Advanced Healthcare & Spine Institute (AHSI)

Health For Life

391 South First Street
Jesup, GA 31545
Office: (912) 427-8433   Fax: (912) 427-9851
www.ahcforhealth.com
Email: info@ahcforhealth.com

Thank you for allowing Advanced Healthcare & Spine Institute (AHSI) to participate in your healthcare needs. We are here to serve you.

Advanced Healthcare & Spine Institute (AHSI) is a multidisciplinary healthcare facility with multiple Medical, Chiropractic, Physical Therapy, Acupuncture, and Massage Therapy Providers working as a team to formulate a comprehensive Evaluation and Treatment Plan that will restore you to maximum medical improvement as soon as possible.

It is important to understand that Garland Martin, MD, is the medical director at AHSI and ultimately reviews all patient charts to make sure ALL medically necessary products and services performed both onsite at AHSI and off site are documented and ordered in your chart. All ordered products and services will then be reviewed with you ASAP in a detailed Report of Findings (ROF) by an AHSI clinical staff member and a Financial Consult (FC) will immediately follow to resolve any and all financial questions you may have involving your plan of care at AHSI.

AHSI takes pride in providing high quality, effective, complete healthcare for EVERY patient. Our slogan is HEALTH FOR LIFE and that is our goal for you. Without you as a valued patient, we would not be in business. Never hesitate to contact AHSI staff or myself with questions or concerns.

Sincerely,

Edwin Davis, Jr., DC

Edwin Davis Jr., DC
AHSI PRESIDENT/CEO
Office: (912) 427-8433
Mobile: (912) 294-0396
Email: drdavis@gachiro.org

Advanced Healthcare & Spine Institute

Patient Information

Initial Appointment Date: ____________________ Patient SSN: ____________________

Last Name: ____________________ First Name: ____________________ MI: ______

Address: ____

City: ____________________ State: ______________ Zip: ________

Gender: ☐ Male ☐ Female Birth date: ____________________

Employer: ____________________ Address: ____________________

City: ____________________ State: ______________ Zip: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Military Duty

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

PHONE: Home:______________ Cell: ______________Work:____________ Emergency: ____________

EMAIL:______________________________ Ethnicity: Caucasian/White__ African American ___ Hispanic ___ Asian ___ Other: ___

Is This Visit Due to an Accident? ☐ YES ☐ NO

(If **checked "NO" please skip steps 1-5 below**)

1) Accident Date:__________ (Required) **2)** Type of Accident: ○ AUTO ○ WORK

3) Has the accident been reported? ○ YES ○ NO **4)** If yes, to whom? ○ Employer ○ Auto Carrier ○ Attorney

5) Attorney/ Employer/ Auto Carrier **NAME**________________ (Required) **Phone**______________ (Required)

Address____________ (If known) **Case Number:** __________________ (If Known)

Insurance Information (Please bring this completed form and insurance card to your appointment.)

Primary Insurance Carrier: ____________________

Primary Insured Person: ____________________

Insured Person Birth Date: ____________________

Insured Person SSN: ____________________

ID/Member #: ____________________

Group Name: ____________________

Group Number: ____________________

Insurance Tel #: ____________________

Patient's relationship to insured: ____________________

Secondary Insurance Carrier: ____________________

Primary Insured Person: ____________________

Insured Person Birth Date: ____________________

Insured Person SSN: ____________________

ID/Member #: ____________________

Group Name: ____________________

Group Number: ____________________

Insurance Tel #: ____________________

Patient's relationship to insured: ____________________

How did you hear about us? ☐ Facebook ☐ Advertisement ☐ Clinixusa.com ☐Insurance Website

☐ Dr. Office:__________________ ☐ Family:__________________ ☐ Friend:__________________

Please sign at both X's

I authorize payment of medical benefits to physician or supplier for these services and all future claims. **X**	I authorize release of any medical information necessary to process this claim and all future claims **X**
Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)

HEALTH HISTORY

Please check to indicate if you are currently (now), or have had any of the following conditions:

New Past
___ ___ High Blood Pressure Duration:______
___ ___ High Cholesterol Duration: ______
___ ___ Chest Pain Duration:_____
___ ___ Shortness of Breath
___ ___ Other heart and vascular disease:
____
___ ___ Asthma/Wheezing
___ ___ Bronchitis or Pneumonia
___ ___ Rash/Hives
___ ___ Congestion
___ ___ Chronic Cough
___ ___ Obstructive Sleep Apnea (OSA), Using CPAP
___ ___ Anemia (low red blood cell count, low iron)
___ ___ Rheumatoid Arthritis
___ ___ Other Immune
___ ___ Vision Problems: blurred / double
___ ___ Cataracts
___ ___ Glaucoma
___ ___ Hearing Difficulty or Hearing Aids
___ ___ Ear Pain
___ ___ Ringing in Ears
___ ___ Balance Problems
___ ___ Nasal or Sinus Problems
___ ___ Hoarseness
___ ___ Nervousness /Anxiety

New Past
___ ___ Breast Lump
___ ___ Fatigue
___ ___ Urinary Discomfort
___ ___ Prostate Problems
___ ___ Diabetes: Type 1 / Type 2
Duration:_____________________
___ ___ Depression Duration:__________
___ ___ Headaches/Migraines
___ ___ Seizures Duration:_____________
___ ___ Dizziness Duration: ____________
___ ___ Thyroid Problems: Hypo /Hyper
___ ___ Paralysis
___ ___ Stroke
___ ___ Head Injury, Memory Loss, Concussion
___ ___ Weight Gain or Loss
___ ___ Sleep Problems
___ ___ AIDS or HIV positive
___ ___ Tuberculosis (TB)
___ ___ Polio
___ ___ Measles
___ ___ Indigestion / Heartburn
___ ___ Bowel Changes
___ ___ Hernia: ___________________________
___ ___ Kidney Disease Duration:___________
___ ___ Kidney Stones

Please List all the medications you are currently taking. *(Please wright on the back of the sheet if necessary) Medication Name, Dosage (#mg), How much/how often (ex. one pill twice a week) or Please have your pharmacy print your medication list:*
____
____
____

PLEASE LIST ANY ALLERGIES: ____

Social History: *Caffeine/Cups per day*: _______ *Alcohol/Drinks per week*:_____ *Cigarettes/Nicotine per day*__________
How many Children? __________ **(Females Only): Are you pregnant? _______ How many weeks?____________**

Past Surgical History: Please list ALL surgeries and/or hospitalizations you have had. (*Type and date***)**
____ DATE: ___________________
____ DATE___________________
____ DATE: ___________________
____ DATE___________________
____ DATE___________________

Is there a family history of any of the following conditions? *(Indicate Family Member: Parents, grandparents, siblings)*
Heart Disease:___________/_________________ Diabetes: ____________/______________ Other: ____________
Cancer (please list type**): _______________/_______________ Arthritis:_______________/_______________**

Current Specialist: *Please provide us with the names and phone numbers of all other doctors you have seen in the past 12 months (i.e Neurologist). Include the names and phone numbers of your medical equipment companies (i.e oxygen, CPAP, machines etc.)*
Name: _____________________________________ Phone: _________________________
Name: _____________________________________ Phone: _________________________
Name: _____________________________________ Phone: _________________________

***Do you have a Primary Care Physician?* _________________________________ *Phone*: ____________________**

Are you in pain?

0	1 - 2	3 - 4	5 - 6	7 - 8	9 - 10
very happy, I do not hurt at all	hurts just a little bit	hurts a little more	hurts even more	hurts a whole lot	hurts as much as you can imagine, you don't have to be crying to feel this bad

Pain Questionnaire

Patient Name: ________________

Neck Pain:
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging
Duration:__________________

Mid Back Pain:
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging
Duration:____________________

Low Back Pain:
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging
Duration:____________________

Headaches:
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging
○ Other
Duration: _____________________

Shoulder Pain: ○ ***RIGHT*** ○ ***LEFT***
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Numbness
○Ache/ Dull ○ Burning/ Stinging
○ Other
Duration: _____________________

Knee Pain: ○ ***RIGHT*** ○ ***LEFT***
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging
○ Other
Duration: _____________________

Hips: ○ ***RIGHT*** ○ ***LEFT***
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging ○ Other
Duration:__________________

Hand/Wrist: ○ ***RIGHT*** ○ ***LEFT***
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Numbness
○Ache/ Dull ○ Burning/ Stinging
○ Other
Duration:_____________

OTHER: ____________________
1 2 3 4 5 6 7 8 9 10

Pain Frequency:
○ Constant/ Daily
○ Comes/Goes ○ Occasional
Type of Pain:
○ Sharp/ Stabbing ○ Stiffness
○Ache/ Dull ○ Burning/ Stinging
○ Other
Duration: _______________

Please rate your pain: (circle if applicable) No Pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain

Signature:____ Date:__________________________________

Neurological and Vascular Questionnaire:

	If YES, on a scale of 1 to 3, How often do these symptoms affect your daily life?	YES 1 = Slight 2 = Moderate 3 = Severe	NO I do not have these symptoms
1)	Do you suffer from neck pain with pain in your shoulder, arms, or hands? Comment:____________________________	YES 1 2 3	NO
2)	Do you have weakness, numbness or burning in your shoulder, arms or hands? Comment:________________	YES 1 2 3	NO
3)	Do your hands and arms fall asleep regulary? Comment:____________________	YES 1 2 3	NO
4)	Do you have reduced feeling (sensation) or swelling in your hands or arms? Comment:______________________________	YES 1 2 3	NO
5)	Do you suffer from loss hand grip strength? Comment:__________________________	YES 1 2 3	NO
6)	Do you suffer from back pain with pain in your buttocks, legs, or feet? Comment:____________________	YES 1 2 3	NO
7)	Do you have weakness, numbness, or burning in your buttocks, legs or feet? Comment:______________________	YES 1 2 3	NO
8)	Do you have reduced feeling (sensation) or swelling in your legs or feet? Comment:____________________	YES 1 2 3	NO
9)	Do you suffer from cold hands or feet? Comment:________________________	YES 1 2 3	NO
	Nurses Only SCORE:		

Please Note:

You may be asked to have the following procedures to better diagnose and treat your condition. We offer these services IN HOUSE for your convenience.

Electromyogram (EMG) / Nerve Conduction Velocity (NCV)

Why It Is Done

To find damage muscle tissue or nerves. Symptoms include: weakness, paralysis, or muscle twitching. This test is also often used to help find nerve problems such as carpal tunnel syndrome or Guillain-Barré syndrome.

Doppler Vascular Ultrasound

Why its done

Doppler ultrasound images can help the physician to see and evaluate:
blockages to blood flow (such as clots).
narrowing of vessels.
tumors and congenital vascular malformations.

Patients Signature:___________________________ Date:________________

Balance Questionnaire:

	If YES, on a scale of 1 to 3, How often do these symptoms affect your daily life?	YES 1 = Slight 2 = Moderate 3 = Severe	NO I do not have these symptoms
1)	Have you fallen in the past year due to dizziness, balance problems, or vision disturbances?	YES 1 2 3	NO
2)	Do you lose your balance when standing?	YES 1 2 3	NO
3)	Do you lose your balance when you initially get up after sitting?	YES 1 2 3	NO
4)	Do you get dizzy, faint, or have seizures?	YES 1 2 3	NO
5)	Do you trip over your own feet or objects on the floor?	YES 1 2 3	NO
6)	Do you use a walker, cane, or need assistance to get around?	YES 1 2 3	NO
7)	Do you have numbness or loss of sensation in your feet or legs?	YES 1 2 3	NO
8)	Have you experienced a stroke, accident, or any other health problems that may have affected you balance?	YES 1 2 3	NO
9)	Do you have ringing in your ears?	YES 1 2 3	NO
	Nurses Only SCORE:	____________	

Please Note:

You may be asked to have the following tests to better diagnose and treat your condition. We offer these services IN HOUSE for your convenience.

Vestibular Autorotation Test (VAT)

Vestibular testing consists of a number of tests that help determine if there is something wrong with the vestibular (balance) portion of the inner ear. Vertigo, dizziness, spinning, wooziness, imbalance, BPPV, off-balance, falls, etc. are all symptoms.

If dizziness is not caused by the inner ear, it might be caused by the brain, by medical disorders such as low blood pressure, or by psychological problems such as anxiety.
Vestibular tests can help determine if more tests, such as a MRI, are needed.

Patients Signature:________________________________ **Date:**____________________

Allergy Questionnaire

This Allergy Questionnaire list symptoms and other factors most commonly found in people sufferingfrom some form of allergy. Filling out this questionnaire should help you and your physician decide if you have an allergy problem.

	If YES, on a scale of 1 to 3 , How often do these symptoms affect your daily life?	**YES** 1 = Slight 2 = Moderate 3 = Severe	**NO** I do not have these symptoms
1)	*Do you have chronic nasal congestion and/or post nasal drip?*	**YES** 1 2 3	**NO**
2)	*Do you lose your balance when standing?*	**YES** 1 2 3	**NO**
3)	*Do you have skin problems such as eczema, hives, or itching?*	**YES** 1 2 3	**NO**
4)	*Do you have asthma, tight chest, wheezing, and or chronic cough?*	**YES** 1 2 3	**NO**
5)	*Frequent ear infections?*	**YES** 1 2 3	**NO**
6)	*Do you have chronic fatigue or tiredness?*	**YES** 1 2 3	**NO**
7)	*Do you have arthritis or muscle aching?*	**YES** 1 2 3	**NO**
	Nurses Only *SCORE:*		

Circle any of the following which seem to trigger (or cause) symptoms or bother you:

Grass Cats Cosmetics Drafts Nervousness Hay Dogs Aerosol sprays House dust Cold AirMold and Mildew Horses Perfumes Smoke Humidity Basements Other animals Insecticides Pollution Weather changes Leaves Alcoholic beverages Odors Exercise Latex (rubber)

When are your symptoms worse?

Year Round January February March April May June July August September October November December

Have you been skin tested?___________ If Yes, When?____________

Allergy Testing: *During allergy skin tests, your skin is exposed to suspected allergy-causing substances (allergens) and is then observed for signs of an allergic reaction.*
Along with your medical history, allergy tests may be able to confirm whether or not a particular substance you touch, breathe or eat is causing symptoms.

EPWORTH SLEEPINESS SCALE

Reviewed:______________ Date:______

How likely are you to doze or fall asleep in the situations described in the boxes below, in contrast to feeling just tired? This refers to your usual way of life in recent times. If you haven't done some of these things recently, try to work out how they would have affected you.

Patient Name:____ Age:________________________

Patient Signature:____ Date:________________________

Neck Circumference:___________________________ Weight:___________________

Using the scale to choose the most suitable number for each situation:

0=would never doze

1=slight chance of dozing

2=moderate chance of dozing

3=high chance of dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching TV	
Sitting, inactive, in a public place (e.g. theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	

TOTAL SCORE = ____

Please check any of the symptoms below that pertain to you:

Loud disruptive snoring		Choking, gasping, or shortness of breath	
Excessive daytime sleepiness		Dry mouth	
Poor judgment or concentration		Frequent trips to the bathroom (night)	
High blood pressure		Acid Reflux (heartburn)	
Witnessed Apnea		Morning headaches	
Stroke		Depression	
Sleep Apnea		Insomnia	
Restless leg syndrome		Heart disease	
Diabetes			

Frequency 0-1 times/week 1-2 times/week 3-4 times/week 5-7 times/week

On average in the past month, how often have you snored or been told that you snore?
Never___ Rarely (+1)___ Sometimes(+2)___ Frequently(+3)___ Almost Always(+4)___
Do you wake up choking or gasping?
Never___ Rarely (+1)___ Sometimes(+2)___ Frequently(+3)___ Almost Always(+4)___
Have you been told that yo stop breathing in your sleep or wake up choking or gasping?
Never___ Rarely (+1)___ Sometimes(+2)___ Frequently(+3)___ Almost Always(+4)___
Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never___ Rarely (+1)___ Sometimes(+2)___ Frequently(+3)___ Almost Always(+4)___

HIPPA Notice of Privacy Practices

Advanced Healthcare & Spine Institute
391 S 1st St, Jesup, GA 31545
912-427-8433

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read and review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that my identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of your physicians practice, and any other uses required by law.

Treatment: We will use and disclose yoru protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians' practice. 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 business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. 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 physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations includes as Required by Law; Public Health Issues as required by law; Communicable Disease Health Oversight, Abuse, or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Worker's Compensation; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as directed in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

Complaints

You may complain to personnel at our office or the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact with your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name:____

Signature:____

Date:____

Advanced Healthcare & Spine Institute Controlled Substance Agreement

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

_____2.) **Refills of controlled substance medications**

_____a) Will be made only during regular office hours *Monday through Friday, in person, once a month, and during a scheduled office visit.* Refills will not be made at night, weekends, or during holidays.

_____b) Will not be made as an "emergency", such as a Thursday afternoon because I suddenly realized that I will run out tomorrow and the office will be closed. **I will call at least (72) hours in advanced if I need assistance with a controlled medication prescription.**

_____3) **I understand the importance of following my treatment plan as directed by my physician/provider and agree:**

a) To keep my appointment (including follow-up and any referrals
b) To permit urine drug screening once a month and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____4) I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and **avoidance of the use of tobacco and alcohol**. I must also comply with the treatment plan as prescribed by my physician.

______5) Fails to comply with medical evaluation and recommended treatment options of pain complaints ordered by AHSI providers such as: Diagnostic tests requested (e.g., Radiology tests, NCV/EMG, EKG) physical therapy, Durable Medical Equipment, Compound topical creams, chiropractic care, pain management, etc.) Your prescriptions for controlled medications may be terminated immediately.

______6) I understand that all the controlled substances must be obtained at the same pharmacy, when possible.

Pharmacy Name: ______________________________ **Phone Number**: ______________________

______ 7) I understand that if I violate any of the conditions listed below, my prescriptions for controlled medications may be terminated immediately and may be subject to dismissal from this facility. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, or sharing/permitting others (including your spouse or family members, who have access to any controlled substance that you have been prescribed). I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

NOTE: We are capable of monitoring your medications through The Georgia *Prescription Drug Monitoring Program*. If we suspect, or feel you have compromised your controlled substance contract with Advanced Healthcare & Spine Institute, we are obligated to use the website for confirmation.

DRUG SCREENS: Urine specimen is collected in the clinic. Patients should not wear coats and other outer clothing or take purses, bags, backpacks into the bathroom. The nurse or provider should confirm promptly that the specimen is appropriately warm and should send it directly to the lab, not give it to the patient to deliver. Drug screens with abnormal results such as:

- Prescriptions patient reports taking daily are not detected on screen.
- Patient tests positive for controlled substances not prescribed by clinic.
- Patient tests positive for illicit substances, particularly cocaine – patients should be referred for drug treatment.
- Patient's drug screen shows negative for drugs prescribe.

After retrieving lab confirmation, it will be determined if the patient should be terminated immediately or may be subject to dismissal from this facility.
Due to the recent law signed by Governor Nathan Deal, concerning controlled substances, we at Advanced Healthcare & Spine Institute, will be instituting the following policies effective ***immediately.*** All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with

*This includes the following:

- All forms of hydrocodone – (Vicodin, Lorcet, Lortab, Norco, Ect.)
- All forms of oxycodone- (Percocet/Percodan, OxyContin, Tylox)
- Most muscle relaxers- (Valium, Soma, Etc.)
- Duragesic, Fentanlyl patches
- Most sleeping agents- (Ambien (Zolpidem), Lunesta, Ect.)
- All Benzodiazepines- (Klonopin (clonazepam), Restoril (temazepam), Serax (Oxazepam), Xanax (Alprazolam)
- Codeine Preparations (Tylenol # 3, Tussionex)
- Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)

INCLUDING: (Concerta, Ritalin (methylphenidate- any brand), Adderall, Dextroamphetamine , and Vyvanse. We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature ______________________________________ Date: ____________________

Advanced Healthcare & Spine Institute
2015

General Consent for Care and Treatment Consent

TO THE PATIENT: This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner or Physician Assistant), Doctor of Chiropractic, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name: ____

Signature: _______________________________________ Date: _______________________

Radiology Fee

This contract is a legal binding agreement between the patient (Name :______________________________) and Advanced Healthcare & Spine Institute. The patient agrees and consents that all the entire X-Ray series preformed and provided will be over read by one or more of the board certified Radiologist on staff with South Georgia Radiology Associates. The patient further agrees to pay a separate, noninsurance reimbursable fee of $15.00 per study area for the above Radiology over read with a written report. This agreement has been reviewed, signed, and agreed by both parties.

Patients Name:____Date:________________

Patients Signature: ____Date:________________

FOR WOMEN ONLY:

Should X-rays be necessary we would like to confirm you are not pregnant at this time

Name:____Date:________________

- There is a possibility I might be pregnant
- Yes, I am definitely pregnant
- No, I am definitely NOT pregnant
- I request the x-ray films NOT to be taken because:____

Date of last menstrual cycle: ___________________________

Patient Signature:____Date__________________________________

Financial Policy Agreement

Advanced Healthcare & Spine Institute

2015

We are dedicated to providing the best possible patient care, and we want you to completely understand our financial policies.

Patients with Insurance

If you have insurance, we will gladly file your claim. Deductibles and co-pays are expected at the time of service. We can only estimate the amount you owe, which is based on the information your insurance carrier provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Insurance claims outstanding 30 days or more will become your responsibility to pay.

Patients with no Insurance

Full payment is expected on the day of service.

Treatment Plans

Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

Missed Appointments

We reserve the right to charge ***$25.00*** for appointments cancelled or missed without 24 hours notice. Example of appointments missed: Medical Follow Up, Diagnostic testing (Vascular, NCV/EMG, Diagnostic Ultrasounds, Etc.) and Physical Therapy. This charge must be paid before another appointment can be scheduled. Arriving ***5 minutes*** or more after your scheduled appointment could result in rescheduling your appointment **without a missed appointment charge.**

Returned Checks

Returned checks will be subject to a ***$30.00*** service fee and charges for any bank fees. This must be paid along with the amount of the check before another appointment can be scheduled. Legal action will take place after 30 days.

Statement of Services

Statement of Services is due upon receipt. We consider an account delinquent after 30 days, and may be assessed a $5.00 per month service charge. Accounts 60 days past due are transferred to collection status. We reserve the right to use outside sources to collect on any past due accounts. You will be responsible for all costs, including attorney fees, court fees, $100.00 administrative fee, etc.

Assignment and Release of Information

I assign the benefits from my insurance carrier to Advanced Healthcare & Spine Institute for the health benefits I am entitled for any services furnished to me. I authorize Advanced Healthcare Center & Spine Institute to release to my insurance carrier any information needed to determine benefits for my care.

Payment Plan Options:

Every patient at AHSI will receive a detailed financial consultation regarding their out of pocket expenses. We offer a variety of payment plan options including hardship agreements when applicable. We make care affordable for everyone.

Authorization

I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time-to-time.

(Please Print)Name of Patient: ______________________________

Signature of patient (or responsible party, if patient is a minor or has a legal guardian):

Signature: ____Date: __________

Medical Records Request

Date:_________________________

Please list the name of the physician(s) who referred you to us or any physician, person(s), business(s), that you would allow us to request medical records from or release your Personal Health information to.

____
____
____
____
____
____
____

I, ____, hereby request that my recent medical records be released to:

____ Physician of Advanced Healthcare Center.

391 S 1st St
Jesup, GA 31545
Phone: 912-427-8433
Fax: 912-427-9851

I understand that this authorization allows the release of all information in my medical records to include lab tests results, x-rays, and any surgical information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 12 months from the date on this form.

Patient Name:____

Patient Address:____

Patient's Date of Birth:____

Patient/Guardian Signature:____