## PATIENT INFORMATION SHEET

Today's Date: ____________________ Primary MD: ______________________________

Patient Name: First: ____________________ Last: _________________ MI.: ___________

Date of Birth: ________________________ SS#: _______________________________

Address: _________________________ City: _________________ State: ___ Zip: ________

Home Phone: _________________________ Cell Phone: _____________________

Primary Language: _______________________ Ethnicity: ______________________

Religion: ______________________________ Occupation: _____________________

Employer: ______________________________ Date symptoms first appeared: __________

**Medical Insurance Info:**

Insurance Company: _______________________________________________________

ID#: _____________________________________________________________________

Primary Subscriber (insured's name): ________________________________________

Primary Subscriber SSN: ________________ Primary Subscriber Date of Birth: ____________

Secondary Health Plan: ______________________ ID#: ______________________________

Secondary Subscriber (1nsured's name): _________________________________________

Secondary Subscriber SSN#: ________________ Secondary Subscriber Date of Birth: __________

I hereby authorize Haider Spine Center to examine and or treat me. I acknowledge that the examination includes physical contact by the doctor and other healthcare providers in the office. I understand that the examination, treatment and/or testing may cause discomfort.

Patient/Parent or Guardian Signature: ___________________________ Date: ____________________

Emergency Contact Information:

Name and Address: ______________________________________ Phone Number: ______________

Financial agreement and authorization for treatment and release of information:
I authorize treatment of the patient named above. I agree to pay all fees and co-payments for services not covered by insurance. It is agreed that payment will be made at the time of service unless prior arrangements have been made with our financial counselors. It is also agreed that payments will not be delayed or withheld because or any insurance coverage or the pendency of claims thereon, and all proceeds are assigned to the Haider Spine Center where applicable, but without their assuming responsibility for collecting or negotiating settlement on disputed claims. A copy of this assignment is valid as original. I understand and agree that I will be assessed finance and penalty fees on balances over 90 days old. I authorize Haider Spine Center end its related entities to release any information in the course of my treatment to the health insurance or workers compensation Insurance carrier or similar agencies.

**Signature:** ____________________________________________ **Date:** __________________

6276 River Crest Drive, Riverside, CA 92507
(951)413-0200 FAX: (951)653-5680

Failed Neck & Back Syndrome
Reconstructive Spine Surgery
Scoliosis & Other Deformities
Spine Rehabilitation
Industrial Medicine
Pain Management
Spine Trauma

## Records Authorization Release

**Patient Information:**

| Patient Name: | |
|---|---|
| Date of Birth: | SSN: |
| Address: | |
| City, State and Zip: | |

**Records to be released:**

___ Medical Records ___ X-Rays ___ MRI Scans ___ CT Scans

___ Operative Reports ___ Lab Reports

**Please fax requested records to:**

Fax#: 951-653-5680

**OR Mail records to:**

Haider Spine Center Medical Group, Inc.
6276 River Crest Drive Suite A Riverside, CA 92507

The information may only be used for the following purpose:

_______________________________________________

**Expiration date of this release:** ________________________

**Patient Signature:** ________________________

**Date:** ________________________

6276 River Crest Drive, Riverside, CA 92507
(951)413-0200 FAX: (951)653-5680

Failed Neck & Back Syndrome
Reconstructive Spine Surgery
Scoliosis & Other Deformities
Spine Rehabilitation
Industrial Medicine
Pain Management
Spine Trauma

**Disclosure of Financial Interests**

Physicians in this facility may have a financial interest in the following entities:

1. X-Ray Imaging
2. MRI Imaging
3. Land Physical Therapy/Pool Physical Therapy
4. Xenco Medical LLC
5. Haider Biologics LLC
6. Durable Medical Equipment- lntellibraces Technology/Orthofix

These services are pr4ovided through this office for the convenience of our patients as well as for quality control. As a patient, you have the option to obtain these services through other sources.

I have read the above statement and understand that I can elect to obtain these products and services through alternative sources.

**Signature:** ____________________________________________

**Date:** ____________________________________________

6276 River Crest Drive, Riverside, CA 92507
(951)413-0200 FAX: (951)653-5680

Failed Neck & Back Syndrome
Reconstructive Spine Surgery
Scoliosis & Other Deformities
Spine Rehabilitation
Industrial Medicine
Pain Management
Spine Trauma

**Disclosure of Physician Assistant Participation in Your Case**

In an effort to provide our patients with timely, as well as quality medical care, Haider Spine Center maintains specially trained Physician's Assistants on its medical staff.

While the initial evaluation and treatment plan will be established by your Primary Treating Physician, routine office visits for medication refills and maintenance of benefits, etc. will often be conducted by a Physician's Assistant under the direction of the physician responsible for your care. However, in most cases, your Primary Treating Physician will be available to address your concerns personally should unusual or unexpected circumstances arise.

The report generated by the Physician's Assistant will be reviewed by your Primary Treating Physician. All recommendations and treatment plans are made by your Treating Physician.

We have found that a team approach to our patient's medical care ensures that his or her needs will be met promptly and professionally.

Thank you for your consideration in this matter.

I have read the above statement and acknowledge that Physician Assistants will be participating in my care under 1he direction of my Primary Treating Physician.

**Patient Signature:** ______________________________________________

6276 River Crest Drive, Riverside, CA 92507
(951)413-0200 FAX: (951)653-5680

Failed Neck & Back Syndrome
Reconstructive Spine Surgery
Scoliosis & Other Deformities
Spine Rehabilitation
Industrial Medicine
Pain Management
Spine Trauma

**HIPAA Privacy Policies and Procedures**
**Haider Spine Center**
**6276 River Crest Drive Suite A**
**Riverside, CA 92507**
**951-413-0200**

**Policy:**

Haider Spine Center Medical Group is committed to protecting the rights of our patients. In compliance with the Health Insurance Po1iability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HlTECH) and applicable federal and state laws and regulations, this policy sets for the Medical Group's practice if implementing, enforcing, updating, and documenting its compliance with HIPAA policies and procedures.

The Medical Group will implement policies and procedures that are reasonably designed to ensure compliance with the HIPAA standards, requirements and implementation specifications.

The Medical Group will monitor changes to HIPAA and will promptly revise its policies and procedures and, if required, its Notice of Privacy Practices.

The Medical Group will maintain documentation required for HIPAA compliance for a minimum period of six years from the date of creation of the document or the date the document was last in effect, whichever is later, Documentation will be retained in written or electronic form in accordance with Medical Group policy.

Applicability
Medical Group HIPAA Privacy Policies and Procedures apply to all the Medical Group Workforce Members, including employees, medical staff, vendors, contractors, consultants, and agents of the Haider Spine Center Medical Group. Policies that address patient's rights apply for any patient of the Medical Group.

Enforcement
The Medical Group's Privacy Manager has general responsibility for implementation of all Internal Audits, Compliance and Enterprise Risk Management (IACERM), H.IPAA Privacy Policies and Procedures.

Members of the workforce who violate these policies will be subject to disciplinary action up to and including termination. Anyone who knows or has reason to believe that another person has violated any of these policies should report the matter promptly to his or her supervisor or the Privacy Manager.

These policies shall remain in effect unless terminated or superseded by a revised and/or updated policy issued *by* IACERM.

6276 River Crest Drive, Riverside, CA 92507
(951)413-0200 FAX: (951)653-5680

Failed Neck & Back Syndrome
Reconstructive Spine Surgery
Scoliosis & Other Deformities
Spine Rehabilitation
Industrial Medicine
Pain Management
Spine Trauma

**Acknowledgement of Receipt of Notice of Privacy Practices**

Haider Spine Center
6276 River Crest Drive Suite A
Riverside, CA 92507

I hereby acknowledge that I have received a copy of the Haider Spine Center HIPAA Privacy Practices and Procedures document. I have reviewed its contents and, understand its intent. I further acknowledge that a copy of the current notice will be posted in the Front Office and Lobby and that 1 will be notified of any amendments to the notice when they occur.

**Signature**: ______________________________ **Date**: ______________________

**Print Name:** ____________________________ **Phone:** ____________________

If not signed by the patient, please indicate relationship;

___ Parent/Guardian of minor patient
___ Guardian/Conservator if incompetent patient
___ Personal Representative

**Patient Authorization for Release or Restriction of PHI**

I authorize Haider Spine Center to use and disclose my protected health information to:

______________________________________________________________________

Effective: ______________________________ through ______________________________
or at such time that I notify MSC that this authorization is null and void.

All medical records, X-rays/MRI/CT/Films Billing Information Progress notes and/or telephone log regarding my care at HSC. Other doctor's reports in my chart, lab reports, other (specify):

______________________________________________________________________

I DO NOT authorize the following individuals and/or entities access to my protected health information:

______________________________________________________________________

I understand that HSC is not obligated to agree with this request if it contradicts with HIPAA or other laws. This restriction is effective from: ________________ through ______________________

**Signature:** ________________________________ **Date:**_______________________

**Patient History Sheet**

**Today's Date:** __________ **Patient Name:** ______________________________________________

**(If you have more than one pharmacy, please indicate which one handles which Rx) Pharmacy Name and Phone Number:**

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________

**Current Medications name, strength and dose (this includes any medications being prescribed by other physicians.)**

______________________ ______________________
______________________ ______________________
______________________ ______________________

**History of medical conditions (i.e.: diabetes, hypertension, cancer):**

______________________ ______________________
______________________ ______________________
______________________ ______________________

**Relevant family history of medical conditions (i.e.: diabetes, hypertension, cancer):**

______________________ ______________________
______________________ ______________________
______________________ ______________________

**History of any surgical procedures:**

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
4. ____________________________________________
5. ____________________________________________

**History of Chiropractic/Physical Therapy/Acupuncture (please indicated if you have had any of the above and if so the timeframe – i.e. 3, months ago, a year ago and how many visits).**

____________________________________________
____________________________________________
____________________________________________
____________________________________________

**History of epidural injections or facet blocks (please indicated if you have had any of the above and if so the timeframe – i.e. 3, months ago, a year ago and how many).**

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Allergies: ______________________________________________________

Tobacco Use: Yes __ No __ How Much/How Often? ________________

Alcohol Use: Yes __ No __ How Much/How Often? ________________

Caffeine Use: Yes __ No __ How Much/How Often? ________________

**If this is a work related injury, please give a brief description of the injury and how it occurred.**

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Patient Signature:** ______________________________ **Date:** ____________