James L. Chappuis, MD, FACS
Julio Petilon, MD

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Kaela White, FNP-BC
Lynelle Endsley, NP-C

Patient Information Form
(Please fill this form out to its entirety)

Date: _____

Patient Name: _____Sex: M____ F____
First Middle Last

Address: _____ Apt#:_____

_____ Zip: _____
City State

Telephone #:_____ Cell#:_____ Email: _____

Birthdate: _____ Age: _____ Marital Status: _____ Social Security#: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Phone: _____

Emergency Contact Person: _____ Phone: _____

Relationship to you: _____ Address: _____

Who referred you to our office? _____

Attorney Name: _____

Have you been treated for this condition elsewhere? Yes _____ No _____

If yes, where and by whom? _____

Is your visit related to an auto accident? Yes _____ No _____ Date of accident: _____

Is your visit related to a work injury? Yes _____ No _____ Date of accident: _____

Have you ever had any previous automobile or work accidents? Yes ____ No ____

Date of accident: _____

Internal Use Only

ATTORNEY INFORMATION

(This form must be completed if the patient is represented by an attorney)

Attorney Name: _____

Street Address: _____

Suite: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

REFERRING PHYSICIAN INFORMATION

(This form must be completed if the patient was referred by another doctor)

Referring Physician Name: _____

Street Address: _____

Suite: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Patient: _____ Date: _____

Past Medical History

Do you have any medical problems? (i.e. high blood pressure, diabetes, cancer, high cholesterol, asthma, heart problems, kidney problems, lung problems, stomach ulcers, stroke):

	Condition:	Treated by (Physician):
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.		

Surgical History

Please list all surgeries in your lifetime, including childhood surgeries (i.e. tonsils, appendix):

	Surgery:	Date:	Physician:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Medications:

Please list all medications and the prescribing physicians:

	Medication and Dose:	Prescribing Physician:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Have you traveled outside of the region (i.e. state of Ga) in the past 21 days? _____Yes _____No

If yes, where? _____

Most Current Medical History

Do you have any of the following syptoms? Circle yes or no.

Fever	YES	NO	Rash	YES	NO
Fatigue	YES	NO	Internal/External Bleeding	YES	NO
Headache	YES	NO	Impaired Kidney/Liver Function	YES	NO
Sore Throat	YES	NO	Oozing from the Gums	YES	NO
Vomiting	YES	NO	Blood in the Stool	YES	NO
Diarrehea	YES	NO			

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Patient Name: _____ Date: _____

Are you allergic to any medications? ____ Yes _____No

If yes, please list medication and type of reaction you have.

1. _____
2. _____
3. _____
4. _____

Social History

Do you smoke: _____Yes _____ No If yes, how long? _____ years How many packs per day? _____

Have you ever smoked? _____Yes _____ No If yes, how long? _____years

How many packs per day? _____ When did you quit smoking? _____

Do you drink alcohol? _____Yes _____ No If yes, circle one: daily occasionally socially rarely

Do you use illicit drugs? _____Yes _____ No If yes, what substance: _____

Name the company you work for: _____

Position: _____

Are you working at this time? _____ Yes _____ No If no, date of the last day worked: _____

Are you _____ single, _____ married, _____divorced, _____ widowed, _____separated

Do you have children? _____ Yes _____ No If yes, how many? _____

Family History

Mother _____ Living _____Deceased Age_____ or age at death _____

Reason for death or other health problems? (i.e. diabetes, high blood pressure, cancer, asthma, heart attack, stomach ulcers, stroke) Please list: _____

Father _____ Living _____Deceased Age_____ or age at death _____

Reason for death or other health problems? (i.e. diabetes, high blood pressure, cancer, asthma, heart attack, stomach ulcers, stroke) Please list: _____

Siblings:

Number of Sisters: _____ Number of Brothers: _____

Any health problems? (i.e. diabetes, high blood pressure, cancer, asthma, heart attack, stomach ulcers, stroke) Please list: _____

Patient Signature: _____

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REVIEW OF SYMPTOMS

Do you currently have any of these symptoms?

Please check the symptoms that best describe you condition.

Constitutional Symptoms

- □ Fever
- □ Night Sweat
- □ Weight Loss

Cardiovascular

- □ Shortness of Breath
- □ Chest Pain
- □ Irregular Heartbeat

Respiratory

- □ Chronic Cough
- □ Coughing Blood
- □ Emphysema
- □ Bronchitis
- □ Palpitations
- □ Asthma

Gastrointestinal

- □ Weight Loss
- □ Blood in Stool
- □ Dark Colored Stool
- □ Abdominal Distention
- □ Diarrhea
- □ Constipation
- □ Abdominal Mass or Lump

Psychiatric

- □ Depression
- □ Disorientation
- □ Hallucination
- □ Euphoria
- □ Anxiety

Genitourinary

- □ Any Burning on Urination
- □ Dark or Discolored Urine
- □ Difficulty Starting/Ending
- □ Urine Stream
- □ Poor Control of Bladder
- □ Excessive Thirst
- □ Any Type of Sexual Dysfunction
- □ Inability to Obtain/Maintain Erection
- □ Loss of Sensation, Genitals

Endocrine

- □ Discharge from Nipples
- □ Poor Appetite
- □ Cold Intolerance
- □ Dry Skin
- □ Excessive Thirst
- □ Loss of Body Hair
- □ Anxiety
- □ Weight Gain
- □ Weight Loss

Skin and Breast

- □ Dry Skin
- □ Discharge from Nipples

Hematolic/Lymphatic

- □ Easy Bruising
- □ Nose Bleeds

Allergic/Immunologic

- □ Body Rash

Musculoskeletal

- □ Swelling
- □ Masses
- □ Neck Pain
- □ Neck Spasm
- □ Cramps
- □ Abnormal Arm of Leg Feelings
- □ Arm or Leg Weakness
- □ Poor Coordination
- □ Numbness
- □ Tingling
- □ Loss of Sensation
- □ Loss of Muscle Bulk

Neurological

- □ Poor Vision
- □ Blurry Vision
- □ Double Vision
- □ Loss of Hearing (one or both)
- □ Ringing in Ears
- □ Numbness in Face
- □ Decreased Ability to Taste
- □ Droopy Face or Eye
- □ Hoarseness
- □ Difficulty of Speaking
- □ Difficulty of Swallowing
- □ Slurred Speech
- □ Headache
- □ Dizziness
- □ Seizures

Handedness: (L or R)

Gender: (M or F)

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RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

To Whom It May Concern:

I do hereby authorize copies of my medical records including findings on examination, plan of management, laboratory studies, and/or radiological report to be sent to:

Orthopaedic and Spine Surgery of Atlanta
Office of: Dr. James Chappuis, MD
Dr. Julio Petilon, MD
Phone Number: 404-351-5812
Fax Number: 404-351-6017

Thank you for your assistance in this matter:

_____ Date: _____

Signature of Patient

Orthopaedic and Spine Surgery of Atlanta
3164 Howell Mill Road Suite 400
Atlanta, Ga 30327

PREGNANCY TESTING

As a routine part of the physical exam, radiographic images may be required to assist in assessing a patient's condition. All women of childbearing age are asked about their pregnancy status and last menstrual period. Women who deny pregnancy will be asked to sign a pregnancy waiver (see below). If unsure, a urine pregnancy test will be offered to you. As there are risks to developing babies in the womb with exposure to radiation, the benefits of this simple test to potential mother and baby are enormous. Your physician will discuss these issues with you and answer any questions you may have. All patients, however, for reasons of privacy or otherwise, may refuse to have this urine pregnancy test performed. We ask only that you fully understand the risks to the developing baby when having radiographic images taken. Our goal is to provide the safest, highest quality of medical care. If you have questions, please consult your physician/provider.

PREGNANCY WAIVER FORM

I, _____ certify that the risks of having radiographic images performed while pregnant have been explained to me, and I am not pregnant or cannot conceive. If the chance of pregnancy is in question, I have been offered the opportunity to take a pregnancy test and I decline. I will also inform the staff of SpineCenterAtlanta at any future visits if I may have become pregnant, and take full responsibility for requesting a pregnancy test. I hereby release SpineCenterAtlanta and Affiliates of any liability if I am indeed pregnant at the time radiographic images are taken.

_____ _____

Patient/Guardian/Parent Signature Date

_____ _____

Witness Signature Date

CANCELLATION POLICY

All appointments missed, cancelled, and rescheduled with a less than **24 HOUR** in advance notice for clinic visits with Orthopaedic & Spine Surgery of Atlanta will be subject to a $150.00 cancellation fee for new patient appointments and $100.00 cancellation fee for follow-up appointments. This fee is the responsibility of the patient and cannot be billed to private insurance companies or attorneys.

DRUG SCREENING POLICY

Orthopaedic & Spine Surgery of Atlanta ("OSSA") employs a policy of **RANDOM DRUG SCREENING** for patients receiving prescription medication(s) ordered by our physicians and mid-level providers. If you are unable to comply with this policy, please notify the medical assistant when they first see you in the treatment room. OSSA providers have the right to (1.) deny medication refills and/or (2.) refer patients who decline a random drug screen to a different medical provider. We appreciate your understanding in this matter.

Print Name: _____

Signature: _____

Date: _____

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Spine Center Atlanta is a program of
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3161 Howell Mill Road NW
Atlanta, Ga 30327
404-351-5812

Assignment of Benefits & Financial Policy

Financial Responsibility:

I have read, understand, and agree to the SpineCenterAtlanta & Affiliates Financial Policy, a policy which covers Orthopaedic & Spine Surgery of Atlanta LLC; I understand co-payments, co-insurance, deductible and all charges not covered by my health insurance are my responsibility. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier or legal counsel. Necessary forms will be completed to file for health carrier payments.

Assignment of Benefits: I hereby ASSIGN all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan or, to issue payment directly to any of the above entities of SpineCenterAtlanta & Affiliates, for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:
I hereby authorize and direct SpineCenterAtlanta and Affiliates to:

1. Release any information necessary to insurance cariers regarding my treatments.
2. Release any information necessary to my attorney regarding my treatments.
3. To process and submit insurance claims generated in the course of examination or treatment.
4. To allow a photocopy of my signature to be used to process insurance claims. This signature will remain in effect until revoked by me in writing.

I have requested medical services from SpineCenterAtlanta & Affiliates on behalf of myself and/or my dependent(s). I understand that I will be responsible for any and all charges incurred in the course of the treatment authorized. In the event that it becomes necessary to employ a collection agency to enforce payment of the balance under this agreement/contract, I agree to pay for collections cost and fees equal to 33.33% of the delinquent balance associated with the collection thereof, including but not, attorney's fees and court costs.

A photocopy of this assignment is to be considered as valid as the original.

Patient Name (Print): _____ Patient Signature: _____ Date: _____

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Notice of Privacy Practices

To our patients, this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to our health information. This is required by the Privacy Regulations creates as a result of the Health Insurance Portability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of Your Health Information

In Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

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Your Rights Regarding Your Health Information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree with your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Orthopaedic & Spine Surgery of Atlanta, Attention Office Manager, 404-351-5812.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Orthopaedic & Spine Surgery of Atlanta, Attention Office Manager, 404-351-5812. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Orthopaedic & Spine Surgery of Atlanta, Attention Office Manager, 404-351-5812. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Orthopaedic & Spine Surgery of Atlanta, Attention Office Manager, 404-351-8512.

I hereby acknowledge that I have been presented with a copy of Orthopaedic & Spine Surgery of Atlanta's Notice of Privacy Practices.

Signature: _____ Date: _____

Name of Patient: _____

Orthopaedic & Spine Surgery of Atlanta LLC
3161 Howell Mill Road N.W., Suite 400
Atlanta, Ga 30327
Tel 404-351-5812 Fax 404-351-601

Spine Center Atlanta is a program of Orthopaedic & Spine Surgery of Atlanta LLC

AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ SSN: _____
DOB: _____/_____/_____

To: SpineCenterAtlanta & Affiliates, including Orthopeadic & Spine Surgery of Atlanta, LLC; SpineCenterAtlanta Rehabilitation & Wellness, LLC; Atlanta Orthopaedic Surgery Center, LLC.

You are HEREBY authorized and directed to permit the examination of, and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by my attorney, _____, or such other persons as they may authorize from the Law office of _____, any or all portion of the following.

Entire Medical record, Abstract of records, Financial record, Pathology reports, Radiological reports, Consent forms, Consultation reports, Discharge summary reports, Doctor's Orders, Doctor's Clinical Records, Face Sheets, History and Physical Record, Intake forms, Laboratory Test Results, Medication Record, Operative Reports, Physical/Occupational/Massage Therapy Reports, Treatment Plans, Evaluations/Plans of Care, Diagnostic photos, MRI Reports/Images, Chiropractic-Specific documentation and clinical findings, Exercise Flow sheets, Anesthesia records.

O.C.G.A. § 9-11-9.2 requires the filing of this authorization and provides in the pertinent part:
"(b) that attorney representing the defendant is authorized to obtain and disclose protected health information contained in the medical records to facilitate the investigation, evaluation, and defense of the claims and allegations set forth in the complaint which pertain to the plaintiff, or, where applicable, the plaintiff's decedent whose treatment is at issue in the complaint. This authorization includes the defense attorney's right to discuss care and treatment of the plaintiff, or where applicable, the plaintiff's decedent with all of the plaintiff's or decedent's treating physicians," and *"(c) the authorization shall provide for the release of such information by any physician or health care records of the plaintiff or plaintiff's decedent would be maintained."*

Nothing contained in O.C.G.A. § 9-11-9.2 requires any health care provided to meet with defense counsel. You shall have no oral communications with the defense counsel regarding the above-named patient's protected health information without said patient's attorney present. Further, pursuant to federal law, specifically the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the secretary of Health and Human Services (HHS) may LEVY CIVIL MONETARY PENALTIES AND IMPOSE CRIMINAL SANCTIONS AGAINST THOSE WHO WRONGFULLY DISCLOSE A PATIENTS PROTECTED HEALTH INFORMATION. See 42 U.C.S. §§ 1320d-6 (2002). The undersigned maintains that this federal law preempts State law, including the provisions of O.C.G.A. § 9-11-9.2. You may wish to consult with an attorney before disclosing the undersigned patients protected health information to anyone other than the patient and his/her legal representative named herein.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by that recipient of the information and may then no longer by protected by the federal privacy regulations. I understand that unless otherwise limited by the state or other federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the provider has taken action with reliance on the authorization. I further understand the Authorization is specific to the information listed above, for the date(s) of service indicated, and the purpose written above. I understand that this disclosure may include psychiatric, drug/alcohol, and or HIV testing results and/or AIDS related information. This provider shall not condition treatment on the receipt of this authorization, except when such conditioning is permitted in the circumstance identified in the policy entitled "Authorization for release/Discloser of protected health Information."

This authorization and/or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of PHI. I understand that a photo static or faxed copy of this authorization is as valid as the original.

You are further authorized to furnish oral and/or written communication to my attorney, or his delegate as requested by said attorney on any of the foregoing matters. You are requested to treat such information as confidential, and you are requested not to furnish and of such information, in any form to anyone, withour express written authorization from me or my attorney, _____. I also authorize my attorney or his delegate to photograph my person while I am present in any hospital, clinic, or medical facility affiliated with SpineCenterAtlana & Affiliates.

I further understand that this Authorization is valid for **ONE YEAR** following the period of time in which I am enrolled in care with SpineCenterAtlanta & Affiliates, unless an earlier expiration date is written here by me _____.

Patient Signature: _____ Date: _____

James L. Chappuis, MD
3161 Howell Mill Road Suite 400
Atlanta, Ga 30327
Phone 404-351-5812
Fax 404-351-6017

PRIVATE CONTRACT

between

Medicare/Medicaid Beneficiary and "Op Out" Physician James L. Chappuis

I, _____, understand that Dr. James L. Chappuis has "opted out" of Medicare and Medicaid, and by signing this private contract, I or my legal representative:

Gives up all Medicare/Medicaid coverage, and payment for, services furnished by the "opt out" physician, Dr. James L. Chappuis;

Agrees not to bill Medicare/Medicaid or ask the physician, Dr. James L. Chappuis to bill Medicare/Medicaid; (This does not apply to emergency care services or urgent care services.)

Is liable for all charges of the physician, Dr. James L. Chappuis, without any limits that would otherwise be imposed by Medicare/Medicaid;

Acknowledges that Medigap will not pay towards the services and other supplemental insurers may not pay either;

Acknowledges that he or she has the right to receive services from facilities (surgical center, etc.), physicians, and practitioners for whom Medicare/Medicaid coverage and payment would be available.

_____ or _____

Patient Signature Legal Representative

_____

Date of Signature

_____

Dr. James L. Chappuis

_____

Date of Signature