CoastalSpine

Dear Patient,

Welcome to Coastal Spine, PC. Our staff is looking forward to meeting you. In order for our doctors to perform a comprehensive assessment on this visit. We must have all information pertinent to your condition.

Please bring the following:

- **License/Photo ID**
- **Health Insurance Cards**
- **Completed Registration Forms**
- **Co-payment** (if applicable)
- **Medication List**
- **ACTUAL Films/CD** (MRI, CT Scans, X-rays, etc.)

If this is related to an auto accident, please bring a copy of your policy declarations pages with your motor vehicle insurance carrier.

Thank you,
CoastalSpine, PC

Appointment Day: _____

Appointment Time: _____

Physician: _____

OFFICE LOCATIONS:

- 4000 Church Road, Mount Laurel, NJ 08054
  Ph:(856) 222-4444 Fax: 856-222-0049
- 102 Heritage Valley Drive, Suite C, Sewell, NJ 08080
  Ph:(856) 222-4444 Fax: 856-740-5363
- 408 Chris Gaupp Drive, Suite 250, Galloway, NJ 08205
  Ph:(856) 222-4444 Fax: 856-222-0049
- 1868 Hooper Avenue, Suite 1, Toms River, NJ 08753
  (Shore Sports Medicine) (Foot and Ankle Associates of Central NJ)
  Ph:(856) 222-4444 Fax: 856-222-0049
- 622 Eagle Rock Avenue, 3rd Floor, West Orange, NJ 07052
  (Inside JAG PT)
  Ph:(856) 222-4444 Fax: 856-222-0049
- 415 West Landis Avenue, Suite 101-B, Vineland NJ 08360
  Ph:(856) 222-4444 Fax: 856-222-0049

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DEMOGRAPHICS

First Name: _____ Last Name: _____ Sex: Male Female Other_____

Address: _____ City:_____ State_____Zip Code:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Date of Birth: _____Age: _____ Social Security Number:_____ Marital Status:_____

Primary Language: English Spanish Other:_____

Race: Caucasian Hispanic Asian African American Other: _____

Pharmacy Name: _____ Address:_____

Primary Doctor: _____ Referring Doctor:_____

INSURANCE INFORMATION

Date of Accident (if applicable):_____ Type of Accident: _____

Primary Insurance Name:_____ Auto Health Workers Comp

Phone #:_____ Adjuster:_____ Ext:_____

Claim or ID#:_____ Subscriber:_____

Relationship:_____ Subscriber Date of Birth:_____ Subscriber SS#:_____

Secondary Insurance Name:_____ Auto Health Workers Comp

Phone #:_____ Adjuster:_____ Ext:_____

Claim or ID#:_____ Subscriber:_____

Relationship:_____ Subscriber Date of Birth:_____ Subscriber SS#:_____

Tertiary Insurance Name:_____ Auto Health Workers Comp

Phone #:_____ Adjuster:_____ Ext:_____

Claim or ID#:_____ Subscriber:_____

Relationship:_____ Subscriber Date of Birth:_____ Subscriber SS#:_____

ACCIDENT INFORMATION

Is there a lawsuit pending related to your injury? (Circle) YES NO

Attorney Name:_____ Firm:_____ Phone #:_____

Employer Name:_____ Phone #:_____

Is your pain the result of a: (Circle) Fall Injury on the job Motor Vehicle Accident Other: _____

What is the date of the injury?_____

Did you have a history of neck pain prior to this injury or accident? (Circle) YES NO

If yes, what treatment have you had?_____

Did you have a history of low back pain prior to this injury or accident? (Circle) YES NO

If yes, what treatment have you had? _____

PLEASE FILL OUT THE BELOW IF YOU WERE INVOLVED IN AN AUTO ACCIDENT ONLY:

(Circle) if you were the ***Driver*** or ***Passenger***?

Where you wearing a seat belt? YES NO

Did the police come to the scene? YES NO

Did the airbags deploy? YES NO

Did the ambulance come to the scene? YES NO

If yes, what hospital/city did you go to?_____

Did they perform any imaging? YES NO

If yes, what testing did you have? _____

EVERYONE PLEASE SIGN ONE OF THE BELOW FOLLOWING STATEMENTS:

1 This injury is **NOT** related to an auto accident, work injury or slip and fall. There is no litigation pending regarding this injury.

Patient Signature _____ Date _____

2. This injury **IS** related to an auto accident, work injury, or slip and fall. *I have provided Coastal Spine, P.C. with all claim and litigation information pertaining to this injury.*

Patient Signature _____ Date_____

HISTORY AND PRESENT ILLNESS

Current Height: _____ Current Weight: _____

Do you have any allergies? (Circle) YES NO

If yes, please list them: _____

Medical History: *(Circle all that apply)*

Heart Attack Pacemaker Stroke Embolism Hypertension
Diabetes A-Fib Clots Cancer Infection
Cholesterol Thyroid COPD Other_____

Surgical History

Date	Type

Family History: *Please indicate who (Father, Mother, Sibling, Grandparent, etc.)*

Heart Attack _____
Stroke_____
COPD_____
Hypertension_____
Diabetes_____
A-Fib_____
Clots_____
Infection_____
Cholesterol_____
Thyroid_____
Embolism_____
Cancer_____

Social History:

List any Recreational Drugs you are taking? _____
Smoke: (Circle) YES NO If Yes: _____ packs per (Circle) Day | Week | Month
Are you prescribed marijuana? YES NO
Alcohol: (Circle) YES NO If Yes: _____ drinks per (Circle) Day | Week | Month
Occupation:_____

Present Illness:

Which of the following describes you currently? (Circle) Working Not Working Unemployed Retired Disabled Student
Job requires: (Circle) Lifting Standing Sitting
How long can you: Sit? _____ Stand? _____ Walk? _____

What medicine for your pain has failed?_____

Circle what you are seeing us for:

Neck Mid Back Low Back Right Leg Left Leg Right Arm Left Arm

Do you have weakness? (Circle) YES NO If yes, where? _____

Are you experiencing numbness? (Circle) YES NO If yes, where? _____

Have you lost control over your bowel or bladder? (Circle) YES NO

What testing/treatment have you had? (Circle)

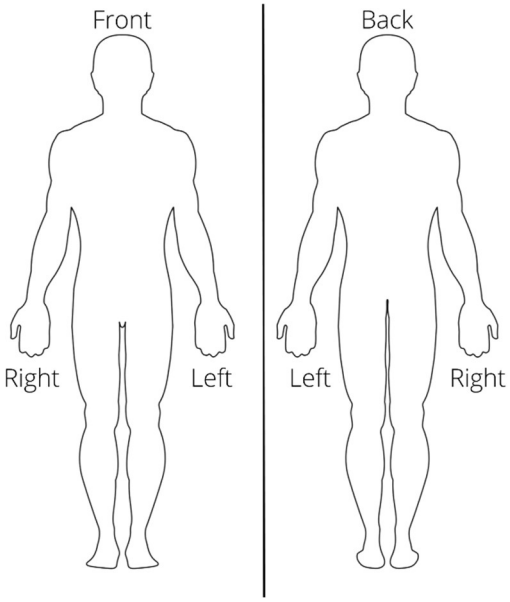
MRI CT Scan X-Rays EMG Bone Scan Chiropractor Bracing TENS Unit

Have you had Physical Therapy? (Circle) YES NO Did it help? YES NO # of Weeks _____
Have you had Chiropractor care? (Circle) YES NO Did it help? YES NO # of Weeks _____
Have you had an Epidural? (Circle) YES NO Did it help? YES NO How many? _____
Pain Management Doctor: _____ City: _____

HISTORY AND PRESENT ILLNESS CONTINUED

MEDICATIONS: *Please Include Over the Counter Vitamins*

	Name	Dose	Amount	Frequency
Ex.	Lipitor	40mg	1	Twice a day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				



Draw on the body diagram using the following abbreviations where your pain is located:

Ache = A
Pins and Needles = P
Burning = B
Stabbing = S
Numb = N
Other = O

Circle your pain level on a scale of 1 to 10.
10 being unbearable, or the worst imaginable, pain.

1 2 3 4 5 6 7 8 9 10

Review of Systems: *(Circle all that apply)*

Headache	Chest Pain	Cough	Incontinence	Transfusions
Dizziness	Weakness	Weight Gain	Arthritis	Hepatitis
Memory Loss	Rapid Beat	Urinary Burning	Depression	Bladder Incontinence
Numbness	Edema	Wheezing	Bleeding Bowel	Shortness of Breath
Blurriness	Diarrhea	MRSA	AIDS/HIV	Swallowing Issues
Deafness	Weight Loss	Insomnia	Anxiety	Other: _____
Ringing	Cough Blood	Constipation	Fatigue	

I consent that all the above is accurate to the best of my knowledge.

Patient Signature _____ Date _____

CoastalSpine

Financial Responsibility / Consent for Treatment

RELEASE OF INFORMATION
I authorize Coastal Spine, P.C. to release or disclose to any insurance company, governmental agency, managed care organization or any other entity or person who may be required to pay all or part of the costs of my treatment, all medical records or other information from Coastal Spine, P.C. records relating to my identity, diagnosis, prognosis and treatment. I understand that the specific type of information to be disclosed may include, but is not limited to diagnosis, discharge summary, history and physical, progress notes, doctors' orders, laboratory, operative and/or radiology reports, nurses' notes, consultations. The purpose of this disclosure is to enable Coastal Spine, P.C. to secure payment of my physician bill from such insurance companies, governmental agencies, managed care organizations or other entities that may be required to pay on my behalf. I authorize Coastal Spine, P.C. to release my medical record information to any physician or caregiver participating in my care while I am being treated at Coastal Spine, P.C. and to any physician or caregiver involved in my continuing care. For Worker's Compensation, I give consent to release to my employer all medical records or other information from Coastal Spine, P.C. records relating to my identity, diagnosis, prognosis and treatment (including follow-up visits and related additional treatment or related testing) for any employment-related testing/injury/illness.

REVOCATION
This consent is subject to revocation (withdrawal) at any time except to the extent that Coastal Spine, P.C. has released or disclosed information because I have signed this consent. If I do not revoke this consent in writing, it will terminate one year from date of signature. I understand that this consent shall operate as a complete release of liability to Coastal Spine, P.C., its trustees, officers, employees and agents for the release of the information authorized to be released on this form.

DISCLOSURE OF FINANCIAL INTEREST
As per the Principles of Medical Ethics of the American Medical Association (H-140.984), the physicians at Coastal Spine, P.C. are required to inform their patients that they do hold a financial interest in Radiology services provided at Coastal Spine, P.C. The physicians may also have financial interest in other services such as Fellowship Surgical Center and various device companies that may be used in your treatment.

Please be reminded there is video surveillance in and around the building.

I acknowledge the receipt of the Coastal Spine, P.C. privacy policy, and I am aware that the privacy policy is available at the front desk for review.

PATIENT SIGNATURE: _____

PERSON SIGNING ON PATIENT'S BEHALF: _____

PARTICIPATING HEALTH INSURANCE PLANS
CoastalSpine, P.C. participates with the following health benefits plans: AmeriHealth Administrators, Independence Administrators, Independence Blue Cross, Independence Personal Choice, Keystone Health Plan East, QualCare and Medicare. *IF YOUR INSURANCE IS NOT LISTED, PLEASE SIGN THE OUT-OF-NETWORK ANDVANCE PATIENT NOTICE FORM.*

FACILITY AFFILIATIONS
CoastalSpine P.C. physicians are affiliated with the following health care facilities: Fellowship Surgical Center, Jefferson Health System of Cherry Hill, NJ, and Virtua Health System of Voorhees, NJ.

CONSENT FOR TREATMENT
I authorize the medical staff, employees and contracted healthcare providers of Coastal Spine, P.C. to provide necessary medical treatment to me, including routine laboratory tests, diagnostic procedures and medical care. Physician, nursing or other healthcare personnel who are in training may be observing and participating in my care under the supervision of Coastal Spine, P.C. and I hereby give my consent to such observations and/or participation.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY
I acknowledge that I have been provided with a copy of Coastal Spine, P.C.'s Assignment of Benefits and Financial Responsibilities form, which is effective as of today's date.

PATIENT SIGNATURE: _____ **DATE** _____

CoastalSpine

Opioid (Narcotic)Agreement/Contract

I understand in order to receive care for the treatment of pain at CoastalSpine, I **MUST** comply with the following rules:

1. I **UNDERSTAND** that narcotic and controlled drug prescriptions are **MY RESPONSIBILTY** once they are given to me. I **UNDERSTAND** that if anything happens to this prescription (i.e. lost, stolen, flushed down the toilet, etc.) I am personally responsible, and the physician and physician assistants **WILL NOT** rewrite the prescription until the designated time.
2. Prescriptions **WILL NEVER** be refilled after hours or on the weekends.
3. All prescriptions should be obtained at the **SAME PHARMACY**. Should the need arise to change pharmacies, CoastalSpine must be informed.
4. I **WILL** take medications at the dose and frequency prescribed. Any changes in the dose or frequency will be discussed with my physician and/or physician assistants at CoastalSpine. If my medications are prescribed on an every six-hour basis, I **WILL** take these medications every six-hours. I **UNDERSTAND** that if I use more than the allowed amount or use up my medication before my appointment date, **NO ADDITIONAL MEDICATION WILL BE GIVEN**.
5. I **WILL** receive prescriptions at the interval determined by the physician or physician assistants at CoastalSpine.
6. I **WILL NOT** receive controlled substances for the treatment of pain from any other source.
7. I **WILL** consent to random drug testing. **I will NOT drink any alcoholic beverages with pain medications.** I will **NOT** use any illegal substances (cocaine, heroin, crystal methamphetamine, PCP, ecstasy, ketamine, etc) or use any other controlled substances which are not prescribed from our practice while being treated with controlled substances at CoastalSpine. Refusal of such testing or positive results will result in prompt termination of care from CoastalSpine.
8. I **UNDERSTAND** taking both narcotic medications and Benzodiazepines (Valium, Ativan, Xanax, Klonopin, Restoril, Prosom, etc.) is **PROHIBITED**. Due to potential serious side effects.
9. I **WILL** safeguard my prescribed medications. I understand that these medications may be lethal or hazardous to a person that is not tolerant to its affects, especially a child.
10. I **UNDERSTAND** that there is a possibility of impairment of thought processes, especially if this narcotic is combined with a sedative, a sleeping pill, tranquilizer or alcohol.
11. I **UNDERSTAND** the possible adverse effects and dependencies associated with these medications. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing, sexual dysfunction, and or depressed respiration.
12. I **UNDERSTAND** that if I plan to become pregnant or become pregnant, I have to inform the physician or physician assistants at CoastalSpine immediately. I **UNDERSTAND** that if I become pregnant, a child WILL likely be physically dependent at birth if I continue narcotics.
13. You are expected to **INFORM OUR OFFICE** of any new medications or medical conditions, and of any adverse effects, you experience from any of the medications that you take.
14. I **UNDERSTAND** that changing date, quantity or strength of medication or altering a prescription in any way, shape, or form is against the law. Forged signatures are also against the law. If there is a violation, this will be reported to the patient's pharmacy, local authorities and DEA.
15. I realize that it is **MY RESPONSIBILITY** to keep others and myself from harm, including safety of driving and the operation of machinery.
16. I **UNDERSTAND** continuous cancelation of appointments will ultimately lead to no prescriptions and a discharge from CoastalSpine.
17. I **UNDERSTAND** if I violate this contract, all medications from CoastalSpine **WILL** thereafter **CEASE**.
18. I **UNDERSTAND** post-op surgery, my physician or physician assistants will determine when to cease medications.
19. I **UNDERSTAND** this mode of treatment will be stopped if any of the following occurs:
    a) I giveaway, sell, or misuse the medication or use other people's medication or illegal substances;
    b) I am noncompliant with any of the terms of this contract;
    c) I disrespect or harass any CoastalSpine personnel;
    d) I do not follow up regularly or as requested by my physician, physician assistants.

I **UNDERSTAND** to request prescription refills, all calls will be made **48-72 hours prior** to needing a refill, and a message will have to be left on CoastalSpine's **PRESCRIPTION REFILL LINE**, promt 3, during regular business hours Monday-Friday 9am-4pm. (excluding holidays). You will receive an automated call from CoastalSpine if an electronic script was sent.

YOU ARE INFORMED that you have the right and power to sign and be bound by this contract, and that you have read, understand and accept all of its items**.** If our physicians feel that you do not require further surgery or injections; but you are in need of long term medication, be assured that we will direct you to another pain management physician to help you cope with your condition.

_____ _____

Print Name Patient Signature Date

CoastalSpine

Coastal Spine Independent Medical Exam Policy

Dear Patient,

Please be advised that Independent Medical Exam requests made by any outside party will result in pended medical treatment.

Once the results of the IME are established the requesting party will generate a report and CoastalSpine must receive a copy of that decision prior to continuation of medical treatment.

Medical services will not be rendered during the IME process and personal medical insurance will not be billed until the results of the IME are received.

If you have any questions, please contact the billing office at 856-222-4444, Option 5.

Patient Signature: _____

Lawyer Name: _____

Lawyer Number: _____

Date: _____

CoastalSpine

Authorization for Health Information Disclosure
4000 Church Road, Mount Laurel, NJ 08054
Phone: (856) 222-4444 Fax: (856) 222-0049

PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

REQUESTOR/RECIPIENT INFORMATION

I give permission to disclose the following information from my health records to Coastal Spine. Any information listed below that is not checked off may not be released. I give consent for the following information to be released.

I give permission for CoastalSpine to disclose the following information from my health records. Any information listed below that is not checked off may not be released. I give consent for the following information to be released.

(Please circle)

Complete Health Record	History and Physical Examinations	Consultations Reports	Progress Notes
Imaging Reports/ Imaging Films	Discharge Summary	Laboratory Results	Billing Statements
Specify dates of treatment/notes if applicable: _____		Other:_____	

I also give my consent for messages from CoastalSpine to be released to:

Spouse/Family Member	Doctor	Attorney	Other
Name: _____	Name: _____	Name: _____	Name: _____
Phone:_____	Phone: _____	Phone: _____	Phone: _____
	Fax: _____	Fax: _____	Fax: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the above-named health care provider/health plan authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary and is not a condition of treatment, payment, enrollment or eligibility for benefits. I understand that if I have any questions about disclosure of my health information, I may contact the healthcare provider/health plan listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Description of Representative's Authority (witness signature required) Signature of Witness

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: *This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.* ***You may review our Notice of Privacy Practices posted in the waiting room or view a copy on our website; www.coastalspine.com ***

I have reviewed an available copy of this office's Notice of Privacy Practices. * You have the right to refuse to sign this document*

_____ _____ _____
(Please Print Name) (Signature) (Date)

Office Use Only:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but the acknowledgement could not be obtained because:
☐Communications conflicts prohibit us from obtaining the acknowledgment ☐The patient or individual refused to sign this document
☐An emergency situation prevented us from obtaining acknowledgment ☐Other (Please Specify) _____