HAYNES NEUROSURGICAL GROUP, P.A.

801 Princeton Avenue Southwest
Suite 310
Birmingham, Alabama 35211
(205)787-8676 office (205)785-7944 fax

R. Cem Cezayirli, M.D Robert J. Johnson Jr., M.D. Daniel K. Harmon M.D.

# Pharmacy Information

Patient: _____

DOB: _____

Patient E-mail: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

I authorize Haynes Neurosurgical Group, PA to download my pharmacy eligibility benefits.

_____
Patient Signature

**801 Princeton Avenue Southwest**
**POB 1 Suite 310**
**Birmingham, AL. 35211**

## Patient Information

Patient Name: Last_____ First _____ Middle _____

Address_____ City_____ State_____ Zip Code_____

Age_____ Date of Birth _____ Sex____ Marital Status _____ SSN#_____

Home Phone_____ Work Phone _____ Cell Phone_____

Employer _____ Address _____

Referring Dr._____ Referring Dr. Ph. #_____

Primary Care Dr._____ Primary Care Dr. Ph. #_____

Spouse's Name_____ Employer _____ Phone_____

Person to notify in case of emergency_____ Phone_____
(Outside your home) (Other than your number)

Chief Complaint_____

**Were you injured at work ☐ YES ☐ NO If so how** _____

Date of Injury ____/____/____

If you were injured at work, please complete the following:

Claim # _____ Contact Person_____

W/C Company _____ Phone_____

Address_____ Fax _____

## Insurance Policy Information

Insurance (**Primary**)_____Contract_____Group_____

Does your insurance require a referral to see a specialist? ☐ Yes ☐ No

Policy holder's name_____ Date of Birth____/____/____ SSN#_____

Employer_____ Relationship to policyholder_____

Insurance (**Secondary**)_____ Contract_____ Group _____

Does your insurance require a referral to see a specialist? ☐ Yes ☐ No

Policy holder's name_____ Date of Birth____/____/____ SSN#_____

Employer_____ Relationship to policyholder_____

**Consent for Treatment-** I consent to necessary treatment, including drugs, medicine, performance of operation and conduct of x-ray's, or other studies that may be used by the attending physician, his nurse or staff.

**Authorization for Release of Information-** I authorize Haynes Neurosurgical Group, P.A. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

**Assignment of Benefits-** I hereby authorize payment directly to Haynes Neurosurgical Group, P.A., to benefit otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Haynes Neurosurgical Group, P.A. charges for these services. I understand that I am financially responsible to Haynes Neurosurgical Group, P.A. for charges not covered by this assignment the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

**Guarantee Account-** For services furnished by Haynes Neurosurgical Group, P.A., I hereby guarantee the payment of all account for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney fees.

SIGNATURE_____ DATE_____

**I have received and read a copy of MY HIPPA PRIVACY NOTICE**

Signature_____ Date _____

**Name _____ Date _____**

**CHIEF COMPLAINT**

_____
_____

**HISTORY OF PRESENT ILLNESS**

- **Location** – Where is the pain/problem?
  _____
  _____

- **Severity** – How severe is the pain/problem?
  _____
  _____

- **Timing** – When does this pain occur?
  _____
  _____

- **Associated signs/symptoms** – What other associated problems have you been having?
  _____
  _____

- **Quality** – What is the quality of your pain/problem?
  _____
  _____

- **Duration** – How long have you had this pain/problems? Or, when did it start?
  _____
  _____

- **Context** – Where were you at the onset of this pain/problem?
  _____
  _____

- **Modifying factors** – What makes the pain/problem worse? What makes the pain/problem better?
  _____
  _____

**MEDICAL HISTORY**
(Check all that apply)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusions
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Cataract
- ☐ Chronic bronchitis
- ☐ COPD
- ☐ Congestive heart failure
- ☐ Deep vein thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Fibromyalgia
- ☐ Gastro esophageal reflux disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Restless leg syndrome
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke

**SURGICAL HISTORY**

Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____

**FAMILY HISTORY**

☐ Adopted

| Father | Mother | Siblings |
|---|---|---|
| ☐ alive | ☐ alive | ☐ alive |
| ☐ deceased | ☐ deceased | ☐ deceased |
| ☐ Alzheimer's | ☐ Alzheimer's | ☐ Alzheimer's |
| ☐ Cancer | ☐ Cancer | ☐ Cancer |
| ☐ Diabetes | ☐ Diabetes | ☐ Diabetes |
| ☐ Heart disease | ☐ Heart disease | ☐ Heart disease |
| ☐ Hypertension | ☐ Hypertension | ☐ Hypertension |
| ☐ Stroke | ☐ Stroke | ☐ Stroke |
| ☐ Other | ☐ Other | ☐ Other |

**SOCIAL HISTORY**

**Employment** ☐ Employed ☐ Unemployed ☐ Retired ☐ Student
**Alcohol** ☐ Never ☐ Moderate ☐ Rarely ☐ Past only
**Illegal Drugs** ☐ Never ☐ Currently ☐ Past only
**Tobacco** ☐ Never ☐ Currently ☐ Past only
**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
**Number of Children**_____

**MEDICATIONS**

**NAME DOSAGE DIRECTIONS**

_____
_____
_____
_____
_____
_____
_____
_____
_____

**FOOD REACTIONS**

☐ No known food allergies

| | | | | | |
|---|---|---|---|---|---|
| ☐ Eggs | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Milk | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Shellfish | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Other (please list) | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| _____ | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| _____ | ☐ headache | ☐ hives | ☐ rash | ☐ other |

**DRUG ALLERGIES**

| | | | | | |
|---|---|---|---|---|---|
| ☐ No known drug allergies | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Aspirin | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Other pain remedies | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Iodine | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Morphine | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Novocaine | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Other anesthetics | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ NSAIDS | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Penicillins | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Tetanus | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Other (please list) | ☐ headache | ☐ hives | ☐ rash | ☐ other |

_____

**ENVIRONMENTAL ALLERGIES**

| | | | | |
|---|---|---|---|---|
| ☐ No known environmental allergies | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Latex | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Tape | ☐ headache | ☐ hives | ☐ rash | ☐ other |
| ☐ Topical Iodine | ☐ headache | ☐ hives | ☐ rash | ☐ other |

**SPECIALTY QUESTIONS**

Who is your family doctor_____
Who referred you to this clinic_____
What other doctors do you see_____
_____
Do you have a pacemaker_____
Do you have a stent_____
Is your pain related to a work injury? ☐ YES ☐ NO
If so, when were you injured_____
If so, how were you injured_____
_____

**CONSTITUTIONAL**

| | | |
|---|---|---|
| Good general health lately | NO | YES |
| Recent weight change | NO | YES |
| Fever | NO | YES |
| Fatigue | NO | YES |
| Headaches | NO | YES |

**EYES**

| | | |
|---|---|---|
| Eye disease or injury | NO | YES |
| Wear glasses | NO | YES |
| Wear contacts | NO | YES |
| Blurred or double vision | NO | YES |
| Glaucoma | NO | YES |

**EARS/NOSE/THROAT/NECK**

| | | |
|---|---|---|
| Hearing loss or ringing | NO | YES |
| Earaches | NO | YES |
| Chronic sinus problem or rhinitis | NO | YES |
| Nosebleeds | NO | YES |
| Mouth sores | NO | YES |
| Bleeding gums | NO | YES |
| Bad breath or bad taste | NO | YES |
| Sore throat or voice change | NO | YES |
| Swollen glands in neck | NO | YES |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Heart trouble | NO | YES |
| Chest pain or pressure | NO | YES |
| Palpitations | NO | YES |
| Shortness of breath | NO | YES |
| Swelling of feet, ankles or hands | NO | YES |

**RESPIRATORY**

| | | |
|---|---|---|
| Chronic or frequent coughs | NO | YES |
| Spitting up blood | NO | YES |
| Shortness of breath | NO | YES |
| Wheezing | NO | YES |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Loss of appetite | NO | YES |
| Change in bowel movements | NO | YES |
| Nausea | NO | YES |
| Vomiting | NO | YES |
| Frequent diarrhea | NO | YES |
| Painful bowel movements | NO | YES |
| Rectal bleeding or blood in stool | NO | YES |
| Abdominal pain | NO | YES |
| Heartburn | NO | YES |
| Peptic ulcer (stomach or duodenal) | NO | YES |

**GENITOURINARY/NEPHROLOGY**

| | | |
|---|---|---|
| Frequent urination | NO | YES |
| Burning or painful urination | NO | YES |
| Blood in urine | NO | YES |
| Change in force of stream when urinating | NO | YES |
| Incontinence or dribbling | NO | YES |
| Kidney stones | NO | YES |
| Sexual difficulty | NO | YES |

**GENITOURINARY/NEPHROLOGY (CONT.)**

| | | |
|---|---|---|
| MALE-Testicular pain | NO | YES |
| FEMALE-Menstrual pain | NO | YES |
| FEMALE-Menstrual irregularity | NO | YES |
| FEMALE-Vaginal discharge | NO | YES |

FEMALE-Number of pregnancies_____

FEMALE-Number of miscarriages_____

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Joint pain | NO | YES |
| Joint stiffness | NO | YES |
| Joint swelling | NO | YES |
| Muscle weakness | NO | YES |
| Muscle pain or cramps | NO | YES |
| Back pain | NO | YES |
| Difficulty in walking | NO | YES |

**DERMATOLOGIC**

| | | |
|---|---|---|
| Rash | NO | YES |
| Itching | NO | YES |
| Change in skin color | NO | YES |
| Change in hair or nails | NO | YES |
| Varicose veins | NO | YES |

**NEUROLOGIC**

| | | |
|---|---|---|
| Frequent or recurring headaches | NO | YES |
| Lightheaded or dizziness | NO | YES |
| Convulsions or seizures | NO | YES |
| Numbness or tingling sensations | NO | YES |
| Tremors | NO | YES |
| Paralysis | NO | YES |
| Stroke | NO | YES |
| Head injury | NO | YES |

**PSYCHIATRIC**

| | | |
|---|---|---|
| Memory loss or confusion | NO | YES |
| Nervousness | NO | YES |
| Depression | NO | YES |
| Insomnia | NO | YES |

**ENDOCRINE**

| | | |
|---|---|---|
| Glandular or hormone problems | NO | YES |
| Thyroid disease | NO | YES |
| Diabetes | NO | YES |
| Excessive thirst or urination | NO | YES |
| Heat or cold intolerance | NO | YES |

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| Slow to heal after cuts | NO | YES |
| Bleeding or bruising tendency | NO | YES |
| Anemia | NO | YES |
| Phlebitis (clot in leg vein) | NO | YES |
| Past transfusion | NO | YES |

**ALLERGIES**

| | | |
|---|---|---|
| Penicillin or other antibiotics | NO | YES |
| Morphine, Demerol or other narcotics | NO | YES |
| Novocaine or other anesthetics | NO | YES |
| Aspirin or NSAIDS | NO | YES |
| Tetanus or other serums | NO | YES |
| Iodine or other antiseptics | NO | YES |

Other drugs_____

Food Allergies_____

# Pain Drawing and Pain Scale

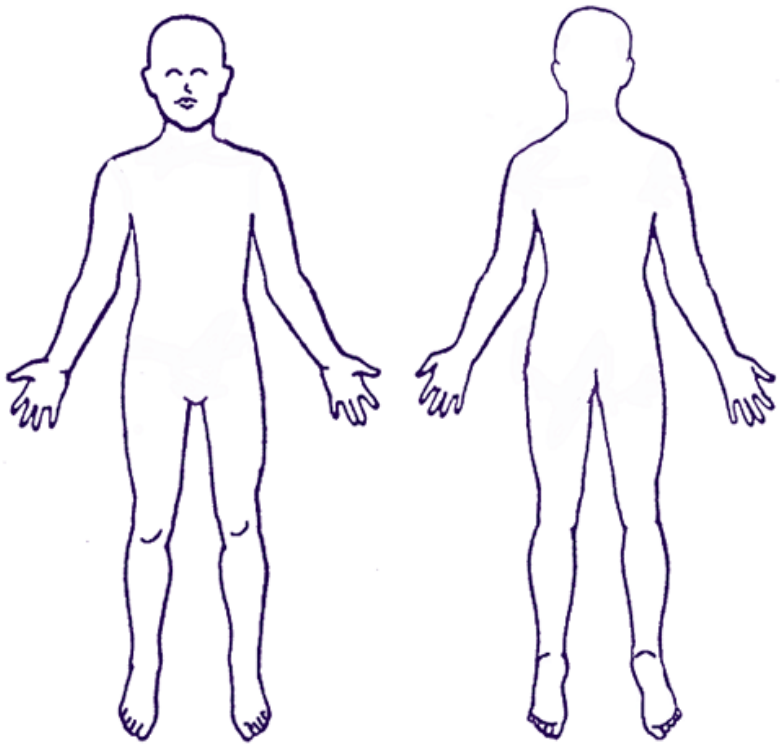
Patient Name_____Date_____

**Pain Location**

Draw the location of your pain on the body below using these symbols:

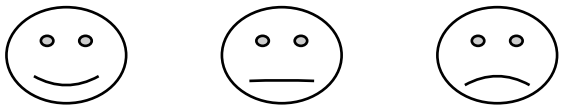
000 – Pins and needles  XXX – Burning  ··· - Numbness

/// - Stabbing  +++ - Dull Ache



**Rate your Pain**

Circle the number on the scale below that best describes your pain today.



0 1 2 3 4 5 6 7 8 9 10

No Pain  Worst Pain

Moderate Pain

**Haynes Neurosurgical Group, P.A.**
*801 Princeton Avenue Southwest*
*Suite 310*
*Birmingham, Alabama 35211*
*(205)787-8676 office* *(205)785-7944 fax*
**R. Cem Cezayirli, M.D.** **Robert J. Johnson Jr., M.D.** **Daniel K. Harmon, M.D.**

## Statement of Patient Financial Responsibility

PATIENT NAME:_____ DOB: _____
(Printed)

Haynes Neurosurgical Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of out fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

In the event that your balance is not paid in full within the allotted time, you understand that collection procedures will begin. Collection procedures include, but are not limited to, a series of collection letters, being turned to a collection agency, 2.5% monthly interest dated back to the date of services performed, and having your account turned over to a lawyer. You waive all claims of exemption under the State of Alabama and agree to pay if necessary, all cost of collection, including attorney fees.

I have read the above policy regarding my financial responsibilty to Haynes Neurosurgical Group, P.A., for providing medical/rehabilitative services to me or to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Haynes Neurosurgical Group, P.A., the full and entire amount of the bill incurred by me or the above named patient; or, if applicable any amoount of due after payment has been made by my insurance carrier is my responsibility.

PATIENT SIGNATURE:_____ DATE:_____

GUARANTOR SIGNATURE:_____ DATE:_____
(If guarantor is not patient)

# HAYNES NEUROSURGICAL GROUP, P.A.
**801 PRINCETON AVENUE SOUTHWEST**
**POB 1 SUITE 310**
**BIRMINGHAM, ALABAMA 35211**

Phone: (205) 787-8676 Fax: (205) 785-7944


## Receipt for HIPPA Privacy Notice and Authorization to Obtain or Release Medical Information

Name:_____ Date of Birth:_____

SSN:_____ Date of Request:_____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Haynes Neurosurgical Group, P.A. in writing, but if I do, it will not have effect on the uses of disclosures prior to the receipt of the revocation.

I hereby authorize Haynes Neurosurgical Group, P.A. to use, disclose health information as follows:

Release to:_____ Relation to patient:_____
(name)

Address:_____ Phone number:_____

Release to:_____ Relation to patient:_____
(name)

Address:_____ Phone number:_____

**PLEASE NOTE THAT BY CHECKING ANY BOX BELOW MAY RESULT IN THE STAFF OF HNS LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE AT THE NUMBER REQUESTED BY YOU.**

YES ☐ NO ☐ The physicians and staff of Haynes Neurosurgical Group may confirm appointments to my answering machine at the number provided on my Patient Information Sheet.

YES ☐ NO ☐ The physicians and staff of Haynes Neurosurgical Group may release information to my pharmacy without prior authorization in order to allow call-in of prescription.

**SPECIAL INSTRUCTIONS:**

_____
_____
_____

My signature below is acknowledgement that I have received a copy of the Haynes Neurosurgical Privacy Notice and that I agree to the conditions stated in the notice:

**Patient Signature:** _____ **Date:** _____

# Haynes Neurosurgical Group, P.A.
# Notice of Privacy Practices

Haynes Neurosurgical Group, P.A. is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Disclosure of Your Health Care Information:**

- We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations.
- We may disclose your health care information to your insurance provider for the purpose of payment or health care operations.
- We may disclose your health care information as necessary to comply with State Workers' Compensation Laws.
- We may disclose your health care information to notify, or assist in notifying, a family member or another person responsible for your care about your medical condition in the event of an emergency or of your death.
- As required by law, we may disclose your health information to public authorities for purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.
- We may disclose your health care information in the course of any administrative or judicial proceeding.
- We may disclose your health care information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose your health care information to coroners or medical examiners.
- We may disclose your health care information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose your health care information to researchers conducting research that has been approved by an Institutional Revenue Board.
- It may be necessary to disclose your health care information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- We may disclose your health care information for military, national security, prisoner and government benefits purposes.

In the event that Haynes Neurosurgical Group, P.A. is sold or mergred with another organization, your health information/records will become property of the new owner.

**Your Health Care Information Rights:**

- You have the right to request restrictions on certain uses and disclosures of your health care information. Please be advised however, that Haynes Neurosurgical Group, P.A. is not required to agree to the restriction that you requested.
- You have the right to have your health care information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.
- You have the right to inspect and copy your health care information.
- You have the right to request that Haynes Neurosurgical Group, P.A. amend your protected health care information. Please be advised, however, that Haynes Neurosurgical Group, P.A. is not required to agree to amend your protected health information. If your request to amend is denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

Haynes Neurosurgical Group, P.A. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Haynes Neurosurgical Group, P.A. is required by law to comply with this notice.

If you are not satisfied with the manner in which this office handles your information, you may contact:

DHHS, Office of Civil Rights
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Haynes Neurosurgical Group, P.A. with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice, effective as of the date signed below.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date