NASHVILLE NEUROSURGERY ASSOCIATES

L. Brett Babat, MD – James M. Barry, MD - Robbi L. Franklin, MD - Khan W. Li –
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 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:_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone:_____

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

PAST SURGICAL HISTORY:

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

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
- ◯ Heart attack
- ◯ Heart disease
- ◯ Peripheral vascular disease
- ◯ Hypertension
- ◯ High cholesterol
- ◯ Diabetes mellitus
- ◯ Stroke
- ◯ Cancer
- ◯ Aneurysm
- ◯ Other_____

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 hurts 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:

On a scale from 0 (no pain) to 10 (worst pain possible), please rate your pain on a daily basis:

0 1 2 3 4 5 6 7 8 9 10

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)

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:

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

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

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

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPPA (Health Insurance Portability and Accountability Act of 1996) allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice offers telehealth services, including secure video, audio, electronic communication, remote platforms and Scribe dictation. Telehealth visits are treated as confidential medical services and are protected under applicable privacy and security laws, including HIPPA. We use reasonable safeguards to protect your health information during telehealth visits. However, as with any electronic communication, there may be some risk of unauthorized access or technical failure.

May we phone, email or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine or cell phone?	YES	NO
May we discuss your medical condition with any members of your family?	YES	NO

If YES, please name the members allowed:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

To help protect your privacy, you may choose to add a secure passcode to your account. If a passcode is established, it may be required before our staff can discuss your medical information by phone or release information to you or authorized individuals.

Would you like to add a security passcode to your chart?

○ YES ○ NO Passcode:_____

This consent was signed by:_____(PRINT NAME)

Signature:_____ Date:_____