any member of the professional staff at Georgia Spine & Orthopedics feels that it is in my best interest that narcotic treatment is stopped
- Any aggressive behavior towards any staff member of Georgia Spine & Orthopedics
- I consistently miss schedule appointments

I understand that this contract also applies to narcotic medications prescribed for me after a surgical/invasive procedure. I understand that one of the goals of my procedure is to reduce/eliminate pain and as such it is expected that I attempt to reduce the amount of narcotic medication that I take as I recover. I understand that at an appropriate point in my

recovery it is expected that narcotic medications be discontinued as part of my treatment from Georgia Spine & Orthopedics.
I understand that Georgia Spine & Orthopedics will provide narcotic medication for me during recovery from a surgical procedure based on he following schedule based on my procedure:

- Anterior cervical procedure: 6 weeks from dos
- Posterior cervical surgery: 3 months from dos
- Lumbar/Thoracic discectomy: 6 weeks from dos
- Anterior lumbar/thoracic surgery: 3 months from dos
- Posterior lumbar/thoracic fusion: 3 months from dos
- Complex reconstructive/deformity surgery: 6 months from dos
- Minimally invasive fusion: 2 months from dos
- Spinal cord stimulator: 2 weeks from dos or as recommended by established pain physician

I understand that I will be informed of the length of narcotic medication treatment that I will receive prior to the planned procedure. I understand that circumstances may arise that require altering the above length o treatment, either shorter or longer.
If I am unable to control my pain or maintain function after the pre-determined length of narcotic treatment after my procedure, I agree to enter treatment with an interventional spine/chronic pain practice and/or physician for any ongoing narcotic treatment. I understand that Georgia Spine & Orthopedics will help with the referral process. Georgia Spine will continue to provide orthopedic spine care after referral to the new prescriber except for narcotic treatment.
It is understood that failure to adhere to this contract may result in cessation of therapy with controlled substance prescribing (No narcotic prescriptions will be written) by Georgia Spine & Orthopedics.
I have read Georgia Spine & Orthopedic narcotic contract and without question understand all of this agreement. By signing this contract, I affirm that I have read, understand, and accept all of the terms of this agreement.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____