

Center for Neuro-Interventional and Functional Pain Medicine

Dr. Allen A. Baidey, M.D.

1501 Laurel St. #102

Sarasota, FL 34236

Last Name _____ First Name _____ Middle _____
Address _____ Phone(____)-____-_____
City _____ State _____ Zip _____
Date of Birth ___/___/___ Age _____ SS# _____ - _____ - _____
Marital Status ___S___M___D___W Male/Female

Insurance Information

Primary Insurance _____
ID# _____ Policy/Group _____
Address _____ City _____ State _____
Zip _____ Phone(____)-____-____ Policy Holder _____

Secondary Insurance _____
ID# _____ Policy/Group _____
Address _____ City _____ State _____
Zip _____ Phone(____)-____-____ Policy Holder _____

Policy Holder Information

Last Name _____ First Name _____ Middle _____
Address _____ Phone(____)-____-_____
City _____ State _____ Zip _____
Date of Birth ___/___/___ Age _____ SS# _____ - _____ - _____

Workers Comp

Were you hurt on the job? _____ Date of Injury _____
Worker Comp Ins. _____

I hereby assign and direct to pay all benefits for medical services under this claim directly to Center for Interventional Pain Management. I hereby authorize the release of any medical information request by the insurance companies with the assignment. I understand that the Center for Interventional Pain Management will bill my Primary Insurance as a courtesy to me. I will be responsible for secondary payment (if applicable) at the time of service. If payment is not received within 30 days from the date of billing, I will be financially responsible for payment in full for all services rendered to myself and/or dependents by Center for Interventional Pain Management. I also agree to pay any and all collection costs, attorney costs, and court costs (if applicable). A 24 hour notice is required for all cancellations or a \$25.00 fee will be applied to your following visit.

Patient/Responsible Party _____ Date _____

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Offices Port Charlotte & Sarasota

Please fill out to the best of your ability. Some questions may not apply to your circumstance and you may opt to leave them blank. Thank You

Date _____

Name: _____ Age: _____

Referring Doctor: _____

Primary Doctor (Family Physician): _____

Height: _____ Weight: _____

Problem:

Describe your issue (Please be specific)

Date of onset : _____

If you are here for implant pre-certification please answer questions about your chronic pain. If this is not your issue please ignore questions about pain.

Describe your pain:

Burning Stabbing Constant Intermittent Dull

Aching Throbbing Tingling Cramping

Rate your pain (1 is least, 10 is worst) 1 2 3 4 5 6 7 8 9 10

What makes your pain worse:

Coughing

Sitting

Bending forward

Bending backwards

Concentrating or Reading

Moving from sitting to standing

Lifting

Driving

Walking

Lying

Twisting

Other: _____

If you have pain, what makes your pain better?

Do you have Depression? Yes No

Do you have any pain at night? Yes No

Do you have trouble sleeping? Yes No

Do you feel like is worth living? Yes No

Is your problem interfering with your ability to work or function ? Yes No

List all medications which have been prescribed for your pain problem, circle the ones you are currently taking. _____

Please list the Doctor or Doctor's prescribing you medications.

Past medical history

List all your past surgeries and dates:

List your current medical problems:

List all your medications (pain/non pain):

List your drug allergies:

Do you take blood thinners? _____

Do you use tobacco? Yes No how many packs/day: _____

If you are a former smoker when did you quite? _____

Do you drink alcohol? Yes No how many drinks/week? _____

Do you drink coffee/tea? How many cups/day? _____

Do you have any children? Yes No

If applicable how many children live at home: _____

Work status: Full-Time Part-Time Unemployment Disability Leave Permanently Disabled

Describe your occupation: _____

Are you happy with your employment? Yes No

Education: high school graduate college graduate postgraduate degree

Do you exercise? Yes No Type of exercise _____

Is there anything causing you severe stress or anxiety in your life? Yes No

If yes please describe:

Review of Systems (circle problems that you have or have had in the past)

Head:	Sinus problems Tooth problems	Headache Cataracts	Migraines Glaucoma	Jaw problems
Respiratory:	Cough Asthma	Shortness of Breath Pneumonia		Emphysema
Cardiac:	Myocardial Infarction(Heart Attack) High Blood Pressure Rapid Heart Rate			Chest Pain/Angina Heart Valve Disease Atrial Eibrillation
Gastrointestinal:	Diarrhea Ulcers Hepatitis Diverticulitis	Constipation Gastritis Crohn's		Hiatal Hernia/Reflux Pancreatitis Ulcerative Colitis
Genitourinary:	Kidney Disease Difficulty Voiding	Kidney Stones Prostate Disease		Dialysis Incontinence
Cancer:	Breast Cancer Lymphoma Other Cancers	Lung Cancer Leukemia		Skin Cancer Prostate Cancer
Neurological:	Seizures Multiple Sclerosis Zoster	Stroke Cerebral Palsy Neuropathy		Paralysis Spasticity Difficulty Swallowing
Psychiatric: Abuse	Depression	Schizophrenia		Manic-depression Drug
Hematologic:	Anemia Coagulation Disorder	Sickle Cell		HIV/AIDS
Endocrine:	Diabetes	Hyperthyroid		Hypothyroid
Skeletal:	Osteoporosis Scoliosis Compression Fracture	Arthritis Lupus		Rheumatoid Broken Bones
Toxins:	Asbestos	Lead		Industrial Chemicals

Neuro-Interventional Spine , Dr. Allen A. Baidey, M.D.

**Authorization To Release Medical Information
(If under 18 years of age, parent or guardian must sign)**

Name of Patient: _____ Date of Birth: _____
Patient Address: _____ Phone: (____)-_____

I authorize and request the release of medical records from Center for Neuro-Cognitive Health, Dr. Allen A. Baidey, M.D. and wish to disclose same to:

Name _____ Address _____
City/State _____ Zip _____

For the purpose of:

Continuation of medical treatment Payment of bill Worker's Comp
 Personal Use Legal or Insurance purposes

The information to be disclosed is:

Discharge summary Operative reports History & Physical
 X-Ray reports Laboratory reports Pathology reports
 Consultations Other (specify)

_____(Initial) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) of Hepatitis. It may also include information about behavior or mental health services, and treatment for alcohol and drug use.

_____(Initial) I have carefully read and understand the above statements, and do hereby expressly and voluntarily consent to disclose the above information about, or medical records of my medical condition to those persons of agencies named above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original.

_____(Initial) The staff at Center for Interventional Pain Management may leave discrete telephone messages on my personal answering machine or at another number that I provide.

If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/she should put an "X" on the signature line and have his/her consent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

This authorization for release of information will not expire unless revoked by patient.

Signature of Patient Date _____

Consenting party signing in lieu of patient Relationship Date _____

Neuro-Interventional Spine , Dr. Allen A. Baidey, M.D.

HIPAA COMPLIANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the “Privacy Rule”. We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent to the use of disclosure of your personal health information. Under this law, we then have the right to refuse to treat you, should you refuse to disclose your personal health information. At any time in the future you may request to refuse all or part of disclosure to your personal health information. However you may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the government ruled, laws and regulations. We want to ensure that our Center never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent any inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Signature of Patient

Date