Advanced Interventional Spine & Sports Medicine Center

20 Crossroads Dr, 210
Owings Mills, MD 21117
Tel: 410 581 2969
Fax: 410 581 5775

REGISTRATION FORM

(Please Print) **Email:**

Today's date:	**Family Physician:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ **Mr.** ❑ **Mrs.**	❑ **Miss** ❑ **Ms.**	**Marital status (circle one)** **Single / Mar / Div / Sep / Wid**

Is this your legal name? ❑ **Yes** ❑ **No**	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ❑ **M** ❑ **F**

Street address:	**Social Security no.:**	**Home Phone no.:** **Cell Phone no.:**

P.O. box: **Race:**	**City:** **Languages spoken**	**State:** **Ethnicity: Hispanic/Non Hispanic**	**ZIP Code:**

Occupation:	**Employer:**	**Office phone no.:** ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ **Dr.**	❑ **Insurance Plan**	❑ **Hospital**

❑ **Family**	❑ **Friend**	❑ **Close to home/work**	❑ **Yellow Pages**	❑ **Other**

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Amit Bhargava, MD, LLC and its employees or insurance company to release any information required to process my claims.

Patient/Guardian signature X _____ *Date* _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Insurance	**Workers comp**	**Auto Accident**

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance					
			❑ Welfare *(Please provide coupon)*	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

PLEASE COMPLETE ALL MARKED QUESTIONS AND BOXES

Advanced Interventional Pain & Sports Medicine Center

1. **Name**_____ **Date**_____
2. Referred by_____ Family Physician_____
3. **Chief complaint** _____ **Pain level ?**____

PAIN SCALE
0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Severe pain

4. **When did your pain start?**_____
5. **Do you have** any weakness, sweating, night time pain, bowel or bladder problems, infection, loss of weight, saddle anesthesia**?** Yes/No
6. **How often is your pain present?** Occasional Frequent Constant
7. **Is the pain** Aching Burning Stabbing Pressure Throbbing Deep Cramping Other
8. Please *circle* ***only one*** choice given below:

• I have only back pain	• I have only neck pain
• I have only leg pain	• I have only arm pain
• Back pain is more than leg pain	• Neck pain is more than arm pain
• Leg pain is more than back pain	• Arm pain is more than neck pain
• Back pain is equal to leg pain	• Arm pain is equal to neck pain

Height_____ Weight_____

Increased weight increases load on your joints.

Do you have any?
Tingling Yes No Where_____
Numbness Yes No Where_____
Weakness Yes No Where _____

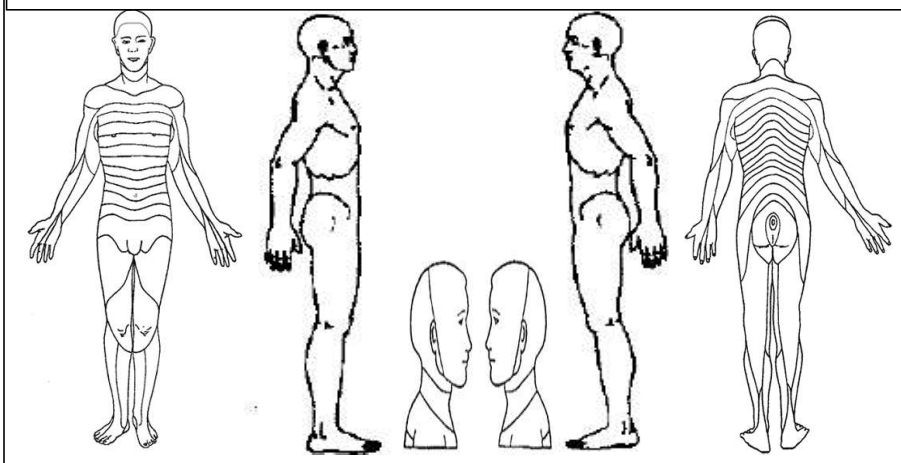
9. **What position worsens your pain:**
Sitting standing walking bending driving lying on back
Lying on stomach lying on the side sitting-to-standing coughing
10. **What position decreases your pain:**
Sitting standing walking bending lying on back
Lying on stomach lying on the side Heat Ice medication
11. **Are you taking any blood thinners?**: Aspirin Plavix Coumadin Ticlid Plavix Trental Persantin Aggrenox Orgaran Lovenox Fish oil_____
12. Current Medications **(list all medications with dosage and starting date)**: (please, use the other side of this page)_____

Previous medical treatment
When was the last time you had PT and how many sessions? _____
When were the last spinal /joint injection?_____
Chiropractic treatment Yes/No
What medications have you taken for this pain? _____
Which treatment decreased the pain?_____
When was the last EMG (nerve test)done? _____
When was the last MRI done? _____
When were the last X-ray done? _____

13. **Medical Problems:** Diabetes Hypertension Stroke Thyroid Heart Kidney Seizures Bleeding Liver Circulation HIV Reflux Pacemaker Defibrillator Asthma Hepatitis Murmur High cholesterol Ulcer COPD Osteoporosis Cancer Depression _____
14. **Date of:** Flu shot_____ pneumonia shot_____ Mammogram_____ DEXA scan_____ Colonoscopy_____
15. **Previous Surgeries / Hospitalizations:** Tonsillectomy Hysterectomy Gall Bladder Foot Knee or Hip replacement Fracture Heart Spine Appendectomy Fractures_____
16. **Please circle if you have any of the following medical problems**

General : *weight change, fevers fatigue*
Eyes: *glasses or contacts*
E.N.T.: *hearing aid, dental, trouble swallowing*
Cardiovascular *chest pain, blood clots, swelling*
Respiratory : *wheezing, shortness of breath*
Gastrointestinal: *ulcers, heartburn, bleeding*
Genitourinary: *infections, night time urination*
Musculoskeletal: *arthritis, gout, osteoporosis*
Integument: *breast lumps, mass, rash*
Neurologic: *fainting, seizures, stroke,*
Psychological: *depression, anxious*
Endocrine: *spontaneous temp. changes*
Hem/lymp: *anemia, bleeding problems*
Immunology: *HIV, Lupus*

Indicate the location of your pain with the following letters
Aching AA Stabbing SSS Burning BB Numbness NN Tingling TT
Pressure PP Cramping CC Other OO



17. **Allergies:(Meds)** _____
Reaction Mild/Moderate/Severe
Latex: Yes/No **Sea food:**Yes/No
Dye: Yes/No
18. **Marital Status**: Single Married Divorced Separated Widowed
Work Status: Full time Part time Where_____ Position
Unemployed Retired Student Homemaker Disability
Alcohol: None/Yes/Quit Type_____Amount: _____for ___yrs
Drugs: None/Yes/Quit Type_____Amount: _____for ___yrs
Smoking: None/Yes/Quit Packs/day _____for ___yrs
Smoking is injurious to your health

Functional History:
Can you Eat , Bathe, Use the toilet, Dress, Get up from bed or a chair by yourself ? ***Yes/No***
Do you use a cane, walker, crutches or wheel chair ? ***Yes/No***
Do you exercise ***Yes/No***

19. **Family history** Age
Father ___ Healthy Diabetes Hypertension Stroke Thyroid Heart Kidney Liver Cancer _____
Mother ___ Healthy Diabetes Hypertension Stroke Thyroid Heart Kidney Liver Cancer _____
20. **Complete this only if you were involved in an auto accident :**
Were you the driver/passenger?
How much damage was done to your vehicle? $_____
How long after the accident did you seek medical attention? _____
Were you wearing a seat belt? Yes / No
Did you lose consciousness? Yes / No
How long after the accident did the pain begin?_____
Did you have ever have any pain before the accident? Yes/No

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Patient Name: _____ DOB: _____

Consent for Treatment , Notice of Privacy Practices and Authorization to Release Medical Information

I acknowledge I have read and understand the Notice of Privacy Practices and a copy is available upon my request. I give the Amit Bhargava, MD, LLC permission to obtain and release medical information to referring physicians, insurance companies and attorneys requesting these records. I authorize the use of this signature for today's visit and all future visits.
I further authorize __Amit Bhargava, MD. LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.
I hereby authorize ____Amit Bhargava, MD. LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Statement of Patient Financial Responsibility

The Amit Bhargava, MD. LLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to _Amit Bhargava, MD, LLC, for providing pain and rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to _Amit Bhargava, MD. LLC, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.
Patients are responsible for providing information for billing.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter. Co-pay is to be paid at the time of your visit. If payment is by check and is not cleared by the bank, there will be an additional charge of $25.00 for processing and for penalty assessed by bank to the medical office.

Self-Pay and Referral

If I do not have health insurance/if my health insurance policy lapses then I will be responsible for services rendered here at Amit Bhargava, MD. LLC. I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.
I am aware that my appointment may be rescheduled if the referral is not available at the time of the appointment and will be responsible for full and entire payment of treatment.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. We urge you to call 24-hours prior to canceling your appointment. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours (work days) in advance you will be charged a **twenty five dollar ($25) fee*; this will not be covered by your insurance company***.

Chesapeake Regional Information System for our Patients, Inc. (CRISP)

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. 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 all 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.

Pain Medication

I have been informed and fully understand and I am aware that I may not be prescribed any narcotic pain medication at this office.

Messages

I choose to receive Email reminders and messaging, SMS mobile text reminders and messaging, voice reminders and messaging. I agree to receive (I "opt in" to receiving) SMS text messages from our organization related to services that we are providing to you. Message and data rates may apply, and message frequency varies. You may text us STOP at any time to opt out of receiving SMS text messages from us. You may text us HELP at any time to receive help.

Patient/Guarantor Signature **X**_____	Date _____

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Physician and Patient Medication Management Agreement

This Agreement between_____("Patient") and Amit Bhargava, MD/_____("Doctor") is for the purpose of establishing an agreement between Doctor/Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medications prescribed by the Doctor for the Patient:

1. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.
2. I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals program.
3. I realize that all medications have potential side effects. I will have the recommended laboratory studies required to keep my regimen as safe as possible and promptly notify the Doctor of any side effects I may experience.
4. I will communicate fully with my doctor 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.
5. I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving.
6. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform that activity until I confer with the Doctor.
7. I will not dispose of any of my medications in any way until I confer with the Doctor.
8. I have the right to stop taking a medication, but I must consult with my doctor first.
9. I will not use any illegal controlled substances, including marijuana, heroine, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to time when I am not driving, operating machinery and will be infrequent.
10. I will not share, sell, or trade any of my medications for money, goods or services.
11. I will not obtain pain medications from any other health care provider. I will inform all health care providers about the pain medications prescribed by the Doctor. I will inform the Doctor of all my current prescriptions.
12. I will safeguard my medications and prescription slips to prevent loss or theft and agree that the consequence of my failure to do so is that I will be without that medication for a period of time.
13. I agree that I will use my medications at a rate **NO** greater than what is prescribed and my use of my medications at a greater rate will result in my being without medications for a period of time.
14. I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
15. I agree to use ×_____Pharmacy, located at ×_____ telephone # _____for all my pain medications. If I change my pharmacy for any reason, I agree to notify the Doctor at the time I receive my prescription/prescriptions.
16. I agree to waive any applicable privilege or right of privacy or confidentiality with the respect to the prescribing of medications and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medications, I authorize the Doctor to provide a copy of this agreement to my pharmacy.
17. I agree that I will promptly submit to a urine, blood and/or saliva test when requested.
18. I will bring unused pain medicine to every office visit.
19. **Noncompliance with the above agreement could be grounds for discharging the patient from the practice.**
20. My questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that the failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medications and termination of the Doctor/Patient relationship.

This Agreement is entered into on the_____day of_____,20_____

×_____	_____	_____
Patient	Physician	Witness

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

_____

2. **The following person (or class of persons) may receive disclosure of protected health information about me:**

Amit Bhargava, MD, MS, RMSK
Name

20 Crossroads Dr, Ste 210
Address

Owings Mills, MD 21117
City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

_____All Medical records, including MRI, EMG, X-ray reports, medication prescribed, procedures_____

___Last 2 notes_____EMG Report_____Urine drug screen_____Procedure notes_____Radiology investigations_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *× _____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 201___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

× _____	× _____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Log #**

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Informed Consent for Telemedicine Services

Name_____ DOB_____

Physician: Amit Bhargava, MD/ _____State_____

Introduction:
Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records · Medical images ·
- Output data from medical devices and sound and video files Live two-way audio and video ·

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected benefits

- Improved access to medical care by enabling a patient to remain in his/her physician's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible risks:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My physician has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Amit Bhargava, MD and his staff to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): X _____Date:_____

If authorized signer, relationship to patient: _____
Witness: _____

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Informed Consent

(Please Print)

Today's date:		
PATIENT INFORMATION		
Patient's name:	**DOB:**	**Location**
Physician		**Location:**

COVID-19 is an infectious virus that currently has no direct treatment and for which there are vaccines. While we have taken reasonable steps to limit the potential for transmission of COVID-19 in our office, you agree that you understand transmission of COVID-19 is still possible.

You understand our office offers a HIPAA compliant telemedicine option. However, your care and/or your preference requires an in-person visit with our staff and health care providers. Where required to provide you care, our staff and health care providers may be within 6 feet of you and may touch you and your personal objects. You understand that person-to-person contact may increase the chance of COVID-19 transmission. It may be necessary that you quarantine and/or take other steps in the event it is determined that you may have been exposed to COVID-19.

Corticosteroids may affect body immunity. There may be decreased immunity with steroids. There are no studies to correlate steroid injections with COVID19 and the possibility of getting it.

You further understand that recommendations and guidelines regarding COVID-19 are subject to modification.

Signature of Patient (or person authorized to sign for patient): **X**_____Date: _____

If authorized signer, relationship to patient: _____

Witness: _____Date:_____

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PERSONAL INJURY VERIFICATION

Patient's last name:	First:	Middle:		
Date of injury		Referred by		

AUTO INSURANCE COMPANY

Name	Policy number:	Claim number:	
Address	City:	State:	ZIP Code:
Phone number:			

ATTORNEY INFORMATION

Name	Legal Assistant:	
Address	City:	State:
Phone number:	Fax number:	

PIP Verification

1. Has the accident been reported to PIP carrier? Yes/No
2. Is PIP available? Yes/No
3. Has PIP been waived? Yes/No
4. Is Med Pay available? Yes/No
5. Do you require CMS 1500 forms instead of statements? Yes/No
6. May we fax claims and notes? Yes/No
7. The attorney may receive copies of bills and records on request Yes/No

8. **Would you prefer the attorney to be billed directly**? **Yes/No**

Patient/Guardian signature X *Date*

Screening checklist for COVID-19

1. Have you been within 6 feet of a person with lab-confirmed COVID-19 for at least 5 minutes, or had direct contact with their mucus or saliva, in the past 14 days?
2. In the last 48 hours, have you had any of the following symptoms?

    a. Fever >100.4° F

    b. Feeling feverish

    c. Cough

    d. Sore throat

    e. Trouble breathing, shortness of breath, wheezing

    f. Unusual fatigue

    g. Chills or shaking

    h. Body ache

    i. Vomiting

    j. Diarrhea

    k. Nausea

    l. Abdominal pain

    m. Loss of smell or taste

    n. Headache

I do not have any of the above symptoms

X _____

Sign

_____

Name

_____

Date