# CENTER FOR BRAIN & SPINE

**Phone: 301.585.7900    Fax: 240.766.8088**
www.Centerbrainspine.com

| **Silver Spring** | **Rockville** | **Cheverly** |
|---|---|---|
| 1300 Spring St. | 9905 Medical Center Dr. | 2900 Mercy Lane |
| Suite 210 | Suite 300 | 2nd Floor |
| Silver Spring MD 20910 | Rockville, MD 20850 | Cheverly, MD 20886 |


Thank you for choosing Center for Brain & Spine, the office of Dr. Amin Amini.

**Please complete the enclosed paperwork *completely* .**

**FOR TELEMEDICINE PATIENTS:**

- Our office **MUST** have received **all paperwork** and copies of all items listed below no less than **48 hours** before your appointment. *Failure to return these items may result in your appointment being cancelled.*

**IN-OFFICE PATIENTS:**

- **Upon your arrival, Please call our office from your car to let us know you have arrived.**
- Please arrive **10-15 minutes** prior to your appointment to allow for parking and checking in for your appointment.
- Please remember that you are allowed **1** guest **(Only if necessary)** and the guest & yourself are required to wear a mask at all times during your visit.
- Please note that we are checking tempuratures and oxygen levels before allowing entry into the office.
- We allow for a 15 minute "Grace Period". If you have not arrived within 15 minutes of your appointment, your appointment will be cancelled & you will need to call to reschedule.

Also, please remember to bring the following with you to your appointment:

- ✓ **Insurance Card(s)**
- ✓ **Drivers Licenses or State ID**
- ✓ **Imaging CD (If you do not have any imaging, Please disregard)**

If your Insurance plan requires a referral please obtain one from your Primary Care Physician and bring it with you to your appointment or you may have it faxed to: **240-766-8088**

If your insurance plan requires you to pay a Co-Pay, please be prepared to pay that at the time of your visit. ***Our office will contact Telemedicine Patients via Phone to collect your co-pay before your visit.***

Thank you and we look forward to caring for you!

# CENTER FOR BRAIN & SPINE

**Today's Date:** ______/______/______

**PATIENT NAME:**

**LAST**____________________ **First**____________________**MI**____

**Date of Birth:** ______/______/______ Male ❑ Female ❑

**Marital Status:** Single ❑ Married ❑ Widowed ❑ Separated ❑ Partnered ❑

**Address:**____________________

**City:**____________________ **State:**__________ **Zip Code:**__________

**PHONE: Home # (______)**____________________ **Cell # (______)**____________________

**Work # (______)**____________________ **Preference of Contact** ❑ Home ❑ Cell ❑ Work

**EMAIL:**____________________

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## PRIMARY INSURANCE

Ins. Company:____________________

**Policy Holder:**____________________ **DOB:** ______/______/______

**Relationship to patient:** ____________________

ID#:____________________ Group#____________________

## Secondary Insurance

Ins. Company:____________________

**Policy Holder:**____________________ **DOB:** ______/______/______

**Relationship to patient:** ____________________

ID#:____________________ Group#____________________

Thank you for choosing the Center for Brain & Spine. We are honored to be your choice in partnering towards your health and are committed to providing you with the highest quality care. Listed below are our financial policies and we ask that you read carefully and sign below.

### I understand that:

The patient (or guardian, if a minor) is ultimately responsible for all services provided.

Center for Brain & Spine will bill my insurance(s), but I am responsible to provide the most current insurance information, and for providing any changes or updates to my insurance as soon as they occur.

I understand that failure to provide accurate insurance information will result in any charges or services not covered becoming my responsibility.

I understand that I am responsible for the payment of copays, coinsurance, deductibles, and the fees for any services/medical equipment not covered by my insurance.

I understand that copays are due at the time of my appointments.

I understand that it is my responsibility to obtain any referrals that are needed before my appointment(s). Failing to obtain a needed referral could result in my appointment being rescheduled.

I understand that I will be charged **$50.00** for any missed appointments or cancellation that are not received **within 24 hours of the appointment**.

I understand that Center for Brain & Spine charges a **$35.00** fee for checks returned for insufficient funds.

I understand that I am responsible for paying or making a payment arrangements for outstanding balances on my account. Failure of non-payment may result in my dismissal from the practice.

I understand that extensive phone consultations and/or after hours phone calls may result in additional fees.

**Medical Records & Forms Completion**

Center for Brain & Spine charges for the completion of forms and the processing of medical records.

1. Medical Records Fee(s): .76 cents per page Postage & Handling $4.00 - $10.00

**There is no charge for picking up records from our office.*

2. Completion of Forms: $35.00 1st page & $5.00 for each additional page. Fees must be paid in advance.

***Please allow 5-7 business days for processing.***

**Financial Authorization**

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Center for Brain & Spine for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

By signing below, I acknowledge, understand and agree to the policies as stated above. I also confirm that all information provided by me is correct and up to date.

________________________________________________________

**Signature** **Date**

CENTER FOR
BRAIN & SPINE

# Health Insurance Portability and Protection Act

## Patient Acknowledgement and Consent Form

Center for Brain & Spine, "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing:

__________ **Patient's Initials**

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post them in our office and you will receive a hard copy of them at your next visit.

__________ **Patient's Initials**

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

__________ **Patient's Initials**

By signing this form below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

______________________________________________________________

**Signature** **Date**

______________________________________________________________

**Printed Full Name**

**Please list below any person(s) that you authorize us to speak to or release medical information to.**

Name:______________________ Relation:______________ Phone #:______________

Name:______________________ Relation:______________ Phone #:______________

I understand that I may revoke this authorization at any time by completing/updating this form.

☐ **Check this box if your symptoms are related to a workers comp or personal injury claim**

Name: ______________________ DOB: ______________ Age: ______

Address: ______________________________ Phones (give all): ______________

| Primary Care Physician Info | | | Referring Physician Info | | |
|---|---|---|---|---|---|
| Name: | | | Name: | | |
| Telephone: | **Fax:** | | Telephone: | **Fax:** | |
| Address: | | | Address: | | |
| City: | State: | Zip Code: | City: | State: | Zip Code: |

**History of Present Illness:**

**Physician Notes**

What is the reason for your visit? Headache / Back pain / Neck pain / Arm pain / Leg pain
Right side / left side / both sides (circle one) Others:..........................................

When did this problem start?

How would you best describe the pain? *Check all that apply.*

☐ Sharp ☐ Burning Sensation ☐ Numbness
☐ Dull ☐ Shooting pain ☐ ______________

Please rate your pain by checking the number that best correlates to your pain level.

***No Pain*** ***Least Pain*** ***Moderate Pain*** ***Most Severe Pain***
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes it worse?

☐ Nothing makes the symptoms worse ☐ Movement of any kind ☐ Sitting
☐ Standing ☐ Walking ☐ Lifting
☐ ______________ ☐ ______________ ☐ ______________

What helps?

☐ Nothing helps the symptoms ☐ Steroid injections ☐ Sitting
☐ Standing ☐ Walking ☐ Laying still
☐ Pain medication ☐ Physical therapy ☐ ______________

Is it worse at certain times of the day or night?

☐ Day ☐ Night ☐ Neither

Do you have any other related symptoms?

☐ Bowel incontinence ☐ Urine incontinence
☐ Weakness of arms or legs (please specify) ______________________

What treatments have been attempted in the past to alleviate your symptoms?

☐ Physical Therapy ☐ Steroid Injections ☐ Prior Surgery
☐ Occupational Therapy ☐ Pain management ☐ ______________

**Please check only those items, which apply to your personal medical history. (PMH)**

☐ High Blood Pressure ☐ Cancer ☐ Lung problems / Asthma
☐ Diabetes ☐ High Cholesterol ☐ Headache
☐ Peptic Ulcers ☐ Hepatitis ☐ Accidents /broken bones
☐ Heart attack ☐ HIV ☐ Back pain
☐ Chest pain/Tightness ☐ Stroke ☐ Neck Pain
☐ Stroke ☐ Seizure ☐ Other ______________

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**Previous Hospitalizations/Surgeries: (not including pregnancy)**

| Illness/Surgery | Date | Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Current Medications: ( including vitamins and over the counter medications)**

| Medication | Dosage | Frequency | Reason for taking medication |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**Please Lists All Allergies:**

| | | | |
|---|---|---|---|
| ☐ No known drug allergies | ☐ Penicillin | ☐ Iodine | ☐ Contrast Dye |
| ☐ | ☐ | ☐ | ☐ |

**Please check if you are experiencing any of the following symptoms: (ROS)**

| | | | | |
|---|---|---|---|---|
| ☐ Chest pain | ☐ Shortness of breath | ☐ Seizures | ☐ Urinary Incontinence | ☐ Fever |
| ☐ Palpitations | ☐ Nausea | ☐ Weakness | ☐ Bowel Incontinence | ☐ Swollen Legs |
| ☐ Chest tightness | ☐ Vomiting | ☐ Headache | ☐ Easy bruising | ☐ Muscle Spasms |
| ☐ Fainting Spells | ☐ Dizziness | ☐ Blurred Vision | ☐ Easy Bleeding | ☐ Neck Pain |
| ☐ Heat Intolerance | ☐ Depression | ☐ Double Vision | ☐ Difficulty Speaking | ☐ Back pain |
| ☐ Cold Intolerance | ☐ Anxiety | ☐ Loss of Vision | ☐ Difficulty Swallowing | ☐ Numbness |

**Social History: Check any of the following if they pertain to your current social situation.**

**Marital Status:**
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ In a relationship

**Employment:**
☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired

Occupation: ______________________________

**How many children do you have?**
0-1-2-3-4-5-more ____

**Tobacco Use:**
Cigarettes ☐ Never ☐ Quit Date __________ ☐ Current smoker: packs/day _____ number of years _____
Other Tobacco ☐ Pipe ☐ Chew ☐ Cigar ☐ Snuff

**Alcohol Use:**
☐ Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week __________

**Drug Use:**
Do you use any recreational drugs? ☐ Yes ☐ No Pain killer / Marijuana / Cocaine / others

**Family History: Check only the condition if a blood relative has suffered.**

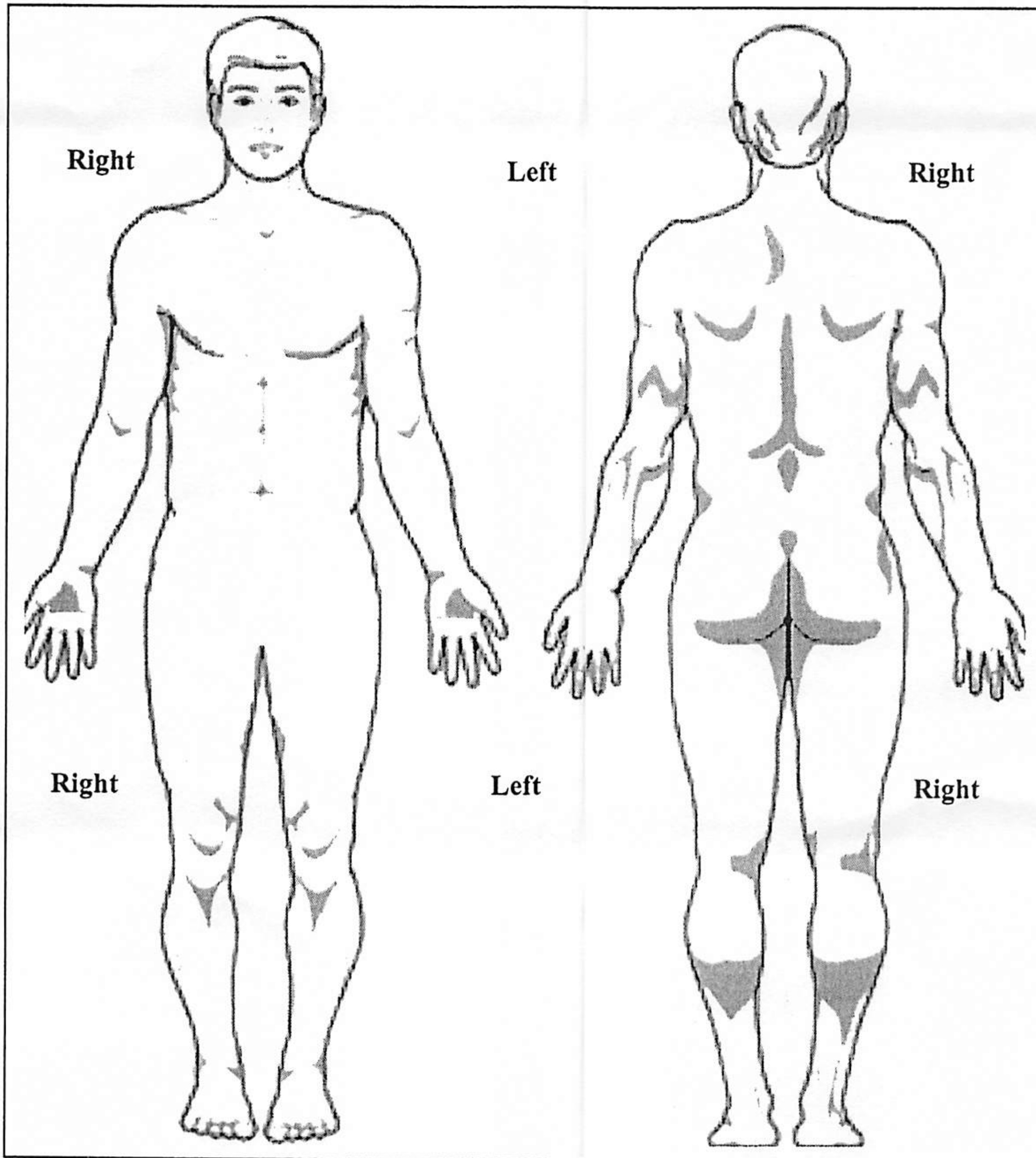
| | | | | |
|---|---|---|---|---|
| ☐ Epilepsy | ☐ Stroke | ☐ Alcoholism | ☐ Brain Tumors | ☐ Osteoporosis |
| ☐ Migraine | ☐ Sickle Cell | ☐ Bleeding Disorder | ☐ Mental Illness | ☐ Arthritis |
| ☐ High Blood Pressure | ☐ Cancer | ☐ Multiple Sclerosis | | |

**Patient Signature:** ______________________________ **Date:** ______________

**Patient Name** ______________________ **DOB** ___________ **Date** _____________

**Please use the following descriptive symbols on the body outlines below to describe the location of your symptoms.**

| Pain | Numbness | Pins & Needles | Burning | Weakness |
|---|---|---|---|---|
| XXXX | 0000 | .......... | BBBB | + + + + |




**Patient Name:** ______________________ **DOB:** ___________ **Date:** ___________

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**PHYSICIAN(S) LIST**

*In an effort to keep your providers informed, we ask that you please provide or update your physician information for our records. Thank you!*

**Patient's Name:** ________________________ ***Date of Birth***: ______________

*****I VERIFY THAT I DO NOT HAVE ANY DOCTORS TO LIST ON THIS FORM.*****

***Signature:*** ______________________ ***Date:*** ____________

***Physician that sent you here:*** ______________________________

**Phone Number:** ____________________ **Address:** ____________________

***Primary Care Doctor:*** ____________________ Phone Number: ______________

Address: ______________________________

***Neurologist:*** ____________________ Phone Number: ______________

Address: ______________________________

***Orthopedic Doctor:*** ____________________ Phone Number: ______________

Address: ______________________________

***Pain Specialist:*** ____________________ Phone Number: ______________

Address: ______________________________

***Rheumatologist:*** ____________________ Phone Number: ______________

Address: ______________________________

***Oncology/Hematology Doctor:*** ____________________ Phone Number: ______________

Address: ______________________________

***Physical Therapist:*** ____________________ Phone Number: ______________

Address: ______________________________

***Cardiologist:*** ____________________ Phone Number: ______________

Address: ______________________________

***Radiation Oncology:*** ____________________ Phone Number: ______________

Address: ______________________________

***Other Doctor:*** ____________________ Phone Number: ______________

Address: ______________________________

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# ****KAISER PATIENTS****

In order for Center for Brain & Spine to provide you with the best possible care, we often times need to request records from your primary care physician or referring physician. Kaiser will not release your medical records to us without the attached form being completed and submitted to them.

We have enclosed the Kaiser required form along with a fax coversheet and a list of fax numbers to the Kaiser Offices. As a courtesy, we will fax your authorization form to the listed Kaiser office for you.

Please complete the attached Kaiser Authorization For Use Or Disclosure Of Patient Health Information form & provide the fax number on the fax coversheet. Once both forms are completed please either ***mail or hand deliver*** both to our office for faxing to the indicated Kaiser facility.

We appreciate your assistance in managing your healthcare!

**MAILING ADDRESS**

**1300 Spring Street**
**Suite 210**
**Silver Spring, MD 20910**

***** Please note that failure to submit the attached forms could mean a delay in your treatment*****

CENTER FOR
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## MAIN OFFICE & FAX NUMBERS FOR MARYLAND KAISER LOCATIONS

Annapolis Maryland **Fax: 410-571-7301** Main: 410-571-7300

Columbia Maryland **Fax: 410-309-4780** Main: 410-309-4600

Camp Springs Maryland **Fax: 301-702-6349** Main: 301-702-6100

Frederick Maryland **Fax: 240-529-1790** Main: 240-529-1700

Gaithersburg Maryland **Fax: 240-632-4177** Main: 240-632-4000

Hyattsville Maryland **Fax: 301-209-6111** Main: 301-209-6000

Kensington Maryland **Fax: 301-929-7430** Main: 301-929-7100

Largo Maryland **Fax: 301-618-5714** Main: 301-618-5500

Marlow Heights Maryland **Fax: 301-702-5291** Main: 301-702-5000

Shady Grove Maryland **Fax:301-548-5718** Main: 301-548-5700

Silver Spring Maryland **Fax: 301-572-1085** Main: 301-572-1000

Towson Maryland **Fax: 410-339-5690** Main: 410-339-5500

White Marsh Maryland **Fax:410-933-7666** Main: 410-933-7600

Woodlawn Maryland **Fax: 443-663-6295** Main: 443-663-6000

(*Kaiser Permanente entities are listed on reverse side of this form)

# AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

**Patient Name:** ______________________
Medical Record number: ______________ Birth Date: __________
Address: ______________________
City: ______________ State: __________
Zip Code: __________ Phone #: ( )
Email: ______________________

**Kaiser Permanente may release this information to:** ☐ Check if same as above
**Recipient Name:** Center For Brain and Spine
Address: 1300 Spring St Ste 210 City: Silver Spring State: MD Zip Code: 20910
Phone # (301 ) 585-7900 Email: centerforbrainandspine@gmail.com

**This disclosure can be used for the following purpose(s):** ☐ Personal Use ☐ Legal ☐ Insurance
☒ Medical Treatment ☐ Medical Condition Verification ☐ Disability ☐ FMLA ☐ Workers' Comp

**Check ONLY one of the following three options to identify the health information to be released.**

☐ **Option 1:** Form Completion (a substitute form or relevant medical records may be released)
☐ **Option 2:** Last 2 years of Kaiser Permanente Medical Office and Kaiser Foundation Hospital records
☒ **Option 3:** Records as specified. You must complete Step 1 and Step 2 below.

Step 1. Enter date range or date(s) of the records to be released: ______________
Step 2. Select types of records to be released:

☒ KP Medical Office ☒ Kaiser Foundation Hospital ☐ Immunization ☒ Lab Results
☒ Diagnostic Images ☐ Copays & Deductibles ☐ Itemized Billing ☐ Pharmacy
☐ Other (provider, department, specialty): ______________

**NOTE:** Hospital and Medical Office records released as part of this authorization may contain references related to mental health, addiction, and HIV medical conditions.

**Check the boxes below if you want this release to include the following information, Otherwise, this information will be excluded.**

☐ Mental Health Treatment Records ☐ Addiction Medicine Treatment Records ☐ HIV Test Results

**Media Type:** ☒ Electronic ☐ Paper **Delivery Preference:** ☒ Electronic ☐ Mail ☐ Pickup

**DURATION:** Authorization shall remain in effect for one year from the date of signature below. However, in Washington, D.C. permission to release addiction medicine treatment records expires after six (6) months.

**REVOCATION:** You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.

**REDISCLOSURE:** Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

Kaiser Permanente may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization. This disclosure is made at your request. For Virginia patients, a copy of this authorization, and a note stating to whom your information was disclosed will be included in your medical record. A copy of the original authorization is valid. You have a right to a copy of this completed authorization.

Date ______ Signature ______ If personal representative, print name/relationship ______