Memphis Spine Center

2120 Exeter Rd.
Suite 130
Germantown TN. 38138

Specializing in:
* *Multidisciplinary Spine Medicine*
* *Cervical & Lumbar Disc Surgery*
* *Minimally Invasive Spine Surgery*
* *Complex Spinal Reconstruction*
* *Total Joint Replacement*

Edward S. Pratt, MD, MBA
Director/CEO

Board Certified:
American Board of Orthopaedic Surgery
Fellow:
North American Spine Society
American Association of Hip & Knee Surgeons
American Academy of Orthopaedic Surgery

Judith Lee-Sigler, M.D.
Physical Medicine

Board Certified
American Board of Physical Medicine & Rehabilitation
Fellow
American Academy of Physical Medicine & Rehabilitation
North American Spine Society
American Association of Academic Physiatrists

Dear Patient:

Thank you for choosing Memphis Spine Center as your Spine Specialists. At Memphis Spine Center we are team oriented. Your surgeon, physiatrist, nurse, clinical specialist and all other members of our team are committed to working together to maximize your chances for improvement.

During your initial visit, you will meet one of our clinical specialists, Jennifer or Kathryn, and have x-rays taken by JJ if you do not have or bring current films with you. You will then be evaluated by one of our providers, Dr. Edward Pratt or Dr. Judith Lee-Sigler.

In order for us to arrive at the correct diagnosis, it is important that you bring all previous medical records and films/cd (X-rays, MRI's, CT's, etc.) related to the problem for which you are being seen. We will need both the films/cd and the written radiological report on all MRI's and CT's. ***Failure to bring any of this information may result in the unfortunate rescheduling of your appointment until the information can be obtained.***

Please complete **ALL** information on the enclosed paperwork prior to your arrival. In order for us to file your insurance you must bring your insurance cards with you. If you are unable to keep your appointment and must reschedule, please give us a 24 hour notice so others in need may be scheduled.

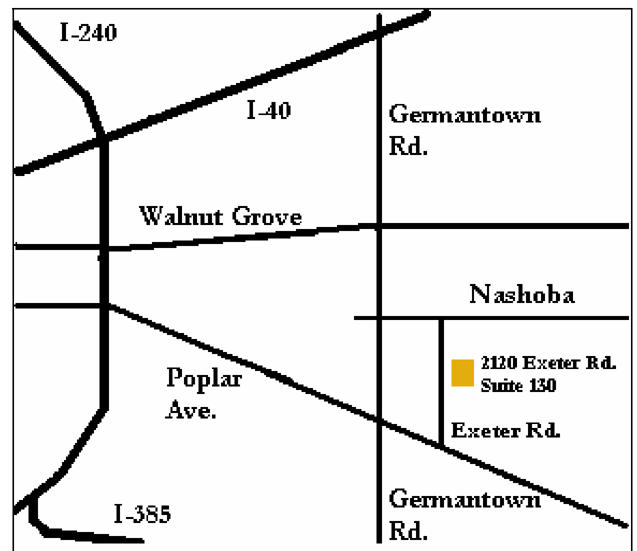
We are located inside the Baptist Rehabilitation Hospital on Exeter Rd in Germantown. If you have any questions please call our office at (901) 507-2225.

Your appointment is scheduled for __________ at _________.

PLEASE ARRIVE AT ____________ TO COMPLETE THE PAPERWORK PROCESS.

Thank you,

Memphis Spine Center



MEMPHIS SPINE CENTER
PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

Last Name ________________ First Name ________________ M.I.______ Birth Date ____________

Address ____________________ City ________________ State________ Zip____________

Home Phone (_____)______________ Cell Phone (______)______________ Work Phone # (______)____________ ☐ Male ☐ Female

At what number do you want us to contact you regarding appointments, scheduling procedures, etc…? ☐ **Home** ☐**Cell** ☐ **Work**

[ ] Employed [ ] Retired [ ] Unemployed [ ] Student Marital Status: ☐ Single ☐ Married

Patient Employer ________________ Occupation ________________ SS# ____________

Referring MD ____________ Phone (_____)__________ Primary Care MD ____________ Phone (_____)__________

If this visit is due to an injury, give date:_______

Work related? ☐ No ☐ Yes Auto Accident? ☐ No ☐ Yes Do you live in a nursing home? ☐ No ☐ Yes

PRIMARY Insurance: ________________ ID #________________ Group#____________

Co-Pay $__________ Deductible $__________ Have you met your deductible? ☐ Yes ☐ No

Primary Care Physician referral required? ☐ Yes ☐ No (It's the patient's responsibility to obtain all required referrals prior their appointment)

☐ Check if the patient is the insured party

Name of Insured: <u>(if other than patient)</u> Last: ________________ First: ________________ M.I.______

Address ____________________ City ________________ State________ Zip____________

Birth Date ____________ SS# ____________ ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Home Phone (_______)____________ Employer ____________________ Work Phone (_____)____________

SECONDARY Insurance: ________________ ID #________________ Group#____________

☐ Check if the patient is the insured party

Name of Insured: <u>(if other than patient)</u> Last: ________________ First: ________________ M.I.________

Address ____________________ City ________________ State_______ Zip____________

Birth Date ____________ SS# ____________ ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Home Phone (______)____________ Employer ____________________ Work Phone (______)____________

Patient's Name: ____________________

If this visit is covered by worker's compensation, skip this page and continue on page 4

MEMPHIS SPINE CENTER FINANCIAL POLICY / WAIVER

PLEASE READ CAREFULLY

If you have any questions, please do not hesitate to ask.

We are committed to providing you with the best medical care possible. If you have medical insurance we are anxious to help you receive your maximum allowable benefit. While the filing of insurance claims is a courtesy we extend to our patients, ALL charges are your responsibility from the date the services are rendered. Your insurance is a contract between you, your employer and the insurance company. Some services may not be a covered benefit under your insurance plan. These non-covered services are your responsibility.

- All co-payments and/or deductibles are due at time of service and prior to surgery / injections
- Any remaining balance, after your insurance has paid its portion, is due in full within 60 days
- If your insurance has not paid within 45 days, the balance becomes your responsibility
- Any incorrect insurance information supplied by you that results in the denial of a claim due to timely filing guidelines will result in your being held responsible for the total amount of the claim
- If your account becomes delinquent and is turned over to a collection agency, a 40% service charge will be added to the balance and you will be responsible for court costs and reasonable attorney fees should such action become necessary.

ASSIGNMENT OF INSURANCE BENEFITS
ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I authorize the direct payment of any medical benefits to Memphis Spine Center, PLC for services rendered.
I agree that I am financially responsible for all charges for services (including those not covered by insurance) rendered to me. Although I might have insurance coverage, this does not relinquish me of my financial responsibility. I recognize my role in any and all necessary pre-certifications or authorizations for referrals, etc. Additionally, I understand that I am responsible for any and all expenses that may be incurred in collecting this account including but not limited to collections agency fees (not to exceed 40% of the balance due), court costs, and reasonable attorney fees should such action become necessary. Due to insurance's timely filing guidelines, I will be held responsible for all charges not paid due to incorrect information given by me. I agree to pay my balance in full within 60 days.

I, the undersigned, do hereby agree and give my consent for Memphis Spine Center to furnish medical care and treatment to myself or dependant, which is considered necessary and appropriate.

( ) **Medicare -** I request that payment of authorized Medicare benefits be made on my behalf to Memphis Spine Center for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the Medicare Administration to release any information regarding Medicare claims for services provided. This release shall be a lifetime assignment.

These authorizations and releases shall remain in effect until I choose to revoke them by delivering a written statement to Memphis Spine Center. A copy of these authorizations can be considered as an original for insurance purposes.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THE ABOVE.

PATIENT SIGNATURE:______________________________________ DATE:_______________

Patient's Name: ____________________

******* Only complete this form if this is a Work Comp injury *******

WORKER'S COMPENSATION AUTHORIZATION

I understand that although Memphis Spine Center has taken my case on a Workman's Compensation basis, i**f my claim is later denied as a worker's compensation case, I will be billed for the total amount for services rendered** by Memphis Spine Center. Additionally, I understand that if my case is denied, I am responsible for all expenses that may be incurred in collecting this account including but not limited to collection agency fees (not to exceed 40% of the balance due), court costs, and reasonable attorney fees should such action become necessary.

I authorize Memphis Spine Center to disclose my health information to my employer and/or workers' compensation carrier/attorney for payment of claim. I understand that the disclosure of my personal health information may include diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus). I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, my refusal to sign will effect payment for services I receive and I will become responsible for all charges incurred. I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

In accordance with Tennessee State Law, THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, the undersigned, do hereby agree and give my consent for Memphis Spine Center to furnish medical care and treatment which is considered necessary and appropriate in diagnosing and treating of my/their physical condition.

By signing below, I acknowledge that I have read and understood the above. These authorizations and releases shall remain in effect until I choose to revoke them by delivering a written statement to Memphis Spine Center.

PATIENT SIGNATURE____________________________________ DATE_________________

Patient's Name: ____________________

AUTHORIZATION TO RELEASE HEALTH INFORMATION

TO FAMILY OR FRIENDS

☐ I give Memphis Spine Center permission to release my information (diagnosis, treatment, appointments, billing, etc..) to the following people:

Name of authorized person	Relationship to patient	Phone Number
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

OR

☐ I do NOT want my information released to any family members or friends.

In case of Emergency, I authorize Memphis Spine Center to contact the following person and release medical information as deemed necessary.

Emergency Contact	Relationship to patient	Phone Number
______________________	______________	______________

Memphis Spine Center is required by law to provide each patient a copy of our Notice of Privacy Practices (**see page 9****), obtain an acknowledgment that the Notice was provided, and keep the acknowledgement in our records.**

I acknowledge that on the date indicted below, I was provided a paper copy of the Notice of Privacy Practices of Memphis Spine Center. I understand that this Notice describes how medical information about me may be used and disclosed and how I can get access to this information. I understand that I should review the Notice of Privacy Practices carefully.

By signing below, I acknowledge that I have read and understood all of the above. These authorizations and releases shall remain in effect until I choose to revoke them by delivering a written statement to Memphis Spine Center.

______________________________ ______________________

Patient Signature Date

****

Patients under the age of 18 must be accompanied to appointments by a parent or legal guardian. If a parent or legal guardian is not available to attend appointments with the patient, please list the names of any adults to which permission is granted to attend appointments with the patient.

____

Alternate Adult Representative

______________________________ ______________________________

Alternate Adult Representative **Parent/Legal Guardian Signature**

Patient Name: ____________________

Memphis Spine Center

Medication Contract

I agree to abide by the following medication rules while under the care of Dr. Edward Pratt and Dr. Judith Lee-Sigler.

I will be provided controlled substances while under his care, only if I adhere to the following regulations:

- I will use the substances only within the parameters given by Dr. Pratt or Dr. Lee-Sigler. If I change the dose of the narcotic medication without prior approval from Dr. Pratt or Dr. Lee-Sigler, and run out of medication early, no additional medication will be prescribed before the next visit.
- I will not receive replacement medication for "lost" or "stolen" medications.
- I will receive narcotic medication only from Dr. Pratt or Dr. Lee-Sigler.
- I will agree to participate in a detoxification program if prescribed by Dr. Pratt or Dr. Lee-Sigler.
- I will notify Dr. Pratt or Dr. Lee-Sigler if I receive mood altering or addictive drugs from other physicians. These medications include non-narcotic pain medications, sleeping medications, tranquilizers, and muscle relaxants.
- I will not hold Dr. Pratt, Dr. Lee-Sigler or their staff liable for any consequences of discontinuance of controlled substances, provided a thirty days notification of termination is given to me.
- I understand that medication refills will only be granted, during office hours of 8:00 am – 5:00 pm, Monday – Friday. **NO EXCEPTIONS ON NIGHTS, WEEKENDS OR HOLIDAYS.**
- I will submit to random drug screens as administered by Dr. Pratt, Dr. Lee-Sigler or at a designated lab. The urine drug screen needs to reflect the medications prescribed by Dr. Pratt or Dr. Lee-Sigler. I will agree to termination of Dr. Pratt's or Dr. Lee-Sigler's care if the urine drug screen is positive for substances other than prescribed by them.
- I will not use drugs such as alcohol, marijuana, cocaine, tranquilizers, or sleep aids recreationally while on narcotic medications prescribed by Dr. Pratt or Dr. Lee-Sigler.
- I understand changes in narcotic medication will be done only after an office visit with Dr. Pratt or Dr. Lee-Sigler.
- I authorize Dr. Pratt and Dr. Lee-Sigler or their staff to obtain a pharmacy profile at any time to review medications prescribed to me.
- I understand that I will be prosecuted if I am found altering prescriptions or diverting medications prescribed to me.
- I will designate only (1) **one** pharmacy to fill my prescription(s):

  Pharmacy Name: ________________________________ Phone #: (_______)__________________

  Pharmacy Location: ____

Any violation of this agreement will result in the termination of care by Dr. Pratt and Dr. Lee-Sigler.

My signature indicates that I have read and agree to the above guidelines.

PATIENT'S SIGNATURE: ____ DATE: __________________________

Patient Name: ____________________

Memphis Spine Center
Physician Disclosure Policy

It has become standard policy in the medical industry in the United States to strive for transparency in all professional relationships in which providers are involved. We believe this is beneficial in building trust between our providers and patients. In accordance with this policy the providers of this practice wish our patients to be aware of the industry relationships in which we are involved.

Dr Pratt has functioned as surgeon educator for Kyphon, Inc. and now Medtronic Inc. since 2002, teaching physicians in all 50 states how to perform Kyphoplasty and X-Stop. He has trained more surgeons in these techniques than anyone in the world. This is a reimbursed activity, paid on a per hour basis.

Dr. Pratt serves as the Chairman of the Department of Surgery for Baptist Memorial Hospital Collierville. This is a reimbursed position, paid on a per hour basis.

Dr. Pratt serves as educator for Medtronic sales personnel teaching them about the operating room environment. He also works with the quality and health hazard departments of Medtronic assisting in preparation of clinical FDA reports on device malfunctions around the world. This is a reimbursed position, paid on a per hour basis.

Dr. Pratt serves from time to time as a medical expert, rendering depositions, and expert opinions on various legal and insurance cases. This is a reimbursed position, paid on a per hour basis.

Dr. Sigler has nothing to disclose.

If you have questions about any of these relationships please do not hesitate to discuss them with your physician. By signing below you acknowledge that you have read and understand this document and have no objection or complaint regarding the industry relationships of our providers.

Patient Signature: ____________________________________ *Date:* _____/_____/______

(PLEASE PRINT)

PATIENT HEALTH HISTORY

Patient Name ___________________________________ Current occupation:______________________________

Pharmacy Name: ________________________________ Pharmacy Location: _____________________________

Pharmacy Phone #: (______)______________________ Pharmacy Fax#: (______)______________________

Referring MD: __________________________________ Primary Care MD: _______________________________

Are you currently taking ANY kind of medications (**including prescription, over-the-counter or herbal medications**)?
☐No ☐Yes If yes, please list below *include dosages*.

Medication Name	**Dosage**	**How often taken?**
Example: name of medication	***200 mg***	***1 capsule twice a day***

Are you ALLERGIC to any medications? ☐ No ☐ Yes - If yes, please list below.

Name of medication allergic to?	**List type of reaction** Example: (shortness of breath, nausea, vomiting, shock, unconsciousness, rash, hives, difficulty breathing, swelling of tongue or mouth, etc…)

Have you ever had any of the following problems with <u>anesthesia</u> (being numbed or put to sleep)? ☐**No** ☐**Yes**

☐ Heart raced after shot of anesthetic ☐ High fever during surgery ☐ Rash ☐ Trouble breathing

☐ Trouble with placement of breathing tube during surgery ☐ Very slow to wake up after surgery

Have you ever been hospitalized for any of the following reasons? ☐**No** ☐**Yes (mark below)**

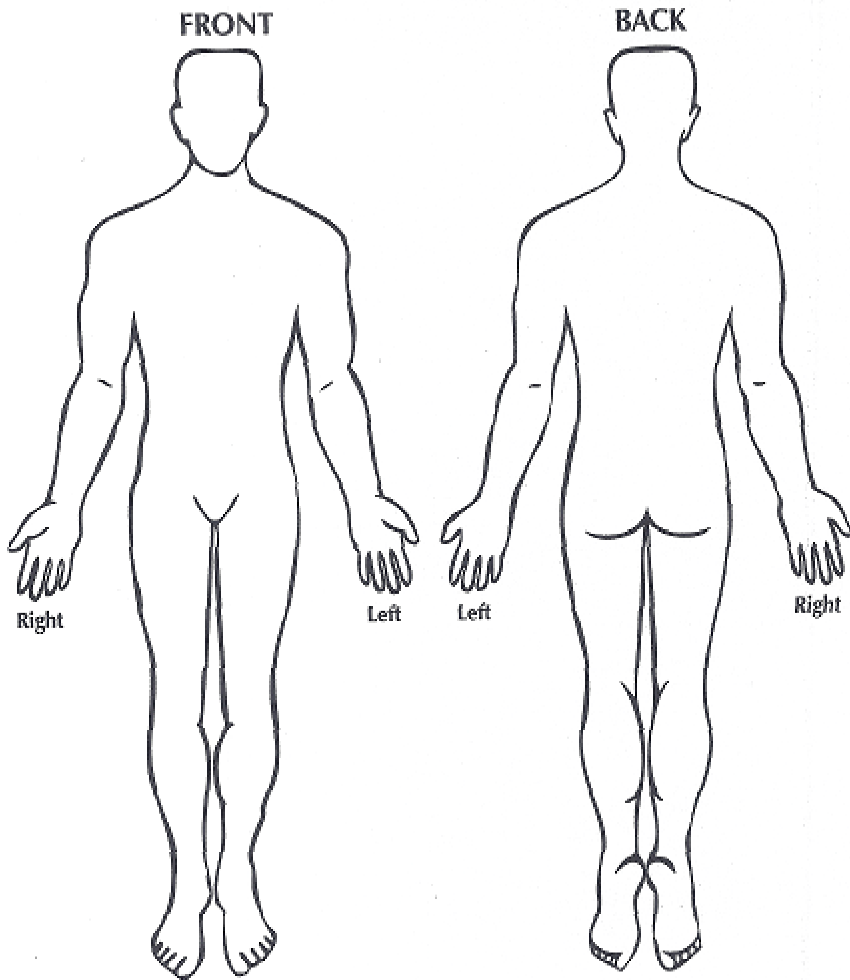
☐ Congestive heart failure ☐ Heart attack ☐ High blood pressure ☐ Stroke

List any SPINE, NECK, or HIP surgeries or orthopedic problems related to these areas including the dates:

Patient's Name: ______________________ Date _________________

PAIN DIAGRAM

Be sure to fill this out as accurately as possible. Mark the area(s) on your body where you feel the described sensation. Use the appropriate symbol. Mark any areas of radiation. Include all affected areas.



Symbols

Numbness: = = = = = = = = = =

Pins and Needles: 0 0 0 0 0 0 0

Burning Pain: x x x x x x x x x

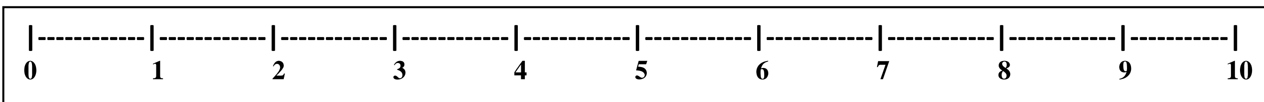
Stabbing Pain: / / / / / / / / / / / /

Aching Pain: A A A A A A A

Shooting Pain: V V V V V V V

On a scale of 1 to 10, please indicate with an "X" the level of pain you are experiencing right now:

(**LEAST** Intense) (**MOST** Intense)



Please circle the frequency at which you experience this level of pain:

Rarely Once a month Once a week Once a day More than once a day Constant pain

(PATIENT'S COPY TO KEEP)

MEMPHIS SPINE CENTER
NOTICE OF PRIVACY PRACTICES **(EFFECTIVE DATE 01/20/06)**

This notice describes how medical information about your may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of providing healthcare to you, we collect, make, use, store and disclose information about you and your health. Federal and State law require that when health information about a person can be used to identify that person, the privacy of that health information must be protected. For this reason, identifying health information is known as "Protected Health Information" or "PHI" for short.

This practice is required by law to give you this Notice to tell you how we will use and disclose your PHI, what our practices are to protect it, and what your rights are. We are allowed to change this Notice if we deem necessary, and we may change it in the future. We will follow the terms of the most current versions of the Notice we have published. Any revised version of this Notice will be effective for all PHI we maintain at the time of the revision and which we receive or create thereafter. You may request a copy of the most current version of this Notice. An additional legal requirement is that you acknowledge that you have received this Notice. For this reason you will be asked to sign a form acknowledging that you received this Notice.

HOW WE USE AND DISCLOSE YOUR PHI

1. Use and Disclosure of Your PHI Without Your Authorization

   Circumstances, in which we will use and disclose your PHI, as well as the purposes for doing so, are described below. Some examples will also be provided. But you should understand that not all purposes can or will be described, and not every example can or will be provided.

   - FOR TREATMENT. We may use your PHI within our organization and disclose it to others outside our organization for purposes related to your care. For example, your PHI may be used to create and carry out a plan of treatment for you, or it may be disclosed to labs, or to others we may refer you to for evaluation or treatment.
   - FOR PAYMENT. We may use or disclose your PHI to get payment for healthcare services you received. For example, we may provide PHI to bill your health plan for healthcare provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
   - FOR HEALTHCARE OPERATIONS. We may use and or disclose PHI in order to manage our programs and activities. For example, we may use PHI to review the quality of services you receive from us. We may use a sign-in sheet, call your name in the waiting room, place your chart on an exam room door, and call or send a postcard to remind you of appointment and report test results.
   - APPOINTMENTS AND OTHER HEALTH INFORMATION: We may use and disclose medical information to contact you as a reminder that you have an appointment. This practice includes contacting you by telephone.
   - HEALTH-REALTED BENEFITS AND SERVICES. We may send you information about health-related benefits or services that may be of interest to you.
   - FOR PUBLIC HEALTH ACTIVITIES. We may disclose your PHI to a public health agency that keeps and updates vital records, such as births and deaths, or which tracks certain diseases.
   - FOR HEALTH OVERSITE. We may use or disclose PHI to agencies that inspect or investigate healthcare providers.
   - AS REQUIRED BY LAW AND FOR LAW ENFORCEMENT. We may use and disclose PHI when required or permitted by Federal or State law or by court order.
   - FOR ABUSE REPORTS AND INVESTIGATIONS. We are required by law to receive and investigate reports of abuse or neglect. When doing so we are required to disclose PHI.
   - FOR GOVERNMENT PROGRAMS. We may use and disclose PHI for public benefits provided by government programs. For example, we may disclose information for the determination of supplemental security income (SSI) or other government benefits.
   - TO AVOID HARM. We may disclose PHI to law enforcement officials in order to avert a serious threat to the health and safety of a person or the public.
   - FOR RESEARCH. We may disclose PHI for research and the development of research reports. (These reports do not identify specific people.)
   - DISCLOSURE TO FAMILY, FRIENDS AND OTHERS. We may disclose PHI to your family, or close personal friends or other persons who are involved in your medical care and/or the payment for it. (You have the right to object to the sharing of information with these persons.)
   - FOR DISASTER RELIEF PURPOSES. We may disclose PHI to government agencies for the purpose of notifying family members or close personal friends about an individual's medical condition. (You have the right to object to the sharing of information for this purpose.)

YOU HAVE THE RIGHT TO OBJECT TO ANY OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION LISTED ABOVE. CONTACT THE PRIVACY OFFICER TO REQUEST A RESTRICTION. IF WE DO NOT AGREE TO YOUR RESTRICTION, WE WILL NOTIFY YOU.

2. Other Uses and Disclosers Require Your Written Authorization. For other situations, we will ask you for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. Obviously, if you cancel this authorization, we cannot take back any uses or disclosers which we had already made with your authorization.

3. Your Rights Concerning Your PHI. The following is a summary of your rights with respect to your PHI:
   - You have the right to inspect and copy your PHI, as permitted by law.
   - You have the right to request restrictions regarding the uses and disclosures of your PHI. (We do not have to agree to your request, however.)
   - You have the right to a request to receive confidential communications from us by alternative means or at an alternative location.
   - You have the right to request that we amend your PHI. (Your request must state a reason for the amendment.)
   - You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.
   - You have the right to obtain a paper copy of our Notice of Privacy Practices from us.

   For a more detailed description of any of these rights, please contact the Privacy Officer listed at the bottom of this Notice. NOTE: Except for the right to obtain a paper copy of our Notice, we require that the requests you make to exercise the foregoing rights to be submitted in writing to the Privacy Officer.

COMPLAINTS

You may complain to us or to the Secretary of the Department of Health and Human Services if you believe the privacy of your PHI has not been properly protected or your privacy rights have been violated by us. Complaints filed with us must be filed in writing. To file a complaint with us, contact the Privacy Officer identified below. We will not retaliate against you for filing a complaint.

Feel free to contact our Privacy Officer if you have any questions about this notice or if you wish to file a complaint.

Privacy Officer: Beth Tapp, 2120 Exeter Road, Suite 130, Germantown, TN 38138 Phone: 901-507-2225