NASHVILLE NEUROSURGERY ASSOCIATES

L. Brett Babat, MD – James M. Barry, MD - Robbi L. Franklin, MD - Khan W. Li, MD –
D. Timothy Lockney, MD - Chine S. Logan, DO - Robert A. Mericle, MD - William R. Schooley, MD –
Jonathan P. Scoville, MD – Christopher M. Storey, MD - Arthur J. Ulm, MD

Dear Patient,

Welcome to Nashville Neurosurgery Associates. We ask that you take some time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to know more about you, your medical condition, your family and your habits. **We ask that you fill out this form in ink prior to your visit and bring it with you on the date of your appointment.** This questionnaire is confidential and will be kept as part of your medical record. If you have any questions about issues of confidentiality, please feel free to contact our office.

Date of visit:____________________ Email Address:____

Patient Name:____ Date of Birth:__________________ SS#:__________________________

Address:___________________________________ City:____________________________ State:__________ Zip:_________________

Phone Numbers (H)___________________________ (W)____________________________ (C)___________________________________

Check all that apply: Message can be left on ◯ Home ◯ Work ◯ Cell   Message may be ◯ Brief ◯ Extended

Height:________ft. ________in. **Weight:** ____________lbs.   **Hand Dominance**: ◯ Right Handed ◯ Left Handed

RACE: Please check one (optional)
___American Indian or Alaska Native
___Asian
___Native Hawaiian or other Pacific
___Black or African American
___White
___Hispanic or Latino
___Other____________
___Declined to Answer

PRIMARY LANGUAGE:
___English ___Spanish
___Arabic ___Chinese
___French ___Italian
___Other___________________

Marital Status: ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Single ◯ Partnership

INSURANCE INFORMATION:

Primary Insurance:____ Policy #______________________________________

Address:____ Group:_______________________________________

Phone:__________________________Name of Insured:_______________________DOB:_____________SSN:____________________

Employer of Policyholder:____

Secondary Insurance:)____ Policy #:_______________________________________

Address:____ Group:_______________________________________

Phone:________________________Name of Insured:_______________________DOB:_______________SSN:__________________

Employer of Policyholder:____

-----OR-----

Worker's Compensation
Insurance Carrier:__________________________________ Claim #:________________________________Date of Injury:___________

Address:____Employer:____

Phone:_________________Adjustor's Name:_______________________________Phone:_________________________

Patient name:____ DOB:_________________________

WHO REFERRED YOU TO OUR OFFICE?

Physician Name:______________________________________ Specialty:____________________________

Address:____

Phone Number:_______________________________________ Fax:__________________________________

WHO IS YOUR PRIMARY CARE PHYSICIAN?

◯ Same as referring provider above

Physician Name:______________________________________ Phone Number:________________________

Address:____ Fax:__________________________________

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:

(1) Name:__________________________________ (2) Name:____________________________________

Address:________________________________ Address:____________________________________

Phone:__________________________________ Phone:______________________________________

Fax:____________________________________ Fax:____

PLEASE LIST ANY OTHER PERSONS YOU WISH TO HAVE ACCESS TO YOUR PRIVATE HEALTH INFORMATION:

(For example: Family, friends, attorney, etc.)

I authorize Nashville Neurosurgery Associates to contact and discuss my Personal Health Information with the following persons:

1.____ 4.____

2.____ 5.____

3.____ 6.____

____ ____

Patient Signature Date

Patient Name:____ DOB:_________________________

REVIEW OF SYSTEMS: Please check all conditions that currently apply to you.

GENERAL:
- ◯ Weight loss or gain
- ◯ Chest pain
- ◯ Change in appetite
- ◯ Altered taste or smell
- ◯ Heart murmur
- ◯ Chest pressure
- ◯ Angina
- ◯ Fainting
- ◯ Excessive sleepiness
- ◯ Low blood pressure
- ◯ Unable to sleep
- ◯ Fatigue
- ◯ Leg swelling

EARS, NOSE & THROAT:
- ◯ Mouth sores
- ◯ Sinus disease
- ◯ Sore throat
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Cataracts
- ◯ Blurred vision
- ◯ Double vision

RESPIRATORY:
- ◯ Shortness of breath
- ◯ Trouble breathing
- ◯ Emphysema
- ◯ Tuberculosis
- ◯ Chronic cough

GENITOURINARY:
- ◯ Sexual dysfunction
- ◯ Impotence
- ◯ Kidney stones
- ◯ Urinary incontinence
- ◯ Urinary urgency
- ◯ Vaginal bleeding
- ◯ Frequent urination
- ◯ Painful urination
- ◯ Blood in urine

PSYCHIATRIC:
- ◯ Anxiety
- ◯ Depression
- ◯ Trouble concentrating

GASTROINTESTINAL:
- ◯ Ulcer
- ◯ Vomiting
- ◯ Constipation
- ◯ Diarrhea
- ◯ Bowel incontinence
- ◯ Hiatal hernia
- ◯ Reflux
- ◯ Rectal bleeding

NEUROLOGICAL:
- ◯ Headache
- ◯ Seizure
- ◯ Memory loss
- ◯ Loss of consciousness
- ◯ Weakness
- ◯ Falling down
- ◯ Vertigo
- ◯ Concussion

MUSCULOSKELETAL:
- ◯ Low back pain
- ◯ Neck pain
- ◯ Joint pain
- ◯ Trouble walking
- ◯ Joint swelling
- ◯ Numbness

HEMATOLOGICAL:
- ◯ Blood disorder
- ◯ HIV
- ◯ Enlarged lymph nodes
- ◯ Hepatitis
- ◯ Tingling leukemia
- ◯ Sickle cell disease

Patient name:____ DOB:_______________________

PAST MEDICAL HISTORY:

◯ GERD/ Heartburn	◯ Atrial fibrillation	◯ Arthritis
◯ Ulcers	◯ Pacemaker	◯ Chronic back pain
◯ Colon polyps	◯ AICD (Defibrillator)	◯ Cancer
◯ Hernia	◯ COPD	◯ Kidney failure
◯ Pancreatitis	◯ Diabetes	◯ Heart attack
◯ Ulcerative colitis	◯ Thyroid problems	◯ Seizures
◯ Hypertension	◯ Elevated cholesterol	◯ Glaucoma
◯ Coronary artery disease	◯ Stroke	◯ Pneumonia
◯ Congestive heart failure	◯ Fibromyalgia	◯ Aneurysm

PAST MEDICAL HISTORY:

◯ Colonoscopy	◯ Bypass surgery	◯ Neck surgery
◯ EGD (Upper endoscopy)	◯ Heart valve replacement	◯ Hip surgery
◯ Ulcer surgery	◯ Hysterectomy	◯ Knee surgery
◯ Colon surgery	◯ Ovaries removed	◯ Weight loss surgery
◯ Cholecystectomy	◯ Breast cancer surgery	◯ Brain surgery
◯ Appendectomy	◯ Spinal cord stimulator	◯ Intrathecal pain pump
◯ Peripheral nerve stimulator	◯ Prostate surgery	◯ Other:_____________________
◯ Hemorrhoidectomy	◯ Back surgery	

Have you ever had a problem with anesthesia? ◯ Yes ◯ No
If yes, please explain.____

Have you ever had a blood transfusion? ◯ Yes ◯ No
If yes, why?____

SOCIAL HISTORY:

Do you drink alcohol? ◯ Yes ◯ No If **yes**, approximately how many drinks per week?_________________________

Do you smoke? ◯ Yes ◯ No If **yes**, how often? ◯ Every day ◯ Some days If **yes**, how many a day?_________

How soon after you wake do you smoke?__________ Are you interested in quitting? ◯ Yes ◯ Thinking about it ◯ No

Work Status: ◯ Full time ◯ Part time ◯ Retired ◯ Homemaker ◯ Student ◯ Unemployed ◯ Disabled

Was the injury due to a work-related accident? ◯ Yes ◯ No

Was the illness/ injury caused by an automobile accident? ◯ Yes ◯ No

Was another party responsible for the accident? ◯ Yes ◯ No

Is there any litigation involved? ◯ Yes ◯ No If yes, please explain___________________

FAMILY HISTORY:

◯ Arthritis	◯ Hypertension	◯ Cancer
◯ Heart attack	◯ High cholesterol	◯ Aneurysm
◯ Heart disease	◯ Diabetes mellitus	◯ Other_____________
◯ Peripheral vascular disease	◯ Stroke	

Patient name:____ DOB:___________________________

MEDICATIONS: Please list all medications and dosages you are currently taking, including over the counter medications. Please also include the length of time you have been taking any narcotic medications.

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

Do you take aspirin or any medicines that contain aspirin, such as Ibuprofen or Motrin? If yes, please specify:

____

PHARMACY: Please provide the name and phone number of your pharmacy so that we may keep this information on file if needed.

Name:_____________________________________ City:__________________________ Phone #:__________________________

PAIN MANAGEMENT:

Are you currently in Pain Management or receiving pain medications from another physician? ◯ Yes ◯ No

If yes, please list below the name and address of the physician:

Name:__________________________________ Address:____

Phone:__________________________________ Fax:____

ALLERGIES: Please list any know drug and/or food allergies:

1.____ 6.____

2.____ 7.____

3.____ 8.____

4.____ 9.____

5.____ 10.____

A. Please complete **ONLY** if you are here because of **BACK** or **LEG** pain:

Does your back or your leg bother you more? ○ Back ○ Leg

Which leg hurts more? ○ Right ○ Left

Do you have pain that goes below your knees? ○ Yes ○ No

There is: ○ Weakness in the feet or legs ○ NO weakness in legs or feet

The worst position for my pain is (check only one): ○ Sitting ○ Standing ○ Walking ○ Lying down

How many minutes can you stand in one place without pain? ○ 0-10 ○ 15-30 ○ 30-60 ○ 60+

How many blocks can you walk without pain? ○ 0-3 ○ 4-7 ○ 1 mile ○ 2 miles or more

Lying down: ○ improves the pain ○ worsens the pain ○ has no effect

Bending forward: ○ improves the pain ○ worsens the pain ○ has no effect

Bending backwards: ○ improves the pain ○ worsens the pain ○ has no effect

B. Please complete **ONLY** if you are here because of **NECK** or **ARM** pain:

Does your neck or your arm bother you more? ○ neck ○ arm

Which arm is hurting more? ○ right ○ left

Raising the arm: ○ improves the pain ○ worsens the pain ○ has no effect

Moving the neck: ○ improves the pain ○ worsens the pain ○ has no effect

There is: ○ weakness in the hands or arms ○ NO weakness in hands or arms

There is: ○ numbness in the hands or arms ○ NO numbness in hands or arms

Do you have difficulty picking up small objects or buttoning your buttons? ○ Yes ○ No

Do you have problems with your balance or trip frequently? ○ Yes ○ No

C. ALL PATIENTS answer the following:

1. Coughing or sneezing: ○ improves the pain ○ worsens the pain ○ has no effect
2. Do you have problems with bowel or bladder control? ○ Yes ○ No
3. How much work have you missed because of this problem? ○ 1-13 days ○ 2-5 days ○ 6 weeks or more
4. What treatments have you tried for the current problem? (Check all that apply)

○ Physical therapy ○ Exercise program ○ Brace ○ Massage ○ Ultrasound ○ Acupuncture
○ Chiropractor ○ Narcotic medications (e.g. Lortab, Percocet, Vicodin, Darvocet)
○ Epidural injections____times > These provided relief for: ○ No relief ○ 1-4 weeks ○ 5-8 weeks ○ +8 weeks

○ Other:____ ○ Anti-inflammatory medications (e.g. Motrin or Naproxen)

5. Are there any other non-surgical treatments left that you would like to try? (Please list)

____

6. What other doctors have you seen for this problem? (Please list the name, specialty, location & treatment):

____

NASHVILLE NEUROSURGERY ASSOCIATES

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name:____ DOB:__________________________

Previous name:____ SS#____________________________

I request and authorize____

to release healthcare information of the patient named above to:

Main office: 330 22nd Ave. – Phone: 615-320-0007

- Arthur J. Ulm, MD - **Fax**: 615-902-3980
- Robert A. Mericle, MD - **Fax:** 615-902-3982
- Robbi L. Franklin, MD - **Fax:** 615-902-3983
- Chine S. Logan, DO - **Fax**: 615-320-3183
- Jonathan P. Scoville, MD – **Fax:** 855-538-3132

Main office: Centennial – Phone: 615-986-1256

- L. Brett Babat, MD - **Fax:** 615-320-3186
- Khan W. Li, MD - **Fax**: 615-320-4178
- William R. Schooley, MD - **Fax**: 615-320-4106
- D. Timothy Lockney, MD - **Fax:** 615-329-3044

Main office: Summit – Phone: 615-320-0007

- Christopher M. Storey, MD - **Fax:** 615-383-6329
- James M. Barry, MD - **Fax:** 615-526-6477

This request and authorization applies to:

◯ ALL healthcare information

◯ Healthcare information relating to the following treatment, condition, or dates:

____

____

◯ Other:____

____

____ __________________________

Patient signature Date signed

Patient Name:____ DOB:__________________

NASHVILLE NEUROSURGERY ASSOCIATES

PATIENT FINANCIAL POLICIES AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

- **Insurance Billing**: As a service to our patients, Nashville Neurosurgery Associates is more than willing to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from Nashville Neurosurgery Associates. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing Nashville Neurosurgery Associates with the most current insurance information (i.e. Insurance card, Spouse's information, etc.). This includes patient providing their insurance with the appropriate information needed in order to process your bills accordingly (i.e. coordination of benefits, pre-existing information requested, surveys needed, etc.). Patients who do not bring their insurance card for their appointment may be asked to pay for the services rendered. If and when the insurance is billed and payment has been received, Nashville Neurosurgery Associates will gladly refund any credits due to the patient.
- **Patient Balances** are due 30 days after the first statement has been sent out. Alternatively, the patient must make acceptable payment arrangements by contacting the Billing Department at Nashville Neurosurgery Associates. Balances may be paid via cash, check, money order, Visa or MasterCard.
- **Unpaid Balances:** If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Billing Manager at Nashville Neurosurgery Associates to make acceptable arrangements. Nashville Neurosurgery Associates reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be on a cash only basis. Nashville Neurosurgery Associates reserves the right to discharge a patient from the practice if balances are not paid.
- **Service Charge:** Nashville Neurosurgery Associates reserves the right to assess a 35% service charge to a patient account, if sent to a collection agency, for any unpaid patient balance over 30 days after the insurance coverage has paid. No service charges will be assessed to a patient account where the patient has made payment arrangements with the Billing Department and payments are being made as agreed.
- All insurance co-pays are due at time of service; patients may be re-scheduled if the co-pay is not made.
- Nashville Neurosurgery Associates will charge the patient account $35.00 for any returned checks to cover the cost of the associated bank charges.

Authorization for Treatment & Financial Agreement

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received in writing within 30 days of statement date. I agree to pay all charges within 30 days of statement date. I agree to assign my insurance benefits to Nashville Neurosurgery Associates, if applicable. I have read and understand these policies and hereby acknowledge receipt of a copy of this form.

X____ ____________________________

Patient Signature Date

Acknowledgement of Nashville Neurosurgery Associates Notice of Privacy Practices

I hereby acknowledge that I have reviewed, received or have been given the opportunity to receive a copy of Nashville Neurosurgery Associates Notice of Privacy Practices defined by HIPPA.

X____ ____________________________

Patient Signature Date

Patient Agreement for Prescribed Medications

The pharmacy that I have selected is:____

Pharmacy address is:____

Pharmacy phone number is:____

I will submit to random pill counts and urine and/or blood drug tests as requested by my provider in order to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to dismissal from care by my provider after my 30-day, emergency-only time period.

I will not share, sell, or otherwise permit others to have access to this medication and I will keep it in a secure location.

I have read the above information or it has been read to me. I understand all of it. I have had all of my questions regarding the treatment of pain with opioids answered to my satisfaction. By signing this form, I voluntarily give my consent to opioid medication therapy and acknowledge receipt of this document.

____ _______________________________

Patient or Parent/ Guardian Signature Date

____

Printed Name of Consenting Person

****I have reviewed the Patient Agreement for Controlled Substances for Nashville Neurosurgery Associates that was provided to me either in an electronic, laminated or printed format at the time of my appointment. I agree to adhere to the rules that are listed in the Agreement and understand that this policy will remain in effect from the date of my electronic or written signature and that it does not expire.****