Center for Diseases and Surgery of the Spine

600 S. Ranch Dr. Suite 107

T:702-878-8370 F: 702-878-9642

www.lvcdss.com

Patient Registration Form

☐ **New Patient** ☐ **Name Change** ☐ **Address Change** ☐ **Insurance Change**

_____**Jr Sr**

First **Middle** **Last**

SS#_____-_____-_____ **DOB:** _____/_____/_____ **Age:** _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Prefer Not to Say

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Height: _____ **Weight**:_____ ☐Smoker ☐ Non-Smoker

Home Address: _____

Home: (_____) _____ Cell: (_____) _____

Email: _____

Race ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Other

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Insurance Information: Do you have health insurance? ☐ Yes ☐ No (if yes, please complete below)

Primary Insurance Carrier: _____ Policy Type: ☐ PPO ☐ HMO

Name of Insured (Guarantor):_____Guarantor Date of Birth ____/____/____

SS#: _____-_____-_____ Policy # : _____

Relationship to Insured:

_____

Secondary Insurance Carrier : _____ Policy Type : ☐ PPO ☐ HMO

Name of Insured (Guarantor):_____Guarantor Date of Birth ____/____/____

SS#: _____-_____-_____ Policy # : _____

Relationship to insured: _____

Emergency Contact (In Case of Emergency) Name of Spouse/Close Relative or Friend:

_____

Home # :(_____) _____ Cell #: (_____) _____

Referring Physician: _____

Phone: (_____) _____Fax: (_____) _____

Primary Care Physician: _____

Phone: (_____) _____Fax: (_____) _____

Pharmacy: _____

Phone: (_____) _____Fax: (_____) _____

Is your visit due to a motor vehicle accident? ☐ YES ☐ NO

☐ Legal Case: I authorize the release of information to the named attorney:

_____

(If you check the above box please complete the Authorization for Use and Disclosure of PHI form)

***Please present your insurance card(s) and your photo ID to the receptionist along with this completed form. The receptionist will make a copy and return them to you promptly. Thank You.**

I certify this information provided is true and correct. I will notify the medical staff of any changes in my health status. I understand that it is my responsibility to update any changes of address, phone number, name, and/or insurance.

I authorize the release of all information necessary to file a complete claim with the insurance company of record. I hereby authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for non-covered services.

In the event of collection proceedings, I agree to pay any and all collection and legal fees. I further understand that balances not paid within 90 days from the date of service will be referred to a third party collection agency and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

1. Where is the pain? _____

_____

2. What date did your pain start? _____

3. Are you pregnant or do you think you might be? ☐ Yes ☐ No

4. Have you been treated for your present problems? ☐ Yes ☐ No

If yes, when?_____

By whom? _____

5. Have you had any of the following diagnostic tests?

Injections: ☐ Yes ☐ No Type of injection:_____ Provider_____ Date: ___/____/__

Nerve conduction test: ☐ Yes ☐ No ☐ UPPER ☐ LOWER Provider: _____

Radiology Testing:

☐ MRI: ☐ Yes ☐ No Body Part:_____ Facility: _____ Date: __/___/___

☐ CT scan: ☐ Yes ☐ No Body Part:_____ Facility: _____ Date: __/___/___

☐ X-ray: ☐ Yes ☐ No Body Part:_____ Facility: _____ Date: __/___/____

Physical Therapy: Body Part:_____ Facility: _____ Date: _____/____/_____

6. Has this problem disabled you from working? ☐ Yes ☐ No

7. Please list all allergies _____

_____

8. Please list all previous surgeries _____

_____

9. Have you been diagnosed with Hepatitis C, HIV, or TB? _____

10. Any Chronic cough lasting longer than 3 weeks, bloody sputum, unexplained weight loss, or night sweats? _____

12. Have you recently traveled outside of the U.S.A? _____

13. Have you been in contact with anyone with active tuberculosis? _____

14. Please list all the medications you are currently taking.

Medication/ Dosage	How is it taken?	Who Prescribed the medication?

15. What percentage of your waking hours do you have pain? _____

16. With respect to your physical condition, rate your present disability level

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No disability Total disability

17. What is your current pain level?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Unbearable pain

18. What is your least pain level?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Unbearable pain

19. What is your Worst pain level?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain Unbearable pain

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

PLEASE READ: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the one box which applies to you. We realize you may consider that 2 of the statements in any one section relate to you but please mark just the box which most closely describes your problems.

Section 1 – Pain Intensity
☐ I can tolerate the pain I have without the use of pain killers.
☐ The pain is bad, but I manage without the use of pain killers.
☐ Pain killers give me complete relief.
☐ Pain killers give me moderate relief.
☐ Pain killers give me very little relief.
☐ Pain killers have no effect on pain. I do not use them.

Section 2 – Personal Care (washing, dressing, etc.)
☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally, but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful
☐ I need help every day with most aspects of self-care.
☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights, but it gives me extra pain
☐ Pain prevents me from lifting heavy objects off the floor but I can lift heavy objects if they are on a table.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if light and medium weights are conveniently positioned (for example, on a table).
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking one block
☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me walking more than 1 mile.
☐ Pain prevents me walking more than ½ mile.
☐ Pain prevents me walking more than ¼ mile.
☐ I can only walk using a cane or assistive device.
☐ I cannot walk and move around in a wheelchair with help.

Section 5- Sitting
☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6- Standing
☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me pain.

☐ Pain prevents me from standing for more than 1 hour
☐ Pain prevents me from standing more than ½ hour.
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me from standing at all.

Section 7- Sleeping
☐ Pain does not affect my sleep.
☐ Pain occasionally interrupts my sleep.
☐ Pain interrupts my sleep half the time.
☐ Pain often interrupts my sleep.
☐ Pain always interrupts my sleep.
☐ I never sleep well.

Section 8- Sex Life
☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal but causes some extra pain.
☐ My sex life is nearly normal bur is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex life at all.

Section 9- Social Life
☐ My social life is normal and gives me no extra pain
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my energetic interests i.e. dancing, gym etc.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of my pain.

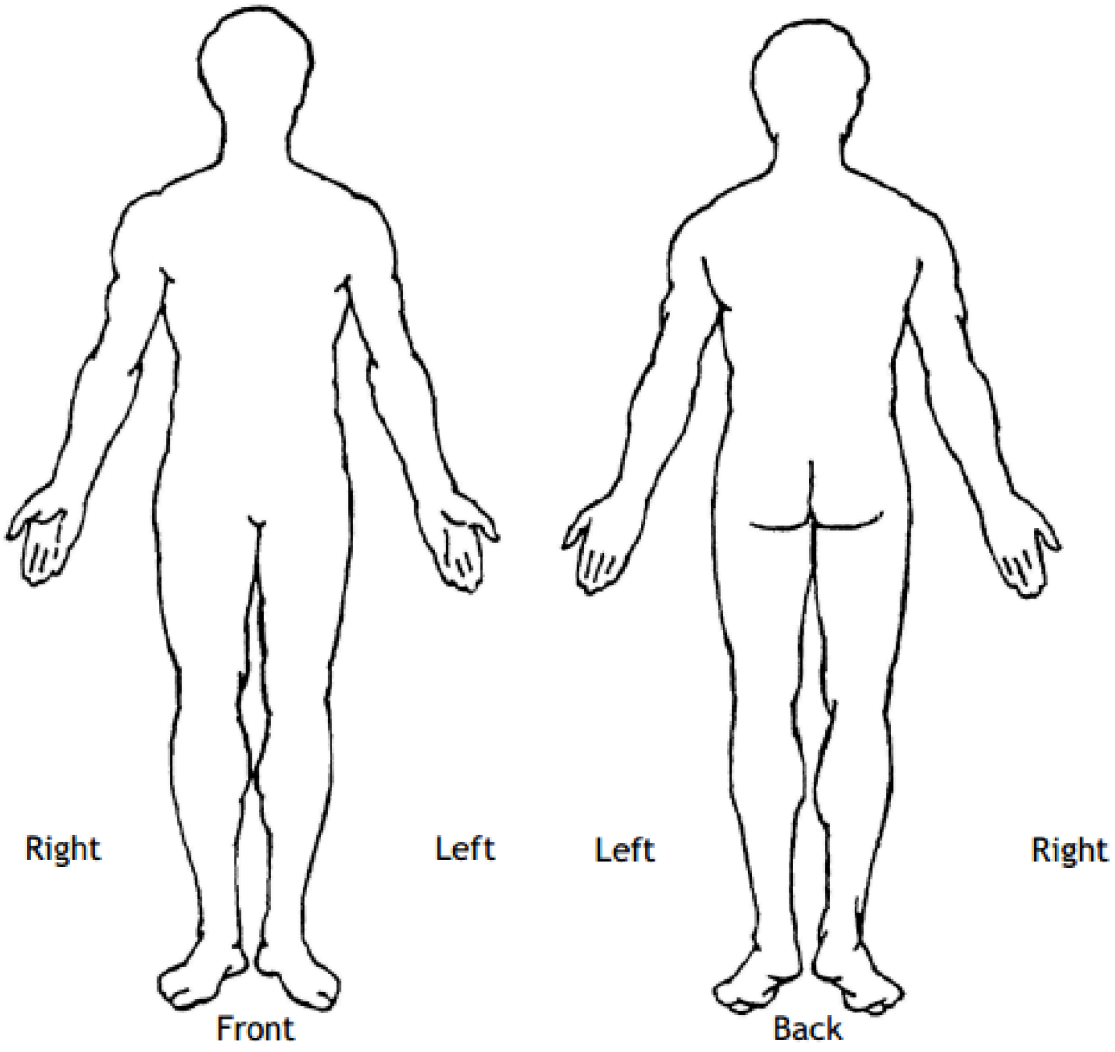
Section 10- Traveling
☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over two hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctors or hospital.

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

Patient Pain Drawing

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

ACHE	NUMBNESS	PINS/NEEDLES	BURNING	STABBING
+++++	=========	^^^^^^^^^^^^^^	xxxxxxxxx	//////////////////



ACCIDENT INJURY QUESTIONNAIRE
(Only answer if applicable)

What type of accident did you have?_____

When did the injury occur? _____

Where did the injury occur? _____

How did the injury occur? _____

What were the weather conditions? (i.e. rain, sun, wind) _____

Were you the driver? _____

If you were a passenger, were you in the front or rear of the vehicle? _____

Were you wearing a seat belt? _____

Did you lose Consciousness? _____

What type of vehicle were you in? _____

How fast was your vehicle moving? _____

Did the airbags deploy? _____

What was the estimated damage to your vehicle? _____

Where was the damage located on your vehicle? _____

Do you believe your injury was work related? ☐ Yes ☐ No

Did you report the injury to anyone? ☐ Yes ☐ No

If yes, to whom? _____ Date _____

Do you expect to receive, or have you been provided with Workers' Compensation benefits? ☐ Yes ☐ No

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

Center for Diseases and Surgery of the Spine

Authorization to Release Medical Records

Full Name: _____Date of Birth: _____

Address: _____Phone Number: _____

I authorize, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

(Name of healthcare provider or organization that **holds** the information)
Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

To Release Information To:
(Name and contact information of the person or organization **receiving** the information)

Name: _____

Address:_____

Phone: (_____)_____ Fax: (_____)_____

PATIENT INFORMATION IS NEEDED FOR: (Circle one)

Continuing Medical Care	Military	Social Security/Disability	Insurance	Personal Use
School	Legal Purposes		Other: _____	

INFORMATION TO BE RELEASED OR ACCESSED: (Circle One)

History & Physical	Consultation Report	All Medical Records
Operative Reports	Discharge/Death	Summary Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
The authorization will expire six (1) year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient

CENTER FOR DISEASES AND SURGERY OF THE SPINE

JOHN S. THALGOTT, M.D.
600 S. RANCHO DR. SUITE 107
LAS VEGAS, NEVADA 89106-4806
PHONE (702) 878-8370 FAX (702) 878-9642

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY
BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH
INFORMATION.

As required by the privacy regulations created as a results of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must provide you with he following important information:

- How we may use and disclose your protected health information (PHI).
- Your privacy rights with regard to your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your personal information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices as permitted by law. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past or that we may create or maintain in the future. Our practice will post a copy of our current Notice in a visible location at all times, and you may request a copy of our most current Notice at any time.

A. USES AND DISCLOSURES OF PHI

The following section describes different ways that we use and disclose your health information. Not every use or disclosure will be listed; however, we have listed the various ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by submitting the revocation to us in writing.

1. Treatment. We may use and disclose medical information in the course of your treatment in order to provide, coordinate or manage your health care and any related services. This may include other providers, pharmacies or others who assist in your care, such as your spouse, children, parents or caretaker.
2. Payment. We may use and disclose your PHI, including records, to obtain payment for services and products you may receive from us. This may include activities associated with authorization of services, eligibility and coverage or obtain payment by your health insurance plan or other third parties that are responsible for such payment or information.
3. Health Care Operations. We may use and disclose your PHI to ensure accurate and appropriate business operations. These activities include, but are not limited to, quality assessment activities, employee review activities, or licensing.
4. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
5. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care or who assists in taking care of you.

B. ADDITIONAL USES AND DISCLOSURE THAT MAY BE MADE **WITH** YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to all or part of your PHI being used or disclosed for these purposes. If you have not able to agree or object, the provider will, using professional judgment, determine whether the use is in your best interest. In any event, only the PHI that is relevant to your health care will be disclosed.

1. Emergencies. We may use or disclose your PHI in an emergency treatment situation. If this happens, your provider will try to obtain your consent as soon as reasonable practicable after the delivery of treatment. If your provider is required by law to treat you and the provider has attempted to obtain your consent but is unable, he or she may still use your PHI to treat you.

2. Others Involved in Your Health Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify or that may be responsible for your care, your PHI that directly relates to that person's involvement in your health care. If you are unable to object to such a disclosure, we may disclose such information if we determine that it is in your best interest. We may use or disclose your PHI to an authorized public or private entity to assist and coordinate uses and disclosures to family or other individuals involved in your healthcare.

3. Communication Barriers. We may use and disclose your PHI if your provider attempts to obtain your consent but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to under the circumstances.

C. ADDITIONAL USES AND DISCLOSURE THAT MAY BE MADE **WITHOUT** YOUR CONSENT, AUTHORIZATION
OR OPPORTUNITY TO OBJECT

1. Public Health. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of.

- Maintaining vital records, such as births and deaths.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure to a communicable disease.
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying appropriate government agencies and/or authorities regarding the potential abuse or neglect of a patient, including domestic violence. However, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight. We may use or disclose PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Required by Law. We may use or disclose PHI to the extent required by law. The use or disclosure will be limited to the relevant requirements by the law. You will be notified, as required by law, of any such uses or disclosures.
4. Legal Proceedings. We may disclose PHI in the course of any judicial or administrative proceeding, in response to a court or administrative order, discovery request, subpoena, or other lawful process by another third party involved in the dispute.
5. Law Enforcement. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes including:

- Legal processes and otherwise required by law.
- Limited information requests for identification and location purposes.
- Pertaining to victims of crime.
- Suspicion that death has occurred as a results of criminal conduct.
- In the event that a crime occurs on the premises of the practice, and
- Medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

6. Coroners, Funeral Directors and Organ Donation. We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for other duties authorized by law. We may also disclose information to a funeral director, as authorized by law, in order to permit the director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
7. Food & Drug Administration. We may disclose your PHI to an FDA authorized person or company to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements or to conduct post-marketing surveillance, as required.
8. Military Activity and National Security. When appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forced personnel (1) for activities deemed necessary by appropriate command

authorities; (2) for purpose of determination by the Department of Veteran Affairs of your eligibility for benefits, or; (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the present or others legally authorized.
9. Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of this notice.

D. YOUR RIGHTS REGARDING YOUR PHI

1. Confidential Communications. You have the right to request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, but not leave a message on the answering machine or with the answering service. We will accommodate reasonable requests. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer, whose name is listed elsewhere in this Notice.
2. Request Restrictions of your PHI. You have the right to ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations (TPO). You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must make your request in writing to the Privacy Officer listed elsewhere in this Notice. You must include (1) the information you wish restricted, (b) whether you are requesting to limit our use, disclosure or both and, (3) to who you want the limits to apply.

Your provider is not required to agree to a restriction. If your provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI may not be restricted. If your provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.
3. Inspect and Obtain Copy of Your PHI. You have the right to inspect and obtain a copy of PHI about you that is contained in your medical record. A medical record includes medical, billing and any other records used for making decisions about you. However, under federal law, you may not inspect or receive copies of the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. You may be required to submit your request for records in writing and a fee may be charged by the practice for the cost of copying, mailing, labor and supplies associated with your request.
4. Request Amendments to Your PHI. You have the right to request an amendment of PHI about you in your medical record for as long as we maintain it. The request must be in writing and submitted to the Privacy Officer listed elsewhere in this Notice. You must provide us with a reason that supports your request for an amendment. In certain cases, we may deny your request for an amendment. If your request is denied, 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.
5. Request Accounting of Certain Disclosures of Your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations (TPO) as described in this Notice. You have the right to specific information regarding these disclosures that occurred after April 14, 2003. This accounting is a list of certain nonroutine
disclosures our practice has made, if any, of your PHI for non-TPO purposes. Use of your PHI as a part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer listed elsewhere in this Notice and you must state a time period, which may not be longer than six (6) years from the date of disclosure, and may not include dates prior to April 14, 2003.
6. To Obtain a Paper Copy of This Notice. Upon request, you have the right to obtain a paper copy of this notice, even if you have previously agreed to accept this notice electronically.
7. Complaints/Questions. You may file a complaint with our office or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint. For information about the complaint process, please contact the Privacy Officer listed elsewhere in this Notice.

E. PRIVACY CONTACT/QUESTIONS AND FURTHER INFORMATION

For questions regarding this notice and further information regarding any of its contents, you may contact:

Angelica Rodriguez, Privacy Officer (702) 878-8370

CENTER FOR DISEASES AND SURGERY OF THE SPINE

JOHN S. THALGOTT, M.D.
600 S. RANCHO DR. SUITE 107
LAS VEGAS, NEVADA 89106-4806
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MEDICATION POLICY

If you are prescribed medication during your treatment, there are several guidelines you must follow and you will be required to take a urinalysis for Therapeutic Drug Evaluation.

1. The medications given to you should be taken as prescribed by your doctor. The medications may not be used for any purpose other than that which they were given to you. These medications may not be given or sold to any other individual.

2. You will be given a specific amount of medication to last a specific length of time. You must keep track of your medications to make sure you do not run out before the specific time. It is your responsibility to have follow-up appointments scheduled far enough in advanced so that you do not run out of medication.

3. We are not a pain management facility and will not refill pain medications, except in instances of surgery. If you need a refill for pain medication, we will be happy to refer you to a pain management facility.

4. Requests for medication refills will only be considered during regular office hours (9:00 a.m. to 5:00 p.m., Monday through Thursday). No refills will be given after hours, weekends or holidays.

5. Requests for medication refills should be called to your pharmacy who will, in turn, call our office. Please allow 48 hours for this procedure. No refills of medications will be given if you have not been seen for 3 months. Your refill will need to be reviewed by your physician and may not be refilled until you have been seen again. It is your responsibility to make a follow-up appointment with your doctor. This will be strictly enforced.

6. If you call for medications or refills outside of regular office hours, you will be instructed to go to the emergency room and the emergency room physician will decide whether or not to refill your medication. Emergency department policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the emergency department is busy, you may be required to wait a long period of time to be seen.

7. While under the care of the physician, all pain medications will be given at the physician's discretion.

8. Telephone requests for prescription renewals are accepted only during regular business hours. In some instances, there is a 24-hour waiting period before prescriptions will be refilled, so call for your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.

Patient/Guardian Signature _____ Date _____

CENTER FOR DISEASES AND SURGERY OF THE SPINE
JOHN S. THALGOTT, M.D.
600 S. RANCHO DR. SUITE 107
LAS VEGAS, NEVADA 89106-4806

PLEASE INITIAL EACH SECTION OF THIS PAGE AND SIGN AT THE BOTTOM INDICATED THAT YOU UNDERSTAND THE POLICIES OF CENTER FOR DISEASES AND SURGERY OF THE SPINE. IF YOU HAVE QUESTIONS, PLEASE DO NOT HESITATE TO ASK FOR AN EXPLANATION FROM ANY MEMBER OF OUR STAFF.

Office hours are 9:00 a.m. to 5:00 p.m., Monday through Thursday. All routine telephone calls to the office should be made during these hours. Routine calls made after business hours will be returned the following business day.
Patient Initials _____

I understand that it is my responsibility to contact the physician's office if I am unable to make my appointment. I understand that if I do not give the office a 24 hour notice, I will be charged a $50 "no show" fee. I also understand that if I'm more than 15 minutes late for my schedule appointment, I may be asked to reschedule.
Patient Initials _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.
Patient Initials _____

I hereby consent to have myself photographed by CDSS or a designated assistant. I understand that the photographs are to be used for purposes of documentation and evaluation of my treatment and will be treated as part of my medical record. I give my permission for these materials to be used by CDSS to assist in my treatment.
Patient Initials _____

I hereby authorize and request John S. Thalgott, M.D. to release my complete medical records (including x-rays) when referring to other facilities concerning my treatment at Center for Diseases and Surgery of the Spine.
Patient Initials _____

I hereby assign to John S. Thalgott, M.D., Physicians' Assistants, and/or surgical techs, all benefits for surgical and medical care payable under the attached policy/policies. I also authorize release of information to secure payment. A photocopy of this assignment is to be considered valid as the original.
Patient Initials _____

I understand that I am financially responsible for all services rendered, whether or not paid by my insurance company. Payment is expected at the time of service. We accept Visa and Mastercard for your convenience. If you are on a lien, it is your responsibility to notify our office in writing if there are any changes in your legal representation. Any services performed prior to this office receiving written notification to bill insurance will be the patient's sole responsibility due to insurances having to be billed in a timely manner. There will be a charge of $35.00 for all returned checks. Patient Initials _____

I understand that I will receive a separate bill from the laboratory for any cultures, blood or urine samples taken at his office. Patient Initials _____

In the event of collection proceedings, I agree to pay any and all collection and legal fees. I further understand that balances not paid within 90 days from the date of service will be referred to a third-party collection agency and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus. Patient Initials _____

ORTHOPAEDIC OR SPINAL EMERGENCIES USUALLY REQUIRE HOSPITAL ADMISSIONS. IF YOU SHOULDFIND YOURSELF IN AN EMERGENCY SITUATION, PLEASE GO TO THE NEAREST HOSPITAL EMERGENCY ROOM AND SOMEONE WILL REACH YOUR PHYSICIAN THROUGH THE ANSWERING SERVICE. PLEASE KEEP IN MIND THAT ON SOME WEEKENDS THERE WILL BE OTHER SURGEONS COVERING YOUR DOCTOR'S PRACTICE AND THEREFORE, YOU MAY BE SEEN BY SOMEONE OTHER THAN YOUR DOCTOR.

Patient/Guardian Signature _____ Date _____