TIMOTHY BASSETT, M.D. / SOUTHEASTERN SPINE SPECIALISTS

PATIENT INFORMATION SHEET

Patient's Legal Name______ Today's Date___/___/___
Address______ City______ State______ Zip______
Home #______ Cell#______ Wk______
Marital Status: S______ M______ D______ W______ Sex______ Race______
Social Security #______ DOB______ Age______

Patient's Employer______ Occupation______
Employer's Address______ Employer's Ph______

Spouse's Name______ Spouse's SS#______
Spouse's Employer______ Phone Number______
Spouse's DOB______

Nearest Friend or Relative (not living with you)______
Relationship to Patient______ Phone Number______

Referral Source______ Primary Care Physician______
Reason for Visit Today______

Have you ever been seen by Dr. Bassett / or Dr. King before? Yes______ No______

If you have been seen by Dr. Bassett before, is today's visit for a NEW problem? ______Yes ______No

Is this due to an injury/accident? Yes______ No______ If yes, what is date of injury? ______/______/______
Is this a Worker's Comp claim? Yes______ No______
Were you in a vehicle accident? Yes______ No______
Have you retained the services of an attorney? Yes______ No______

Have you ever had the same or similar symptoms before? Yes______ No______
Give approximate date when problem began:______

<u>If patient is a minor, we must have the following information:</u>

Parent's Name______ SS#______
Billing Address______ City______ State______ Zip______
Home#______ Cell#______ Work#______
Parent's Employer______

Insurance Information

Primary Insurance______ Policy #______
Secondary Insurance______ Policy#______
Other Insurance______ Policy#______

If this is a W/C Claim, please provide the following:

Your Employer's Name______ Employer Address______
City______ State______ Zip______ Ph#______
Worker's Compensation Claim Number______
W/C Insurance Carrier Name______
W/C Address______ City______ State______ Zip______
W/C Contact Name______ Ph______ Ext______

Please read and sign: I hereby authorize SouthEastern Spine & Joint Specialists to disclose to my insurance carrier or third party, complete information concerning medical findings, treatment, and charges incurred and assign all payments for medical services rendered to myself or my dependents. I understand some procedures and supplies provided by my physician may not be covered by my insurance and I accept responsibility for the payment of any charges not covered by my insurance and agree to pay attorney's fees, court costs, and other reasonable costs of collection should I fail to pay such charges.

Patient's Signature (or Responsible Party Signature)______ Date______

Medical History

Please circle all previous illnesses/medical issues:

Anxiety	Depression	Kidney Problems	Diabetes	Thyroid Disease
Liver Disease	Stroke	Asthma	Lupus	Lung Disease
Stomach Problems/Ulcers	Bladder Problems	HIV/AIDS	Arthritis	Blood Disorders
Transfusion	Heart Disease	Pneumonia	Gout	Cancer
Hepatitis	Phlebitis/Vein Issues	Tuberculosis (TB)	Migraines	Leukemia
High Blood Pressure	Colon Problems	Sickle Cell Trait	Seizures	Circulation Issues

OTHER____

Past Surgical History

Have you ever been hospitalized before? Yes_____ No _____ If yes, please list in space(s) provided all reasons for hospitalizations Including all past surgeries and approximate dates of those surgeries.

1. __________________________________Date____________________
2. __________________________________Date____________________
3. __________________________________Date____________________
4. __________________________________Date____________________
5. __________________________________Date____________________

Have you ever had any problems with anesthesia? Yes_____No_____ If yes, please describe problem(s).________________

Family History

Relative	Current Age	Major Illnesses	If deceased, cause of death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Social History

Marital Status (circle one)	Single	Married	Divorced	Widowed	
Use of Alcohol (circle one)	Never	Social Use	Moderate Use	Daily Use	Previous but quit
Use of Tobacco (circle one)	Never	Social Use	Moderate Use	Heavy Use	Previous but quit

*If you do use tobacco, how many packs / cigarettes/ chew tins/ pouches do you use per day?________________

Living Situation (circle one) Alone Spouse/Family With Friends

Hobbies/Activities you enjoy____

Are you RIGHT or LEFT hand dominance? RIGHT________________ LEFT________________

Allergies

Are you allergic to any drugs? YES__________ NO__________

If YES, please list drugs you are allergic to:__________

Are you allergic to any of the following (circle all that apply): Iodine Latex Tape Other__________

Are you allergic to X-Ray dye? YES__________ NO__________

Medications

Please list all current medications including non-prescription/over-the-counter medications

NAME OF DRUG	DOSAGE AMOUNT	HOW OFTEN TAKEN?	HOW LONG ON THIS DRUG?

If given a prescription, what Pharmacy would you like us to contact? __________

Pharmacy Phone Number: __________

Systems Review (circle any that apply)

GASTROINTESTINAL
Good general health lately
Nausea or vomiting
Frequent diarrhea
Rectal bleeding
Abdominal pain
Hepatitis
Peptic Ulcers

GENITOURINARY
Frequent urination
Burning / painful urination
Difficulty urinating
Blood in urine
Kidney stones

MUSCULOSKELETAL
Osteoporosis
History of fractures
History or arthritis
History of bursitis
Rheumatoid disease
Gout
Lupus

CARDIOVASCULAR
Chest pain
Palpitations (Irreg. Heartbeat)
Swelling of feet/ankles/hands
Abnormal blood pressure
Heart disease

CONSTITUTIONAL SYMPTOMS
Heat or cold intolerance
Recent weight gain over 10 lbs
Recent weight loss over 10 lbs
Fever
Fatigue
Constant headaches

EYES
Wear corrective lenses
Blurred or double vision
Glaucoma
Other eye disorders

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing
Chronic earaches / drainage
Chronic sinus problems
Consistent sore throat
Bronchitis
Pneumonia

PULMONARY
Chronic or frequent cough
Shortness of breath
Sleep apnea
Disturbed breathing

NEUROLOGICAL
Lightheaded or dizzy
Tremors / shaking
Vertigo
Numbness or tingling

HEMATOLOGIC/LYMPHATIC
Anemia
Phlebitis

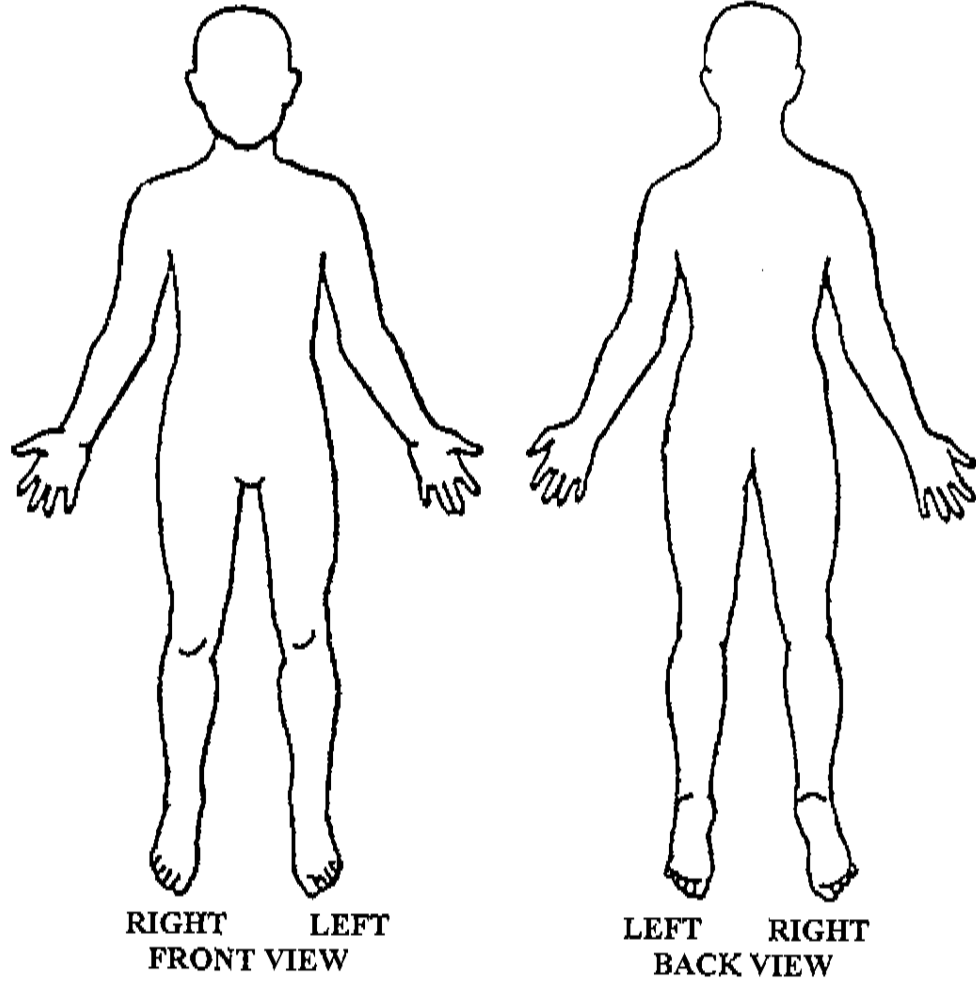
ENDOCRINE
Loss of appetite
Diabetes (sugar)

OTHER __________
____
____
____
____

Where is Your Pain Now?

Mark on the drawings the areas on your body where you feel the sensation described below. Use the appropriate symbol(s) provided. Mark all affected areas.

Pins and Needles = OOOO **Burning = XXXX** **Stabbing = ////** **Deep Ache = ZZZZ**



Rate Your Pain (circle one) 0 = No Pain 10 = Extremely Intense Pain											
1. Pain Right Now	0	1	2	3	4	5	6	7	8	9	10
2. Pain at Its Worst	0	1	2	3	4	5	6	7	8	9	10
3. Pain at Its Best	0	1	2	3	4	5	6	7	8	9	10

Agreement to Pay

The Patient and the Responsible Party listed below agree to pay all amounts and charges submitted by SouthEastern Spine & Joint Specialists, for services rendered by the practice during the course of treatment for the Patient, including hospitalization, unless the Physician or contractors are otherwise obligated to accept payment from a third party. The Patient and the Responsible Party understand and agree that they are financially responsible to the Physician even though there may be insurance or other third party coverage and agree that failure to make payment when requested is the basis for legal action, and agree to pay all costs of collection, including a reasonable attorney's fee. The Patient and the Responsible Party agree that their obligations to make payments are joint and severable and that the Physician may pursue either or both parties for payment, and that the Patient and the Responsible Party, and not any insurance company, are solely responsible for the entire bill, even though the cost of their medical care may exceed the amount reimbursed by third-party insurers or payers.

Responsibility for Non-Covered Services

The Physician may determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by your BlueCross/PMD contract, other insurance contract, HMO or other third party insurance coverage. Charges not covered may include services, and/or any annual deductibles or co-pays. Patient and Responsible Party agree to be fully responsible for all charges by the Physician for such non-covered charges in amounts set forth on the fee schedule which is available upon request. The Physician will order only tests that are deemed medically necessary in the Physician's opinion. Patient and Responsible Party are accountable for knowing their specific medical insurance contract and the covered versus non-covered tests and services mandated by said contract.

Authorizations

Patient and the Responsible Party understand that the following authorizations are to be used by the Physician to effect the collection of benefits on the Patient's behalf. These authorizations become effective on the date of the first service rendered and remain in effect until specifically revoked in writing by Patient and the Responsible Party. Copies of this agreement will be as valid as the original.

- Release of Information: The Patient and the Responsible Party authorize the release and disclosure of all medical information related to the Patient's treatment and care to any entity which is, or may be liable for, Physician charges or to any Professional Review Organization or Utilization review Organization associated therewith. The Patient and the Responsible Party authorize the release and disclosure of all or any part of the Patient's medical records to any other health care provider who may be of assistance, in the opinion of the Physician, in

providing medical care and treatment for the Patient, and/or for assisting in any reimbursement or benefits to which the Patient may be entitled.

- Assignment of Benefits: The Patient and the Responsible Party authorize and request that payment of any authorized insurance benefits made either to the Patient or on a Patient's behalf, be in turn made to the Physician for services furnished to the Patient by the Physician. This authorization allows the Physician to file "assigned" claims only for the purpose of having benefits paid to the Physician and does not imply that the Physician accepts insurance as payment in full, unless the Physician has a contractual agreement with the Patient's insurance carrier or is otherwise legally obligated to accept less than the actual charges. The signatures below are deemed sufficient for all insurance forms on a continuing basis.

- For Treatment: The Patient and the Responsible Party authorize the Physician to perform any procedures which may be deemed necessary in the judgment of the attending Physician in the diagnosis and treatment of the Patient's condition. The Patient and the Responsible Party consent to the administration of such drug(s) as may be considered necessary or advisable for the treatment of the Patient with the exception of ____________________.

Today's Date ____________________

Patient's Name(Print) ____________________

Patient's Signature ____________________

Today's Date ____________________

Responsible Party Name(Print) ____________________

Responsible Party Signature ____________________

Policies and Procedures

Appointments

Our office will try to contact each patient the day before his/her appointment. If you need to cancel your appointment, please advise us as soon as possible so that we may offer the appointment to another patient. Patients who "no call, no show" for their scheduled appointment may be charged a $25.00 fee.

Patients who are 15 or more minutes late may be asked to reschedule their appointment.

Prescriptions

Patients should request any medication refills at the time of their appointment.

Refills for some prescriptions may require a visit to the doctor (especially if it has been 6 months or more since your last appointment) or may require lab work.

Narcotics cannot be called in to a pharmacy. This is state and federally mandated. All narcotics require a written prescription. Narcotics are not allowed by law to be refilled. A new prescription must be written each and every time. No narcotic prescriptions will be filled during non business hours.

Insurance

Please inform our office immediately if your insurance or personal information changes. Insurance rules on *timely* filing of insurance claims have recently changed so we need to get your claim completed as soon as possible.

Insurance co-pay is required by your insurance company and is due at the time of your appointment. We will not bill your account for the insurance co-pay. Your appointment will be rescheduled if you do not have your co-pay at the time of your appointment.

Account Balances

Patient balances that are not paid within 90 days may be subject to a finance charge of 1.5% per month or 18% per year unless arrangements have been made otherwise between the patient and the Practice Administrator. We accept cash, personal check, and all major credit and debit cards. If you are unable to pay your account within 90 days, please contact our billing department to discuss payment arrangements. Payment arrangements that are not adhered to may be subject to further measures with the account being turned over to a billing agency.

Returned Checks

If our bank returns your check for NSF (non sufficient funds), we will ask that you come into the medical office to cover the amount of the returned check plus a fee of $30.00 for a returned check. We will not reprocess/redeposit returned checks back through the bank. Returned checks that are not immediately covered will be turned over to a billing agency.

Medical Records

Federal law requires our office to keep medical records on each of our patients for a specific number of years. All medical records kept in our office are the property of our office. A patient may request a copy of his/her records at any time. Alabama law allows us to charge a fee for copying records. The current fee is $5.00 retrieval fee, $1.00 per page for pages 1-25, and $0.50 for each page thereafter. There is no fee to have your records sent to another physician. When requesting a copy of your medical records, please allow 5 to 7 days for processing.

X-Rays are considered medical records and may be checked out for 5 to 7 days to be viewed by another physician. The patient is responsible for any x-ray records taken out of the office.

Disability-Insurance-Special Letters

If you have medical forms that need to be filled out by our office, please observe the following guidelines:

- Be sure to fill out and sign your section of the form. Incomplete forms will be mailed back to the patient for completion. This will only serve to delay the entire process.
- Forms are only completed one day per week (Wednesday). Forms turned in on a Wednesday will be completed the following Wednesday. Some forms may require further time to complete because of the need for research or the need for additional records/information from other medical facilities.
- A fee will be charged to fill out forms. The standard fee is $10.00 per page payable at the time the form is handed into the medical office for completion. Forms which have not been prepaid will not be completed.

Narcotic Policy

Dear Patient,

You are receiving this form because we may prescribe narcotic pain medication for you in the course of your treatment here at SouthEastern Spine & Joint Specialists. We strongly believe in relieving your pain to the best of our ability. Our primary goal is to treat the pain source so that long term use of pain medication is not necessary. However, we realize that this will not always be possible due to the many chronic pain conditions which we treat. In order to assure your safety and to conform to the recommendations and policies of the Alabama Board of Medical Examiners, our medical practice has the following expectations, policies and procedures in place. Failure to abide by our policies will result in our being unable to continue prescribing narcotic pain medication to you.

- You must receive pain medications from our office only. If other physicians prescribe pain medication for you for any reason, you must contact our office immediately with this information.
- Replacement prescriptions for lost or stolen prescriptions will NOT be issued.
- You must use only one pharmacy when filling any and all pain medication prescriptions. This will be the pharmacy on record in your medical chart. You will be responsible for informing the office of any changes in this area.
- Do not take your pain medication any more frequently than is prescribed. If you do not follow the specific dosage instructions as prescribed by the physician and you run out of your prescription before you should, we will NOT supplement your prescription because of your non-compliance. If you feel that your pain medication is not being adequately controlled, contact our office for a follow-up appointment to discuss your pain management.
- Refills will be given to last until your next scheduled follow-up visit. If this appointment is not kept, no refills of narcotic pain medication will be given or phoned in.

I,______________________________agree to the aforementioned conditions. Furthermore, I have completed a medical history information sheet and, to the best of my knowledge, all information contained in this medical history is accurate, true, and complete.

____________________	____________________
Name of Patient (Print)	Signature of Patient
____________________	____________________
Today's Date	SESJS Representative / Signature

Privacy Notice

This notice describes how your protected health information (PHI) may be used and disclosed and how you can gain access to this information. Please review it carefully.

We are required under the federal health care privacy rules (the "Privacy Rules"), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and health claims and medical payment history (hereto known collectively as "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies, and terms in this Privacy Notice unless and until it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will promptly make available a revised copy of the notice to you. Additionally, we will post a copy of the revised Privacy Notice in a prominent location within our office.

PERMITTED USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION (PHI)

A. **General Uses and Disclosures:** Under the Privacy Rules, we are permitted to use and disclose your Health Information for the following purposes without obtaining your permission or authorization:

- **Treatment:** We are permitted to use and disclose your Health Information in the provision and coordination of your health care. For example, we may disclose your Health Information to your primary care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment.
- **Payment:** We are permitted to use and disclose your Health Information for the purposes of determining insurance coverage, billing and reimbursement. This information may be released to an insurance company, third party payer, or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.
- **Health Care Operations:** We are permitted to use and disclose your Health Information during our health care operations, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your Health Information to internally assess the quality of care provided to our patients.
- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care, to protect your health

or safety or the health and/or safety of others, or for the safety and security of the correctional institution.

- **Workers' Compensation:** We may disclose your Health Information to your employer to the extent necessary to comply with the Alabama laws or other state laws relating to Workers' Compensation or other similar programs.
- **Marketing:** We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us
- **Appointment Reminders/Treatment Alternatives:** We may use and disclose your Health Information to remind you of an appointment for treatment and medical care at our office or to provide you with information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Business Associates:** We may disclose your Health Information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your Health Information, too.
- **Other Uses and Disclosures:** In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by the Privacy rules.

B. Uses and Disclosures Which require Patient Opportunity to Verbally Agree or Object: Under the Privacy Rules, we are permitted to use and disclose your Health Information: (i) for the creation of facility directories, (ii) to disaster relief agencies, and (iii) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care and/or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.

C. Use and Disclosures Which Require Written Authorization: As required by the privacy Rules, all other uses and disclosures of your Health Information (not described above) will be made only with your written authorization. For example, in order to disclose your Health Information to a company for marketing purposes, we must obtain your written authorization. Under the Privacy Rules, you may revoke your authorization at any time. The revocation of your authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

SouthEastern Spine Specialists, Inc.
Attn: Privacy Officer
1781 Commons North Loop
Tuscaloosa, Alabama 35406
Main Ph: (205) 750-0447
Fax: (205) 750-0276

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with our office. Complaints filed directly with us must be in writing and made to the attention of the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at: 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the U.S. department of Health and Human Services must be made in writing and filed within 180 days of the time you knew or should have known of the violation.

The effective date of this Privacy Notice is ______________________,200___.

By signing below, I hereby acknowledge receipt of this Privacy Notice.

______________________________ ______________________________
Name of Patient (Print) Today's Date

____
Signature of Patient or Patient's Representative

____
Printed Name of Patient's Representative (if applicable)

If signed by someone other than the patient, please state your relationship to patient:
____

To Be Completed By SESS Representative:

After a good faith attempt to obtain an Acknowledgement of Receipt, the Patient or Patient Representative refused or was unable to sign the Privacy Notice for the following reason(s)-

____
____
____

Signature of SESS Rep____________________ Date____________________

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Our "Notice of Privacy" practice provides information about how we may use and disclose your protected health information (PHI). The notice contains a "Patient's Rights" section describing your rights under the law. You have the right to review our notice before signing this consent. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request restrictions regarding how protected health information (PHI) about you is used or disclosed for treatment, payment, and/or health care operations. We are not required to agree to this restriction, but if we do, we will honor that agreement.

By signing this form, you agree to the use and disclosure of your protected health information (PHI) for treatment, payment, and/or health care operations. You have the right to revoke this consent, in writing, signed by you. However, a revocation shall not affect any disclosures we have already made based on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing below, the Patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment, and/or health care operations
- SouthEastern Spine & Joint Specialists has "Notice of Privacy" policies and the Patient has the right and opportunity to review this notice at any time.
- The Practice has the right to change the "Notice of Privacy" policies as deemed necessary.
- The Patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this consent in writing at any time with all future disclosures thereby ceasing.
- The Practice may condition treatment upon execution of this consent.

Name of Patient (Print)____

Signature of Patient or Responsible Party____________________________

*If signed by someone other than the Patient, please state relationship to Patient:*________
____

Today's Date____

SESJS Representative (Witness)______________________________

SouthEastern Spine & Joint Specialists
1781 Commons North Loop
Tuscaloosa, Alabama 35406
(205) 750-0447 Fax (205) 750-0276

PATIENT CONFIDENTIALITY FORM

I understand that SouthEastern Spine & Joint Specialists has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information. I may elect to provide SouthEastern Spine & Joint Specialists with the names of up to three individuals who may obtain medical information concerning me.

Name ____________________ Relationship____________________

Name ____________________ Relationship____________________

Name ____________________ Relationship____________________

I understand that on occasion SouthEastern Spine & Joint Specialists may have the need to contact me at home or work. Employees of SESJS (please initial one of the following):

____________________May leave messages on my home answering machine

____________________May *not* leave messages on my home answering machine

I agree that my obligations under this agreement regarding patient information will continue as long as I am a patient of SESJS or at the time I provide written revocation of this document.

Patient Signature____

Witness ____