Dear New Patient:

The Doctors and staff of Wyoming Spine and Neurosurgery would like to welcome you to our practice. We appreciate the trust you have provided to us as your surgical specialists. Our office would like to make every attempt to alleviate any concerns you may have by providing the detailed enclosed information:

- Patient information form-Please complete all pages and bring the form with you to your scheduled appointment, as this information is vital for appropriate medical treatment.

- Insurance cards are required for verification of coverage and pre-authorization. Co-payment and deductible amounts are due at the time of service.

- If you do not have medical benefits, a fee of $280.00 is required at the time of your initial office visit; otherwise your appointment will be rescheduled when you are able to provide our office with such funds.

- Please provide detailed information if this is a workers compensation claim. The information should include the case number, date of injury and state where the injury occurred. Also, if you are insured with a private payer, that information will be required in the event that that your workers compensation claim is denied.

- Our office requires a 24-hour cancellation notice. In the event of a missed appointment, a charge will be incurred on your account. However, in incidences of inclement weather or unforeseen circumstances, please contact our office, as this charge will then be waived.

If you have any questions, please contact our office Monday-Thursday, 8:00am to 5:00pm, and Fridays, 8:00am to 3:00pm.

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Andrew T. Beguin, PA-C **Terra A. Hines, RN BSN**
1950 Bluegrass Circle, Suite 170 Cheyenne WY 82009
Phone: 307-778-2860 Toll-Free: 800-450-4729 Fax: 307-778-2866

Patient_____
Last First Middle

Date of birth_____Age_____Sex M F Email address_____

Social Security_____HomePhone_____Cell_____

Billing Address_____

City_____

State_____Zip_____

Employer_____Work _____

Phone_____

Employers
Address_____

Occupation_____

If retired, previous occupation_____

Spouse Full Legal
Name_____

Full legal name of emergency contact person_____

Full
address_____

Contact
Phone_____Relationship_____

How were you referred to our office? Doctor Friend Phone Book
Advertisement/Website

Name of doctor who referred you to our office_____

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Primary Insurance Coverage:

Company_____Policy_____Group_____

Policy Holders Name_____Policy holders DOB_____

Secondary Insurance Coverage:

Company_____ Policy_____Group_____

Policy Holders Name_____Policy holders DOB_____

Is this a Workers Compensation claim? Yes No

Docket #_____

Date of injury_____State in which you were injured_____

Company Name_____

If your insurance company indicates a Doctors fee is above the "usual and customary," please understand that the reimbursement rates insurance companies choose to pay are below most Doctors fees. Each insurance company and all of the different plans underwritten by each insurance company may reimburse at different rates. We do not and can not allow the payment or the insurance company to set the amount that we charge for services. As a courtesy to our patients, our staff calls for preauthorization of your surgical procedure. However, this does not guarantee payment by your insurance company. Should you wish to determine the benefits to which you are entitled under the provisions of your contract, we recommend you call your insurance company to obtain the precise information about the extent of your coverage. I hereby authorize Wyoming Spine and Neurosurgery to furnish the above insurance company(s) or to a designated attorney, all information, which said insurance company(s) or attorney may request including hospital records. I hereby assign all moneys to which I am entitled for medical and/or surgical expenses relative to the services rendered, but not to exceed my indebtedness to said physician. It is understood that any money received from the above named company(s) over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible to Wyoming Spine and Neurosurgery for charges not covered by this assignment. I further agree, in the event of non-payment, to bear the cost of collection and/or court costs and reasonable fees should this be required.

Patient/Legal GuardianSignature_____Date_____

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PATIENT DATA BASE

Name_____Date of birth_____Age_____

Referring Physician_____Primary Care_____

Are you [ ] Right handed, or [ ] Left handed? Weight_____ Height_____

CURRENT MEDICAL HISTORY
Briefly describe your current medical problem that brings you to our office today:

_____

Where is the pain located?

_____

When did it first start?

_____

Is your pain: ____constant, ____comes and goes, ____worse in the morning, ____worse later in the day.

____burning, ____stabbing, ____aching, ____throbbing, ____sharp, ____dull____mild, ____moderate,

____severe

Describe anything that makes the pain worse:

_____

Describe anything that makes the pain better:

_____

Describe the distribution of pain as a percentage of 100 (i.e. back 50% and leg 50%, or as neck 50% and arm 50%)

Back_____ Leg_____ Neck_____ Arm_____

Do you have numbness? If so, where:

_____

Do you have weakness? If so, where:

_____

Do you have bladder or bowel problems?

_____

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Have you had any, ____Physical Therapy, _____Chiropractic Therapy_____ Epidural Injection_____

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REVIEW OF SYMPTOMS

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PAST MEDICAL HISTORY

List your current or previous severe illness such as diabetes, hypertension, heart attack, cancer, ECT.

_____

List your severe injuries such as broken bones.

_____

List your surgeries.

_____

List your allergies to medications and explain your reaction.

_____

List medications taken regularly, including prescription, over-the-counter, and herbal drugs.

Medication **Dose** **Reason**

_____

_____

FAMILY HISTORY

Do you have a family history of the following? (Please circle)

Stroke	Diabetes	Hypertension	Heart Disease
Kidney Disease	Bleeding	Cancer	Hepatitis

SOCIAL HISTORY

Do you smoke cigarettes? _____ If so, how many? _____ How long?_____
If you quit, when?_____ How much when you quit? _____

Do you consume alcoholic beverages? _____, liquor? _____, wine? _____, beer?
quantity per week? _____

Are you married? _____ Single? _____ Divorced? _____ Widowed? _____ Do you have children? _____

Do you have any risk factors for the AIDS virus? _____

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AGREEMENT AS TO RESOLUTION OF CONCERNS

"I"," Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean Steven J. Beer, M.D and Wyoming Spine and Neurosurgery Associates, L.L.C

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to the medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning standard of care), only neurological surgeons who are board certified by The American Board of Neurological Surgery. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Association of Neurological Surgeons.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Association of Neurological Surgeons.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/Guardian and Physician agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Patient/Guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____

Physician Patient/Guardian

_____ _____

Effective from date of Treatment Date of Signature

_____ _____

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Witness Signature Printed Name of Witness

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Pain Medication Refill Policy

I, _____, clearly understand and will abide by the office policy that no pain medication refills may be called-in on Friday, Saturday or Sunday. I will not call the office or try to contact the on-call physicians on these days in order to obtain pain medications. I also understand that there may be up to a 2 working day minimum turn around time on refills. I understand that refusing to be cooperative with this policy and the office staff may result in my discharge from the clinic. I also understand that should I need pain medications during these days I will obtain them through my primary care physician or I will proceed to the emergency room if necessary.

Patient's Signature _____ Date _____

Witness' Signature _____ Date _____

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Patient Agreement & Informed Consent for Opioid Therapy

I, _____, understand that my physicians at Wyoming Spine and Neurosurgery Associates have initiated narcotic management. I have been informed and clearly understand the following issues regarding the treatment of pain with these medications, as well as other analgesic and sedative medications and I am fully aware that failure to abide by any of these conditions will be considered a breach of contract and may result in the termination of the patient-physician relationship.

1. Sole providers: The physicians at Wyoming Spine and Neurosurgery Associates will be the only providers to write narcotic prescriptions. **I will not obtain or accept** prescriptions for narcotic medications (related to my neurosurgical issues) from any physicians outside of this professional group. Nor will I take medications prescribed to someone else or allow someone else to take medications prescribed to me.

2. Safekeeping: I understand that I am responsible for the safekeeping of my prescriptions and medications. If I should lose them or if they are stolen, I will not be given replacements and I could experience the symptoms of withdrawal.

3. Pharmacy: I agree to use only one pharmacy in my town of residence.

4. Medication Dosages: I understand that my physician will prescribe my medications in dosages the he/she deems necessary. **I will not adjust the amount of medications I take without first contacting the prescribing physician**. If I should adjust the medication I am taking, and run out early, I will **not** be given additional medications to "get me through" until my next scheduled appointment. I understand that increasing my dose without medical supervision could lead to drug overdose, causing severe sedation, respiratory depression and death.

5. Side Effects: I am to notify my provider of any adverse effects that I might experience while taking narcotic medications. Adverse effect include but are not limited to: over-sedations, nausea, vomiting, constipation, euphoria, dysphoria, dizziness, sweating, itching, rashes, swelling, difficulty breathing, dysuria, dry mouth, insomnia, disorientation, decreased sex drive and potency and abnormal jerking motions in the arms and legs. While on narcotic medications, I will not operate a **motor vehicle** of any type or any other form of machinery that could cause injury to others or myself.

6. Physical Dependence: It is clearly understood that the use of these medications may result in physical dependence.

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7. Psychological Addiction: I understand that psychological addiction is a possible risk associated with these medications. If I exhibit such behavior, I will be tapered off my medications and will no longer be considered a candidate for narcotic therapy. Recognized addictive behaviors include but are not limited to: abuse of the drug to obtain mental numbness or euphoria, drug craving behavior, "doctor shopping", escalating drug usage without correlation with pain relief, and manipulative behavior toward the medical provider in order to obtain prescriptions.

8. Other Drugs: I will not use alcohol or other recreational drugs while on narcotic medication as this could cause profound sedation, respiratory depression, low blood pressure and death.

9. Pregnancy: If I am female, I agree to advise my physicians if there is any chance that I am or may become pregnant. I understand that infants born to mothers on narcotics will likely be dependent at birth and could possibly have birth defects as a result of the medications.

10. Release of Information: I agree to allow my physicians contact with other providers, emergency departments, pharmacies and urgent care facilities regarding information related to this agreement. I further allow these outside entities to disclose to my physicians any information required to ensure my adherence to this agreement.

11. Severability: I understand that if any provision of this agreement is determined to be invalid or unenforceable, then the remainder of the agreement will remain in force.

12. Termination: I understand that either party upon 30 days written notice to the other may terminate this agreement. Delivery of such notice by US postal service certified mail to my address of record shall be deemed sufficient notice. It is the patient's responsibility to ensure that Wyoming Spine and Neurosurgery Associates has a current and legitimate address on file.

I have read the above information (or it has been read to me), have received a copy of the agreement and all of my relevant questions have been answered to my satisfaction

Patient's printed name: _____ Patient's signature: _____

Witnesses printed name: _____ Witness' signature: _____

Date signed by both parties: _____

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PATIENT CONSENT FORM

By signing this consent form, I am giving permission to Wyoming Spine and Neurosurgery Associates to use and disclose my protected health information for the purposes of my treatment, obtaining payment, and the Organization's health care operations.

Our Organization's Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to receive, and review if you would like, our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we make changes to our Notice of Privacy Practices, you may obtain a copy of the revised notice by contacting our Organization's Privacy Officer at (307) 778-2860.

You have the right to request that our Organization restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we will be bound by our agreement to comply with such restrictions.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I understand that I am required to sign this Consent, subject to certain exceptions, as a condition of receiving treatment from Wyoming Spine and Neurosurgery Associates.

Signed: _____ Date: _____

Signature of Patient or Personal (legal) Representative

Relationship of Personal (legal) Representative to Patient: _____

Witnessed By: _____ Date: _____

PATIENT CONSENT FORM MAY NOT BE COMBINED IN A SINGLE DOCUMENT WITH THE NOTICE OF PRIVACY PRACTICES OR AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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INTERNAL POLICY AND PROCEDURE REGUARDING DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

WHAT INFORMATION IS PROTECTED?
The privacy rule protects all identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

REQUIRED DISCLOSURES
A covered entity must disclose protected health information in only two situations: (a) to individuals or their personal representatives specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to health and human services (HHS) when it is undertaking a compliance investigation or review or enforcement action.

PERMITTED DISCLOSURE AND USES
A covered entity is permitted, but not required, to use and disclose PHI, without an individual's authorization, for the following purposes or situations:

1. To the individual (unless required for access or accounting disclosures) a covered entity may disclose PHI to the individual who is the subject of the information;

2. Treatment, Payment and Health Care Operations. A covered entity may use and disclose protected health information for its own treatment, payment, and health care operation activities. A covered entity may also disclose protected health care information for the treatment activities of any health care provider, the payment activities of another covered entity and any other health care provider or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship.

3. Opportunity to agree or object

4. Incident to an otherwise permitted use and disclosure

5. Public interest and benefit activities

6. Limited data set for the purpose of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

Patient's signature: _____ Date _____

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