For Staff Use
Reviewed: Y / N
Date: ________________
Initialed: _____________

New Patient Information Packet

Patient Demographics

First Name: _______________________ Middle: _______________ Last: _________________

Patient's Address:____

City: _________________ St: ___________ Zip:_________ Email: ____

Home Phone: ______________________________ Work Phone: _______________________ Cell: __________________

SSN: ______--_____--_______ Gender: M F Date of Birth: ______/______/________

Marital Status: Single Married Divorced Widowed Legal Separated

Employment Status: Employed Self-Employed Unemployed Disabled Retired

Part-time Student Full-time Student

If employed, where?____

Insurance Information

Insurance Carrier: ________________________________

Group #: __________________ Start Date: __________________ Member ID: _________________________________

Is the patient the subscriber/policy holder: Y / N

If no, patient's relationship to subscriber: Child Wife Husband Parent Special Dependent

Grandparent Aunt Uncle Grandchild Niece Other

If no, subscriber's name: ____ SSN: ______--_____--_______

Gender: M F Date of Birth: ______/______/________

Marital Status: Single Married Divorced Widowed Legal Separated

Employment Status: Employed Self-Employed Unemployed Disabled Retired

Part-time Student Full-time Student

If employed, where?____

Subscriber's Address (if different from patient): ____

City: _________________ St: ___________ Zip:_________ Email: ____

Home Phone: ______________________________ Work Phone: _______________________ Cell: __________________

For Staff Use
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Initialed: _____________

Emergency Contact

Emergency Contact Name: ____ Gender: ☐ M / ☐ F

Home Phone: __________________________ Work Phone: ____________________ Cell: ________________

Relationship to patient: ____

Parent/Guardian (If patient is minor, please complete)

Parent/Guardian same as Emergency Contact: ☐ Y / ☐ N

Parent/Guardian Name: ____

Relationship to patient: ____

SSN: ____________________________________ Gender: ☐ M / ☐ F

Home Phone: __________________________ Work Phone: ____________________ Cell: ________________

Pharmacy

Preferred Pharmacy: _________________________________ City: _______________ Phone: _____________

I understand that I am requesting to receive care from Narayana Healthcare Alliance LLC. I also authorize the clinic to contact my emergency contact in case of emergency. Also, by leaving my contact numbers I am consenting to leaving messages regarding my care and appointments. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

____

Patient Printed Name

____ _________________________

Patient's Signature Date

Patient Medical History

Patient Name: ____ Chart #: __________________ Date: _________________

Date of Birth: _______________ Age: _______ Sex: _______ Primary Care Physician: ____________________________________

How were you referred to us? ☐Self ☐Work Comp ☐Chiropractor ☐Primary Care Physician

What is the main reason for this visit? ____

On a scale of 0 to 10 what number would you give your pain today? ______ (0 no pain, 1-3 mild, 4-6 moderate, 7-10 severe)

PAST HEALTH HISTORY OF PATIENT - Please check **Y** or **N** for each condition listed below. **Do not leave any blanks.**

Metabolic Disease
- Diabetes ☐Y ☐N
- High Blood Pressure ☐Y ☐N
- Thyroid Disease ☐Y ☐N
- Osteoporosis ☐Y ☐N

Pulmonary Disease
- Pneumonia ☐Y ☐N
- Asthma ☐Y ☐N
- COPD ☐Y ☐N
- Tuberculosis ☐Y ☐N

CNS Disease
- Stroke ☐Y ☐N
- Seizure ☐Y ☐N

Cardiac Disease
- Heart Attack ☐Y ☐N
- Angina ☐Y ☐N
- Heart Murmur ☐Y ☐N
- Arrhythmia ☐Y ☐N
- Valve Problems ☐Y ☐N

Psychiatric Disease
- Depression ☐Y ☐N
- Schizophrenia ☐Y ☐N
- Bipolar Disorder ☐Y ☐N

GI Disease
- Ulcer ☐Y ☐N
- Gall Bladder ☐Y ☐N
- Hernia ☐Y ☐N
- GI Bleed ☐Y ☐N
- Obstruction ☐Y ☐N

Urologic Disease
- Urinary Tract Infection ☐Y ☐N
- Kidney Stone ☐Y ☐N
- Dialysis ☐Y ☐N

Cancer
- Location ______________
- Year Diagnosed ______
- Reoccurrence ☐Y ☐N
- Current Treatment ☐Y ☐N

Infections
- After Surgery ☐Y ☐N
- Venereal Disease ☐Y ☐N
- Hepatitis ☐Y ☐N
- AIDS ☐Y ☐N
- HIV Positive ☐Y ☐N
- Osteomyelitis ☐Y ☐N

Blood Disorders
- Anemia ☐Y ☐N
- Clotting Problems ☐Y ☐N
- Hemophilia ☐Y ☐N

Arthritis ☐Y ☐N
- Rheumatoid ☐Y ☐N
- Osteoarthritis ☐Y ☐N
- Gout ☐Y ☐N

Miscellaneous
- Blood Clots ☐Y ☐N
- Thrombophlebitis ☐Y ☐N
- Prior Blood Transfusion ☐Y ☐N

Explain any other conditions not listed above that you have been diagnosed with: ____

____

SURGICAL PROCEDURES (include approximate dates): ☐**NONE**

____ ____

____ ____

____ ____

____ ____

Have you ever had a problem with anesthesia? ☐No ☐Yes If yes, explain ____________________________________

ALLERGIES: ☐ **NONE**

Medication / Other	**Reaction**	**Severity of Allergy - circle level of severity**
____________________	____________________	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
____________________	____________________	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
____________________	____________________	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
____________________	____________________	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
____________________	____________________	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐

Reaction Examples: *Unknown, Breathing Difficulty, Nausea, Rash, Anaphylaxis, Vomiting, Diarrhea, Hives, Dizziness*

CURRENT MEDICATIONS: ☐**NONE** *Include medications prescribed by a physician, Over-the-Counter (OTC), Herbal Supplements and Vitamins.*

Medication & Dosage	**Prescribing Physician**	**Medication & Dosage**	**Prescribing Physician**

HIPAA Acknowledgement Form

This notice describes how our practice may use/or disclose your protected health information (PHI). PHI is the individual identifiable health information including actual medical information, your name, address, phone number, identification number, insurance information, or other identifiers. Please review this notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use and/or disclosure of protected health information. The notice takes effect April 14, 2003.

A patient's information may be used and/or disclosed for the following reasons:

Treatment- we may use PHI to provide you with medical treatment or services. This includes communications between other health care professionals, other healthcare facilities, and other providers for administering treatment.

Payment - we may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third-party. This includes typical payment activities such as verification of coverage, pre-certification, referrals, and claims processing.

Administrative or Healthcare Operations Activities - we may use and or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement, and business planning. These uses and or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services.

For Communicable Diseases/Public Health Safety - we may disclose your PHI if Authorized by law, if the public may have been exposed to a communicable disease.

For Legal Proceedings - we may disclose PHI in response to a court order.

The patient reserves the right to request restrictions on the policies listed in this notice, and receive a copy of all information used and or disclosed. Request for patients own PHI will be provided only with a photo proof of identification from the patient. You have the right to designate a personal representative to authorize the disclosure of protected health information.

We reserve the right to contact patients regarding appointments. Also, please be advised we have open adjusting areas. If you wish any discussion to be confidential please request a private room. If you believe your privacy rights have been violated with respect to our protection of your PHI please contact us in writing.

I hereby verify that I have read and understand this notice of privacy practices.

Patient/Representative Signature___________________________________Date_____________

Financial Policy

Patient Name: ____ **Date:**_________________

Thank you for choosing Narayana Healthcare Alliance LLC. We strive to offer the best healthcare services to our patients. Part of that service is providing transparency regarding any financial responsibilities. If at any time during your visit you have questions or concerns regarding your potential costs of services, please alert one of our team members.

Please review the following.

1. Narayana Healthcare Alliance LLC verifies your benefits with your insurance company prior to each visit. Verification of your benefits with your insurance company is not a guarantee of benefits or payment. You are responsible for paying any out-of-pocket expenses as part of your benefit coverage. Copayments, deductibles, and coinsurance for clinic visits are due at the time of the service, in accordance with the carrier 's plan. If you are unable to pay at the time of services, NHA reserves the right to reschedule your appointment. Be advised having more than one insurance policy is not a guarantee that all of your out-of-pocket expenses will be covered.
2. Assignment of Benefits: In consideration of the treatment being rendered, you hereby irrevocably assign any and all insurance benefits you have to Novus Spine & Pain Center for services provided to you. You understand you remain personally financially responsible for any services not covered by your insurance benefits or plan.
3. Your insurance policy is a contract between you and your insurance cerrier. You are ultimately responsible for payment, in full, for all medical services provided. Any charges not paid by the carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.
4. Coverage changes and timely submission. Is it your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which a claim can be submitted on your behalf. If NHA is unable to process your claim within this period due to incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.
5. Insurance Plan Participation. NHA has specific network agreements with many insurance carriers, but not all. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for. If your insurance plan requires you to have a referral, it is your responsibility to obtain this referral. Without a referral, you will hold financial responsibility for the visit and subsequent services rendered. NHA, as a courtesy to our patients, will make a good-faith effort to obtain prior authorization, if needed. Ultimately, it is your responsibility to ensure that the service provided to you is covered in your benefits and authorized by the insurance carrier.

3. For Self-Pay patients with no active insurance coverage, Narayana Healthcare Alliance LLC offers a flat rate of $300.00 for the initial office visit and $250.00 for each follow-up office visit. Please note separate fees apply for Urine Drug Screens. Additional charges apply for services not included in the office visit (examples procedures, injections, etc.). Payment is required prior to services being rendered.

4. If your balance is not paid or a payment arrangement has not been made after two (2) attempts to collect, a **$25 service charge** may be assessed as a late fee on your account. Any unpaid balance may be turned over to an outside collection agency.

5. There is a charge for completing individual medical forms, disability, work restriction, employer forms, school forms, etc. Please allow five (5) business days to process all form requests.

6. There is a cost for other service(s) such as copying x-ray images and medical records.

By signing below I understand and accept the financial policy Novus Spine & **Center.**

_______________________________________ ___________________________

Patient or Patient's Representative or Responsible Party Date

____

Print Name (and relationship to patient)

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. (If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing must sign. If a patient is incompetent, a legal guardian or conservator must sign.)

I consent to the use or disclosure of my protected health information by Narayana Healthcare Alliance LLC (NHA) for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations for NHA. I understand that diagnosis and/or treatment of me by NHA may be conditional upon my consent, as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. NHA is not required to agree to the restrictions that I may request; however, if NHA agrees to a restriction that I request then the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that NHA has taken action in reliance on this consent.

I understand I have the right to review NHA's Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of health care operations of the NHA. The Notice of Privacy Practices for NHA is also posted at each office location. This Notice of Privacy Practices also describes my rights and NHA's duties with respect to my protected health information.

NHA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

I hereby authorize the release of my Protected Health Information to the following individuals (Please Print):

____

____

____

Release of information authorization

Type of authorization: Release of Protected Health Information to a designated person / entry.

Patient Name: ____ **Date of Birth:** __________________________

Maiden name, if applicable: ____

Address: ____

I authorize (from): ____ to release medical information, about me, to Narayana Healthcare Alliance.

Description of information to be disclosed: I authorized a physician/facility noted above to disclose the following protected information about me to the person identified above.

Information requested: ____for the dates of/from __________________ to __________________. I understand that information in my medical records concerning HIV treatment/status, depression, mental, social, health issues, and drug/alcohol use will be released unless initialed below:

__________________ Mental health __________________ HIV __________________ Drug/Alcohol

Purpose of disclosure: (please circle choice below)

1. Further treatment 2. Personal Records 3. Transfer Care 4. Other: _____________________

Expirations of Termination of Authorization: This authorization will expire upon completion of this transaction. You have the right to terminate this authorization at any time. This request will be honored except to the extent of any action already taken on this authorization prior to revocation.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by requesting so.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected in health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirement to the Privacy Rule and will no longer be the responsibility of Narayana Healthcare Aliance LLC. **I understand that if I refuse to sign and agree with this release, but in doing so, I will not have access to my records.**

Patient Signature: ____ **Date**: ________________________

Witness Signature: ____ **Date**: ________________________