Registration and Billing Information
Vermont Interventional Spine Center

LAST NAME _____ FIRST NAME _____ MI _____

MAILING ADDRESS _____

CITY_____STATE_____ZIPCODE _____

PHONE NUMBERS: HOME: _____ CELL: _____ ALTERNATE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SEX (M/F) _____MARITAL STATUS: (MARRIED/SINGLE) _____

SOCIAL SECURITY # _____ FORMER NAME(S) _____

EMERGENCY CONTACT & PHONE # _____

REFERRED BY: _____ PRIMARY CARE DOCTOR: _____

ETHNICITY (Please Check one):
__Latino/Hispanic
__Not Hispanic/Latino
__Decline to answer
__Don't Know

Race (Please check one):
__Asian
__African American/Black
__American Indian/Alaskan Native
__Native Hawaiian/Other Pacific Islander
__More than one race
__White
__Decline to answer

PREFERRED LANGUAGE: _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING ADDRESS (if different than above) OR ALTERNATE SEASONAL ADDRESS:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

RELATIONSHIP _____ PHONE NUMBER _____

INSURANCE INFORMATION:

INSURANCE 1 _____ **COPAY AMOUNT $** _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

IDENTIFICATION # _____ GROUP # _____

INSURANCE 2 _____ **COPAY AMOUNT** $ _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

IDENTIFICATION # _____ GROUP # _____

I authorize the release of any medical information necessary to determine my benefits and to process my claims for all services. Signature_____Date _____	I authorize payment of medical benefits for all services provided to Vermont Interventional Spine Center. Signature_____ Date _____

IS CONDITION RELATED TO EMPLOYMENT? _____ AUTO ACCIDENT? _____ OTHER ACCIDENT? _____ rev 10/01/2014

PAYMENT POLICY FOR SERVICES RENDERED

IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES, please initial the appropriate line. We are providers for these companies and will bill them directly. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are also responsible for any deductible or out of pocket expense stipulated by your contract with your insurance company. your should always check with your insurance company for

____ BCBS Out of State Plan or Federal
____ Medicare
____ VT Medicaid
____ CBA
____ Aetna Medicare
____ BCBS of Vermont
____ MVP
____ CIGNA/ Great West
____ United Health Care NY
____ Tricare For Life or Prime

IF YOU HAVE WORKERS COMPENSATION COVERAGE, we must have information approving the claim from your employer and accurate billing address information to process the claim. Without this, we will consider payment for this visit to be your responsibility. Vermont Interventional Spine Center requires authorization in writing for all workers compensation visits.

Name of Insurance Company: _____
Address: _____
Claim Number: _____ Date of Injury: _____
Contact Person and their title: _____
Phone: _____ Fax: _____

IF YOU HAVE COVERAGE WITH ANOTHER INSURANCE COMPANY, WE MAY NOT HAVE A CONTRACT WITH THEM. With a copy of your card, we will submit a claim directly to your insurance company for reimbursement. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to the office for payment. If the payment is sent to me, I will forward this payment to the office <u>immediately</u>. If payment is not received by the office within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: _____Signed: _____ Date: _____

IF YOU DO NOT HAVE INSURANCE, you are responsible for payment of your bill, in total, at the time of your visit. We accept personal checks, credit cards or cash. Any Self Pay must be pre-approved before scheduling.

FOR ALL PATIENTS TO READ AND SIGN:

"I understand and agree that regardless of my insurance, I am in the end responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Vermont Interventional Spine Center incurs any collection charges, they will be my responsibility."

<u>If the patient is a minor</u>: **"By consenting to care at Vermont Interventional Spine Center, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

_____ _____
Patient or Guardian Signature Revised 10/26/2017 Date

Vermont Interventional Spine Center
356 Mountain View Drive, Suite 200
Colchester, VT 05446

Consent to Use or Disclose Protected Health Information for Treatment, Payment and Healthcare Operations

I consent to allow *Vermont Interventional Spine Center* to use or disclose my protected health information for treatment, payment and healthcare operations.

-Treatment means the provisions, coordination, or management of healthcare and related services by one or more healthcare providers.

-Payment means the activities undertaken by a healthcare provider or health plan to obtain or provide reimbursement for the provisions of healthcare.

-Healthcare operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; business management and general administrative activities of *Vermont Interventional Spine Center*.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information for treatment activities of another healthcare provider.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information to another covered entity or to another healthcare provider for the payment activities of the entity that receives the information.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information to another covered entity for healthcare operations activities, provided that *Vermont Interventional Spine Center* and the other entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or healthcare operations or for the purpose of healthcare fraud and abuse, detection, or compliance.

I acknowledge that I have received a copy of *Vermont Interventional Spine Center's* Notice of Privacy.

Name of patient_____

(PLEASE PRINT)

_____

Signature of Person Authorizing Consent Date

_____

Vermont Interventional Spine Center
Consult Form

Thank you for choosing to receive your care at VISC. We are dedicated to providing quality consultative and interventional services in a safe, supportive and efficient manner. To that end, you can assist us greatly by filling out the follow form to the best of your knowledge. This will provide you with an opportunity to express, in your own words, some of the symptoms you have been experiencing. Together with the information provided by your referring physician, we hope to accurately assess your condition as well as your concerns.

Name: _____DOB_____ Date: _____

Referring Physician: _____ Primary Care Physician: _____

Circle or **fill in** where appropriate.

1. Where is the **primary** location of your pain?

a. Low Back
b. Mid back
c. Neck
d. Head/Face
e. Hip
f. Shoulder
g. Knee
h. Other:_____

OFFICE USE ONLY
PAIN LEVEL:
BP:
PULSE:
TEMP:
HT:
WT:
FLU: YES / NO DATE:
PNEU: YES / NO DATE:

2. Please **circle** any of the following that describe the primary or secondary areas of pain.

a. Aching
b. Dull
c. Sharp
d. Burning
e. Numb/Tingling
f. Electric shock like
g. Pressure
h. Stabbing
i. Pinching

3. General intensity of pain (scale of 0-10): _____

4. How long have you had this pain? _____ is the pain constant or intermittent? _____

5. Is this pain the result of an accident or injury? Yes / No

a. When? _____

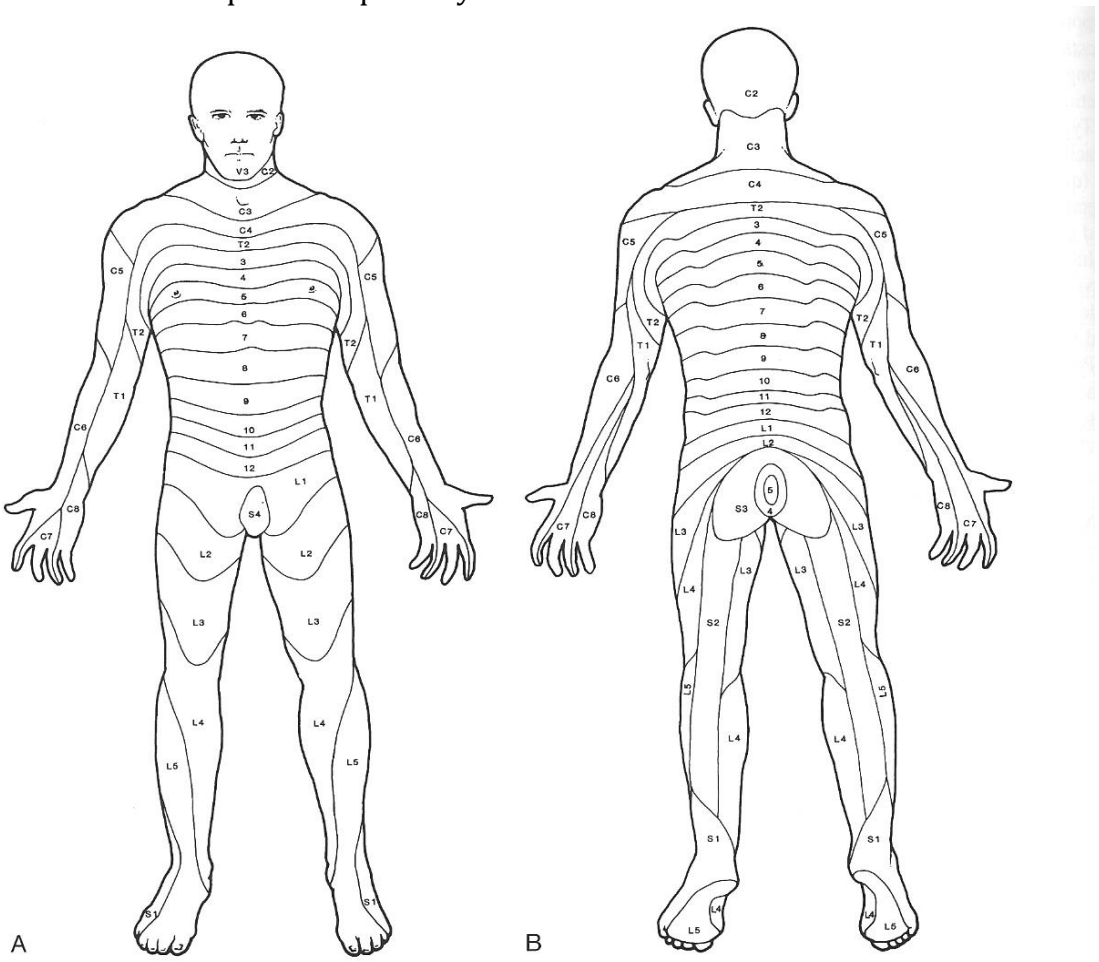
b. Litigation involved? _____

6. Have you ever had pain in the same or similar location in the past? Yes / No

If so, when? _____

Name: _____

7. On the figures below please draw an X (or X's) over the primary location of your pain. Shade in areas that the pain radiates to or is painful separately.



Anterior *(A)* and posterior *(B)* dermatomes of the body. (From Baker AB, Baker LH: Clinical Neurology. Vol 1. New York, Har

8. Activities which increase pain: _____

9. Activities which decrease pain: _____

10. Previous Tests <u>MRI:</u> Yes / No <u>CT Scan:</u> Yes / No <u>X-RAYS</u>: Yes / No

When?_____Where?_____Ordering Provider?:_____

11. Have you received any of the follow treatments in the past?

☐	Physical Therapy	Yes/No	Did it help?	Yes / No
☐	Physical Modalities (Ice/Heat)	Yes/No	Did it help?	Yes / No
☐	Chiropractic Manipulation	Yes/No	Did it help?	Yes / No
☐	Osteopathic Manipulation	Yes/No	Did it help?	Yes / No
☐	Surgery	Yes/No	Did it help?	Yes / No
☐	Injection Therapy	Yes/No	Did it help?	Yes / No
☐	Biofeedback/Relaxation Techniques	Yes/No	Did it help?	Yes / No
☐	Acupuncture	Yes/No	Did it help?	Yes / No
☐	Naturopathic/Herbalist Treatment	Yes/No	Did it help?	Yes / No

Name:_____

12**. PAST Medications**: Please list all the medications you have taken in the past for your current pain:

1. Medication:_____Dose:_____Frequency:_____Did it help?_____
2. Medication:_____Dose:_____Frequency:_____Did it help?_____
3. Medication:_____Dose:_____Frequency:_____Did it help?_____
4. Medication:_____Dose:_____Frequency:_____Did it help?_____
5. Medication:_____Dose:_____Frequency:_____Did it help?_____
6. Medication:_____Dose:_____Frequency:_____Did it help?_____
7. Medication:_____Dose:_____Frequency:_____Did it help?_____
8. Medication:_____Dose:_____Frequency:_____Did it help?_____
9. Medication:_____Dose:_____Frequency:_____Did it help?_____
10. Medication:_____ Dose:_____Frequency:_____Did it help?_____

If you are not presently taking a medication that was effective for you, what is the reason your stopped? (Side effects,
etc)_____
_____

13. **CURRENT Medications:** Please list all medications,including over the counter medications, vitamins or herbal/naturopathic medications/supplements. Include medications you currently take, sometimes take or have taken in the past two weeks. (use back of form if needed)

1. Medication:_____Dose:_____Frequency:_____
2. Medication:_____Dose:_____Frequency:_____
3. Medication:_____Dose:_____Frequency:_____
4. Medication:_____Dose:_____Frequency:_____
5. Medication:_____Dose:_____Frequency:_____
6. Medication:_____Dose:_____Frequency:_____
7. Medication:_____Dose:_____Frequency:_____
8. Medication:_____Dose:_____Frequency:_____
9. Medication:_____Dose:_____Frequency:_____
10.Medication:_____Dose:_____Frequency:_____

14. **Allergies:** Please list all known allergies **( ) Please check if no known allergies**

Allergen:_____Reaction:_____

Allergen:_____Reaction:_____

Allergen:_____Reaction:_____

15: **History of falling:** Please check one of the following:

___No falls in the past year ___One fall without injury in the past year
___Any fall with an injury in the past year ___Two or more falls in the past year

Name: _____

16. **PAST/PRESENT Medical History**. Please check or list any **previous or current** medical conditions/illnesses which you are taking medication for or have required treatment, consult, or evaluation.

	Medical History		Medical History		Medical History
	Fatigue		Easy bleeding		Urinary tract infection
	Fever/Chills		Rash		History of Stroke
	Weight loss (unexplained)		Cancer Type:		History of heart attack
	Vision changes		Night Sweats		Chest Pain
	Central Serous Retinopathy		History of HIV		High Cholesterol
	Hearing loss		History of Hepatitis		High Blood Pressure
	Lightheaded/dizzyness		Heartburn/gastric ulcer		Difficulty breathing
	Headache		Nausea		Cough
	Sinusitis		Vomiting		Asthma
	LimbWeakness		Constipation		COPD
	Limb numbness		Change in bowel movement		History of Pneumonia
	Swelling in hands		Diabetes		History of Bronchitis
	Swelling in feet		Thyroid disorder		Anxiety
	Arthritis		Change in Urinary Habits		Depression
	Use of walker/cane		Kidney disease		Bipolar disorder
	Easy bruising		History of kidney stones		Other:

17. **PAST Medical History:** Please list ALL medical conditions not listed above:

_____
_____
_____
_____
_____

18. **PAST Surgical History:** Please list any and all surgeries:

_____
_____
_____
_____
_____
_____

19. **Known Family History:** If Yes, Please indicate family member

Heart Disease:	Yes/No	__Mother __Father __Sister __Brother
Diabetes:	Yes/No	__Mother __Father __Sister __Brother
Cancer:	Yes/No	__Mother __Father __Sister __Brother

Name: _____

Personal History:

19. **Tobacco Use:** ____Current Smoker, every day ____Heavy Tobacco Smoker ____Former Smoker
____Current Smoker, some days ____Light Tobacco Smoker ____Never Smoked

When did you start? _____ When did you quit? _____

Do you use other tobacco products? Yes / No How much? _____

20. **Alcohol Use:**
- Do you drink alcohol? Yes / No
- How often? _____ drinks per day / week / month / year

20. **Other Substances:** (Current and or past use)

a.	Marijuana	Never Used___	Past Use ___	Current Use___
b.	Cocaine	Never used___	Past Use ___	Current Use ___
c.	Heroin	Never used___	Past Use ___	Current Use ___
d.	Other street narcotics	Never used___	Past Use ___	Current Use ___
e.	Amphetamines (speed)	Never used___	Past Use ___	Current Use ___
f.	Barbiturates (downers, etc.	Never used___	Past Use ___	Current Use ___

21. **Occupation / Education**:

Are you presently employed? Y / N Occupation: _____
Retired? Y / N Previous Occupation: _____
Disabled? Y / N Date last able to work: _____

Highest grade completed _____

22. **Social Arrangements:** (Please Circle)

Single
Married
Divorced
Living with other *Do you have Children: Yes / No
Widowed *Children in same household: Yes / No

Other information that may be important for your care:

_____
_____
_____
_____
_____

Directions

Coming from the North: Travel south on I-89, take exit 16, go left off the exit, take your first left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200

Coming from the South: Travel north on I-89, take exit 16, go right off the exit, take your first left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200

From the Winooski Circle: Head north on RT 7 (Main Street), you will pass under I-89, take a left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200