NEUROSURGERY
Robert H. Bradley, M.D.
F. Donovan Kendrick, M.D.
Khaled Krisht, M.D.

PHYSICAL MEDICINE
& REHABILITATION
Jeffry G. Pirofsky, D.O.

NEUROSURGERY
&
SPINE
ASSOCIATES
OF CENTRAL ALABAMA P.C.

Parker Pavilion 2065 East South Boulevard, Suite 204
Montgomery, Alabama 36116-2463

Phone: 334-281-6990 Fax: 334-281-9725
Toll Free: 800-223-5533 www.alneurospine.com

ADMINISTRATION
Liz Taylor

PHYSICIAN ASSISTANT
Amy D. Rapp, PA-C

NURSE PRACTITIONER
Ashley Powell, NP

PATIENT INFORMATION FORM

Name_____
LAST FIRST MIDDLE

Date of Birth_____ Age_____ Sex_____ Marital Status_____ SS Number_____

Race_____ Language_____ Caucasian_____ Hispanic_____ Other_____

Address_____ City, ST Zip_____

Phone: Home _____ Cell _____(Carrier_____) Work _____

Email _____

Communication Preference: Patient Portal_____ Phone_____ (Number_____) Mail_____

Employer_____ Address_____

Pharmacy Name_____ Pharmacy Phone_____

Contact Person Not Living With You_____ Phone_____

Referring Physician_____ Family Physician_____

Have you ever been treated by Robert Bradley, M.D., Donovan Kendrick, M.D. or Jeffry Pirofsky, D.O.?_____ When? _____

INSURANCE INFORMATION

If Worker's Compensation/Name of Carrier_____

Telephone_____ Contact Person_____

I request that payment of authorized MEDICARE benefits be made on my behalf to Neurosurgery & Spine Associates of Central Alabama, P.C., for any services or items furnished to me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Medicare Number_____ Medicaid Number_____

OTHER INSURANCE

Name of Company_____ Name of Insured_____

Contract Number_____ Group Number_____ Spouse DOB_____

I authorize the release of any medical information necessary to process any claim attached with this authorization. I hereby understand that I am financially responsible to the physician for charges. I request that insurance payments be made directly to Neurosurgery & Spine Associates of Central Alabama, P.C.

Signed_____ Date Signed_____

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Date of Appointment: ____/____/_____ Chart # _____

NAME _____ Referring Physician _____
SOCIAL SECURITY # _____ City, State _____
DATE OF BIRTH _____ AGE _____ Family Physician _____
OCCUPATION _____ Other Physicians _____

MEDICAL HISTORY/CONSULTATION
CURRENT PROBLEMS

1. What is your main symptom?_____
2. When did it begin?_____
3. Is this problem related to your job? ☐ No ☐ Yes Describe if other than injury_____
4. Is your current problem related to an accident? ☐ No ☐ Yes If so, please describe it in detail (date, place, cause, injuries received, ER visits). Use the back of this page if needed._____
5. Were any of your symptoms present before your accident? ☐ No ☐ Yes Which ones?_____
6. What other symptoms do you have and when did they begin?_____
7. What test (electrical studies, x-rays, MRI, CT scan, myelogram, bone scan) have you had for these problems? (may circle) Other_____
8. Have you had physical therapy for this problem? ☐ No ☐ Yes ☐ Same ☐ Better ☐ Worse after
9. Have you had any spine injections for this problem? If so, what type (trigger point, epidural, nerve root blocks) and when?_____ What Physician?_____ ☐ Same ☐ Better ☐ Worse after
10. What other treatments have you had for this problem? Circle: (bed rest, chiropractor, massage, TENS unit, home traction, ice, heat, ointments) Other:_____
11. What medications are you currently taking for this problem?_____
12. Is your problem getting better, worse, or is it unchanged?_____
13. Have you had any other accidents or injuries that contributed to this problem? ☐ No ☐ Yes Describe_____
14. Are you working currently? ☐ No ☐ Yes ☐ Usual Position ☐ Light Duty
15. What dates have you missed from work because of this problem?_____
16. Have you hired an attorney regarding this problem? ☐ No ☐ Yes ☐ N/A

Neurosurgery & Spine Associates of Central Alabama, P.C.
PATIENT HISTORY SHEET

Patient:_____ DOB:_____

For patients with pain: please circle any of the following that describe your symptoms.

Location – Head, Face, Neck, Back (upper, middle, lower), Arm, Leg, left, right, both, Other_____

Quality – Sharp, Dull, Throbbing, Stabbing, Burning, Constant, Intermittent

Severity – Mild, Moderate, Severe, Varies

Timing – At night, awakens from sleep, with activity, when awakening in the morning

Circle any of the following that make your symptoms **WORSE**: Sitting, Standing, Walking, Twisting, Bending, Lifting, Work, Cough, Sneeze, Strain, Other_____

Circle any of the following that make your symptoms **BETTER**: Sitting, Lying Down, Standing, Medication, Ice, Heat, Other _____

SYSTEM REVIEW: Please check any of the following symptoms that you have experienced in the past six months, or check none at the end of each category.

GENERAL
- ☐ Weakness
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ NONE

SKIN
- ☐ Rash
- ☐ Cancer
- ☐ Itching
- ☐ NONE

HEAD
- ☐ Headache
- ☐ Trauma
- ☐ Dizziness
- ☐ Vertigo
- ☐ NONE

EYES
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Visual Loss
- ☐ Cataracts
- ☐ Glaucoma
- ☐ NONE

EARS
- ☐ Ringing
- ☐ Hearing Loss
- ☐ Drainage
- ☐ NONE

NOSE
- ☐ Bloody Nose
- ☐ Discharge
- ☐ Loss of Smell
- ☐ Facial Pain
- ☐ NONE

THROAT
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ NONE

NECK
- ☐ Pain
- ☐ Stiffness
- ☐ Mass
- ☐ NONE

HEART
- ☐ Chest Pain
- ☐ Irregular Beat
- ☐ NONE

EXTREMITIES

	Numbness	*Weakness*
Arm	☐L ☐R	☐L ☐R
Leg	☐L ☐R	☐L ☐R

- ☐ Ankle Swelling
- ☐ Blood Clot
- ☐ Arthritis
- ☐ Injury
- ☐ NONE

LUNGS
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Frequent Cough
- ☐ COPD/Emphysema
- ☐ NONE

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Reflux
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Loss of Bowel Control
- ☐ NONE

GU
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Loss of Bladder Control
- ☐ Blood in Urine
- ☐ NONE

BACK
- ☐ Pain
- ☐ Stiffness

BREAST
- ☐ Masses
- ☐ Pain
- ☐ Discharge
- ☐ NONE

NEURO/PSYCH
- ☐ Loss of Consciousness
- ☐ Weakness
- ☐ Tingling
- ☐ Seizures
- ☐ Balance Problems
- ☐ Frequent Falls
- ☐ Coordination Problems
- ☐ Difficulty Concentrating
- ☐ Poor Memory
- ☐ Excess Anxiety
- ☐ Depression
- ☐ Difficulty Speaking
- ☐ NONE

BLOOD
- ☐ Anemia
- ☐ Easy Bleeding
- ☐ On Blood thinner
- ☐ NONE

ENDOCRINE
- ☐ Thyroid Disease
- ☐ Heat/Cold Intolerance
- ☐ NONE

NEUROSURGERY & SPINE USE ONLY: Reviewed by_____ Date_____

Neurosurgery & Spine Associates of Central Alabama, P.C.
PATIENT HISTORY SHEET

Patient:_____ DOB:_____

PAST MEDICAL HISTORY: Please check any of the following problems that you have experienced in the past or now

- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Heart Attack
- ☐ Epilepsy (Seizure)
- ☐ Fibromyalgia
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Lupus
- ☐ Mental Problems
- ☐ Osteoporosis
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ TIA
- ☐ Ulcer Disease
- ☐ Other_____
- ☐ None of These

SURGICAL HISTORY:

Have you had previous neck or lower back surgery? ___NO ___YES Surgeon _____ When _____
What other operations have you had? _____

Any problems with anesthesia? ____NO ____YES Describe _____
Have you had any other accidents or injuries in the past? ____NO ____YES Describe _____

MEDICATIONS: Please list all of your current medications and dosages.
Please include all over-the-counter medications such as Advil, Tylenol, herbal, vitamin, and weight-loss supplements.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES: Please list all medication or dye allergies and your reaction to each. ☐ **NO KNOWN ALLERGIES**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY HISTORY: Please check any of the following diseases affecting your blood relatives.

- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Heart Attack
- ☐ Epilepsy (Seizure)
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Lupus
- ☐ Mental Problems
- ☐ Muscular Dystrophy
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ None of These

Are there any other problems that seem to run in your family?_____

SOCIAL HISTORY:

Last grade completed in school ___1-8 ___9-12 ___College ___Post graduate
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily – Amount/Type_____
Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Currently ___packs/day How long ___years
Recreational Drugs: ☐ Never ☐ Yes Type/Frequency_____

Have you applied for or are you on Social Security Disability
☐ Yes ☐ No

VOCATIONAL HISTORY:

☐ Retired ☐ Unemployed ☐ Disabled ☐ Work Full-time ☐ Work Part-time
Employer_____ How long? _____
Usual job duties_____
Type: ☐ Heavy Labor (up to 100lbs.) ☐ Medium (up to 50lbs.) ☐ Light (up to 20lbs.) ☐ Sedentary (up to 10lbs.)
Last date you worked ___/___/___

NEUROSURGERY & SPINE USE ONLY: Reviewed by_____ Date_____

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Physical Medicine & Rehabilitation
Parker Pavilion
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MEDICAL RELEASE FORM

Effective April 14, 2003 (due to federal guidelines under HIPAA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

NAME	RELATIONSHIP	PHONE NUMBER
1)		
2)		
3)		

May we leave medical information on your "home" answering machine?

Yes_____ **No**_____ **Phone Number:**_____

Patient Name: _____ **Date of Birth:** _____

Signature of Patient/Parent_____ **Date:** _____

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign here.

Patient Name: _____ **Date of Birth:** _____

Signature of Patient/Parent_____ **Date:** _____

The above information is private and confidential and will be placed in your medical chart.
The information on this form will remain valid until we are notified otherwise.

NeuroSurgery & Spine Associates of Central Alabama

Robert H. Bradley M.D., F. Donovan Kendrick M.D., Jeffry G. Pirofsky D.O. & Khaled Krisht, M.D.

Patient Policy and Financial Agreement

We hope the following information will be helpful to you. We respect your time and we would like to make your visit to our office as efficient as possible.

Information to bring with you: Please remember to bring all prescription medications, X-Ray films or CD's and any other medical records pertaining to your visit.

Medical Billing Services: We will file directly to your primary and secondary insurance carriers. After your insurance pays, you will be responsible for the remaining balance. You will receive a statement(s) explaining your balance 30, 60, and then 90 days later. If no arrangements have been made with the billing department prior to your 90 day statement, your account will be flagged for collections. If you have a question about your bill please ask to speak with our billing department or management.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE

MVA Insurance: We will be glad to file your motor vehicle insurance in case of an accident. If you require surgery due to the accident a fee will be collected up front prior to the surgery. We have experienced many insurance policies with benefits that are exhausted prior to the patient's surgery.

Co-Pays: Are always collected at the check-in desk before you see the doctor. If you do not have your co-pay, we reserve the right to reschedule your appointment depending on the reason for your visit.

Payment methods accepted: For your convenience we accept Debit Cards, Visa, MasterCard, Discover Card, money orders, cash, and personal checks with proper ID.

Deductibles: If your insurance has an office visit deductible, you are required to pay the estimated deductible in full up to $100 at the time of the visit. If it is more, you will be billed the remaining balance after your insurance has been processed. Any refunds will be sent back to you within 2 weeks of insurance payment.

Self-Pay Visits: You must pay a deposit in advance at the check-in desk, cash or credit/debit card. After your visit you will pay the balance at check-out, depending on what services you received, exam, x-ray, injection.

Insufficient funds: If your check is returned due to insufficient funds you will be charged a $35 fee by us, in addition to whatever your bank charges you. We will contact you be phone or registered mail regarding your returned check. When paying for your returned check we will only accept cash or money order for the full amount.

Cancellations / No Shows: If you do not show up for your appointment this interrupts the scheduled patient flow. Please call if you cannot make your appointment so we can reschedule you. If you are late for your appointment we reserve the right to reschedule your appointment.

Patients in Collections: Patients with unpaid balances (in collections) will not be scheduled for appointments unless approved by management. Generally "Collections/Old Balances) must be paid in full before you can be seen here again.

Surgery Patients: Our doctors have privileges at Baptist Medical Center South. Our surgery scheduler will handle all your surgical arrangements, including when to arrive at the hospital, where to go, and your pre-op appointment. If you have to be admitted for surgery we will call your insurance for precertification. If you have a deductible we will collect that amount prior to your surgery. If you are a cash paying patient we will make payment arrangements with you prior to your surgery and have you sign a financial form. You will be **required** to make a down payment before your surgery; the amount of the payment will depend on what surgery is performed.

Prescription Refills: Please note our doctors are not Pain Management specialists. We will not automatically begin prescribing your previous narcotic medications. We will generally provide narcotic medicine after surgery for a reasonable period of time, usually no more than 90 (ninety) days. After that you we may ask you to have your narcotic medicine filled by your primary care doctor, or we will arrange referral to a pain management specialist.

Pharmacies: If you need a prescription refilled have your pharmacy call our office. Our doctors will not accept a fax or e-mail for refill purposes.

Requesting your medical records: Prior to receiving your medical records, you will need to sign a medical release form. You will be charged a fee for obtaining your records in either hardcopy or electronic format. Charges are determined by State/Federal Law.

I understand that by signing this agreement I have read and agree to the terms outlined above. I am ultimately responsible in full for all charges and balances on my account for all services rendered by NeuroSurgery & Spine Associates of Central Al... This form will be retained in my EHR chart, and a copy of this agreement will be provided to me upon my request.

Patient Name (print) _____ **Date:** _____

Patient Signature: _____ **DOB:** _____