NEXT GENERATION
ORTHOPEDIC AND SPINE INSTITUTE

Patient Demographic

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Emergency Contact: _____ Contact Phone: _____

Birth Date: _____ Are You Presently Working: Yes No

IF you answered "Yes", you are presently working, What's your occupation: _____

What was the name of your employer at the time of the accident (if applicable): _____

Meaningful Use Criteria

Email Address: _____

Marital Status: _____

Race: _____

Ethnicity: _____

Accident Information

Were you involved in a Motor Vehicle Accident? Yes No

Were you involved in an accident at work? Yes No

Injury Date: _____

Name of Attorney (if applicable) : _____

How did you hear about us? If you were referred, please put the Doctor's name that referred you. Thanks!

_____

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Chief Complaint

What is your reason for today's visit? _____

What kind of pain is it? Burning / Throbbing / Achy / Sharp / Dull / Other _____

When at rest, rate the pain from 0-10 (0=no pain, 10=worst pain of your life): _____

How did the problem start/occur? _____

_____

_____

Medical History

Were you hospitalized for this problem / injury? Yes No

If Yes, please provide dates of hospital admission: _____

If you were/are unable to work due this problem/injury please list dates of disability:

From _____ To _____

Have you been seen and/or treated by anyone else for this problem/injury: Yes No

If Yes, then by whom? _____ Date(s): _____

Have you had Physical Therapy for this problem: Yes No

If Yes, when and for how long? _____

Have you had surgery for this problem?

Date(s): _____

Procedure(s): _____

_____

_____

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Workers Compensation Information

Works Compensation: _____

Adjustor Name: _____

Claim Number: _____

Health Insurance Information

Name on Insurance Policy: _____
Last *First* *M.I.*

Relationship to Patient: _____

Insurance Carrier: _____
(example: Blue Cross, Medicare, UnitedHealth Care)

Policy Number: _____

Auto Insurance

Name on Auto Policy: _____
Last *First* *M.I.*

Date of Birth: _____ Relationship to Patient: _____

Auto Insurance Carrier: _____

Policy Number: _____

PLEASE NOTE

Please Note: We need as much information as possible to fill out your chart. If you are a Personal Injury Claim, we still require your auto and health insurance information. If you are a Workers Compensation, we still require your health insurance information. This does not mean we will bill any or all of these policies, it just allows us to have all of your information. If you have any questions about our billing process, please feel free to talk with one of our wonderful staff. *Thank You!*

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Disclosure of Physician Financial Interest

This document is to disclose that either Next Generation Orthopedic and Spine Institute or one or more of its affiliates, or owner have a financial interest in one or more of the following organizations:

L2 Surgical LLC

EPIOM,PLLC

National Neuromonitoring Services, LLC

Comprehensive Home Health Inc.

Paesanos Parkway Imaging

Patients of Next Generation always have the option of utilizing an alternative health care facility or provider. Our physician welcomes any questions regarding this aspect of their patient's care. Next Generation wants you to know that you do have the option to use an alternative health care provider.

Please sign below acknowledging receipt of this disclosure:

_____ _____

Patient's Signature Date

Acknowledgement of Individual's Responsibility and Assignment of Benefits

Individual's Responsibility for Non-covered Services:
In consideration of services rendered by Anthony Owusu, M.D. to the undersigned patient, the undersigned promise(s) to pay to Anthony Owusu, M.D. any co-payment, coinsurance or other charges required to be paid by my health insurance coverage.

Assignment of Benefit Proceeds:
I request that payment of authorized HMO/third-party payer/governmental agencies (Medicare and Medicaid) benefits be made to Next Generation Orthopedic and Spine Institute for services furnished to me by the provider.

Referrals/Co-payments:
HMO PLANS: For plans requiring referrals from the primary care physician, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF THE VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, you will be billed the regular fee schedule.

_____ _____

Patient's Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Next Generation Orthopedic and Spine Institute (Next Generation) maintains your health information in records that are kept in a confidential manner, as required by law. Next Generation must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: Next Generation Orthopedic and Spine Institute has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with radiologists or other consultants to make a diagnosis. Next Generation may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment.

Your Authorization Is Required for Other Disclosures. Your authorization will be required for most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute a sale of protected health information. Except as described above, we will not use or disclose your medical information, unless you allow the Next Generation Orthopedic and Spine Institute in writing to do so. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Next Generation Orthopedic and Spine Institute's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Next Generation Orthopedic and Spine Institute's Notice of Privacy Practices, please do not hesitate to contact a clinic representative as indicated on your Notice.

_____ _____

Patient's Signature Date

Authorization to Release Records

I hereby authorize Anthony Owusu, M.D. to release to my insurer/HMO/third-party payer, governmental agencies, or to whoever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

_____ _____

Patient's Signature Date

PLEASE NOTE

Contact one of Next Generation Orthopedic and Spine Institute Representatives at if:

- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- You wish to obtain a form to exercise your individual rights.

PLEASE RETURN THESE FORMS TO THE FRONT DESK AND WE WILL BE WITH YOU SHORTLY. THANK YOU!