Sky Spine Endoscopy Institute New Patient Contract

Thank you for choosing Sky spine Endoscopy Institute. We appreciate that you are trusting us with your healthcare needs and look forward to caring for both you and your family.

You, as our patient, are the center of our activity. Your satisfaction is our primary goal. Sky Spine Endoscopy Institute is different than other medical offices you may have visited. This is a private practice, not a large healthcare organization. Dr. Osman focuses on spending time with each of his patients in order to understand your needs and to better treat you.

This New Patient Packet is designed to help us understand and assist your needs so that we can improve your quality of care. We look forward to seeing you in our office at your scheduled time. To save time and to ensure scheduling efficiency within our office, we ask that you complete the New Patient Packet that is enclosed. Please bring the completed packet along with the information listed below to your appointment. Neglecting to complete this packet could result in a rescheduled appointment.

Appointment:
Please arrive at least 15 minutes prior to your scheduled appointment in order for our front desk staff to properly check you in and to answer any questions you may have. Sky Spine also has a no-show policy. We ask that you give our office a 48-hour notice if you need to cancel or reschedule your appointment. Failure to do so could result in a $50.00 no-show charge.

Co-pay/Self-pay/Deductibles:
To comply with federal regulations, we are required to collect your co-payment and/or deductible (should you have one) at the time-of-service. Neglecting to pay your co-payment will result in a $25.00 fee. Our policy for cash paying patients is to collect payment for physician and hospital charges at the time services are rendered. Additional charges that result from the visit, i.e. casting, lab etc., will be applied and billed to you. You may pay by cash, check, or credit card. There is a $35.00 fee for returned checks.

Please bring the following information to your New Patient appointment:

- Current insurance card
- Photo ID or Driver License
- A copy of your referral from primary care physician, if required
- Any required payments, deductibles, or co-payments
- Current x-rays or MRI
- Any medical records pertaining to the reason for your visit
- A list of medications that you are currently taking, or the original medication bottle

We thoroughly look forward to serving your orthopedic and spine care needs. Our staff thanks you for assisting us by completing this packet before your scheduled appointment.

Sincerely,

Dr. Said Osman and Staff
Limited Opiate Prescribing Policy

At Sky Spine Endoscopy Institute, we have the following policy, which all patients must sign and adhere to, prior to receiving any prescriptions for narcotics or other potentially abusable drugs. This policy is based on a standard from The American Academy of Family Practitioners.

We are very hesitant to prescribe any narcotic and/or benzodiazepine medications. Please note that any patient, regardless of whether you are a new or a long-term patient, may be limited to fewer than 10 pills and/or one week of your prescription.

Please initial the items below confirming that you have read our policy.

I understand that if a physician at Sky Spine Endoscopy Institute is prescribing either narcotic pain medication(s) and/or controlled benzodiazepine medication(s), I will take the medication only as prescribed. If indicated for the future, I understand that my doctor may require a specialist's evaluation for my pain management, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made.

I understand that my physician is under no obligation to provide these medications to me. At the time of the appointment, if prescriptions for narcotics or benzodiazepines are written, the patient must provide a pharmacy name and number, where the patient will go for the medication.

I understand that immediate termination of this agreement will happen if I give, sell or in any way distribute prescribed medications to any other person(s), or if I, in any way, attempt to forge or alter a prescription.

I understand that by signing this agreement, I must abide by the rules reviewed above, and that failure to abide by these agreements will result in the termination of medication prescriptions, and possibly the termination of services from Sky Spine Endoscopy Institute.
E-PRESCRIBING PBM CONSENT FORM

E-Prescribing is defined as a physician’s ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an essential element in improving the quality of patient care. Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM’s are third party administrators of prescription drug program whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a benefit plan. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an E-Prescribe program. These include:

- Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.

- Medication history transactions — Provides the physician with the information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Sky Spine Endoscopy Institute can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefits payers for treatment purposes.

I am granting the following PMB permission:

- No Consent is granted to retrieve the PBM (+the doctor will be unable to prescribe medications for you.)

- Yes — Consent is granted to retrieve the PBM

- Physician Only: Consent is granted but only for the medications prescribed by Sky Spine Endoscopy Institute

Please complete the information below if you are interested in e-prescribing.

Name of Pharmacy: 
Address: 
City: 
State: 
Zip Code: 
Phone Number: 

Patient Name (printed)_________________________ Date of Birth__________________

Signature of patient (or representative) _________________ Date ________________
Subject: Join MyHealthRecord.com to connect with us online

Dear Patient,

As part of our ongoing commitment to your health, we’d like to invite you to connect with your patient information and Advanced Spine Endoscopy and Pain Institute online. Having new ways to manage your health can help you achieve your goals, and we think MyHealthRecord.com will meet many of your needs, no matter when or where they arise.

At MyHealthRecord.com, you can:

- See all your health information, including your care plan and lab results, on any Internet-enabled device, including smartphones and tablets
- Send secure messages to ask non-urgent questions about your care and receive prompt replies
- Request prescription refills and appointments
- Send your health records to other providers electronically

My hope is that this convenient way to manage your care will save you time, so you can get back to doing the things you love most, while still feeling confident about your health and treatment plans.

You can request a MyHealthRecord.com account by responding to this email or sending an email to contact@skyspineEl.com

If you have any questions, please let me know.

Sincerely,

Said G. Osman, M.D.
Chesapeake Regional Information System (CRISP)

"We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers."
Medical Forms Fee

Disability/ FMLA Forms:

If you need disability / FMLA forms filled out for any time off from work due to surgery - please make sure you fill out all your paperwork in the sections marked 'Employee' and sign all employee signature areas before bringing them to the office. In addition to the forms provided by your employer, you will also need to fill out our Disability Forms Request.

Please allow up to 7 business days for forms to be completed and there is a $20 form fee (per set of forms) that will need to be paid before the forms are picked up. If you need them faxed back – please provide your credit card information.

You can fax your forms to the office at 1-800-589-8662, email to contact@skyspineEI.com or simply drop them off during normal business hours.

Our fee to complete any form shown below is $20.00 per form.

Forms include, but are not limited to: FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgage. Letters include, but are not limited to: attorneys, insurance companies, employers, schools, airlines, gyms etc.

Fee is due at the time forms are dropped off or mailed to our office. You are still responsible for fees if forms are sent directly to us from your disability company.
Authorization to Discuss Information with Designated Person(s)

For various reasons, it is often difficult to reach a patient to discuss appointments, medications, and other information that is pertinent to our patients’ care. In this event, we would discuss such information only with the person(s) that you authorize and designate below. Please complete the following:

I hereby authorize Sky Spine Endoscopy Institute to discuss any information required throughout my examination or treatment in the event that I cannot be reached by phone to the following designated person(s):

*Should you wish to elect no designee, please circle NO designee and provide your signature and date of signing.*

Name of Designee: ___________________________ Phone Number: ___________________________
Relationship to Patient: ___________________________

Name of Designee: ___________________________ Phone Number: ___________________________
Relationship to Patient: ___________________________

Name of Designee: ___________________________ Phone Number: ___________________________
Relationship to Patient: ___________________________

NO Designee – I prefer all information to be relayed only to myself, the patient.

Signature: ___________________________ Date: ___________________________

***This form will expire one year from today’s date unless an updated Designee Form is completed. In that case, the update will void the previously signed document.***
Workers’ Compensation

If you are seeing the doctor for an on-the-job injury or accident, please notify our staff immediately to ensure appropriate claims processing. We will need to know your:

- Employer name and address
- Adjuster's Name and Contact Information
- Date of injury
- Claim number
- Social Security Number

Other Fees

- Copy of medical records -.76 cents per page copied, plus the actual cost of shipping
- Form completion fees - $20.00 for the 1st page, $5.00 for each additional page
- Charge for returned checks - $35.00
- Costs associated with collection of patient balances including attorney fees if applicable

I understand that I am responsible for paying all copayments, coinsurances and outstanding deductibles in full at the time services are received. If I am a self-pay patient, payment in full will be required at the time services are received.

I understand that I am ultimately financially responsible for payment of all services received. I have read and understand my financial responsibilities.
Assignment of Insurance Benefits

As the patient whose name appears below, I hereby authorize Sky Spine Endoscopy Institute to file on my behalf for payment and/or appeal letters of any medical benefits arising out of any policy of insurance covering me and hereby assign the benefits to Sky Spine Endoscopy Institute for application on the patient's bill. I certify that the information reported regarding my insurance coverage is accurate and complete and further authorize the release of any necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization be used in place of the original. I understand that I am liable for payment to Sky Spine Endoscopy Institute, all co insurance, co-pays, and deductibles as required by my insurance policy and participating agreements (if any) between the insurance carrier and Sky Spine Endoscopy Institute. Further, I will be responsible for charges not covered by my insurance.
Patient Financial Policy

Thank you for choosing Sky Spine Endoscopy Institute. It is important that you understand your financial responsibilities prior to receiving services. All patients (or their guardians, if a minor) are ultimately responsible for payment of all services rendered. Please take the time to review the information below regarding patient financial responsibility.

Insurance Coverage

• As a courtesy, Sky Spine Endoscopy Institute will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately financially responsible for the payment of your bill.

• It is your responsibility to be aware of your insurance eligibility and coverage, including but not limited to:
  - Copayment amounts
  - Coinsurance amounts
  - Deductible amounts
  - Authorization requirements
  - Policy provisions
  - Exclusions
  - Limitations

Please refer to the Summary of Benefits from your insurance carrier or employer, and contact them directly if you have any questions regarding your coverage.

• Sky Spine Endoscopy Institute will attempt to verify that your coverage is valid at the time of your visit(s). However, if your coverage is not in effect at the time of your visit(s), the financial responsibility is yours.

• Sky Spine Endoscopy Institute will make every effort to determine the amount of applicable copayment, coinsurance or deductible that you owe prior to your appointment based on the information available from your insurance carrier.

• **You are financially responsible for paying all copayments, coinsurance, and deductibles due at the time services are received.** After your insurance carrier processes a claim, if they determine that you have a greater financial responsibility, you will receive a bill due in 30 days of receipt. If your insurance carrier determines that you owe less, any overpayment will be refunded.

• If your insurance carrier denies any, all or any part of your claim, you are financially responsible for the unpaid amount.
• You are responsible for responding to any requests from your insurance carrier for additional information. Not responding to these requests will result in the claim(s) being denied and you will be financially responsible for payment of any claims affected.

• You are responsible for notifying Sky Spine Endoscopy Institute of any changes to your insurance coverage, including eligibility and you are financially responsible for any charges incurred if the information provided is incorrect or out of date.

• Sky Spine Endoscopy Institute is contracted with various insurance carriers and is required to collect in full all copayments, coinsurances and deductibles associated with your policy per the requirements outlined in our contracts. Therefore, we are unable to waive or discount copayments, coinsurances or deductibles that are your responsibility without violating our contract with your carrier.

**Self-Pay/Uninsured Patients**
Patients who do not have insurance, or who do not have or present valid insurance information at the time of their appointment, they will be considered "self-pay patients."

• If you do not have insurance you must pay in full at the time of your visit. We offer a discount for patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed, and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action. Accounts referred to a collection agency will encounter additional fees and charges.

• If you are unable to provide valid insurance information at the time of your visit, you will be expected to pay in full at the time of service until valid insurance information is obtained.

• When we have your valid insurance information we will bill your insurance carrier. After payment from your insurance carrier is received, our billing department will issue a refund check less applicable copayment, coinsurance and deductible.

**Third Party Billing/Attorneys**
We do not participate or become involved in third party billing or waiting for liability cases to settle. Any agreement made between you, your attorney, or the liability company does not relieve you of your financial responsibility to our office. You will be considered a self-pay patient and payment will be expected at time-of-service. We do not accept “promise of payment letters” from attorneys.
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

Sky Spine Endoscopy Institute is required by law to maintain the privacy and confidentiality of your protected health information, and to provide our patients with notice of our legal duties and privacy policies with respect to your protected health information.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Advanced Spine Endoscopy and Pain Institute. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality and improvements.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. If you should change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
**Appointment reminders.** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition/s. We may also send you information describing other health-related products and services that we believe may be of interest you.

**Fund raising.** Unless you request us not to, we will use your name and address to support our fundraising efforts. If you do/do not want to participate in fundraising efforts, please indicate so by circling Yes or No below and initialing in the line provided.

**Individual Rights**
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice

**Sky Spine Endoscopy Institute Duties**
Again, we are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information**
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office staff. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.
Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Sky Spine Endoscopy Institute
Said G. Osman, MD

Please Fax a copy of this form and the requested records to 240.523.8729

Patient Name: __________________________ Date of Birth: __________________________

The information you may release subject to this signed release form is as follows:

☐ Complete Records  ☐ History and Physical  ☐ Progress Reports
☐ Care Plan  ☐ Lab Reports  ☐ Radiology Reports
☐ Pathology Reports  ☐ Treatment Records  ☐ Operative Notes
☐ Hospital Reports  ☐ Medication Records  ☐ Other _______________

The purpose/reason for this release is as follows:

________________________________________________________________________

I, __________________________, authorize the physician/practice/hospital/etc., listed below to release my protected health information to:

Sky Spine Endoscopy Institute 915 Toll House Ave. Suite 207, Frederick, MD 21701

Physician/Practice/Hospital: ________________________________________________
Address: ________________________________________________________________
City, State, Zip: __________________________________________________________

_________________________________________  ________________
Patient/Guardian Signature  Date

Relationship to Patient if signed by a Guardian
Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Said Osman
Sky Spine Endoscopy Institute
915 Toll House Ave. Suite 207
Frederick, MD 21702

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
For further information concerning our privacy practices, please contact:

MANAGER:

Linda Ehrhart
Sky Spine Endoscopy Institute
915 Toll House Ave. Suite 207
Frederick, MD 21701
240-367-9601

Effective Date
This notice is effective on or after January 1, 2017

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES UNDER HIPAA GUIDELINES
PATIENT’S BILL OF RIGHTS

Sky Spine Endoscopy Institute is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities.

You have the right to:

- A personal physician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the physician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment, and in accordance with applicable state and federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plans.
- Have your pain evaluated and managed appropriately.
- Refuse to participate as a subject in research.
- An explanation of your medical bill, regardless of your insurance, and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment, or service; or to select a different physician.

You are responsible for:

- Knowing your health care physician’s name and title.
- Giving your physician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your Physician, so we can reach you in the event of a schedule change, or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your physician.
- Signing a “Release of Information” authorization form when asked so your physician can get medical records from other physicians involved in your care.
- Telling your physician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your physician about any changes in your condition or reactions to medications or treatment.
► Asking your physician questions when you do not understand your illness, treatment plan or medication instructions.
► Following your physician’s advice. If you refuse treatment or refuse to follow instructions given by your health care physician, you are responsible for any medical consequences.
► Keeping your appointments. If you must cancel your appointment, please call the office at least 24 hours in advance.
► Paying copayments at the time of the visit or other bills upon receipt.
► Following the office’s rules about patient conduct; for example, there is no smoking in our office.
► Respecting the rights and property of our staff and other persons in the office.

By signing below I acknowledge that I have received a copy of Sky Spine Endoscopy’s New Patient Contract and agree to the terms within.

Patient Name:

Patient Signature:

Date:

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem, please contact the office manager, or the state health office:

Maryland Department of Health and Mental Hygiene
Healthcare Quality Spring Grove Center
Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228
1.800.492.6005
# Patient Demographic Information

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Nickname</th>
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<tr>
<th>Date of Birth</th>
<th>Social Security #</th>
<th>Gender</th>
<th>Marital Status</th>
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<tr>
<td></td>
<td></td>
<td>M/F</td>
<td>Married □ Single □ Divorced □ Separate □ Widowed</td>
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<tr>
<th>Language</th>
<th>Race</th>
<th>Employment Status</th>
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<tbody>
<tr>
<td>□ American Indian</td>
<td>□ Black</td>
<td>□ Full-time □ Student □ Disabled □ Unemployment</td>
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<tr>
<td>□ Hispanic</td>
<td>□ White</td>
<td>□ Part-time □ Military □ Homemaker □ Retired</td>
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<td>□ Other</td>
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<th>Address</th>
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<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
<th>Email Address</th>
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## PHYSICIAN REFERRAL INFORMATION

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<tr>
<th>Referring Physician</th>
<th>Primary Care Physician</th>
<th>Reason for Visit</th>
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## INSURANCE INFORMATION

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<th>Policy Number</th>
<th>Group Number</th>
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<th>Insured/Policy Holder</th>
<th>Policy Holder's Date of Birth</th>
<th>Relationship to Insured</th>
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<th>Policy Holder's Date of Birth</th>
<th>Relationship to Insured</th>
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## WORKER'S COMPENSATION INSURANCE INFORMATION

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<thead>
<tr>
<th>Were you injured at Work?</th>
<th>Date of Injury</th>
<th>Adjuster's Name</th>
<th>Phone #</th>
<th>Claim Number</th>
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<tr>
<td>□ Yes □ No</td>
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<tr>
<th>Worker's Comp Insurance Co.</th>
<th>Claims Address</th>
<th>City, State</th>
<th>Employer</th>
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## AUTO/LIABILITY INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Is your injury related to a liability or automobile accident?</th>
<th>Do you have an attorney?</th>
<th>Attorney's Name</th>
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<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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<thead>
<tr>
<th>Claim Number:</th>
<th>In which state did the accident happen?</th>
<th>Date of Accident:</th>
<th>PIP? □ Yes □ No</th>
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<tr>
<th>Liability Insurance Company</th>
<th>Claims Address</th>
<th>City, State, Zip</th>
<th>Zip Code</th>
</tr>
</thead>
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</table>

By signing below, I certify all information is true and correct to the best of my knowledge.

**PATIENT/GUARDIAN'S SIGNATURE**

<table>
<thead>
<tr>
<th>Date</th>
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## EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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<tbody>
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<tr>
<th>Emergency Contact Information</th>
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</table>
Sky Spine Endoscopy Institute
History and Physical Assessment

Name: ________________________________  Today's Date: __________________

MEDICATIONS

1. Do you have any Allergies to Medications, Food or Latex?
   □ Yes  □ No Known Allergies
   Allergies: ______________ Reaction: _____________________________
   Allergies: ______________ Reaction: _____________________________
   Allergies: ______________ Reaction: _____________________________

2. Current Medications:
   □ None  □ Yes, listed below:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Purpose</th>
<th>Prescribing Physician</th>
<th>Date Prescribed</th>
</tr>
</thead>
<tbody>
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</table>

Medical Staff Use:

Weight: __________
Height: __________
Pulse: __________
BP: __________

Verified by: __________  Date: __________________
Sky Spine Endoscopy Institute
History and Physical Assessment

Visit Date: __________ Name (Last, First): __________________________
Date of birth: __________ Age: ______ Sex: □ Male □ Female

Who referred you to Sky Spine Endoscopy Institute?
□ Referring Doctor: __________________________ Address: __________________________
□ Primary Physician: __________________________ Address: __________________________
□ Self Referred □ Friend/Relative: __________________________

1. Please check any other medical problems or conditions that you may have below:
□ High blood pressure □ Low blood pressure □ Diabetes □ Heart disease: type __________
□ Osteoporosis □ Stroke □ High Cholesterol □ Arthritis □ Cancer: type __________
□ Stomach Ulcer □ Asthma □ Thyroid □ Kidney Stones □ Blood clots in leg □ Blood clots in lung
□ Depression □ Anxiety □ AIDS/HIV □ Sleep Apnea: CPAP/Other machine used □ Yes □ No
□ History of Positive MRSA Screening
□ Other __________________________

2. Have you had Spine Surgery in the past? □ No □ Yes
   Type of spine surgery __________________________ Date: __________________________
   Type of spine surgery __________________________ Date: __________________________

3. Please list other non-spinal surgeries:
   Type of surgery __________________________ Date: __________________________
   Type of surgery __________________________ Date: __________________________
   Type of surgery __________________________ Date: __________________________

A. Family Medical History (please check all that apply)
□ Arthritis □ Bone Disease □ Heart Disease □ Diabetes □ Cancer __________

Mother’s Age: _____ □ Healthy □ Deceased due to: __________________________
Father’s Age: __________ □ Healthy □ Deceased due to: __________________________
Brother / Sister’s Age: _____ □ Healthy □ Deceased due to: __________________________
Brother / Sister’s Age: __________ □ Healthy □ Deceased due to: __________________________
Sky Spine Endoscopy Institute

History and Physical Assessment

Name: _______________________ Today's Date: _______ 

B. Social History

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed | Number of children: ______  Do you drink alcohol? □ No □ Yes If yes, how much? ________________  

Do you smoke? □ No □ Yes If yes, how much? ________________  

Do you use recreational substances? □ No □ Yes If yes, Type & Frequency ________________  What is your work status? □ Employed □ Retired □ Disabled □ Temporary Disability □ Unemployed Employer: ___________________________________________ Job Title: __________________  Are you able to perform your usual duties? □ No □ Yes If No, Why? ________________  

C. Review of Systems (please check any current problems)

<table>
<thead>
<tr>
<th>Skin</th>
<th>Neurological</th>
<th>Eyes</th>
<th>Bone/Joint/Muscle</th>
<th>Ears/Nose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin Rash</td>
<td>□ Headache</td>
<td>□ Visual Loss</td>
<td>□ Muscle Wasting</td>
<td>□ Deafness</td>
</tr>
<tr>
<td>Easy Bruising/Bleeding</td>
<td>□ Migraine</td>
<td>□ Double Vision</td>
<td>□ Muscle Cramping</td>
<td>□ Hoarseness</td>
</tr>
<tr>
<td>Abnormal Hair Loss</td>
<td>□ Seizure</td>
<td>□ Glaucoma</td>
<td>□ Joint Pain</td>
<td>□ Vertigo/Dizziness</td>
</tr>
<tr>
<td>Other</td>
<td>□ Paralysis</td>
<td>□ Glasses/Contacts</td>
<td>□ Arthritis</td>
<td>□ Sinusitis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genitourinary</th>
<th>Mental Status</th>
<th>Respiratory</th>
<th>Gastrointestinal</th>
<th>Constitutional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood in urine</td>
<td>□ Anxiety</td>
<td>□ Shortness of breath</td>
<td>□ Appetite changes</td>
<td>□ Fever/chills</td>
</tr>
<tr>
<td>Impotence</td>
<td>□ Hallucination</td>
<td>□ Asthma</td>
<td>□ Jaundice</td>
<td>□ Weight loss</td>
</tr>
<tr>
<td>Painful urination</td>
<td>□ Depression</td>
<td>□ Tuberculosis</td>
<td>□ Irritable bowels</td>
<td>□ Weight gain</td>
</tr>
<tr>
<td>Kidney stones</td>
<td>□ Sleep Disturbance</td>
<td>□ Pneumonia</td>
<td>□ Nausea</td>
<td>□ Fatigue</td>
</tr>
<tr>
<td>Incontinence</td>
<td>□ Suicidal thought</td>
<td>□ Emphysema/COPD</td>
<td>□ Vomiting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine</th>
<th>Cardiovascular</th>
<th>Blood System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goiter</td>
<td>□ Palpitations</td>
<td>□ Anemia</td>
</tr>
<tr>
<td>Heat/Cold Intolerance</td>
<td>□ Leg swelling</td>
<td>□ Bruising</td>
</tr>
<tr>
<td>Increase in size</td>
<td>□ Chest Pains</td>
<td>□ Bleeding tendency</td>
</tr>
<tr>
<td></td>
<td>□ Arrhythmia</td>
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