Bruce E. Mullen, M.D. *A professional corporation
Dan Brady, P.A.C.

Spine Care and Rehabilitation

755 North Roop Street, Suite 112 Carson City, Nevada 89701 Telephone (775)883-7938 Fax (775)883-0907

Patient Information

Name _____ Date of Birth ____/____/____ SS # _____ (for insurance purposes)

Physical Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

E-Mail Address: _____

Emergency Contact (name and phone number): _____

Primary Care Doctor: _____ Referring Doctor: _____

Employer _____ Occupation _____

Relationship to Insured: Self __ Spouse __ Child __ Other __ If other, please explain _____

Insurance Information - Primary
Insurance Company _____ Member/Subscriber ID _____

If different from above:
Policy Holder Name _____ Date of Birth ____/_____/___ SS #_____
Address _____ City _____ State _____ Zip _____
Insured's Employer _____ City _____ State _____ Zip _____

Insurance Information - Secondary
Insurance Company _____ Member/Subscriber ID _____

If different from above:
Policy Holder Name _____ Date of Birth ____/_____/___ SS #_____
Address _____ City _____ State _____ Zip _____
Insured's Employer _____ City _____ State _____ Zip _____

I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignment.
I am also responsible for payment of non-covered services.

Signature _____ Date _____

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NAME_____

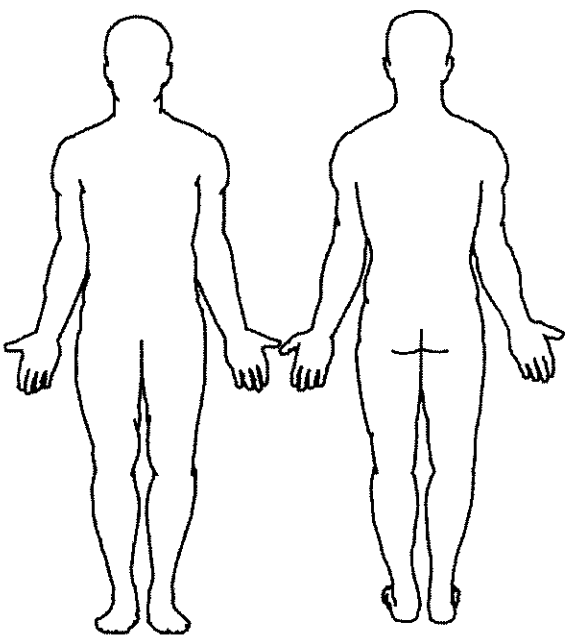
AGE_____

REFERRED BY_____R or L HANDED

IS THIS A WORK RELATED INJURY? _____

MARK ON THE DIAGRAM USING THE FOLLOWING CODES:

----- NUMBNESS	____CONSTANT	____INTERMITTENT
ccccc PINS & NEEDLES	____	____
xxxxx BURNING PAIN	____	____
//////// STABBING PAIN	____	____
^^^^^ ACHING PAIN	____	____



RATE THE USUAL INTENSITY OF YOUR PAIN USING A SCALE FROM 1-10

1 BEING NO PAIN AND 10 BEING INTENSE PAIN

MORNING _____ NOON _____ EVENING _____ SLEEP _____

SITTING _____ BENDING _____ WALKING _____ LIFTING_____

DATE OF INJURY/ DATE THE SYMPTOMS STARED _____

DESCRIBE INJURY/SYMPTOMS IN YOUR OWN WORDS _____

_____

_____

HOW LONG BEFORE YOU HAD TREATMENT _____

WHO TREATED YOU? _____

TYPES OF TREATMENT AND DID THEY HELP? _____

_____

WHAT MEDICATIONS HAVE YOU TRIED AND DID THEY HELP _____

_____

TESTINGS PERFORMED (APPROXIMATE DATE AND WHERE PERFORMED)

X-RAY _____ CT SCAN _____ BONE SCAN _____

MRI SCAN _____ EMG/NCS _____ OTHER _____

ANY HOSPITALOZATIONS RELATED TO THIS CURRENT INJURY/ PAIN PROBLEM

_____

HAVE YOU UNDERGONE ANY PHYSICAL THERAPY? _____

IS YES, WHERE AND HOW OFTEN? _____

WAS THE PHYSICAL THERAPY BENEFICIAL? _____

ASSOCIATED INJURIES IN THE PAST RELATED TO THIS CURRENT INJURY/PROBLEM?

_____

DATE_____

DIAGNOSIS _____

RESULTS AFTER SIX MONTHS _____

ASSOCIATED PREVIOUS OPERATIONS ON THE SAME BODY PART _____

_____

POST SURGERY WORK STATUS _____

ANY LIMITATIONS YOU HAVE EXPIRIENCED WITH THIS PROBLEM

SITTING _____ WALKING _____ BENDING _____ LIFTING _____ STANDING _____

HAS YOU BOWEL HABITS CHANGED? ___YES ___NO

HAS YOUR BLADDER FUNCTION CHANGED? ___YES ___NO

HAS YOUR SEXUAL FUNCTION CHANGED? ___YES ___NO

DO YOU HAVE TROUBLE SLEEPING? ___YES ___NO

DOES THIS INJURY/CONDITION MAKE YOU SAD OR DEPRESSED ___YES ___NO

IF YES, PLEASE EXPLAIN HOW YOU FEEL _____

_____

PRESENT MEDICATIONS

PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING AND THE AVERAGE NUMBER YOU ARE TAKING PER DAY (OR PER WEEK)

1)_____ 2) _____

3)_____ 4) _____

5)_____ 6) _____

7)_____ 8) _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ___YES ___NO

IF SO, WHAT ARE THEY?

1)_____ 2) _____ 3)_____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE FOR ANY MEDICAL CONDITION?

IF YES, PLEASE DESCRIBE _____

_____

_____

PLEASE CHECK THE FOLLOWING IF YOU AND/OR A FAMILY MEMBER SUFFER FROM THESE MEDICAL CONDITIONS:

	YOU	FAMILY MEMBER
HYPERTENSION	_____	_____
DIABETES	_____	_____
HEADACHES	_____	_____
ASTHMA	_____	_____
LUNG DISEASE	_____	_____
KIDNEY DISEASE	_____	_____
ULCERS	_____	_____
CANCER	_____	_____
STOMACH PROBLEMS	_____	_____
RHEUMATIC FEVER	_____	_____
ANEMIA	_____	_____
TUBERCULOSIS	_____	_____
LIVER DISEASE	_____	_____
THYROID DISEASE	_____	_____
HEPATITIS	_____	_____

SOCIAL HISTORY

ARE YOU:

MARRIED _____ DIVORCED _____ SEPERATED _____WIDOWED _____ SINGLE _____

WITH WHOM DO YOU LIVE? _____

WHAT WAS THE HIGHEST GRADE COMPLETED:

HIGH SCHOOL ____ TECHNICAL/BUSINESS SCHOOL_____ COLLEGE_____OTHER_____

DO YOU USE TOBACCO ___YES ___NO HOW MUCH DO YOU SMOKE? _____

_____ NEVER SMOKER _____FORMER SMOKER _____ CURRENT SMOKER

DO YOU USE ALCOHOL ___YES ___NO HOW MUCH DO YOU DRINK? _____

DO YOU USE NON-PRESCRIPTION DRUGS ___YES ___NO

ARE YOU CURRENTLY WORKING? ___YES ___NO IF NO, SINCE WHEN? _____

FULL TIME _____ PART TIME _____ FULL DUTY _____ LIGHT DUTY _____

JOB DESCRIPTION AT THE TIME OF INJURY AND HOW LONG AT THIS JOB _____

_____

PREVIOUS TYPES OF JOBS/OCCUPATIONS _____

WE ARE IN THE PROCESS

OF MOVING OVER TO

ELECTRONIC MEDICAL RECORDS

PLEASE FILL IN THE FOLLOWING:

SURGICAL HISTORY (WHAT KIND OF SURGERY AND YEAR)

THANKS. THE STAFF.

SPINE CARE AND REHABILITATION
755 N. Roop Street, Suite 112
Carson City, NV 89701
(775) 883-7938

FINANCIAL POLICY

All copays are due at the time of service. We accept cash, check, or credit card. Failure to pay your bill MAY result in discharge from this practice.

There is a $50.00 service charge, plus the bank service fee, and amount of the returned check for all returned checks. If you have difficulty paying your balance in full, within 30 days of receiving a statement, please contact our office to arrange a payment schedule.

Make all payments payable to:
Bruce Mullen, MD
755 N. Roop Street, Suite 112
Carson City, NV 89701

CANCELLATION/NO SHOW POLICY

We require 24 hours' notice for cancellations. You will be charged $75.00 for an office visit and $200 for procedure appointments, if less than 24 hours' notice is received by this office. **IF YOU HAVE 3 NO SHOW OR LATE CANCEL APPOINTMENTS, YOU WILL BE DISCHARGED AS A PATIENT. Initial: _____**

INSURANCE

MEDICARE: (Be sure you include the letter after the nine digit number as it appears on you Medicare card.) Please sign so we may have your Medicare authorization on file: *I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier of any information needed for this Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits.* **Initial: ____**

ALL other insurances including Medicare:

1. Office copays are due at the time of service.
2. Deductibles and co-insurance are due at the time of service. (As a courtesy we will bill your insurance company for you, but request that you pay 20% of the billed charges.)
3. If you do not have insurance the cost of the office visit is due the time of service.
4. If this is a worker's comp claim your copay should be covered by worker's compensation.
5. Non-payment of your bill **WILL** result in discharge from the practice.

I, the patient/guarantor, acknowledge that I am responsible for any benefits not paid or denied by my insurance policy.

Please sign here to acknowledge your understanding of the above policies.

Signature _____ Date _____

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OUR OFFICE POLICY

It is YOUR responsibility to know your insurance:

- Do you need prior authorization for procedures?
- Do you have a co-payment?
  If so, payment is required at the time of service, otherwise a charge of $15.00 will apply AND/OR you will not be seen?
- Do you have a yearly deductible? Has it been met?
  If not, you are responsible to make a payment at the time of service.
- There is a charge for any paperwork that you may need done. Please allow up to 7-10 days for it to be completed.

Please help us help you. There are hundreds of insurance companies and it is impossible for our staff to know the specific requirements for each of them.

Thank you.

Signature: _____Date:_____

H.I.P.A.A.

Acknowledgment of Receipt of Notice

SPINE CARE & REHABILITATION
755 N. ROOP ST., SUITE 112, CARSON CITY, NV 89701
PHONE: (775) 883-7938
FAX: (775) 883-0907

I, _____ (print name) hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

Your medical information will only be shared with your referring Physician, insurance company(ies), and our billing company.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by the patient, please indicate relationship:

( ) Parent or Guardian of minor patient ( ) Beneficiary or Representative of Deceased

( ) Guardian or Conservator of an incompetent patient ( ) Other (Specify) _____

Name of Patient : _____

****

I authorize Bruce E. Mullen, M.D. and his staff to discuss my health information, including billing/account information, with the following person(s):

(Family, Friends, and Other Physicians, etc.)

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signed: _____ Date: _____