Maryland Spine and Sports Medicine

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Patient Privacy Policy and
HIPAA Requirements

IMPORTANT: PLEASE NOTE

Due to government regulations, and to insure continuation of care, please provide us with the name of your referring physician and/or primary care provider, and sign the form below to authorize the release of your records.

By signing this policy, I, the patient, or the patient's legal representative, authorize Maryland Spine and Sports Medicine to **release my records to the following physician(s) and or healthcare provider(s). Please remember to include your Primary Care Provider so that they can be aware of the care you are receiving.**

_____ _____

Primary Care Provider **Referring Physician**

_____

Patient Signature

_____ _____

Print Name **Date**

It is the policy of MARYLAND SPINE AND SPORTS MEDICINE to protect the privacy of our patients to the fullest extent. In order for us to do this, we will also need the co-operation of you, our patient. The following are required to be compliant with the Health Insurance Portability and Accountability Act (HIPAA).

1. All patient health information (PHI) is kept within the confines of this office.
2. No records will be displayed where they are in a position to be read by any parties unrelated to their testing or treatment.
3. No records will be relayed via mail or fax unless written permission is given by the patient or guardian, or it is a matter of continued medical care. No patient records will be given to any other parties, such as attorneys or employers, without written permission from the patient or guardian.
4. We only use the most up-to-date methods for our Electronic Claims Transmission, and these relay facilities have taken every step to also be in compliance with the HIPAA regulations and have given us written notice of such actions.
5. Our staff has received instructions, both verbal and written, regarding maintaining the confidentiality of the patient and the inappropriateness of discussing personal or medical patient information outside the confines of this office.
6. Our office is prohibited from selling your PHI.
7. Your PHI will not be used for fundraising
8. You have the right to restrict disclosure of any records for visits paid for out of pocket.
9. You have the right to limit the use of genetic information for underwriting.
10. It is our duty and intent to notify you immediately should there be a breach in the privacy of your PHI.

It is our intent for these measures to protect our patients' medical information. We thank you for your attention and co-operation in this matter.

Maryland Spine and Sports Medicine
Patient Demographics and Insurance Information

Patient Update

Primary Care Provider or Referring Physician

Primary Care Provider or Referring Physician: _____

Phone #: _____

Patient Demographic Information

First Name: _____ MI: ____ Last Name: _____

Street Address: _____ City, State, ZIP: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #:_____

Date of Birth: _____ Social Security #: **xxx-xx-** _____ Gender: Male/Female

Patient's Employer and Address: _____

In case of emergency, notify: _____ Daytime Phone #: _____

Primary Insurance Information

Insurance Company Name: _____ Phone #:_____

Policy Number: _____ Group #: _____

Policy Holder Name: _____ Employer: _____

Policy Holder's Birth Date: _____ Relationship to Patient: _____

Secondary Insurance Information

Insurance Company Name: _____ Phone #:_____

Policy Number: _____ Group #: _____

Policy Holder Name: _____ Employer: _____

Policy Holder's Birth Date: _____ Relationship to Patient: _____

Insurance Authorization and Assignment (please read and sign)

I hereby authorize Maryland Spine and Sports Medicine, P.C. to furnish information to insurance carriers concerning my physical condition and treatments, and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents' understand that I am responsible for all fees and financial charges for the above named patient, regardless of insurance coverage. If not covered by insurance, I understand that payment is required at time of service.

Signature: _____ **Date:**_____



Maryland Spine and Sports Medicine
Medical History Form

Date: _____ **Patient Name:** _____ **SS#: xxx-xx-**_____

Medications: Please list names of **ALL** medications, including over the counter medications, and dosages:

_____

_____

Allergies (to medications/latex/iodine/dyes): _____

Please check one or more of the following reasons for your visit

Pain in the:

O Neck O Shoulder O Arm O Wrist/Hand O Back O Ankle/Foot O Hip O Leg O Headaches

O Numbness in the _____

Injury Or Date of Onset: _____/_____/_____

O Right or O Left Handed

Type of injury/symptoms: _____

O Job Accident O Slip/Fall O Sports Injury O Car Accident: O Driver O Passenger

O Other: _____

Did you go to the emergency room after the injury? O Yes O No

Did you have x-rays taken? O Yes O No

Work History:

Occupation: _____ Have you missed any work or school? O Yes O No If yes, how much time has been lost? _____ I am qualified to do the following: _____

Treatment:

Since the injury, what types of treatment have you received for this condition?

Medical

Physician's Name _____ Date of first treatment: _____

Length of Treatment: _____ Medications given: _____

Physical Therapy

Facility Name _____ Date of first treatment: _____

Length of Treatment: _____

O Hot/Cold Packs O Traction O Aqua Therapy O Other_____

Additional Treatment:

Surgery

Physician's Name: _____ Date of surgery: _____

Type of surgery: _____

Chiropractic

Physician's Name: _____ Date of first treatment: _____

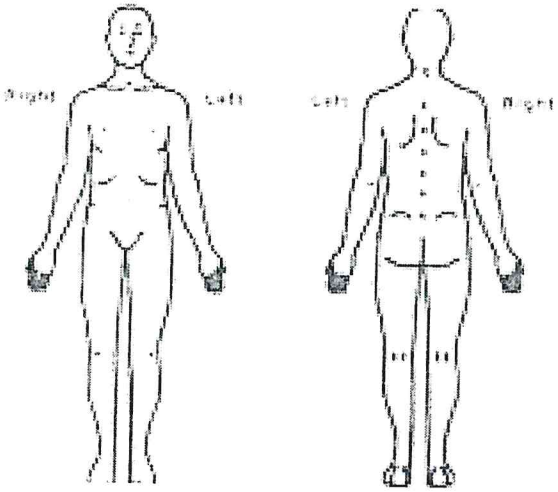
Length of Treatment: _____

O Adjustments O Electrical Stim O Traction O Hot/Cold Packs O Ultrasound O Massage

Pain

On these diagrams, show where you are experiencing pain and/or numbness. Please use the symbols below to describe the type of pain.

Stabbing: ///// **Numbness ------** **Achy AAAA** **Burning: XXXXX** **Pins and needles: *****



If you are in pain, describe your pain in detail: _____

_____

What is your pain on a scale of 1 to 10? 1 2 3 4 5 6 7 8 9 10

low pain medium pain high pain

What makes your pain worse? _____

What makes your pain better? _____

Do you have a prior history of neck or back problems or surgery? O Yes O No

Tests: What tests have you had so far relating to this condition?

Type of Test	Date	Body Part	Results
X-rays			
CT Scan			
MRI			
EMG/NSC			
Bone Scan			
Other Tests:			

Medical Problems (check all that apply):

Medical Problems (check all that apply):

O Diabetes O Thyroid O Asthma O HIV/AIDS O Kidney O Stomach Ulcers O Osteoporosis O Stroke O Hepatitis

O Tuberculosis O Cancer O Arthritis O Heart problems O Rheumatoid arthritis O Seizures O Psychiatric illness

O High blood pressure O Other _____

Surgery: _____

Family History (check all that apply):

O High Blood Pressure O Cancer O Diabetes O Depression O Rheumatoid arthritis O Stroke O Heart disease

O Thyroid disease O Tuberculosis O Osteoporosis

Social History (check all that apply):

Marital status: O Married O Single O Divorced O Widowed

O Live in house O Live in apartment O Number of children _____ Ages: _____

Education: O High school O College

Cigarettes: O Yes O No If yes, _____ packs per day. Alcohol: O Yes O No If yes, _____ per week _____ years

Bleeding tendencies O Yes O No **Recent infection/fever:** O Yes O No

Previous reaction to anesthesia: O Yes O No **Family History:** O Yes O No

Functional history (check all that apply):

I am not able to do the following:

O Cook O Wash the car O Twist O Clean O Lift O Laundry O Yard work O Bend O Open jars O Other: _____

I require the use of the following:

O Cane O Crutches O Wheelchair O Neck brace O Back brace O Splint O Other: _____

Review of systems (check all that apply): O Fever O Chills O Sweats O Significant weight loss O Significant weight gain

Dermatological: O Jaundice O Rash O Hives O Itching O Easily bruised

Hearing: O Deafness O Ear discharge O Ear ringing

Vision: O Glasses O Blindness O Blurred vision O See rings around lights

Pulmonary: O Shortness of breath O Wheezing O Chronic cough O Coughing up blood

Cardiovascular: O Chest pain O Varicose veins O Racing heart O Use 2-3 pillows at night O Shortness of breath w/exertion

Gastrointestinal: O Nausea O Vomiting O Diarrhea O Constipation O Blood in stool O Change in stool color O Hemorrhoids
O Difficulty feeling bowels O Difficulty controlling bowels

Genitourinary: O Blood in urine O Penile discharge O Urination at night O Pregnant O Frequent urination O Menopause
O Pelvic infections O Irregular menstruation O Urgency w/urination O Difficulty feeling urine
O Difficulty controlling urine O Difficulty w/erection O Painful menstruation O Vaginal discharge
O Vaginal bleeding O Sexually transmitted disease O Last Monthly Period: _____

Endocrine: O Thyroid enlargement O Goiter O Hyperthyroidism O Hypothyroidism

Neurological: O Headaches O Fainting O Paralysis O Balance problems O Light headedness O Dizziness O Seizures
O Memory loss O Numbness O Coordination problems

Psychological: O Trouble w/nerves O Depressed O Anxious O Suicide attempt O Difficulty sleeping O Emotional problems

Alcohol abuse/addiction: O Yes O No **Illicit drug abuse/addiction:** O Yes O No **IV drug abuse/addiction:** O Yes O No

Prescription drug abuse/addiction: O Yes O No

Physician Use Only

___ Patient is cleared for procedure in an ambulatory setting

Heart: _____ WNL _____ Lungs: _____ WNL _____