Registration and Billing Information
Vermont Interventional Spine Center

LAST NAME ______________________ FIRST NAME ______________________ MI ___________
MAILING ADDRESS ____
CITY______________________ STATE__________ ZIPCODE ______________
PHONE NUMBERS: HOME: _____________ CELL: ____________ ALTERNATE: ______________
EMAIL ADDRESS: ______________________________
DATE OF BIRTH: _____________ SEX (M/F) ______ MARITAL STATUS: (MARRIED/SINGLE) ___________
SOCIAL SECURITY # __________________ FORMER NAME(S) ______________________
EMERGENCY CONTACT & PHONE # ______________________________________
REFERRED BY: ____________________ PRIMARY CARE DOCTOR: ______________________

ETHNICITY (Please Check one):
__Latino/Hispanic
__Not Hispanic/Latino
__Decline to answer
__Don't Know

Race (Please check one):
__Asian
__African American/Black
__American Indian/Alaskan Native
__Native Hawaiian/Other Pacific Islander
__More than one race
__White
__Decline to answer

PREFERRED LANGUAGE: ______________

EMPLOYER INFORMATION:

COMPANY NAME ______________________________ WORK PHONE _____________ EXT ______
ADDRESS ______________________ CITY ______________ STATE _____ ZIP CODE ________

BILLING ADDRESS (if different than above) OR ALTERNATE SEASONAL ADDRESS:

NAME OF RESPONSIBLE PARTY (if other than self) ______________________________________
ADDRESS ______________________ CITY ______________ STATE _____ ZIP CODE ________
RELATIONSHIP ______________________ PHONE NUMBER ___________________________

INSURANCE INFORMATION:

INSURANCE 1 ____ **COPAY AMOUNT $** __________
SUBSCRIBER NAME ___________________________ RELATIONSHIP ______________________
IDENTIFICATION # ___________________________ GROUP # ___________________________
INSURANCE 2 ____ **COPAY AMOUNT** $ __________
SUBSCRIBER NAME ___________________________ RELATIONSHIP ______________________
IDENTIFICATION # ___________________________ GROUP # ___________________________

I authorize the release of any medical information necessary to determine my benefits and to process my claims for all services. Signature____________________Date _______	I authorize payment of medical benefits for all services provided to Vermont Interventional Spine Center. Signature____________________ Date _______

IS CONDITION RELATED TO EMPLOYMENT? ________ AUTO ACCIDENT? _______ OTHER ACCIDENT? ________

rev 10/01/2014

PAYMENT POLICY FOR SERVICES RENDERED

IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES, please initial the appropriate line. We are providers for these companies and will bill them directly. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are also responsible for any deductible or out of pocket expense stipulated by your contract with your insurance company. your should always check with your insurance company for

____ BCBS Out of State Plan or Federal
____ Medicare
____ VT Medicaid
____ CBA
____ Aetna Medicare
____ BCBS of Vermont
____ MVP
____ CIGNA/ Great West
____ United Health Care NY
____ Tricare For Life or Prime

IF YOU HAVE WORKERS COMPENSATION COVERAGE, we must have information approving the claim from your employer and accurate billing address information to process the claim. Without this, we will consider payment for this visit to be your responsibility. Vermont Interventional Spine Center requires authorization in writing for all workers compensation visits.

Name of Insurance Company: ______________________________
Address: ______________________________
Claim Number: ____________________ Date of Injury: ________
Contact Person and their title: ______________________________
Phone: ____________________ Fax: ____________________

IF YOU HAVE COVERAGE WITH ANOTHER INSURANCE COMPANY, WE MAY NOT HAVE A CONTRACT WITH THEM. With a copy of your card, we will submit a claim directly to your insurance company for reimbursement. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to the office for payment. If the payment is sent to me, I will forward this payment to the office <u>immediately</u>. If payment is not received by the office within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: ____________________Signed: ________________________ Date: _______

IF YOU DO NOT HAVE INSURANCE, you are responsible for payment of your bill, in total, at the time of your visit. We accept personal checks, credit cards or cash. Any Self Pay must be pre-approved before scheduling.

FOR ALL PATIENTS TO READ AND SIGN:

"I understand and agree that regardless of my insurance, I am in the end responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Vermont Interventional Spine Center incurs any collection charges, they will be my responsibility."

<u>If the patient is a minor</u>: **"By consenting to care at Vermont Interventional Spine Center, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

____ ________________
Patient or Guardian Signature Date

Vermont Interventional Spine Center
356 Mountain View Drive, Suite 200
Colchester, VT 05446

Consent to Use or Disclose Protected Health Information for Treatment, Payment and Healthcare Operations

I consent to allow *Vermont Interventional Spine Center* to use or disclose my protected health information for treatment, payment and healthcare operations.

-Treatment means the provisions, coordination, or management of healthcare and related services by one or more healthcare providers.

-Payment means the activities undertaken by a healthcare provider or health plan to obtain or provide reimbursement for the provisions of healthcare.

-Healthcare operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; business management and general administrative activities of *Vermont Interventional Spine Center*.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information for treatment activities of another healthcare provider.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information to another covered entity or to another healthcare provider for the payment activities of the entity that receives the information.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information to another covered entity for healthcare operations activities, provided that *Vermont Interventional Spine Center* and the other entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or healthcare operations or for the purpose of healthcare fraud and abuse, detection, or compliance.

I acknowledge that I have received a copy of *Vermont Interventional Spine Center's* Notice of Privacy.

Name of patient____
(PLEASE PRINT)

____
Signature of Person Authorizing Consent Date

____

Vermont Interventional Spine Center
Consult Questionaire

Thank you for choosing to receive your care at VISC. We are dedicated to providing quality consultative and interventional services in a safe, supportive and efficient manner. To that end, you can assist us greatly by filling out the follow form to the best of your knowledge. This will provide you with an opportunity to express, in your own words, some of the symptoms you have been experiencing. Together with the information provided by your referring physician, we hope to accurately assess your condition as well as your concerns.

Name: ______________________________ DOB______________ Date: ______________________

Referring Physician: ______________________ Primary Care Physician: ______________________

Circle or **fill in** where appropriate.

1. Where is the **primary** location of your pain?

   a. Low Back
   b. Mid back
   c. Neck
   d. Head/Face
   e. Hip
   f. Shoulder
   g. Knee
   h. Other:________________

OFFICE USE ONLY
PAIN LEVEL:
BP:
PULSE:
TEMP:
HT:
WT:
FLU: YES / NO DATE:
PNEU: YES / NO DATE:

2. Please **circle** any of the following that describe the primary or secondary areas of pain.

a. Aching
b. Dull
c. Sharp
d. Burning
e. Numb/Tingling
f. Electric shock like
g. Pressure
h. Stabbing
i. Pinching

3. General intensity of pain (scale of 0-10): ______________________________

4. How long have you had this pain? ____________ is the pain constant or intermittent? ____________

5. Is this pain the result of an accident or injury? Yes / No

   a. When? ______________________________

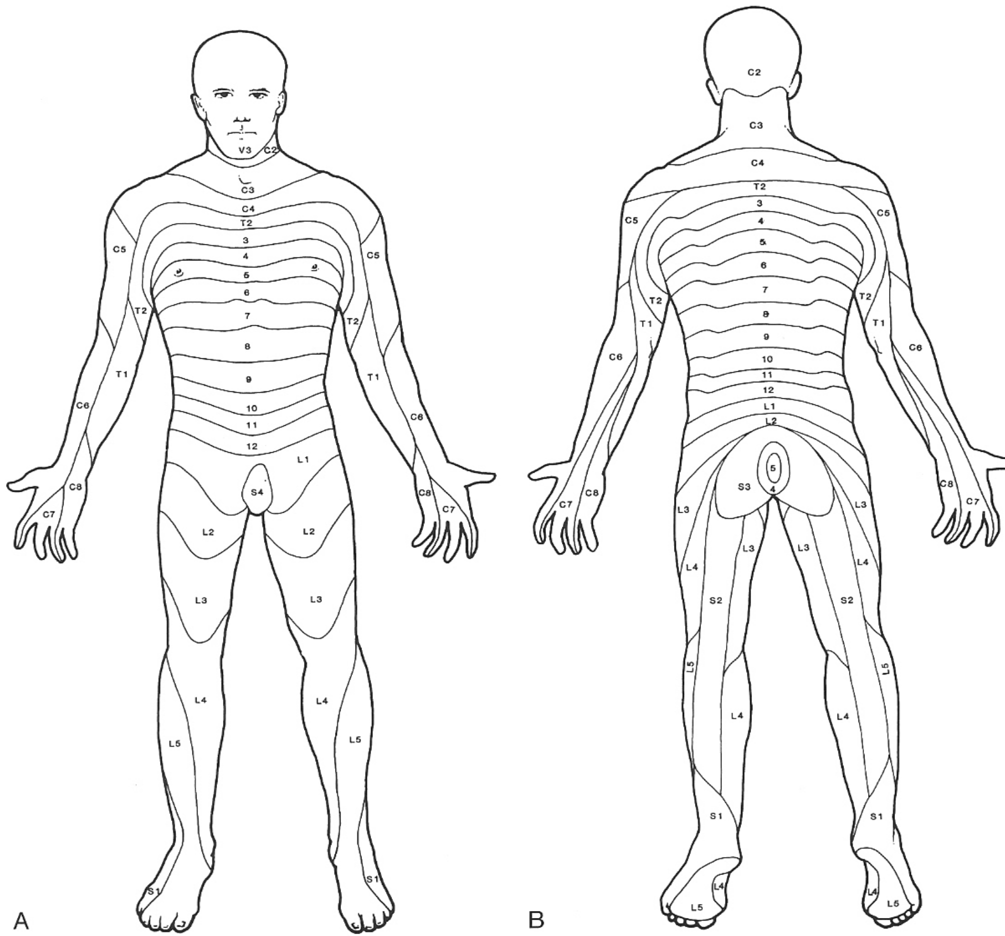
   b. Litigation involved? ______________________________

6. Have you ever had pain in the same or similar location in the past? Yes / No

If so, when? ______________________________

Name: ____

7. On the figures below please draw an X (or X's) over the primary location of your pain. Shade in areas that the pain radiates to or is painful separately.



Anterior *(A)* and posterior *(B)* dermatomes of the body. (From Baker AB, Baker LH: Clinical Neurology. Vol 1. New York, Har

8. Activities which increase pain: ____

9. Activities which decrease pain: ____

10. Previous Tests <u>MRI:</u> Yes / No <u>CT:</u> Yes / No <u>X-RAYS</u>: Yes / No

When?______________Where?____________________Ordering Provider?:____________________

11. Have you received any of the follow treatments in the past?

Physical Therapy	Did it help? (Even if temporarily)	Yes / No
Physical Modalities (Ice/Heat)	Did it help? (Even if temporarily)	Yes / No
Chiropractic Manipulation	Did it help? (Even if temporarily)	Yes / No
Osteopathic Manipulation	Did it help? (Even if temporarily)	Yes / No
Surgery	Did it help? (Even if temporarily)	Yes / No
Injection Therapy	Did it help? (Even if temporarily)	Yes / No
Biofeedback/Relaxation Techniques	Did it help? (Even if temporarily)	Yes / No
Acupuncture	Did it help? (Even if temporarily)	Yes / No
Naturopathic/Herbalist Treatment	Did it help? (Even if temporarily)	Yes / No

Name: ______________________________

12. **Medications**: Please indicate if you have ever taken or been prescribed any of the following. If you do not know the strength of a medication, please leave the second column blank.

Anti-Inflammatories	**Milligrams**	**Average Daily Dose**	**Maximum Daily Dose**	**Effective**
Aspirin				yes / no
Motrin/Advil (Ibuprofen)				yes / no
Tylenol/Acetaminophen				yes / no
Other Anti-Inflammatory				yes / no

Narcotics	**Milligrams**	**Average Daily Dose**	**Maximum Daily Dose**	**Effective**
Tylenol #3				yes / no
Ultram (Tramadol)				yes / no
Lorcet/Vicodin (Hydrocodone)				yes / no
Percocet/Oxycontin (Oxycodone)				yes / no
Dilaudid (Hydromorphone)				yes / no
MSIR, MS Contin (Morphine)				yes / no
Duragesic Patch (Fentanyl)				yes / no
Methadone				yes / no
Suboxone/Subutex (Buprenorphine)				yes / no

Anti-Convulsants	**Milligrams**	**Average Daily Dose**	**Maximum Daily Dose**	**Effective**
Neurontin/Gabapentin				yes / no
Lyrica				yes / no
Other Anti-Convulsant				yes / no

Anti-Depressants	**Milligrams**	**Average Daily Dose**	**Maximum Daily Dose**	**Effective**
Elavil (Amitriptyline)				yes / no
Cymbalta (Duloxetine)				yes / no

If you are not presently taking a medication that was effective for you, what is the reason you stopped? Side effects, etc.

1. ______________________________
2. ______________________________
3. ______________________________

Name: ____________________________________

13. **CURRENT** medications. Please list all medications. Include over the counter medications, vitamins or herbal/naturopathic medications/supplements. Please include medications that you are currently taking, sometimes take, or have taken within the past two weeks. (use back of form if needed)

1. Medication: ______________________ Dose: ________ Frequency: ______________
2. Medication: ______________________ Dose: ________ Frequency: ______________
3. Medication: ______________________ Dose: ________ Frequency: ______________
4. Medication: ______________________ Dose: ________ Frequency: ______________
5. Medication: ______________________ Dose: ________ Frequency: ______________
6. Medication: ______________________ Dose: ________ Frequency: ______________

14. **ALLERGIES** Please list all known allergies **( ) Please check if no known drug allergies**

Allergen: ______________________________ Reaction: ______________________________

Allergen: ______________________________ Reaction: ______________________________

15. **History of Falling** Please check one of the following:

____ Any fall with an injury in the past year ____No falls in the past year

____One fall without injury in the past year ____Two or more falls in the past year

16. **Medical History.** Please check or list any **previous or current** medical conditions/illnesses which you are taking medication for or have required treatment, consult, or evaluation.

	Medical History		ROS/Medical History		ROS/Medical History
	Diabetes		Fatigue		Reflux (GERD)
	Arthritis		Fever/Chills		Nausea
	COPD		Weight Loss(unexplained)		Vomiting
	Asthma		Changes in Vision		Constipation
	High Blood Pressure		Loss of Hearing		Frequent Bowel Movement
	High Cholesterol		Sinusitis		Easy Bruising
	Anxiety/Depression		Headache		Easy Bleeding
	Bipolar Disorder		Lightheaded/Dizziness		Skin Rash
	Hepatitis		Limb weakness		Change in Urinary Habits
	Central Serous Retinopathy		Limb Numbness		Urinary Tract Infection UTI
	Cancer: ______________		Swelling in Hands		Other:
	Thyroid disorder		Swelling in Feet		
	Kidney Disease		Limb Numbness		
	History of HIV		Chest Pain		
	History of Pneumonia		Heart Problems		
	History of Bronchitis		Difficulty Breathing		
	History of Heart Attack		Cough		
	History of Stroke		Heartburn/Gastric Ulcer		

Name: ____

17. **PAST Surgical History** (any and all surgeries): ____
____
____

18. **Known Family History**: If Yes, Please indicate Family Member (Mother, Father, Sister, Brother)

<u>Heart Disease</u>: Yes / No____________ <u>Diabetes</u>: Yes / No ___________ <u>Cancer</u>: Yes / No___________

19. **Tobacco Use:** ____Current Smoker, every day ____Heavy Tobacco Smoker ____Former Smoker
____Current Smoker, some days ____Light Tobacco Smoker ____Never Smoked

When did you start? __________________ When did you quit? ________________________________

Do you use other tobacco products? Yes / No How much? ____________________

20. **Alcohol Use:**

- Do you drink alcohol? Yes / No
- How often? _____________________________ drinks per day / week / month / year

20. **Other Substances:** (Current and or past use)

a.	Marijuana	Current Use?	Yes / No	Never used
b.	Cocaine	Current Use?	Yes / No	Never used
c.	Heroin	Current Use?	Yes / No	Never used
d.	Other street narcotics	Current Use?	Yes / No	Never used
e.	Amphetamines (speed)	Current Use?	Yes / No	Never used
f.	Barbiturates (downers, etc.)	Current Use?	Yes / No	Never used

21. **Occupation / Education**:

Are you presently employed? Occupation: ______________________________________
Retired? Previous Occupation: ______________________________
Disabled? Date last able to work: ______________________________

Highest grade completed ____

22. **Social Arrangements**

Single
Married
Divorced
Living with other *Do you have Children: Yes / No
Widowed *Children in same household: Yes / No

<u>**Other information that may be important for your care:**</u>
____
____
____

Directions

Coming from the North: Travel south on I-89, take exit 16, go left off the exit, take your first left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200

Coming from the South: Travel north on I-89, take exit 16, go right off the exit, take your first left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200

From the Winooski Circle: Head north on RT 7 (Main Street), you will pass under I-89, take a left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200