

Mid-Atlantic Spine & Orthopaedics LLC

305 Hospital Drive, Suite 303

Glen Burnie, MD 21061

Phone 410-553-8290 Fax 410-553-8288

NEW PATIENT INFORMATION LETTER

Dear Patients:

We are pleased to welcome new patients to the new offices of Mid-Atlantic Spine & Orthopaedics. (If you need directions please refer to this packet.)

In order to facilitate the speed and comfort of your first visit to our practice, we are sending ahead the information forms which must be **completed and brought in with you to your first visit.**

It is also **MANDATORY** that any **MEDICAL REPORTS and RECENT X-RAYS WITH CORRESPONDING XRAY/MRI REPORTS,** (MRI's or Cat Scans), that you have undergone in preliminary evaluation of your current health condition -- **BE BROUGHT TO OUR OFFICE FOR YOUR FIRST VISIT.** Please make sure that you contact your referring Doctor and make arrangements to obtain these records so that you can **BRING THEM WITH YOU.** If you do not have these test results for your first visit, it will substantially delay our physician's ability to evaluate your situation thoroughly and **it may be required to re-schedule your initial visit if you arrive without the necessary records.**

Thank you for your cooperation, we look forward to seeing you in our office.

Sincerely,

Randy F. Davis, M.D.

P.S. - Please note our attached policies concerning billing, insurance, co-payments and referral requirements. Your understanding and cooperation in all these areas will allow us to more readily facilitate the speed and comfort of your care program with our group.

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HIPPA POLICY ACKNOWLEDGEMENT

I have reviewed this practices' Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual right, how I may exercise these rights, and the practices legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. A copy is available upon my request of the Notice of Privacy Practices for my records.

Patient Signature: _____

Date: _____

****Privacy Practice are in the patient waiting room and a copy is available for your records by request.****



(Please fill in all spaces in print)

Name: _____ SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Alternate Phone (Cell) _____ Email: _____

Sex: M/F Marital Status (circle one) S M D W DATE OF FIRST SYMPTOM/INJURY: _____

Employer: _____ Work Phone: _____ Position: _____

Work Address: _____ FT/ PT (circle one) If Disabled, Since When? _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Who Referred you to our Office? _____

FAMILY PHYSICIAN'S NAME _____ PHONE _____ FAX _____

PHARMACY NAME: _____ PHONE _____

HEALTH INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE

Insurance Company: _____ Phone# _____

Insurance ID: _____ Group# _____

Insured's Name: _____ Relationship to patient: Spouse Parent Other

Insured's Employer: _____

SECONDARY HEALTH INSURANCE

Insurance Company: _____ Phone# _____

Insurance ID: _____ Group# _____

Insured's Name: _____ Relationship to patient: Spouse Parent Other

Insured's Employer: _____

Other Insurance: Workers Comp _____ Auto Accident _____ Insurance Company _____

Address: _____ Phone: _____

Claims Adjuster Name/Phone: _____ Claim# _____

Date of Injury or Accident: _____

Describe Problem, Injury or Reason for seeing the Doctor: _____

If Minor Parents Name: _____ SS: _____ DOB _____

****A copy of your insurance card and driver's license will need to be scanned into our medical system for future reference³**

The above stated information is true to the best of my knowledge.

Signature _____ Date: _____



Patient History & Data Base Form

Name: _____ Age: _____ Date: _____

Occupation: _____ Referred by: _____

Description of job duties: _____

If on a Sports Team - Name & Phone for Coach _____

Sports you play regularly: _____

HISTORY OF PRESENT PROBLEM

Symptoms/Presenting Problem: _____

Date of Injury: _____ Problem first started about: _____

This occurred at: Work ___ home ___ motor vehicle ___ other: _____

Describe how you were injured: _____

P Location of your pain: _____

A Usual severity of pain: 1 2 3 4 5 6 7 8 9 10 (Please circle, worst pain = 10)

I Severity of pain today 1 2 3 4 5 6 7 8 9 10 (Please circle, worst pain = 10)

N Type/Quality of pain: dull ___ burning ___ aching ___ throbbing ___ sharp ___ (indicate all appropriate)

Other type of pain describe: _____

Is WORSE by: Moving ___ lifting ___ twisting ___ walking ___ running ___

Other: _____

Get RELIEF by: _____

Is pain as bad at night? Y ___ N ___ Hours of sleep you now usually get: _____

Is pain affecting your ability to sleep? Y ___ N ___ Sometimes _____

TREATMENT

Treatment you have had: None _____ Medication(s) _____

Physical Therapy: _____ How long? _____

Date stopped working _____ I'm still working _____

PAST HEALTH HISTORY

Check if you have ever had:

- | | | |
|--|----------------------------|----------------------------|
| ___ Diabetes ___ | ___ Asthma ___ | ___ Kidney/bladder disease |
| ___ High blood pressure ___ | ___ Chronic Cough ___ | ___ Blood clots in legs |
| ___ Irregular heart beat ___ | ___ Ulcers ___ | ___ Bleeding disorder |
| ___ Angina ___ | ___ Hiatal hernia ___ | ___ Infected/bleeding gums |
| ___ Emphysema/lung disease ___ | ___ Jaundice/hepatitis ___ | ___ Stroke |
| ___ Heart attack/disease ___ | ___ Depression ___ | ___ Thyroid Disease |
| ___ Surgical Complications (please list) _____ | | |

___ Cancer of: _____

Please continue to next page

Other Medical Problems or details about past health history: _____

Please list any surgeries you have had, with approximate dates:

Surgery Date Surgery Date

Please list any Allergies to Medicine and type of reaction:

HABITS

Smoking: _____ packs/day x _____ years. If quit, how long ago? _____ Never smoked _____

Drink Number of _____ beers _____ glasses of wine _____ cocktails per day _____

Exercise – Please check any of the following forms of exercise, in which you regularly engage, and indicate frequency:

Activity/Exercise	# of Times Per Week (Frequency)	Activity/Exercise	# of Times Per Week (Frequency)
Walking	Running		
Golf	Tennis/Soccer/Football/Baseball		
Swimming	Aerobic Exercise		

CURRENT MEDICATION

Please list any medication you currently take on a regular basis: _____

Signature of Patient (or parent if patient is under 18 years of age)

Date

Signature of Provider/Physician

Date



MEETING MANAGED CARE GUIDELINES

On behalf of our patients, our practice participates with a wide variety of managed care plans. All of these plans have different requirements and policies concerning arranging for ongoing care, diagnostic testing (such as X-ray or laboratory) and procedures or surgery. Additionally each plan (even within the same insurance company) has different guidelines for how often, and where, services may be provided.

Our staff makes every effort to stay informed concerning these requirements, but we also count on our patients to participate actively in this process in order to make sure that services which your physician has determined are necessary and appropriate are:

- pre-approved - via referral from your primary care, or
- authorized by your insurance carrier with a pre-authorization #, and
- provided by a health care group authorized by your insurance.

It is our goal to provide and facilitate the highest possible quality of care for the patients of our practice. **Ensuring that this care is provided in the context of the guidelines of your current insurance policy is a project that requires real teamwork -- yours and ours!**

Each time a health care service is scheduled for you, you must participate by making sure that a **required referral is in-hand** from your primary care provider, or that the service is scheduled with a provider approved by your plan.

If you do not inform us of special requirements of your plan, so that we can make sure they are met in the process of your care, then any resulting bill for services denied by your plan, will become your direct responsibility.

Let's work together in order to make sure that your managed care plan works to your benefit in delivery of your health care needs.

I HAVE READ AND UNDERSTAND THIS POLICY AND MY RESPONSIBILITY AS DESCRIBED.

Patient Name (Printed) _____

Patient Signature

Date

Witnessed

Date



Insurance Authorization and Assignment

Patient Name: _____

We accept assignment and bill all insurance carriers with whom we are contracted, participating providers. We follow the insurance billing guidelines and referral process. All co-pays and deductibles are due at time of visit.

I _____, hereby authorize Mid Atlantic Spine & Orthopaedics to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance.

I also understand and agree that I accept responsibility for paying the physician's bill and any other bills relating to this case, including equipment and supplies regardless of insurance payments.

I, _____, understand that I am personally responsible for charges incurred for the collection of my account. These charges commence when my account has remained outstanding for 120 days or longer. A 1 ½% monthly interest charge will be assessed to any outstanding balance of 120 days or older. Should collection proceedings be necessary, a 15% service charge will be assessed to cover attorney fees. This applies to any denial of a Workmen's Compensation claim or other pending litigation.

Date _____ **Signature** _____

AUTO ACCIDENTS & WORKERS COMPENSATION PATIENTS ONLY

SIGN BELOW

STATUTE OF LIMITATIONS WAIVER

I _____, do hereby waive my right to the three year statute of limitations for the collection of any medical services that may be denied or go unpaid by workers compensation and/or my auto policy.

Date: _____ **Signature:** _____



DIRECTIONS

Parking: Parking is available on the side of the Tate Center building or you may park in the parking garage that is attached to the building (free parking). If you park on the 3rd floor of the garage you may take the covered walkway across to the Tate Center.

From Baltimore:

Take 95 South to Baltimore Beltway 695 to exit 4-Route 97 South to Route 100 East toward Gibson Island. Take Exit 15 (Oakwood Road), take Right off exit and immediate right onto Hospital Drive. Go thru 1st light and make immediate left into Tate Center Parking Lot.

From Washington D.C.

Take 95 North to exit 43, Route 100 East, Take exit 15 (Oakwood Road). At bottom of exit, turn right and a quick right on to Hospital Drive. Go thru 1st light and make immediate left into Tate Center Parking Lot.

From Columbia

Take 95 North, 295 North or 29 North to Route 100 east to Exit 15 (Oakwood Road) quick right at bottom of exit and quick right onto Hospital Drive. Go thru 1st light and make immediate left into Tate Center Parking Lot.

From BWI Airport:

Leaving the airport, via Elm Street turn right at the light onto Aviation Blvd. Take to Dorsey Rd. Turn left at the traffic light for entrance ramp onto 97 South right lane and follow signs to Route 100 East. Take Route 100 East to Exit 15 (Oakwood Road), right onto Oakwood and immediate right onto Hospital Drive. Go thru 1st light and make immediate left into Tate Center Parking Lot.

From Annapolis/Eastern Shore

Take Route 50 West until Route 97 North to Baltimore. Follow Route 97 to the New Cut Road Exit (Exit 12). At the traffic light turn right onto Crain Highway and continue until Hospital Drive. Make a Right onto Hospital Drive. Make right into Tate Center Parking Lot.

From Johns Hopkins

Out of the Johns Hopkins Outpatient garage make a left on to North Caroline Street. Make a right onto Orleans Street. Orleans Street turns into Franklin Street @ St. Paul. Stay straight to Green Street and make a left turn. This turns into 295-S. Take exit for Route 100 east towards Glen Burnie. Follow Route 100 to Exit 15 (Oakwood Road). Make a right onto Oakwood and an immediate right onto Hospital Drive. Go thru 1st light and make immediate left into Tate Center Parking Lot.

From Points North:

Take 95 South to 895 South toward Annapolis. Keep right to take I-895 Spur South Via exit 6 toward 97 South Annapolis/Bay Bridge. Take the MD-2 South Exit toward Glen Burnie. Merge onto I-97 South. Take Route 100 East via Exit 14A on the Left toward Gibson Island. Take Exit 15 (Oakwood Road) Right onto Oakwood and an immediate right onto Hospital Drive. Go thru 1st light and make immediate left into Tate Center Parking Lot.