Endoscopic & True Minimally Invasive Spine Expert
MICROSPINE
A Non-Fusion Alternative

2155 E Conference Dr. #115, Tempe, AZ 85284
Tel: 602-833-2141 Fax: 602-610-3878
Email: microspinemd@gmail.com
www.microspinemd.com

WHAT TO BRING TO YOUR VISIT

- ❑ **MICROSPINE Information Sheet**
  Complete this information sent to you.

- ❑ **Medication List | Drug Allergies**
  Make a list of any medications you are currently taking including dosages and frequency. Include a list of any drug allergies you may have. Provide us your current pharmacy telephone and fax numbers.

- ❑ **Insurance Company Information**
  Please have your insurance card and insurance company information, including the group number and address where claims should be sent.

- ❑ **Workers Compensation Information**
  Bring the claim number, insurance carrier, address, contact person and phone number if you are covered by workers compensation.

- ❑ **Co-pay**
  If your insurance has a co-pay, you must pay this amount before being seen. We Accept cash, debit or credit cards. Sorry, no checks are accepted.

- ❑ **Insurance Authorization | Doctor Referral**
  We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company, if this is required. We will not see you if we don't have a required referral and authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Please have your authorization number when you make your appointment with us.

- ❑ **X-rays, MRI Scan, CT Scan, Other Studies: MUST bring CD or actual images**
  Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiologist reports. Bring all studies that have been done.

- ❑ **If You Require Disability Forms –**
  We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration free of charge. However, If you require disability forms completed for privately-held policies such as those that protect your car, wages, home or credit cards, we charge $5 per page up to a maximum of $25/form. Your insurance plan will not reimburse you for the preparation of these forms nor will it reimburse Microspine PLC.; therefore, we require payment before completing the form. Upon receipt of full payment and your signature which acknowledges your understanding of our policy, we will complete your forms. Ask to sign our Disability Form Acknowledgement if you need disability forms filled out.

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PATIENT INFORMATION RECORD

Patient Name _____Age_____ Male Female
Last First Middle Initial

Race/Ethnicity: Decline to answer American Indian Asian Black/African American White/Caucasian
Alaskan native Pacific Islander Unknown Hispanic Multi-racial Native Hawaiian Other: _____

Date of Birth: _____/_____/_____ Social Security Number _____-_____-_____ Marital Status: S M W D

Mailing Address_____ City_____ State ___ Zip Code _____

Home phone Number (____) _____ Alternate Daytime Phone Number (____) _____

Cell phone (____) _____ Work phone (____) _____ Primary Language Spoken: _____

EMAIL address: _____ Alternate EMAIL ADDRESS: _____

What is best way to reach you? Home Cell Work EMAIL Other: _____

Can we leave a message on your home or cell phone that contains personal information? Yes No

May we send you updates about our practice to your email? Yes No N/A

Employer _____ Occupation _____ How Long? _____

Street Address _____City _____ State _____ Zip Code _____

Patient's Primary Doctor _____ Phone (___) _____

Your Doctor's Address _____ City _____ State _____ Zip _____

Patient's Pharmacy _____ Phone (___) _____

Your Doctor's Address _____ City _____ State _____ Zip _____

How did you hear about us?

Healthcare Provider: (Name) _____ is an MD DO PA NP PT DC

Family/Friend/Co-worker Workers' Comp Referral Spine seminar|Class Attorney

Online Search (circle one) Google | Yahoo | Bing | Other:_____ ❑ Microspine website

Health Insurance Phonebook|DEX TV TV-The Doctors Show Phoenix Magazine Top Docs

Other:_____

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ADDITIONAL INFORMATION

Spouse (parent, if minor) _____
Last First Middle Initial

Date of Birth: _____/_____/_____ Social Security Number ____-____-____ Phone (___) _____

Street Address _____ City _____ State ____ Zip Code _____

Employer _____ Occupation _____ How Long? _____

Street Address _____City _____ State _____ Zip Code _____

Name of Nearest Relative Not Living With You_____ Relationship_____

Address _____City _____ State ____ Zip Code _____ Phone (___) _____

INSURANCE INFORMATION

Primary Insurance Company _____

Is this a work-related injury? Yes No Do you have a health savings account (HSA)? Yes No

Street Address _____City _____ State _____ Zip Code _____

ID# _____ Policy # _____ Group #_____

Policy Holder Name _____ Date of Birth ____/___/____ Relationship to Patient_____

Policy Holder's Address, if not patient_____ City_____ State_____ Zip_____

Policy Holder's Employer Address _____City _____State _____ Zip_____

Secondary Insurance Company _____

ID# _____ Policy # _____ Group #_____

Policy Holder Name _____ Date of Birth ____/___/____ Relationship to Patient_____

Policy Holder's Address, if not patient_____ City_____ State_____ Zip_____

Policy Holder's Employer Address _____City _____State _____ Zip_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that Microspine, PLC. bills my insurance carrier as a courtesy, but I am responsible for paying all changes incurred by me and/or my dependents. I understand that if my account is turned over for collections, I will incur a collections fee. I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize my insurance carrier(s), including Medicare, any private or public insurer and any other insuring party to issue payment directly to Microspine PLC. for all medical expenses for me and/or my dependents regardless of insurance benefits, if any. I authorize Microspine PLC. to release any and all information regarding my condition and care to myself, my insurance carriers, or other healthcare providers or referring physician associated with my care.

_____ INITIALS

I have read and understand this form.

X_____ Date_____

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MEDICAL INFORMATION

NAME:_____ DATE: _____

BIRTHDATE:_____/_____/_____ HEIGHT:_____ FT._____IN. WEIGHT _____LBS.

REFERRING PHYSICIAN NAME (First, Last Name): _____ Phone: _____

INTERNIST OR FAMILY PHYSICIAN NAME: _____ Phone: _____

**MICROSPINE transmits prescriptions electronically (except those that must be handwritten by law) to your pharmacy. Which PHARMACY will you using for any prescriptions from us?

NAME OF PHARMACY _____ CITY _____CROSSSTREETS _____

Chief complaint (check all that apply):

- ❑ Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, etc.)
- ❑ Neck pain Arm: ❑ Pain ❑ Numbness ❑ Weakness
- ❑ Back pain Leg: ❑ Pain ❑ Numbness ❑ Weakness Other: _____

How long has the pain (or your problem) been present? _____

Has your problem worsened recently? ❑ No ❑ Yes How recently?_____

What started the pain (or problem)? _____

For NECK or ARM complaints (If you have no NECK or ARM complaints, go to NEXT Question):

1. What % of your symptoms are in the neck and what % are in the arm? (check ONE of the following)
   ❑ All arm ❑ Neck 25%, Arm 75% ❑ Neck 50%, Arm 50% ❑ Neck 75%, Arm 25% ❑ All Neck
2. Which side are your symptoms on (check ONE of the following):
   ❑ Right 0%, Left 100% ❑ R 25%, L 75% ❑ R 50%, L 50% ❑ R 75%, L 25% ❑ R 100%, L 0%
3. There is: ❑ No pain of the arms and hands ❑ Pain of the (check the following):
   ❑ Right: ❑ Upper back ❑ Shoulder ❑ Upper arm ❑ Forearm ❑ Hand/finger
   ❑Left: ❑ Upper back ❑ Shoulder ❑ Upper arm ❑ Forearm ❑ Hand/finger
   a. Raising the arm: ❑ Improves the pain ❑ Worsens the pain ❑ Does not affect the pain
   b. Moving the neck: ❑ Improves the pain ❑ Worsens the pain ❑ Does not affect the pain
4. There is: ❑ No weakness of the arms and hands ❑ Weakness of the (check the following):
   Right: ❑ Shoulder ❑ Upper arm ❑ Forearm ❑ Hand/finger
   Left: ❑ Shoulder ❑ Upper arm ❑ Forearm ❑ Hand/finger
5. There is: ❑ No numbness of the arms and hands ❑ Numbness of the (check the following):
   Right: ❑ Upper arm ❑ Forearm ❑ Thumb ❑ Index finger ❑ Long finger ❑ Ring finger ❑ Small finger
   Left: ❑ Upper arm ❑ Forearm ❑ Thumb ❑ Index finger ❑ Long finger ❑ Ring finger ❑ Small finger
6. There (❑ is ❑ is no) difficulty picking up small objects like coins or buttoning buttons.
7. There (❑ is ❑ is no) problem with balance or tripping frequently.
8. There are: (❑ Frequent ❑ Occasional ❑ No) headaches in the back of the head.

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For BACK or LEG complaints:

1. What % of your complaint is in the back and what % is leg or buttock? (check appropriate box):
   ❑ All Leg ❑ Back 25%, Leg 75% ❑ Back 50%, Leg 50% ❑ Back 75%, Leg 25% ❑ All Back
2. Symptoms are (check ONE of the following):
   ❑ Right 0%, Left 100% ❑ R 25%, L 75% ❑ R 50%, L 50% ❑ R 75%, L 25% ❑ R 100%, L 0%
3. There is: ❑ No leg pain ❑ Leg pain as follows (check the following):
   Right: ❑ Buttock ❑ Thigh-front ❑ Thigh-back ❑ Calf ❑ Foot
   Left: ❑ Buttock ❑ Thigh-front ❑ Thigh-back ❑ Calf ❑ Foot
4. There is: ❑ No weakness of the legs ❑ Weakness of the (check the following):
   Right: ❑ Thigh ❑ Calf ❑ Ankle ❑ Foot ❑ Big toe
   Left: ❑ Thigh ❑ Calf ❑ Ankle ❑ Foot ❑ Big toe
5. There is: ❑ No numbness of the legs ❑ Numbness of the (check the following):
   Right: ❑ Thigh ❑ Calf ❑ Foot
   Left: ❑ Thigh ❑ Calf ❑ Foot
6. The worst position is: ❑ Sitting ❑ Standing ❑ Walking
7. How many minutes can you stand in one place without pain? ❑ 0-10 ❑ 15-30 ❑ 30-60 ❑ 60+
8. How many minutes can you walk without pain? ❑ 0-10 ❑ 15-30 ❑ 30-60 ❑ 60+
9. Lying down: ❑ Eases the pain ❑ Does not ease the pain ❑ Sometimes eases the pain
10. Bending forward: ❑ Increases the pain ❑ Decreases the pain ❑ Doesn't affect the pain

For patients with a SPINAL DEFORMITY/CURVATURE (If you have NONE, go to NEXT Question)

How was your spinal deformity discovered? _____

Do you know your present curve measurement(s)? ❑ No ❑ Yes _____

Reasons for seeking treatment now: ❑ Progressive deformity ❑ Pain ❑ Can't stand straight
❑ I don't like the appearance of my back/waistline ❑ Other: _____

ALL PATIENTS SHOULD ANSWER THE FOLLOWING

1. Coughing or sneezing (❑ Increases ❑ Sometimes increases ❑ Does not increase) my symptoms.
2. There is: ❑ No loss of bowel or bladder control ❑ Loss of bowel or bladder control since_____
3. I have: ❑ Not missed any work because of this problem ❑ Missed (how much?) _____ work

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4. Treatments have included: ❑ No medicines, therapy, manipulations, injections, or braces

Neck	Back		Relief	No Relief	How many times	Date
❑	❑	Physical therapy, exercise	❑	❑	_____	_____
❑	❑	Massage & ultrasound	❑	❑	_____	_____
❑	❑	Traction	❑	❑	_____	_____
❑	❑	Chiropractic care	❑	❑	_____	_____
❑	❑	Braces	❑	❑	_____	_____
❑	❑	Tens Unit	❑	❑	_____	_____
❑	❑	Trigger point injections which	❑	❑	_____	_____
❑	❑	Facet joint injections/ablation	❑	❑	_____	_____
❑	❑	Epidural steroid injections	❑	❑	_____	_____
❑	❑	Anti-inflammatory medications	❑	❑	_____	_____
❑	❑	Narcotic medication	❑	❑	_____	_____

5. Previous doctors seen about this problem: ❑ None

Doctor	Specialty	City	Treatment

6. Previous imaging studies (MRI, CT, DEXA Scan, bone scan, etc): ❑ None

Imaging Test	Date	Facility

ALL MEDICATIONS YOU TAKE: ❑ None (include over-the-counter medications, aspirin, supplements)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS: ≤ No known drug allergies. If past adverse reaction, check boxes below:

Medications	Reaction					
	Rashes	Swelling Wheezing	Shock	Upset Stomach	Unknown	Other

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MEDICAL HISTORY: Check all that apply. ❑ None apply

❑ Heart attack ❑ Diabetes ❑ Lung disease ❑ Liver disease ❑ Asthma
❑ Heart failure ❑ Stroke ❑ HIV ❑ Hepatitis ❑ Tuberculosis
❑ High blood pressure ❑ Seizures ❑ AIDS ❑ Thyroid trouble ❑ Anemia
❑ Irregular heart beat ❑ Mental illness ❑ Bleeding disorders ❑ Blood clot in leg ❑ Blood clot in lung
❑ Cancer ❑ Kidney stones ❑ Kidney failure ❑ Stomach ulcers ❑ Gout
❑ Alcoholism ❑ Rheumatoid arthritis ❑ Osteoporosis ❑ Osteoarthritis ❑ Fibromyalgia
❑ Ankylosing spondylitis ❑ Serious injuries _____ ❑ Other: _____

SURGICAL HISTORY: Previous surgeries - List procedures, surgeon and date. ❑ None OPERATION

Operation	Date	Surgeon

FAMILY HISTORY: (Check all that apply) ≤ None apply

❑ Stroke ❑ Arthritis ❑ Mental illness ❑ Alcoholism
❑ Heart trouble ❑ Gout ❑ Kidney trouble or stones ❑ Osteoporosis
❑ High blood pressure ❑ Seizures ❑ Cancer ❑ Diabetes
❑ Spine problems ❑ Bleeding disorder ❑ Other: _____

SOCIAL HISTORY:

1. Work status: ❑ Homemaker ❑ Retired ❑ Disabled ❑ On leave ❑ Unemployed
   ❑ Working: ❑ Full time ❑ Part time Occupation:_____
2. Marital status: ❑ Married ❑ Single ❑ Cohabitating ❑ Widowed ❑ Divorced
3. Number of living children: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
4. I live: ❑ Alone ❑ With: (please include their first name and relationship)_____
5. I participate in sports: ❑ Golf ❑ Tennis ❑ Jog ❑ Bike ❑ Baseball ❑ Basketball ❑ Other _____
6. Tobacco use: ❑ Never ❑ Cigar ❑ Chew ❑ Pipe ❑ Cigarettes_____ packs per day for _____ years.
   ❑ Quit – When?_____ after smoking _____ packs per day for _____ years (total)
7. Alcohol: ❑ Never or rare ❑ Social ❑ Frequently intoxicated (more than 2x a week)
   ❑ Alcoholic ❑ Recovering alcoholic
8. Drug overuse/abuse: ❑ Never ❑ Currently ❑ In the past
9. Because of this spine problem, I have filed or plan to file:
   ❑ A lawsuit ❑ A Worker's Compensation claim ❑ Neither a lawsuit or Worker's Comp

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REVIEW OF SYSTEMS: Check all that apply. ❑ None apply

❑ Reading glasses	❑ Abnormal heartbeat	❑ Frequent constipation	❑ Hot or cold spells
❑ Change of vision	❑ Swollen ankles	❑ Hemorrhoids	❑ Recent weight change
❑ Loss of hearing	❑ Calf cramps w/ walking	❑ Frequent urination	❑ Nervous exhaustion
❑ Ear pain	❑ Poor appetite	❑ Burning on urination	❑ Hoarseness
❑ Toothache	❑ Difficulty starting urination	❑ Nosebleeds	❑ Gum trouble
❑ Get up more than once every night to urinate		❑ Difficulty swallowing	❑ Nausea or vomiting
❑ Morning cough	❑ Stomach pain	❑ Frequent headaches	❑ Shortness of breath
❑ Ulcers	❑ Blackouts	❑ Fever or chills	❑ Frequent belching
❑ Seizures	❑ Heart or chest pain	❑ Frequent diarrhea	❑ Frequent rash
Woman Only:	❑ Irregular periods	❑ Vaginal discharge	❑ Frequent spotting

1. Generally speaking, are your symptoms getting better or worse?
   - ❑ Getting much better
   - ❑ Getting somewhat better
   - ❑ Staying about the same
   - ❑ Getting somewhat worse
   - ❑ Getting much worse

2. If you had to spend the rest of your life with the symptoms you have right now, would you be:
   - ❑ Very dissatisfied
   - ❑ Somewhat dissatisfied
   - ❑ Neutral
   - ❑ Somewhat satisfied
   - ❑ Very satisfied

_____ _____

Patient Signature Date Physician Signature Date

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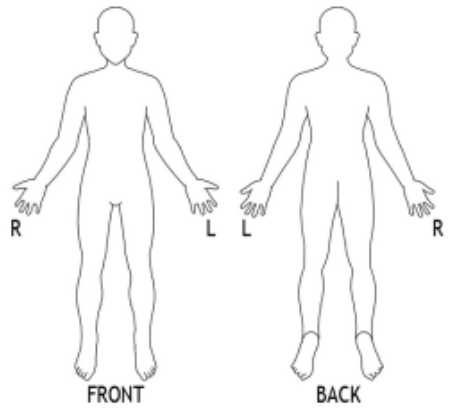
PLEASE CHECK YES/NO FOR EACH OF THE 5 SECTIONS BELOW
IF YES, PLEASE SHADE IN THE AFECTED AREAS

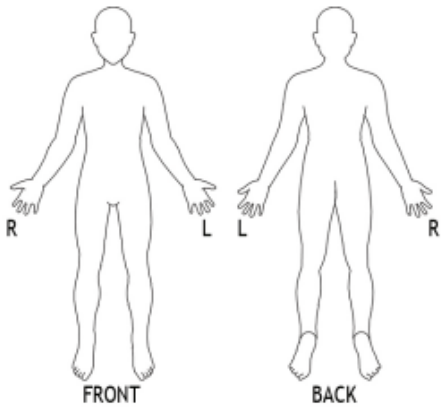
ACHING

❑ YES ❑ NO



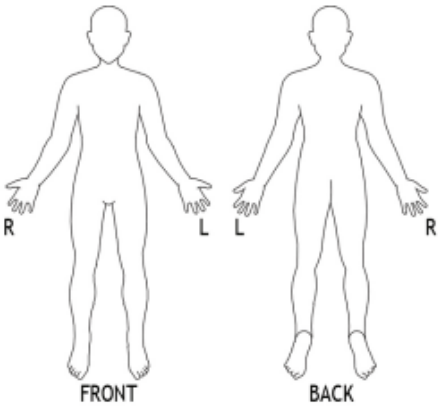
NUMBNESS

❑ YES ❑ NO



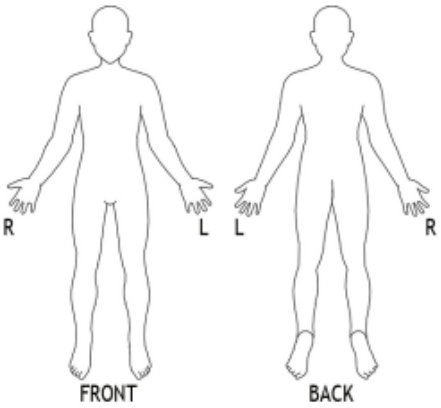
PINS AND NEEDLES

❑ YES ❑ NO



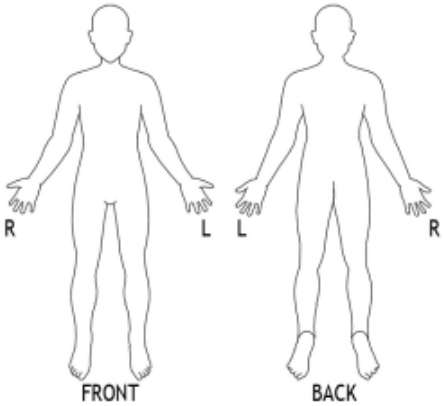
BURNING SENSATION

❑ YES ❑ NO



STABBING PAIN

❑ YES ❑ NO



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OSWESTRY FUNCTION TEST – FOR BACK AND LEG PAIN

Please make ONE answer in each section that most clearly described your BACK problem

01. Pain Intensity
0. I can tolerate the pain I have without having to use pain killers
1. The pain is bad but I manage without taking pain killers
2. Pain killers give complete relief from pain.
3. Pain killers give moderate relief from pain.
4. Pain killers give little very little relief from pain.
5. Pain killers have no effect on the pain, I do not use them.

02. Personal Care (Washing, Dressing,
0. I can look after myself normally without it causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but manage most of my personal care.
4. I need help everyday in most aspects of self care.
5. I do not get dressed, wash with difficulty and stay in bed.

03. Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g. on a table)
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

04. Walking
0. Pain does not prevent me from walking any distance.
1. Pain prevents me walking more than 1 mile.
2. Pain prevents me walking more than ½ mile.
3. Pain prevents me walking more than ¼ mile.
4. I can only walk using a cane, crutches or walker.
5. I am in bed most of the time and have to crawl to the toilet.

05. Sitting
0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than 30 minutes
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

06. Standing
0. I can stand as long as I want without extra pain.
1. I can stand as long as I want but it gives extra pain.
2. Pain prevents me from standing more than one hour.
3. Pain prevents me from standing more than 30 minutes.
4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

07. Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using tablets.
2. Even when I take tablets I have less than 6 hours sleep.
3. Even when I take tablets I have less than 4 hours sleep.
4. Even when I have tablets I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

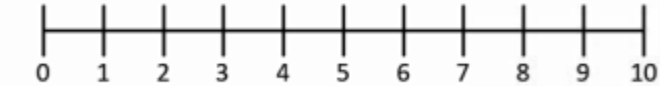
08. Employment/Homemaking
0. My normal homemaking/job activities do not cause pain.
1. My normal homemaking/job activities increase my pain but I can still perform all that is required of me.
2. I can perform most of my homemaking /job duties, but pain prevents me from performing more physically stressful activities (lifting, vacuuming).
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from performing any job or homemaking chores.

09. Social Life
0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases my degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc).
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to home.
5. I have no social life because of the pain.

10. Traveling
0. I can travel anywhere without extra pain.
1. I can travel anywhere but it gives extra pain.
2. Pain is bad but I manage journeys over two hours.
3. Pain restricts me to journeys less than 1 hour.
4. Pain restricts me to journeys under 30 minutes.
5. Pain prevents me from traveling except to the doctor or hospital.

MY PAIN / DISCOMFORT FOR MY **BACK** IS (circle number)

MY PAIN / DISCOMFORT FOR MY **LEG** IS (circle number)



Pain medications currently taking:

_____

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NECK DISABILITY INDEX

Please make ONE answer in each section that most clearly described your NECK problem

01. Pain Intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain is severe but comes and goes.
5. The pain is severe and does not vary much.

02. Personal Care
0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, washing with difficulty and stay in bed.

03. Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy objects off the floor, but I can if they are conveniently positioned, for example, on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

04. Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate neck pain.
4. I cannot read as much as I want because of severe neck pain.
5. I cannot read at all.

05. Headaches
0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all of the time.

06. Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate with slight difficulty.
2. I have a fair degree of difficulty in concentrating.
3. I have a lot of difficulty in concentrating.
4. I have a great deal of difficulty in concentrating.
5. I cannot concentrate at all.

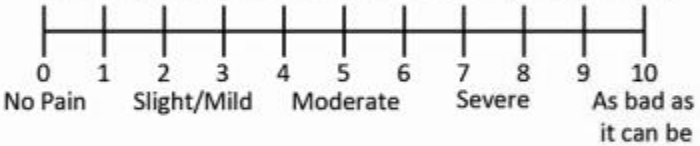
07. Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do my usual work.
5. I cannot do any work at all.

08. Driving
0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

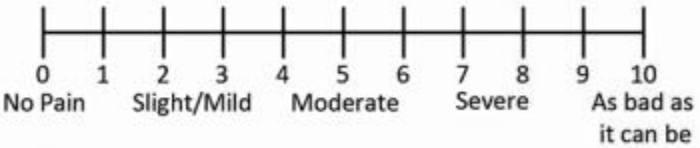
09. Sleep
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

10. Recreation
0. I am able to engage in all recreational activities with no pain in my neck at all.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all, recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
4. I can hardly do recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

MY PAIN / DISCOMFORT FOR MY **NECK** IS (circle number)



MY PAIN / DISCOMFORT FOR MY **ARM** IS (circle number)



Pain medications currently taking:

_____

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2155 E Conference Dr. #115, Tempe, AZ 85284
Tel: 602-833-2141 Fax: 602-610-3878
Email: microspinemd@gmail.com
www.microspinemd.com

I hereby acknowledge that I have been presented with a copy of Microspine's Notice of Privacy Practices and I am requesting that the following individuals be allowed to my health information (HIPAA).

Date _____

Name _____

Relationship _____

Date _____

Name _____

Relationship _____

Date _____

Name _____

Relationship _____

I hereby acknowledge that I can revoke the authorization to the above mentioned individuals at my discretion with a written notification to Microspine.

Signature _____ Date _____
of patient or legally authorized individual signature

Patient Name (PRINT) _____ Date of Birth _____

Relationship _____
(Parent, Guardian, Personal Representative, etc.)

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Welcome to Microspine. We want to make you aware of our policy regarding health insurance.

It is the responsibility of our insured patients to be aware of their health insurance benefits and restrictions prior to visiting our facility. This would include copayments, deductibles, coinsurance, authorization/referral requirements, policy exclusions, and pre-existing condition restrictions.

As a courtesy to our patients, our office will verify your eligibility prior to your visit. Please be aware that the insurance always has a disclaimer stating that **"this does not guarantee payment for services – the claim will be subject to policy benefits and restriction once the claim is received"**. Therefore there is no way we can be 100% certain they will pay part or all of your claim.

If your visit requires pre certification or a referral, it is the patient's responsibility to obtain this from the primary care physician or insurance company directly.

If our patients require surgery, we will do our best to make sure we use a contracted facility and that precertification is obtained if necessary. If you have not met your deductible or your out of pocket maximum benefit, a deposit may be required prior to your surgery. If so we will discuss this prior to your surgery to avoid cancellations.

Please know that we do our best to provide you with the most accurate information available to us but it is ultimately the patient's responsibility for any charges incurred. If you disagree with the way the insurance has processed your claim, please contact your insurance company.

I understand that I am responsible for any charges incurred that are not covered by my insurance carrier.

_____ _____

Patient Signature Date

If Guardian, Relationship to Patient _____

_____ _____

Patient Name (PRINT) Date of Birth

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HIPAA Omnibus Notice of Privacy Practices

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

Patient Name _____ Date of Birth _____

Our commitment to your privacy

Our practice is dedicated to maintaining your 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 information.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our business associates and their subcontractors, 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 may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USE 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 the physician's practice, and any other use required by law.

Treatment: We will use and disclose your 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 physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical student, licensing, fundraising, 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, and inform you about treatment for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

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USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the 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 of disclosure indicated in the authorization.

YOUR RIGHTS

The following are statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used, in a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of 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 any 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 described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to 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 any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures; pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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COMPLAINTS

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

HIPAA COMPLIANCE OFFICER	PHONE	EMAIL
Issada Thongtrangan, MD	602-833-2141	info@microspine.sprucecare.com

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Signature Date

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Pt Name: _____ Date of Birth: _____

Your surgeon may consult for companies and engage in implant design and research. If these products are approved by the FDA and appropriate for use in your surgery, they may be used.

Your surgeon may have an ownership stake in a facility where you receive healthcare. You can choose a different center if that is your desire.

Your surgeon may have an ownership stake or other participation in manufacturing companies that design and make spinal implants. If these products are approved by the FDA and appropriate for use in your surgery they may be used. If this is a concern for you, please consult with your surgeon before your procedure.

Your surgeon may elect to use an FDA approved product in an "off Label" way, if it is judged to be more beneficial to your surgery's success than other methods. An example may include screws in the back of your cervical spine for stabilization.

Your surgeon may have a relationship with the distributor who provided the spinal instrumentation or other medical product.

Bone morphogenic Protein (BMP) has been FDA approved but it is commonly used "off label" to help the spine heal in fusion procedures involving the spine. Your surgeon may elect to use this FDA approved fusion enhancement technology in an "off label" way, if it is judged to be more beneficial to your surgery's success than other methods.

If you have any concerns with the information above, please feel free to discuss them with your surgeon prior to your surgery.

Microspine, PLC

Patient Signature _____ Date _____
I have read and acknowledge the above

PRINT NAME _____