GEORGIA SPINE
& Orthopedics

**First Name:** _____ **MI:** _____ **Last Name:** _____

**SSN:** _____ **DOB:** _____ □**MALE** □**FEMALE** □**OTHER**

**Race:** □ African American □Caucasian □ Asian □American Indian □Other

**Mailing Address:** _____

**City** _____ **State:** _____ **Zip:** _____

**Cell Phone (Primary):** _____ **Home Ph:**_____

**E- Mail:** _____ **Power of Attorney:** □Yes □ NO

**Work Status:** □Full Time □Part Time □Light Duty □Retired □Unemployed □Student

**Occupation:** _____ **Employer:** _____

**EMERGENCY CONTACT:**_____ **Phone:**_____

| |
|---|
| Pharmacy Name: |
| Address/City: |

| | |
|---|---|
| Referring Physician Name: | Phone: |
| Primary Care Physician Name: | Phone: |

| | |
|---|---|
| Primary Insurance: | Secondary Insurance: |
| Member ID: | Member ID: |
| Group #: | Group #: |
| Subscriber Name: | Subscriber Name: |
| Subscriber SS#: | Subscriber SS#: |
| Subscriber DOB: | Subscriber DOB: |

** The above information is true best to my knowledge. I hereby authorize payment directly to Georgia Spine & Orthopedics, LLC for any surgical and/or medical benefits due. I further authorize the release of any information, photographs, and or/or slides acquired in the course of my examination and/or treatment to recover such patients. I understand that payment is due at the time of service. I further understand and agree that my insurance is filed as a courtesy and I am ultimately responsible for any balance due after the insurance company has made payment.

_____ _____

Patient Signature Date

**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.*

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Georgia Spine & Orthopedics to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

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

_____ _____

NAME RELATIONSHIP

□ I do NOT authorize Georgia Spine & Orthopedics to release any or all information concerning my medical care to any individual

---

**Workers Compensation (SKIP if NOT APPLICABLE)**

Were you injured on the job? Yes or No

**ATTORNEY:** _____

| | | |
|---|---|---|
| W/C Insurance Company: | Adjusters Name: | Phone:<br><br>Fax: |
| Employer: | Claim #: | Date of Injury: |

---

## Auto Accident (SKIP if NOT APPLICABLE)

Date of Accident: _____ Auto Policy # _____

Insurance Company: _____

**Please note that Georgia Spine & Orthopedics 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 or/and office manger must approve your visit if you do not have regular medical insurance and are being seen due to an accident. **

## CONSENT TO TREATMENT AND OTHER ACKNOWLEDGEMENT

### 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.

### Assignment of Insurance Benefits to Physician and Patient Responsibilities

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 request payment of authorized insurance benefits to be paid to Georgia Spine & Orthopedics. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept responsibility. I agree that I am responsible for any balance due after the insurance company pays.

### Referral Policy (HMO's)

Please note that if your insurance policy requires a referral to a specialists' office, such as ours, it is your responsibility as guardian to obtain a referral/authorization before your appointment. If there is no valid referral or authorization on file at the time of your appointment, this will cause a wait time and may result in a rescheduling. If you are seen, you will be responsible for the charges not covered by your insurance.

### 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.

### Acknowledgement of Receipt of Privacy Notice

I acknowledge that Georgia Spine & Orthopedics Privacy Notice has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also available on the Georgia Spine & Orthopedics website www.gaspine-ortho.com.

### Independent Contractors

Georgia Spine & Orthopedics may utilize independent contractors for office, outpatient, or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, neuromonitoring and consultants. Healthcare professionals that are independent contractors are not agents or employees of Georgia Spine & Orthopedics and are responsible for their own actions. I understand that Georgia Spine & Orthopedics shall not be liable for the acts or omissions of independent contractors. This consent to treatment also applies to any independent contractor utilized by my physician.

I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making. By signing this document, I certify I have read and understand its contents.

---

Signature Printed Name Date

GEORGIA SPINE
& Orthopedics

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

PATIENT'S NAME: _____

DOB: _____

**ACKNOWLDEGEMENT OF PRIVACY NOTICES (HIPAA) 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 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.

I have received an amended and updated copy of Georgia Spine & Orthopedics, LLC Notice of Privacy Practices for Protected Health Information. The notice has been amended to show the practice's participation in the GRAChIE network and I understand to opt out of this network. I must opt out at GRAChIE.org as detailed in the Notice of Privacy Practices for Protected Health Information. The Privacy Notice has also been amended to allow verbal requests for additional PHI without written authorization, such as sports physicals and claim summaries. I have been given the opportunity to ask any questions regarding this notice.

_____ _____

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
STAT FAX: 478-621-4170
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. 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. There is potential that information disclosed pursuant to the authorization is subject to redisclosure by the recipient and no longer protected by HIPAA.

_____
SIGNATURE OF PATIENT DATE
PARENT/LEGAL GUARDIAN

GEORGIA SPINE & Orthopedics

# Patient Medical History Information

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

## 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 "SEE SHEET"

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Allergies

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

| ALLERGY | Reaction |
|---|---|
| □ **Latex Allergy** | |
| □ **Tape Allergy** | |
| □**Iodine/Betadine Allergy** | |
| □ **Shellfish** | |
| □ **OTHER** _____ | |
| □ **OTHER**_____ | |
| □ **OTHER** _____ | |

## 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 | |

# 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

| |
|---|
| Mother: □ Alive □ Deceased<br>Health Problems: _____ |
| Father: □ Alive □ Deceased<br>Health Problems: _____ |
| Siblings: □Brother (alive/deceased) □Sister (alive/deceased)<br>Health Problems: _____ |

## Social History

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □Domestic Partner
Hand Dominance: □Right □Left □Bilateral
Exercise Level: □None □Occasional □Moderate □Heavy

Smoking Status: □ Never Smoker □ Former Smoker □ Current Every Day Smoker
How Much Do You Smoke? □ 1PPW □2PPW □1/4 PPD □1/2 PPD □1PPD □2PPD □3+PPD
Chewing Tobacco: □ None □ 1 per day □ 2-4 per day □ 3+per day

Illicit Drugs: _____ Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy
Marijuana? □Admits □ Denies Are you pregnant: □ Yes □ No

Caffeine Intake: □ None □ 1-2 cups a day □ 2-3 cups a day □ 3+cups a day

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

If you were injured, is litigation ongoing? □ Yes □ No
Do you have an attorney? If so, please list the firm: _____

# 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

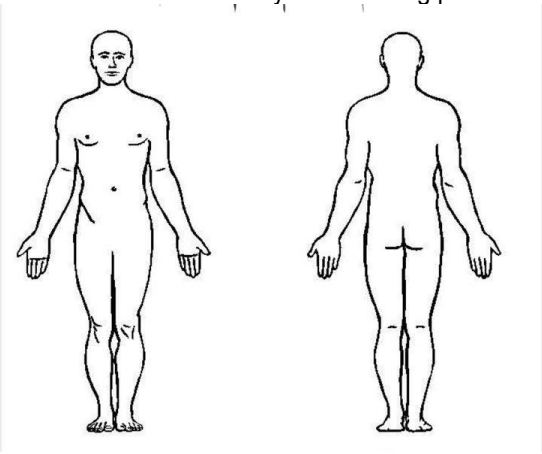
Please describe your reason for today's visit: _____

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 about this problem? □ Yes □ No Who? _____Date Seen: _____

*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**

**Does your pain radiate?** □ Yes □ No
**Where?**
□Upper Extremity □Lower Extremity
□ Right □ Left □ Bilateral

**Pain is:** □ Constant □ Intermittent □ Nagging □ Shooting □ Throbbing □ Aching
□ Burning □ Sharp □ Stinging □ Dull □ Worse on right □ Worse on left
□ Equal of both sides □ Only on the right side □ Only on the left side □ Middle

# Patient Medical History Information

## Symptoms continued

**Makes Pain Worse:**

□ All Activity
□ Sitting
□ Standing
□ Walking
□ Wakes from sleep
□ Lifting
□ Bending
□ Twisting
□ Coughing
□ Sneezing
□ Lying Down
□ Nothing
□ Other:
□ Physical Activity

**Makes Pain Better:**

□ Nothing
□ Lying Down
□ Ice
□ Heat
□ Activity
□ Exercise
□ Sitting
□ Standing
□ Walking
□ Twisting
□ Bending Forward
□ Resting
□ Other:
□ 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

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

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

**COVID VACCINATED ?** □ Yes □No

**Pneumococcal Vaccinated?** □ Yes □ No

**Women, over 65, have you ever had a DEXA Bone Scan Performed?** □ YES □ NO
Approximate Date of Study: _____

**Have you fallen in the last year?** □ Yes □ No (current year only)
If yes, How Many Times? _____
Were you injured? _____

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the practice 15 minutes after the expected arrival time for the scheduled appointment.

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. GSO's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message **at least 24 hours** before their appointment. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

New Patients:

a. Appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled time.
b. In the event of two (2) documented "no shows or same-day cancellations", patient will not be scheduled further. If a patient was referred, we will notify the referring physician.

Established Patients:

a. Appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled time.
b. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit.
c. Any established patient who **"no shows"** for a scheduled appointment will be charged at **$25.00** fee in order to be rescheduled and will be required to pay at next visit.
d. Any established patient who has a **"same day cancellation"** for a scheduled appointment will be charged a **$25.00** fee in order to be rescheduled and will be required to pay at next visit.
e. In the event a patient has incurred two (2) documented "no shows and/or same day cancellations", the patient may be subject to dismissal from GSO. The patient's chart will be reviewed, and dismissals are determined by a physician only, no exceptions.
f. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office manager, who may be able to waive the fee.

Date

**Medical Insurance Benefits:**

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. It is your

responsibility to inform Georgia Spine & Orthopedics timely of any changes to your health coverage, such as loss of coverage. You are financially obligated for any services you receive.

**Copayment/Coinsurance/Deductibles**

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. If you do not have your co-payment at the time of the visit, your appointment will be rescheduled unless approved by management.

**Delinquent Balance Appointment**

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance of more than 120 days if the patient has not made any payments or sought assistance during this time. If such payment is not made, services may be refused. Any unpaid balance regardless of payment plan, must be paid in full before moving forward with a new illness/injury.

**Nonpayment**

All patient balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. Please be aware that if a balance remains unpaid, you maybe be discharged from this practice.

**Behavior**

It is your responsibility to demonstrate respect and be considerate of caregivers, staff, other patients, property of others, and the facility. Be aware that any behavior considered disrespectful, disruptive or abusive will result in a dismissal from our practice.

I have read and understand the Georgia Spine & Orthopedics financial policy and patient responsibilities. I agree to its terms.

_____ _____

Signature Date