Saeid Aryan, D.O.

Karthik Sabapathy, D.O.

Phone: 817.502.7411 ● Fax: 817.502.7412

www.brainandback.com

New Patient Intake Forms

Patient Information

Last Name: _____ First Name: _____ Initial: _____

Address: _____ Apt# _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____-_____

Date of Birth: ____/____/____ Gender: □ M □ F SSN # ____-____-____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Parent/ Legal Guardian if Patient is a Minor: _____

Primary Doctor _____ Phone Number/ City _____

Referring Doctor _____ Phone Number/City_____

□ Insurance Carrier □ Friend/Family □ Internet □ VA □ Other_____ □ Hospital: _____

Employer's Name: _____ Occupation: _____

Employers Number: (_____) _____ - _____ Are you a Veteran of the US Armed Forces? □ YES □ NO

Emergency Contact

Name: _____Relationship: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Alternate #: (_____) _____ - _____

Insurance Information

Policy Holder: _____ SSN # _____-_____-_____ D.O.B ____/____/_____

Primary Insurance Company: _____Policy #_____Group # _____

Second Insurance Company: _____ Policy # _____ Group #_____

Email Address: _____

Race: □ Asian □ White □ American Indian/Alaska Native □ Hispanic □ African American □ Other: _____

Language: □ English □ Spanish □ Other: _____

Pharmacy Name: _____ Phone#: (____) ____-_____ Location: _____

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Office Policies

CONSENT FOR TREATMENT FORM

_____ I understand that I have presented myself to AXBBI, PLLC for evaluation and/or treatment for my condition. I authorize and direct AXBBI, PLLC to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his/her associates, or colleagues.

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

_____ I hereby give authorization of insurance benefits to be made directly to AXBBI, PLLC services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. If I have multiple primary insurance policies, I acknowledge I am responsible for coordinating primary vs. secondary with my insurance companies. Failure to do so will result in claim denials and refusal to pay. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ I understand payment is due at time of service. Payment can be made by cash, check Visa, MasterCard, Discover or Amex. There is a $2000 limit for credit card transactions.

_____ I understand that I am financially responsible for all charges at time of service including copays, deductibles and coinsurances. In the event of denials, errors, service caps, policy exclusions or non-covered services, I am responsible for payment of all services rendered. I understand that any account balance incurred must be paid in full prior to scheduling surgery.

_____ I understand AXBBI, PPLC reserves the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery. In the event of default, I agree to pay all costs of collections which constitutes balance due plus a 35% collection fee.

SHARING OF INFORMATION FOR PURPOSE OF PAYMENT

_____ I acknowledge that AXBBI, PLLC will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

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COMMUNICATION AUTHORIZATION

_____ I acknowledge that AXBBI, PLLC may communicate with me via US mail, Home/Cell Phone (____) _____ - _____) and through the patient portal for both medical and financial purposes.

ACKNOWLEDGEMENT OF PATIENT RIGHTS

_____ I, have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. But any disclosures given in reliance on this prior consent will be permissible.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ I acknowledge that AXBBI, PLLC has provided me with the opportunity to view and read a written copy of **NOTICE OF PRIVACY PRACTICE.**

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

_____ I acknowledge that Dr. Saeid Aryan at any given time may be a consultant, owner, manager, director, or developer of various entities including but not limited to companies that develop, distribute, and/or manufacture spinal biologics and implants and may have financial interests in various physician owned entities including but not limited to: management companies, laboratories, medical device manufacturers, pharmacies, neuromonitoring, imaging, first assist and/or anesthesia companies, ambulatory surgery centers and/or hospitals, that may pertain to your care. Some of which may be out of network, and as a result you may receive an out of network bill. However, you have the right to choose the providers and healthcare facilities of your choice.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

_____ I acknowledge that AXBBI, PLLC will disclose my protected Health Information (PHI) to a family member, other relative, close friend or any other person I identify that directly relates to that person's involvement in my care. The following are authorized person(s) who my PHI may be disclosed to:

Name(s):_____

Name(s):_____

Name(s):_____

_____ **I OBJECT** to the disclosure of my Protected Health Information to a family member, other relative, close friend or any other person.

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient Printed Name

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Pain Medication Policy

At Axis Brain & Back Institute, PLLC, our goal is to address your condition with the most innovative, minimally invasive, and cost-conscious treatments available. When appropriate, providers at Axis Brain & Back Institute, PLLC will prescribe ***ONE 30-day supply of pain medication for post-operative pain***. This prescription is given to you after surgery upon discharge from the hospital.

There are federal and state laws, regulations and policies regarding the use and prescribing of controlled substances. Controlled substances are drugs that are subject to statutory control. If patients experience pain beyond the 30-day post-operative follow-up appointment they will be referred to a pain management provider for continued care. **Axis Brain & Back Institute, PLLC does not offer pain management**. If the prescriptions are lost or stolen, **they will not be replaced.**

By signing below, I agree to the Pain Medication Policy and understand the following:

I. Axis Brain & Back Institute, PLLC does **NOT** provide pain management.
II. Pain medication is **NOT** prescribed before surgery.
III. Pain medication prescribed to me will be after surgery for post-operative pain.
IV. I will only be prescribed **ONE** 30-day supply of pain medication.
V. If a prescription is lost or stolen they **will not** be replaced.
VI. If pain management is needed, Axis Brain & Back Institute, PLLC will refer me to an appropriate pain management provider.
VII. If I am under Pain Management, it is **my responsibility** to comply with my pain contract in regards to prescriptions.

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient Printed Name

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Chief Complaint: □ Neck Pain □ Low Back Pain □ Mid Back Pain □ Headaches

1. Symptoms have been present since: □ Years _____ □ Months _____ □ Weeks _____

   Is your condition the result of a Work Injury? □ Yes □ No Auto Accident? □ Yes □ No

   Was there a trauma or inciting incident? _____ Date of injury? _____
2. Symptoms described as: □ Sharp □ Dull □ Achy □Burning □ Spasms
3. Arm symptoms: □ Right Arm □ Left Arm □ Pain □ Numbness □ Weakness

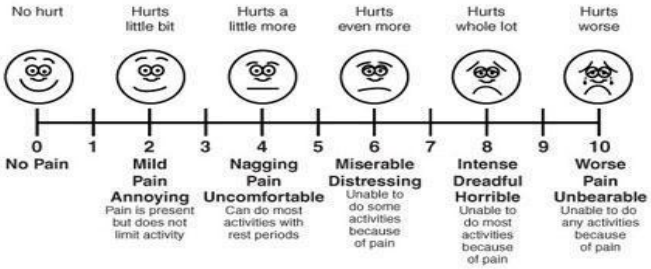
   Leg symptoms: □ Right Leg □ Left Leg □ Pain □ Numbness □ Weakness

   Other: _____
4. Activities that **relieve** your pain: □ Sitting □ Standing □ Walking □ Lying Down

   □ Bending/twisting □ Other: _____
5. Activities that **worsen** your pain: □ Sitting □ Standing □ Walking □ Lying Down

   □ Bending/twisting □ Other: _____
6. How many minutes can you stand/walk before you need to rest?

   □ less than 5 □ less than 30 □ less than 60 □ 60 or more □ Other: _____
7. On a PAIN SCALE of 1- 10 what number would you consider yourself?



□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

8. Do you have problems with balance or frequent falling/tripping? □ Yes □ No
9. Do your symptoms interfere with your daily activities? □ Yes □ No
10. Pain is: □ Improving □ Worsening □ Same (unchanged) □ Other: _____

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Treatments Include:

□ **NONE** medication, physical therapy, chiropractic manipulations, injections or bracing

□ Medication, such as anti-inflammatories, oral steroids, muscle relaxers, narcotics, other

(names/duration: _____)

□ Physical Therapy (when/duration: _____) □ Chiropractic Manipulation □ Acupuncture

□ **Injections:** □Trigger Point □ Epidural Steroid □ Facet □ Sacroiliac

□ Previous surgery (when/physician: _____)

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List ALL CURRENT Medications and doses: □ None

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medication Allergies (Food, Latex): □ No Known Drug Allergies

_____

Patient Medical History

Check all that apply: □ None apply

□ Osteoarthritis	□ Depression	□ High Blood Pressure	□ Diabetes	□ Kidney Failure
□ Anemia	□ Migraines	□ Seizures	□ Heart Attack	□ Osteoporosis
□ Blood Clot(s)	□ Liver Disease	□ Stroke	□ Cholesterol	□ Cancer: _____
□ Lung Disease	□ Heart Failure	□ Chronic Pain	□ Asthma	□ Rheumatoid Arthritis

Past Surgical History:

Type of Surgery	Approx. Year	Type of Surgery	Approx. Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History □ None apply

Check all that apply: □ Deceased □ Mother (M) _____ □ Father (F) _____ □ Substance Abuse M/F

□ Stroke M/F □ Diabetes M/F □ Seizures M/F □Heart Disease M/F □ High Blood Pressure M/F

□ Mental Illness M/F □ Arthritis M/F □ Gout M/F □ Cancer M/F _____ □ Bleeding Disorders M/F

Additional Questions

Do you smoke/use tobacco? Yes / No _____ packs/day for ___ years (Quit?: Y /N If yes, when: _____)

Do you drink alcohol? Yes / No (If yes, frequency: □ Daily □ 1-2 x/week □ Occasional)

Do you have a history of substance abuse? Yes / No (If yes, what substance and when last used: _____

_____)