SWAID CLINIC

1021 Montgomery Hwy, Suite 302
Birmingham, AL 35209

Phone: (205) 949-1800
Fax: (205) 870-7735

PATIENT INFORMATION

Patient Name:_____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: _____

SS#: _____ Preferred Language: _____

Race: __ African American __ American Indian __ Asian __ Caucasian __ Other _____

Ethnicity: _____ Hispanic/Latino _____ Non Hispanic/Latino

Phone: Primary: _____ Secondary: _____

Address: _____

Email: _____

Emergency Contact: _____ Phone: _____

Employer: _____

Who referred you to our physician? _____

Who is your primary care doctor? _____

Phone: _____

Would you like your primary care doctor/referring doctor (circle one or both) to receive a copy of your treatment records by our physician? If no, check here: _____

Primary Insurance: _____

Policy # _____ Group # _____

Who is the insured: _____

Relationship to patient: _____ Date of birth: _____

Secondary Insurance: _____

Policy # _____ Group # _____

Who is the insured: _____

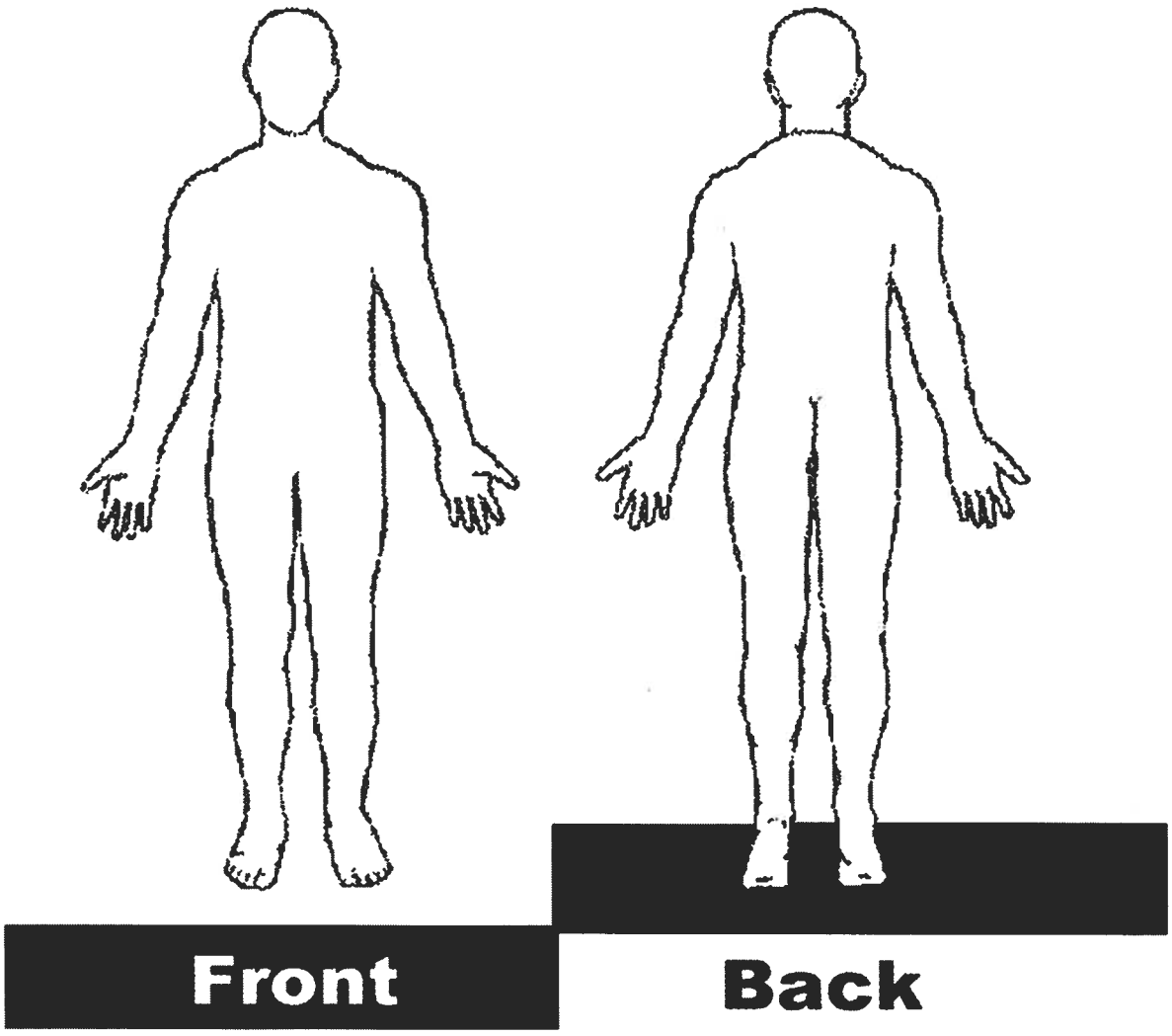
Relationship to patient: _____ Date of birth: _____

NAME:_____ AGE:_____DATE:_____

PATIENT PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensation. Include all affected areas.

Other	Aching	Numbness	Pins & Needles	Burning	Stabbing
0000	▲▲▲	====	++++	xxxx	/////



NAME:_____ AGE:_____DATE:_____

What is your primary complaint?_____

When did your symptoms begin?_____

Did you injure yourself at work? _____ Date of injury:_____

Are you currently working now?_____ Full-duty _____ Light-duty_____

How did you get injured?_____

Have you had previous back or neck problems?_____ Describe_____

_____

What makes it worse?_____

What makes it better?_____

Does coughing or sneezing make it worse? _____

Any change in bowel or bladder habits?_____

Which is worse, back pain or neck pain?_____ Which is worse, back pain or leg pain?_____

Which is worse, leg pain or arm pain?_____ Which is worse, neck pain or arm pain?_____

Which is worse, left arm or right arm?_____ Which is worse, left leg or right leg?_____

Do you have leg weakness? _____ If yes, which leg?_____

Do you have leg numbness?_____ If yes, which leg?_____

Do you have arm weakness?_____ If yes, which arm?_____

Do you have arm numbness?_____ If yes, which arm?_____

Have you ever had an epidural block or steroid injection for pain? _____

For what part of the body?_____ How many blocks have you received?_____

When did you receive them? _____

Name of MD who performed blocks_____

How long did you get relief from the block?_____

Have you ever seen a Chiropractor?_____ If yes, who and when?_____

Have you undergone any physical therapy?_____ If yes, please circle which treatments you received

TENS UNIT HEAT ULTRASOUND POOL THERAPY EXERCISE TRACTION MASSAGE

What are the dates you participated in physical therapy?_____

NAME:_____ AGE:_____DATE:_____

Please list any allergies you have, or specify none: _____

What reaction does each medication allergy cause:_____

_____

Are you in a medication management clinic with another physician?_____ Where?_____

Do you receive medications from another doctor?_____ What doctor?_____

What is your height?_____ Weight?_____ Tobacco use?_____ How much?_____

Do you currently drink alcohol? _____ How much?_____

Please list all current medications (name and dose):_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had any previous back or neck surgery?_____ If yes, please list with date:_____

_____

_____

Have you had any other major surgeries?_____ If yes, please list with date:_____

_____

_____ _____

PLEASE LIST ANY MAJOR COMPLICATION AFTER ANY MAJOR SURGERY PERFORMED IN THE PAST. (i.e. infections, blood clots, lung disorders, nerve damage, bleeding disorders, anesthesia, sexual dysfunctions.)

_____

_____

Please list all past and present medical problems:_____

_____

_____

Signature of patient:_____ Date:_____

NAME:_____ AGE:_____DATE:_____

The following people have my permission to obtain or have discussed with them my Protected Health Information (PHI):

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

The following people have my permission to verify that I am at, or have been at, my doctor visit or treatment:

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

NAME: _____ Relationship to patient: _____

_____ I do not wish to list anyone. I do not want any information to be released.

Authorization to leave messages with other persons or o answering machines/voice mail

I, the undersigned, authorize Neurological Surgery Associates, P.C. to leave messages containing medical information, test results, doctor's recommendations on an answering machine/voice mail at the following phone number(s): _____

Assignment and release

I, the undersigned, authorize my insurance carrier/worker's compensation carrier to pay benefits directly to Neurological Surgery Associates, P.C. and furthermore authorize the release of any and all information required to process my claim. I understand I am responsible for all non-covered services, deductibles, and copays. In the event of a nonpayment or denial of payment by my insurance carrier/worker's compensation carrier, I agree to pay all costs of services and collections, including reasonable attorney's fees, as well as the legal interest on the account until paid in full.

Notice of Privacy Practices

I, the undersigned, have received a copy of Neurological Surgery Associates' Notice of Privacy Practices.

Name (please print)_____ Date: _____

Signature: _____

NAME:_____ AGE:_____DATE:_____

Consent for HIV (AIDS) Screening

HIV screening and hepatitis profile may be done on patients who must be hospitalized for surgery. This screening will not be done until pre-admission testing for surgery. This information is confidential and may not be released to anyone without specific written consent.

I, the undersigned, hereby authorize Neurological Surgery Associates, P.C. to test me for the following:

1) HIV (AIDS) virus
2) Hepatitis

I understand that if either of these tests are positive, the staff of Neurological Surgery Associates, P.C. are authorized to report these findings to the following, and by signing this consent give my permission to release information to:

1) The State Health Department
2) Healthcare workers involved in my care

Name: _____ Date of birth: _____

Signature: _____ Date: _____

NAME:_____ AGE:_____DATE:_____

SWAID CLINIC

1021 Montgomery Hwy, Suite 203
Birmingham, AL 35209

Phone: (205) 949-1800
Fax: (205) 870-7735

Swaid N. Swaid, M.D., F.A.C.S.

Martin P. Jones, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The policy of Neurological Surgery Associates, P.C. is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access, use, or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to persons who are current or former patients of Neurological Surgery Associates, P.C.

Individually identifiable health and personal information is any information obtained by Neurological Surgery Associates, P.C. in connection with providing healthcare treatment and related healthcare operations, and obtaining payment for services. This relates to past, present, or future information that Neurological Surgery Associates, P.C. receives from you as our patient.

Neurological Surgery Associates, P.C. collects personal information in order to learn about your medical history and medical conditions, render treatment, and collect payment for our services. We gather this information from your patient forms, health questionnaires, and other forms you will be asked to complete from time to time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative, and your family members. Your healthcare plan or insurance carrier may also provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment, discussion regarding treatment alternatives or other health-related benefits, and communications such as follow-up and appointment reminders. As part of our standard treatment and healthcare operations, we may share some information with a facility such as a hospital, laboratory, diagnostic service, or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review, and related activities. For worker's compensation, information about work-related conditions can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in your electronic medical record. Neurological Surgery Associates, P.C. limits the access to your protected health information to those employees and business associates who need to know

NAME:_____ AGE:_____DATE:_____

that information. With some limitations, you have the right to inspect, amend, copy, and receive an accounting of disclosures of your medical billing records.

We do not disclose personal information outside of the reasons listed above to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, and the applicable dates. This authorization must be signed by the patient (or guardian). You may revoke this authorization by providing a written statement to Neurological Surgery Associates, P.C.
- Federal, State, or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Neurological Surgery Associates, P.C. will give you a notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the right to request your records to be amended, to request special accommodations and restrictions of your health information, and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communication of your information. Neurological Surgery Associates, P.C. is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact the Practice Manager at (205) 949-1800. You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

Other uses of PHI:

- We may leave a message on your answering machine or voice mail to contact you about appointments or to have you call our office.

NAME:_____ AGE:_____DATE:_____