DISC PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Date: _____

PATIENT DEMOGRAPHICS

Patient Name: _____
(LAST, FIRST)

Home Address: _____
STREET CITY STATE ZIPCODE

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Fax #: _____ **E-mail:** _____

Date of Birth: _____ **SS #:** _____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partnership

Emergency Contact: _____ **Phone:** _____

Relation to You: _____

Occupation: _____ **Employer:** _____

Employer Address: _____ **Phone:** _____
STREET CITY STATE ZIPCODE

PHYSICAN INFORMATION (LEAVE BLANK IF YOU DO NOT HAVE ONE)

Internist / Primary Care Physician: _____ *Phone:* _____

Cardiologist: _____ *Phone:* _____

Other Specialist: _____ *Phone:* _____

INSURANCE INFORMATION

Primary Insurance: _____ ☐ HMO ☐ PPO ☐ POS ☐ EPO

Insurance Address: _____
STREET CITY STATE ZIPCODE

Insurance Phone: _____ Group#: _____ ID#: _____

Effective Date: _____ Coverage Code: _____ Subscriber's Name: _____

If Patient Is Not The Subscriber: DOB: _____ SS#: _____

Secondary Insurance: _____ ☐ HMO ☐ PPO ☐ POS ☐ EPO

Insurance Address: _____
STREET CITY STATE ZIPCODE

Insurance Phone: _____ Group#: _____ ID#: _____

Effective Date: _____ Coverage Code: _____

Subscriber's Name: _____
(LAST, FIRST)

****PLEASE PROVIDE A COPY OF THE FRONT & BACK OF THE INSURANCE CARD(S)****

How were you referred to DISC? ☐Existing Patient / Friend ☐Online ☐Advertisement ☐Physician (explain below)

Please explain: _____

PAIN DESCRIPTION

Where is your pain right now?

INSTRUCTIONS: Mark the areas on the body below where to where you hurt. (If the right side of your neck hurt, mark the drawing on the right side of the neck, etc.) Please indicate which sensations you feel by referring to the key below.

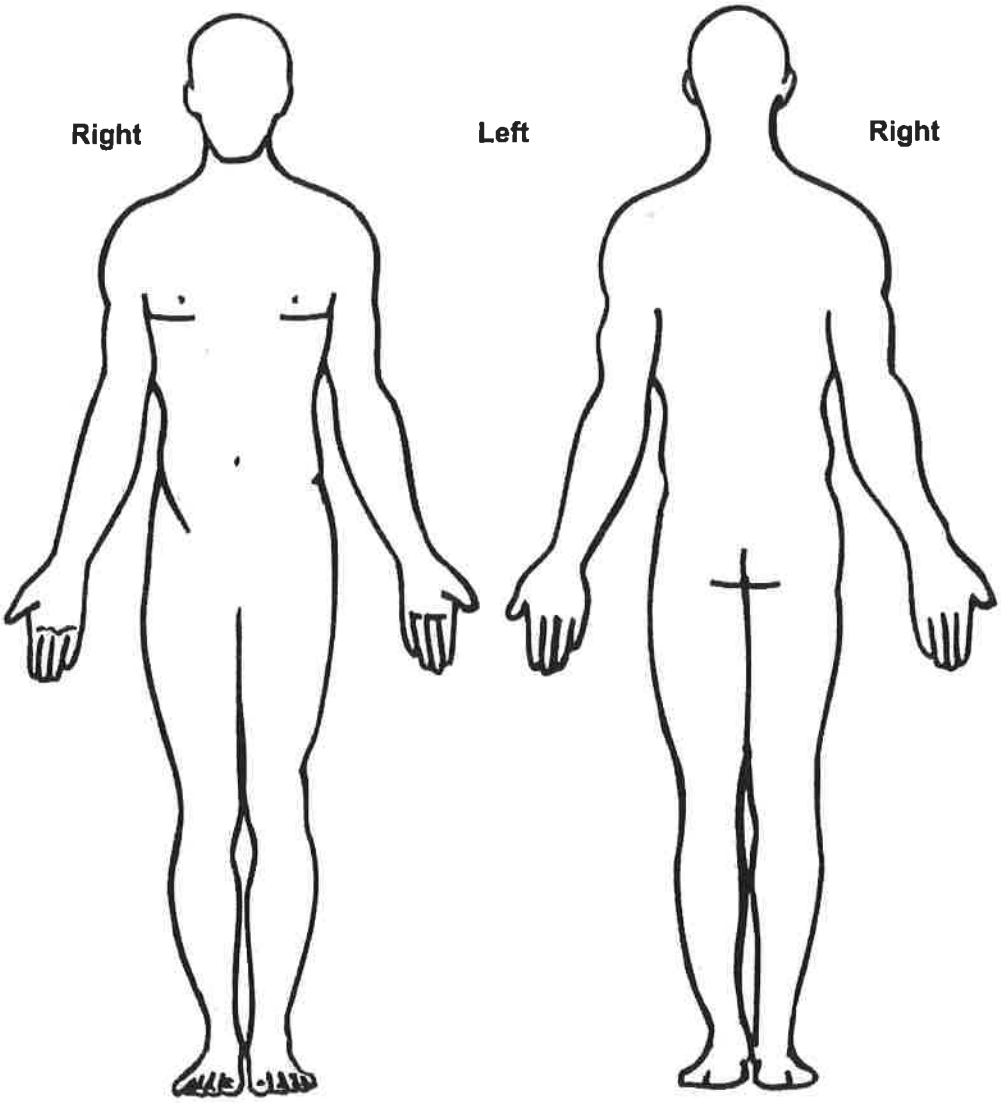
KEY	
ΛΛΛ	Ache
000	Numbness
■■■	Pins & Needles
XXX	Burning
///////	Radiating Pain

I can tolerate my pain at a pain score of:

☐

Please check the box the best indicates the duration of your pain:

- ☐ Continuous
- ☐ Positional
- ☐ Intermittent (on/off)
- ☐ Unable to Rate



How bad is your pain right now? (indicate on the line)

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

No Pain **Intermediate Pain** **Worst Pain**

PATIENT'S SIGNATURE _____ DATE _____

SPINE / PMR NEW PATIENT PACKET

PLEASE PRINT CLEARLY

Date: _____

Patient Name: _____ **Age:** _____
LAST FIRST

Are you right or left handed? ☐ Right ☐ Left

When did symptoms first start? _____ **Are they getting:** ☐ Worse ☐ Better ☐ Stable

Please describe all present pain:

Body Parts Affected	
Type of Pain	
Pain Radiation	

Describe any other symptoms	
What position and/or medication relieves your pain?	
Do you have any pain, numbness tingling or weakness in your arms or legs? (Describe)	

Are you presently working? ☐ Full Time ☐ Part Time ☐ Not Working ☐ On Disability ☐ Partial Disability

If you are on Disability/Partial Disability, when did it begin? _____

Have you had any Treatment (Including X-rays, tests, therapy, etc.) or seen any health providers for this injury? *Please Describe:*	
Have you tried any home treatments or medication?	
Please list previous diagnosis and treatments recommended:	

Please list any test you have had in the past related to your problem (MRI, X-ray, CT, etc.):

TEST/STUDY	DATE	RESULT

Have you recently had any of the following? *(Please check all that apply)*

☐Fatigue
☐Fainting
☐Memory Loss
☐Depression
☐Stress
☐Loss Of Concentration
☐Heartburn
☐Difficulty Voiding
☐Shortness Of Breath
☐Sleep Difficulty
☐Weakness
☐Itching
☐Headaches
☐Numbness
☐Tingling
☐Nervousness
☐Loss Of Appetite
☐Urinary Incontinence
☐Nausea
☐Vomiting
☐Chest Pain
☐Ulcers
☐Bowel Problems
☐Early Awakening
☐Facial Pain
☐Hearing Difficulty

☐Other:_____

Past Medical History: *(please check any of the following which you have had)*

☐Urinary Problems
☐Heart Disease
☐Problems with Ears, Eyes, Nose, Throat
☐Respiratory
☐Circulatory / CVA
☐Problems With Asthma, Hay fever
☐Arthritis / Gout
☐Cancer
☐Liver Problems
☐Hypertension
☐Kidney Problems
☐Diabetes / Hypoglycemia
☐Drug Abuse / Alcohol Abuse
☐Gastrointestinal Problems / Ulcers
☐Depression Or Psychological Problem

*Please explain any of the checked above:*_____

Have you had any prior surgeries? ☐ Yes ☐ No

*If yes, explain?*_____

Have you had any prior spine surgeries? ☐ Yes ☐ No *If yes, what year?*_____

*Type:*_____

CURRENT MEDICAL STATUS

Are you currently receiving treatment for any other medical condition? ☐Yes ☐No

*If yes, please explain:*_____

Medications: *please list all medications you are currently taking and the daily dosage*

MEDICATION	DOSAGE	DATE MEDICATION STARTED

Are you taking any herbal or vitamin supplements? ☐ Yes ☐ No

If yes, please list all:

Are you allergic to any medications/foods/other? ☐ Yes ☐ No

If yes, please explain:

Do you have latex allergy? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Is there a family history of spinal problems in your family? ☐ Yes ☐ No

If yes, please explain:

Is there a family history of other medical problems? ☐ Yes ☐ No

If yes, please explain:

SOCIAL HISTORY

Age: _____ **Height:** _____ **Weight:** _____ lbs

Do you smoke? ☐Yes ☐No *If so, how much?*_____

Alcohol intake? ☐Yes ☐No *If so, how much?*_____

Is there any history of alcohol or drug abuse? ☐Yes ☐No

Describe usual physical activity/exercise:

- Type:_____
- Frequency:_____

_____ _____

PATIENT'S SIGNATURE DATE

ALTERNATE CONTACT INFORMATION & RELEASE OF INFORMATION CONSENT FORM

Patient Name: _____ **Home Phone:** _____

Patient Date of Birth: _____ **Work Phone:** _____

Cell No./Pager: _____

I. Alternate Contact Information Consent

DISC Sport & Spine Center has my consent to:

a) ☐ Y ☐ N Leave medical information on my home answering machine.

b) ☐ Y ☐ N Leave medical information on my personal cell phone.

c) ☐ Y ☐ N Contact me at my place of employment.

d) ☐ Y ☐ N Leave medical information on voice mail at my place of employment.

e) ☐ Y ☐ N Leave medical information on ☐ **Family,** ☐ **Friends or** ☐ **Co-Workers** voice mail. (Check those that apply)

f) ☐ Y ☐ N Leave/discuss medical information on ☐ **Family,** ☐ **Friends or** ☐ **Co-Workers** e-mail. (Check those that apply)

NOTE: Messages will not be left on answering machines or voice mail if the recorded greeting does not include confirmation of your name or phone number.

II. Family/Friends/Co-Workers Release of Information Consent

I authorize DISC Sport & Spine Center to discuss any information regarding my care with below-mentioned family member(s), friend(s) or co-worker(s).

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

_____ _____

PATIENT OR GUARDIAN'S SIGNATURE DATE

This Authorization is valid until revoked by the patient orally or in writing at any time.
The exception is when communication has already occurred as instructed in this consent.

DISC SPORTS & SPINE CENTER
Marina del Rey 310.574.0400 | Newport Beach 949.988.7800
www.discmdgroup.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At DISC Sports & Spine Center ("DISC"), we understand that medical information about you and your health is personal, and we are committed to protecting that information, This Notice of Privacy Practices describes how we and the medical staff and personnel who provide you with care or services at this facility may use and disclose your Protected Health Information ("PHI") to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services. We are required by law to maintain the privacy of your PHI, to provide notice of our legal duties and privacy practices with respect to your PHI, to notify affected individuals following a breach of unsecured PI-11, and to abide by the terms of this Notice of Privacy Practices.

We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, you can receive any revised Notice of Privacy Practices by accessing our website www.discmdgroup.com, contacting the facility where you received services, or by contacting the Privacy Officer: 310-574-0400.

1. How We May Use and Disclose Your PHI. We may use or disclose your PHI as described in this section. The following are examples of the types of uses and disclosures of your PHI that DISC is permitted to make without your specific authorization. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our facility. Where State or federal law restricts one of the described uses or disclosures, DISC will follow the requirements of such State or federal law. The following are general descriptions only. They do not cover every example of disclosure within a category. However, all of the ways DISC is permitted to use and disclose your PHI will fall within one of the categories in this Notice of Privacy Practices.

Treatment. We may use PHI about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved in your care to, for example, plan a course of treatment for you. We also may disclose PHI about you to individuals outside of DISC who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.

Payment. Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a surgery may require that your relevant PHI be disclosed to your health plan.

Healthcare Operations. We may use or disclose your PHI as needed to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other healthcare operations. For example, your health information may be disclosed to members of the medical staff; risk or quality improvement personnel and others to: evaluate the performance of our staff, assess the quality of care and outcomes in your case and similar cases; learn how to improve our facilities and services; or determine how to continually improve the quality and effectiveness of the health care we provide.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We will share your PHI with third party "business associates" that may perform various activities (e.g., billing or transcription services) for DISC. Whenever an arrangement between our facility and a business associate involves the use or disclosure of your PHI we will require the business associate to appropriately safeguard it.

2. Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object. You have the opportunity to authorize or object to the use or disclosure of all or part of your PHI. You may revoke your authorization at any time, but your revocation will only be effective for future uses and disclosures and will not affect any use or disclosure made in reliance on your authorization. If you are not present or able to authorize or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest In this case, only the PHI that is relevant to your healthcare will be disclosed. We may use and disclose your PHI in the following instances. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with your written authorization.

Facility Directories. Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms) and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told of your religious affiliation.

Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, about your general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare. In addition, with few exceptions, unless you provide written authorization, we will not use or disclose your PHI for marketing purposes and we will not sell your PHI.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object. We may use or disclose your PHI without your authorization in the following situations:

Required By Law. We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health. We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases. We may disclose your PHI, if authorized by Jaw, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect. We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI to the governmental entity or agency authorized to receive such information if we believe that you

INSURANCE ACKNOWLEDGEMENT & FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions about your account, charges, insurance, or payments, please speak with one of our Billing Representatives.

Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card so that we may copy the front and back of the card for accurate insurance information.
2. Your driver's license so that we may copy the card for accurate demographic and patient specific data.
3. Your referral or authorization for services when applicable.

Self-pay Accounts

If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

Insurance Plans

If you are insured, we will bill your insurance plan. However, it is ultimately your responsibility to become familiar with the details of your insurance plan coverage. We recommend you contact your insurance company prior to any service so you may understand your allowable benefits. If you have a PPO or HMO insurance plan, we will collect the required co-payment, co-insurance, and any deductible if applicable. In the event that your health plan determines a service to be "non-covered," we will bill you, and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you. As a courtesy, we will submit a claim to your insurance company on your behalf.

Medicare

Your physician may or may not be a participating Medicare provider. If your physician is a participating provider, we will bill your Medicare insurance and your supplemental, if you have one.

Workers' Compensation

If you are involved in an "on-the-job" work injury, prior to seeing the physician, the following information must be obtained and verified prior to your visit:

- Date of Injury
- Case or claim number
- WCAB#, if applicable
- Workers' Compensation carrier information
- Adjuster's name
- Adjuster's telephone number
- Employer

Insurance Updates

Due to frequent changes in insurance plans and the benefits offered under those plans, our staff is required to review and update your insurance information on a regular basis.

Other Fees:

- Copy of Records
- Copy of X-rays
- Form Completion Fees

X-ray

Please note that your referring provider's contract affiliation will have no bearing on the processing of the claims for x-ray. There is no affiliation with Mink Radiology. This notice is for x-rays taken at 13160 Mindanao Way, Marina del Rey, CA 90292.

Should you have any questions regarding the billing associated with your x-rays please contact Marina Physician Services at 310.574.0442.

I understand that DISC Sports & Spine Center agrees to bill my insurance as a courtesy and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for payment for all services.

Insurance Plan: _____

_____	_____	_____
Name of Patient (please print)	Signature of Patient or Responsible Party	Date
_____	_____	_____
Interpreter/Representative Name	Interpreter/Representative Signature	Date

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