SOUTHEASTERN SPINE SPECIALISTS/DR TIM BASSETT
PATIENT INFORMATION SHEET

Patient's Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Home# _____ Work# _____ Cell# _____
Marital Status: S___ M ___ D ___ W ___ Sex: Male/Female Race: White/Black/Hispanic/Other _____
Social Security# _____ Date of Birth _____ Age _____

Patient's Employer _____ Occupation _____
Employer's Address _____ Employer's Phone# _____

Spouse's Name _____ Spouse's Phone# _____
Spouse's Date of Birth _____ Spouse's SSN# _____

If patient is a minor, we must have the following information:
Parent's Name _____ Phone# _____
Address _____ City _____ State ___ Zip _____
Date of Birth _____ Social Security # _____
Parent's Employer _____ Parent's Work # _____

Name of nearest friend or relative not living with you: _____
Relationship to patient: Father/Mother/Son/Daughter/Friend/Other _____
Friend/Relative's Phone Number: Home# _____ Cell# _____ Work# _____

Primary Physician _____ Referral Source _____

Have you seen Dr. Bassett before? Yes/No
Reason for visit today: Back/Neck/Other _____

Is this due to an injury/accident? Yes/No If yes, date of injury/accident _____
Were you in a vehicle accident? Yes/No
Have you retained an attorney? Yes/No
Is this a Worker's Comp claim? Yes/No
If yes, please provide the following: Claim Number _____
W/C Insurance Name _____
W/C Insurance Address _____
City _____ State _____ Zip _____
W/C Contact Name _____
Phone# _____ Extension _____

Primary Insurance Name _____
Primary Insurance Contract# _____ Group# _____
Secondary Insurance Name _____
Secondary Insurance Contract# _____ Group# _____

Please read and sign: I hereby authorize Southeastern Spine Specialists to disclose to my insurance carrier or third party, complete information concerning medical findings, treatment, and charges incurred and assign all payments for medical services rendered to myself or my dependents. I understand some procedures and supplies provided by my physician may not be covered by my insurance and I accept responsibility for the payment of any charges not covered by my insurance and agree to pay attorney's fees, court costs, and other reasonable costs of collection should I fail to pay such charges.

PATIENT'S/RESPONSIBLE PARTY SIGNATURE _____ DATE _____

MEDICAL HISTORY

Please circle all previous illnesses/medical issues:

Anxiety	Depression	Kidney Problems	Diabetes
Liver Disease	Stroke	Asthma	Lupus
Stomach Problems	Bladder Problems	HIV/AIDS	Arthritis
Ulcers	Heart Disease	Pneumonia	Gout
Transfusion	Phlebitis/Vein Issues	Tuberculosis (TB)	Migraines
Hepatitis	Colon Problems	Sickle Cell Trait	Seizures
High Blood Pressure	Thyroid Problems	Lung Disease	Cancer
Blood Disorders	Leukemia	Circulation Issues	

Other _____

PAST SURGICAL HISTORY

Have you ever been hospitalized? Yes/No

If yes, please list all past surgeries and approximate dates:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____

Have you ever had any problems with anesthesia? Yes/No

If yes, please describe: _____

FAMILY HISTORY

Relative:	Current Age:	Major Illnesses:	If Deceased, Cause Of Death:
Father			
Mother			
Brother/Sister			
Brother/Sister			

SOCIAL HISTORY

Marital Status (circle one)	Single	Married	Divorced	Widowed	
Use of Alcohol (circle one)	Never	Social	Moderate	Daily	Quit
Use of Tobacco (circle one)	Never	Social	Moderate	Heavy	Quit

If you use tobacco, how many packs/chew tins, do you use per day? _____

Living Situation (circle one)	Alone	Spouse	Family	Friend

Hobbies/Activities _____

Are you Right or Left hand dominance? Right/Left

ALLERGIES

Are you allergic to any drugs? Yes/No
If yes, please list: _____
Are you allergic to any of the following: Iodine Latex Tape Other _____
Are you allergic to xray dye? Yes/No

MEDICATIONS

Please list all current medications including non-prescription/over-the-counter/prescribed:

Name of Drug	Dosage Amount	How Often Taken	How Long On This Drug

(If you need additional space, please use back side of this page)

If a prescription needs to be called or faxed in, what is the name of the pharmacy you use?
Pharmacy Name _____
Pharmacy Address _____
Pharmacy Phone# _____ Fax# _____

SYSTEMS REVIEW (circle all that apply)

Gastrointestinal:
Good general health lately
Nausea or vomiting
Frequent diarrhea
Rectal bleeding
Abdominal pain
Hepatitis
Peptic Ulcers

Constitutional Symptoms:
Heat or cold intolerance
Recent weight gain over 10 lbs
Recent weight loss over 10 lbs
Fever
Fatigue
Constant headaches

Neurological:
Lightheaded or dizzy
Tremors/shaking
Vertigo
Numbness or tingling

Genitourinary:
Frequent urination
Burning/painful urination
Difficulty urinating
Blood in urine
Kidney stones

Eyes:
Wear corrective lenses
Blurred or double vision
Glaucoma
Other eye disorders

Hematologic/Lymphatic:
Anemia
Phlebitis

Musculoskeletal:
Osteoporosis
History of fractures
History of arthritis
History of bursitis
Rheumatoid disease
Gout
Lupus

Ears/Nose/Mouth/Throat:
Hearing loss or ringing
Chronic earaches/drainage
Chronic sinus problems
Consistent sore throat
Bronchitis
Pneumonia

Endocrine:
Loss of appetite
Diabetes (sugar)

Cardiovascular:
Chest Pain
Palpitations (Irregular heartbeat)
Swelling of feet/ankles/hands
Abnormal blood pressure
Heart disease

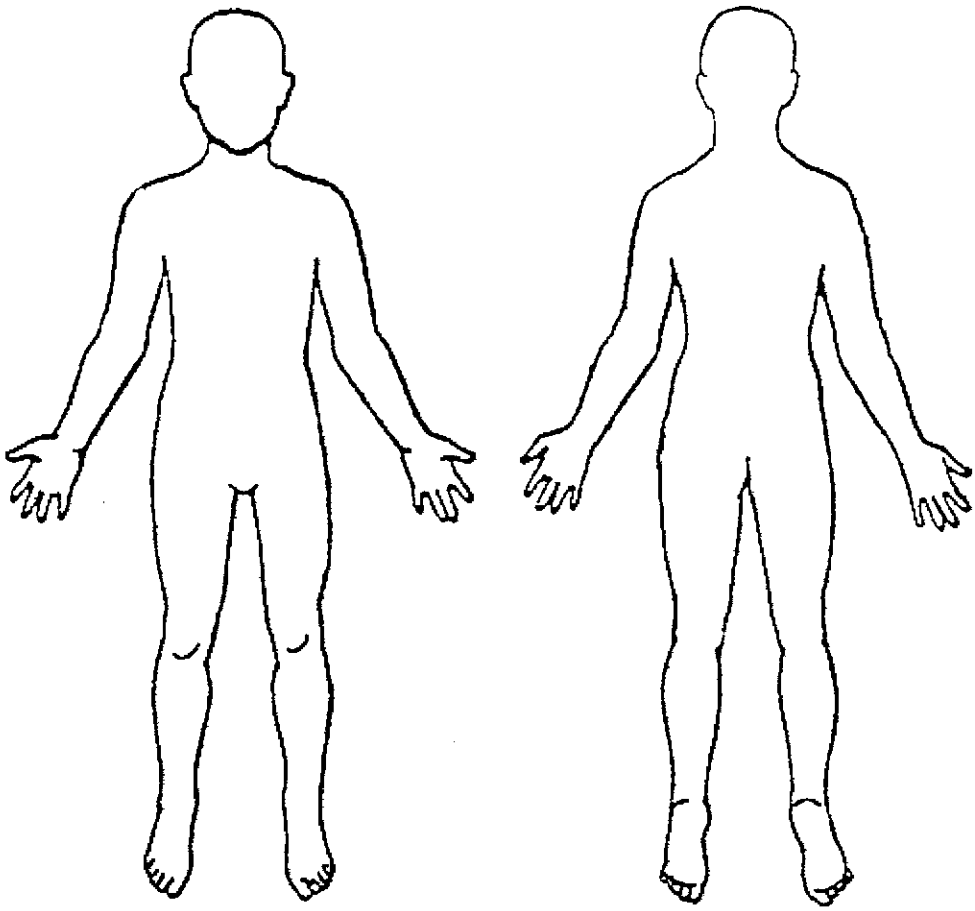
Pulmonary:
Chronic or frequent cough
Shortness of breath
Sleep apnea
Disturbed breathing

Other:
_____
_____
_____
_____

Where is Your Pain Now?

Mark on the drawings the areas on your body where you feel the sensation described below. Use the appropriate symbol(s) provided. Mark all affected areas.

Pins and Needles = OOOO Burning = XXXX Stabbing = //// Deep Ache = ZZZZ



RIGHT LEFT
FRONT VIEW

LEFT RIGHT
BACK VIEW

Rate Your Pain (circle one)	0 = No Pain									10 = Extremely Intense Pain
1. Pain Right Now	0	1	2	3	4	5	6	7	8	9	10
2. Pain at Its Worst	0	1	2	3	4	5	6	7	8	9	10
3. Pain at Its Best	0	1	2	3	4	5	6	7	8	9	10

AGREEMENT TO PAY

The patient and the responsible party listed below agree to pay all amounts and charges submitted by Southeastern Spine Specialists, for services rendered by the practice during the course of treatment for the patient, including hospitalization, unless the physician or contractors are otherwise obligated to accept payment from a third party. The patient and the responsible party understand and agree that they are financially responsible to the physician even though there may be insurance or other third party coverage and agree that failure to make payment when requested is the basis for legal action, and agree to pay all costs of collection, including a reasonable attorney's fee. The patient and the responsible party agree that their obligations to make payments are joint and severable and that the physician may pursue either or both parties for payment, and that the patient and the responsible party, and not any insurance company, are solely responsible for the entire bill, even though the cost of their medical care may exceed the amount reimbursed by third party insurers or payers.

RESPONSIBILITY FOR NON-COVERED SERVICES

The physician may determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by your Blue Cross/PMD contract, other insurance contract, HMO or other third party insurance coverage. Charges not covered may include services, and/or any annual deductibles or co-pays. Patient and responsible party agree to be fully responsible for all charges by the physician for such non-covered charges in amounts set forth on the fee schedule which is available upon request. The physician will order only tests that are deemed medically necessary in the physician's opinion. Patient and responsible party are accountable for knowing their specific medical insurance contract and the covered versus non-covered tests and services mandated by said contract.

AUTHORIZATIONS

Patient and the responsible party understand that the following authorizations are to be used by the physician to effect the collection of benefits on the patient's behalf. These authorizations become effective on the date of the first service rendered and remain in effect until specifically revoked in writing by patient and the responsible party. Copies of this agreement will be as valid as the original.

Release of Information: The patient and the responsible party authorize the release and disclosure of all medical information related to the patient's treatment and care to any entity which is, or may be liable for, physician charges or to any professional review organization or utilization review organization associated therewith. The patient and the responsible party authorize the release and disclosure of all or any part of the patient's medical records to any other health care provider who may be of assistance, in the opinion of the physician, in providing medical care and treatment for the patient, and/or for assisting in any reimbursement or benefits to which the patient may be entitled.

Assignment of Benefits: The patient and the responsible party authorize and request that payment of any authorized insurance benefits made either to the patient or on a patient's behalf, be in turn made to the physician for services furnished to the patient by the physician. This authorization allows the physician to file "assigned" claims only for the purpose of having benefits paid to the physician and does not imply that the physician accepts insurance as payment in full, unless the physician has a contractual agreement with the patient's insurance carrier or is otherwise legally obligated to accept less than the actual charges. The signatures below are deemed sufficient for all insurance forms on a continuing basis.

For Treatment: The patient and the responsible party authorize the physician to perform any procedures which may be deemed necessary in the judgment of the attending physician in the diagnosis and treatment of the patient's condition. The patient and the responsible party consent to the administration of such drug(s) as may be considered necessary or advisable for the treatment of the patient with the exception of _____.

Today's Date _____
Patient's Name (Print) _____
Patient's Signature _____

Today's Date _____
Responsible Party's Name (Print) _____
Responsible Party's Signature _____

POLICIES AND PROCEDURES

Appointments:

Our office will try to contact each patient the day before his/her appointment. If you need to cancel your appointment, please advise us as soon as possible so that we may offer the appointment to another patient. Patients who "no call or no show" for their scheduled appointment may be charged a $25.00 fee. Patients who are 15 or more minutes late may be asked to reschedule their appointment.

Prescriptions:

Patients should request any medication refills at the time of their appointment. Refills for some prescriptions may require a visit to the doctor (especially if it has been 6 months or more since your last appointment) or may require lab work. NARCOTICS (PAIN MEDICATIONS) CAN'T BE CALLED INTO A PHARMACY OR BE REFILLED, A NEW PRESCRIPTION MUST BE WRITTEN EACH TIME, THIS IS A STATE AND FEDERAL MANDATED LAW.

Insurance:

Please inform our office immediately if your insurance or personal information has changed. Insurance rules on timely filing of insurance claims have recently changed so we need to get your claim completed as soon as possible. Insurance co-pays are required by your insurance company and is due at the time of your appointment. Your appointment may be rescheduled if you don't have your co-pay.

Account Balances:

Patient balances that are not paid within 90 days may be subject to a finance charge of 1.5% per month or 18% per year unless arrangements have been made between the patient and the Practice Administrator. We accept cash, personal checks, and all major credit and debit cards. If you are unable to pay your account within the 90 days, please contact our billing department to discuss payment arrangements. Payment arrangements that are not adhered to may be subject to being turned over to our collection agency.

Returned Checks:

If our bank returns your check for NSF (non-sufficient funds), we will ask that you come into our office to cover the amount of the returned check plus a fee of $35.00 for a returned check fee which will have to be done with cash or credit/debit card only. We will not process/redeposit returned checks back through the bank. Returned checks that are not immediately taken care of will be turned over to our collection agency.

Medical Records:

Federal law requires our office to keep medical records on each of our patients for a specific number of years. All medical records kept in our office are the property of our office. A patient may request a copy of his/her records at any time. Alabama law allows us to charge a fee for copying records. The current fee is $5.00 retrieval fee, $1.00 per page for pages 1-25, and $0.50 for each page thereafter. There is no fee to have your records forwarded to another physician's office or medical facility. When requesting a copy of your medical records, please allow 5 to 7 business days for processing.

Xrays are considered medical records and may be checked out for 5 to 7 days to be viewed by another physician. The patient is responsible for any xrays taken out of our office.

Form(s) - Disability/Insurance/Special Letters/Etc:

If you have medical forms that need to be filled out by our office, please observe the following guidelines:

Be sure to fill out and sign your section of the form(s). Incomplete forms will not be filled out and will be mailed back to patient for completion.

Form(s) will be completed within 7 business days from the day they are received by our office. A fee of $10.00 per page must be paid before form(s) can be picked up, faxed, or mailed.

Today's Date _____

Patient's Name (Print) _____

Patient's Signature _____

Today's Date _____

Responsible Party's Name (Print) _____

Responsible Party's Signature _____

NARCOTIC POLICY

Dear Patient/Responsible Party:

You are receiving this form because we may prescribe narcotic pain medication for you in the course of your treatment here at Southeastern Spine Specialists. We strongly believe in relieving your pain to the best of our ability. Our primary goal is to treat the pain source so that long term use of pain medication is not necessary. However, we realize that this will not always be possible due to the many chronic pain conditions which we treat. In order to assure your safety and to conform to the recommendations and policies of the Alabama Board of Medical Examiners, our medical practice has the following expectations, policies, and procedures in place. Failure to abide by our policies will result in us being unable to continue prescribing narcotic pain medication to you.

You must receive pain medications from our office only, if we issue you a prescription for treatment of your condition. If other physicians prescribe pain medication for you for any reason, you must contact our office immediately with this information.

Replacement prescriptions for lost or stolen prescriptions will not be issued.

You must use only one pharmacy when filling any and all pain medication prescriptions. This will be the pharmacy on record in your medical chart. You will be responsible for informing the office of any changes.

Do not take your pain medication any more frequently than is prescribed. If you do not follow the specific dosage instructions as prescribed by the physician and you run out, we will not supplement your prescription because of your non-compliance. If you feel that your pain medication is not being adequately controlled, contact our office for a follow up appointment to discuss your pain management.

Refills will be given to last until your next scheduled follow up appointment. If this appointment is not kept, no refills of narcotic pain medication will be given.

I, _____, agree to the aforementioned conditions. Furthermore, I have completed a medical history information sheet and to the best of my knowledge, all information contained in this medical history is accurate, true, and complete.

_____ _____

Name of Patient (Print) **Signature of Patient**

_____ _____

Today's Date **SESS Representative's Signature**

PRIVACY NOTICE

This notice describes how your protected health information (PHI) may be used and disclosed and how you can gain access to this information. Please review it carefully.

We are required under the federal health care privacy rules (the "Privacy Rules"), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, health claims, and medical payment history (hereto known collectively as "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies, and terms in this Privacy Notice unless and until it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will promptly make available a revised copy of the notice for you. Additionally, we will post a copy of the revised Privacy Notice in a prominent location within our office. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PERMITTED USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION (PHI)

General Uses and Disclosures: Under the Privacy Rules, we are permitted to use and disclose your Health Information for the following purposes without obtaining your permission or authorization:

Treatment: We are permitted to use and disclose your Health Information in the provision and coordination of your health care. For example, we may disclose your Health Information to your primary care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment.

Payment: We are permitted to use and disclose your Health Information for the purposes of determining insurance coverage, billing, and reimbursement. This information may be released to an insurance company, third party payer, or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

Health Care Operations: We are permitted to use and disclose your Health Information during our health care operations, including, but not limited to quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your Health Information to internally assess the quality of care provided to our patients.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care, to protect your health or safety or health and/or safety of others, or for the safety and security of the correctional institution.

Workers' Compensation: We may disclose your Health Information to your employer to the extent necessary to comply with the Alabama laws or other state laws relating to Workers' Compensation or other similar programs.

Marketing: We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us.

Appointment Reminders/Treatment Alternatives: We may use and disclose your Health Information to remind you of an appointment for treatment and medical care at our office or to provide you with information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.

Business Associates: We may disclose your Health Information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your Health Information, too.

Other Uses and Disclosures: In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by the Privacy Rules.

Uses and Disclosures which require Patient Opportunity to Verbally Agree or Object: Under the Privacy Rules, we are permitted to use and disclose your Health Information: (i) for the creation of facility directories, (ii) to disaster relief agencies, and (iii) to family members, close personal friends, or any other person identified by you, if the information is directly relevant to that person's involvement in your care and/or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.

Use and Disclosures which require Written Authorization: As required by the Privacy Rules, all other uses and disclosures of your Health Information (not described above) will be made only with your written authorization. For example, in order to disclose your Health Information to a company for marketing purposes, we must obtain your written authorization. Under the Privacy Rules, you may revoke your authorization at any time. The revocation of your authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Southeastern Spine Specialists, Inc.
Attn: Privacy Officer
1781 Commons North Loop
Tuscaloosa, Alabama 35406
Main Phone # (205) 750-0447
Fax # (205) 750-0276

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with our office. Complaints filed directly with us must be in writing and made to the attention of the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at: 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the U.S. department of Health and Human Services must be made in writing and filed within 180 days of the time you knew or should have known of the violation.

The effective date of this Privacy Notice is _____, 20___.

By signing below, I hereby acknowledge receipt of the Privacy Notice.

_____ _____

Printed Name of Patient or Patient's Representative **Today's Date**

_____

Signature of Patient or Patient's Representative

_____

Patient's Representative - Relationship To Patient

To Be Completed By SESS Representative:

After a good faith attempt to obtain an Acknowledgement of Receipt, the Patient or Patient's Representative refused or was unable to sign the Privacy Notice for the following reason(s):

_____

_____

_____

Signature of SESS Representative _____ Date _____

PATIENT CONFIDENTIALITY FORM

I understand that Southeastern Spine Specialists has a legal and ethical responsibility to maintain patient privacy, including obligations to protect the confidentiality of patient information and to safeguard the privacy of patient information. I may elect to provide Southeastern Spine Specialists with the names of up to three individuals who may obtain medical information concerning me.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand that on occasion employees of Southeastern Spine Specialists may have the need to contact me at home or work, for that reason please select one of the following:

_____May leave messages on my home answering machine.

_____May not leave messages on my home answering machine.

I agree that my obligations under this agreement regarding patient information will continue as long as I am a patient of Southeastern Spine Specialists or at the time I provide written revocation of this document.

Patient Signature _____ **Date**_____

SESS Representative's Signature _____