Luna Spine and Orthopaedic Surgery

Mario E. Luna, MD

PATIENT REGISTRATION FORM

PATIENT INFORMATION					
NAME (Last, First, Middle Initial)			EMERGENCY CONTACT NAME (Relationship to Patient)		
PRIMARY ADDRESS			CITY, STATE, ZIP		
CITY, STATE, ZIP			PHONE	( ) HOME ( ) CELL ( ) OTHER	
SSN#	BIRTHDATE / /	SEX ( ) M ( ) F	REFERRING PHYSICIAN/PRIMARY CARE PHYSICIAN		
EMAIL			ADDRESS		
PHONE	( ) HOME ( ) CELL ( ) OTHER		CITY, STATE, ZIP	PHONE	
PHONE	( ) HOME ( ) CELL ( ) OTHER		PHARMACY NAME		
PHONE	( ) HOME ( ) CELL ( ) OTHER		ADDRESS		
MARITAL STATUS	( ) M ( ) S ( ) D ( ) W		CITY, STATE, ZIP	PHONE	

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION (If different than above)			
NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE / /	SEX ( ) M ( ) F
PRIMARY ADDRESS	SECOND CONTACT BILLING ADDRESS (If Applicable)		
CITY, STATE, ZIP	CITY, STATE, ZIP		
PRIMARY CARE PHYSICIAN	RELATIONSHIP TO PATIENT		
PHONE	CITY, STATE, ZIP		

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY #	
NAME OF PRIMARY MEMBER INSURED	D.O.B.	GROUP #	
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)			
NAME OF INURANCE COMPANY		POLICY #	
NAME OF PRIMARY MEMBER INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

REFERRAL SOURCE (How did you hear about our clinic?)

( ) INTERNET / WEBSITE ( ) FAMILY MEMBER ( ) HOSPITAL ( ) OTHER

WORK RELATED PERSONAL INJURY CLAIMS ONLY			
DATE OF ACCIDENT	BODY PART	EMPLOYER NAME	EMPLOYER CONTACT #
W/C INSURANCE CO. NAME		CLAIM #	PHONE #

I hereby assign the insurance benefits to which I am entitled, directly to LUNA SPINE AND ORTHOPAEDIC SURGERY (LSOS), a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility, I authorize release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by MARIO E. LUNA, M.D. INC. A phostat of this authorization is accepted with the same authority as original.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required. It is the patient's responsibility to notify LSOS of any changes in information.

Patient History

Name: _____ Date: _____

Age: _____ DOB: _____ Sex: ☐ M ☐ F ☐Right-handed ☐ Left-handed

SSN: _____ Height: _____ Weight: _____

Referring MD: _____ Phone: _____

Address: _____

Primary Care Physician (if different): _____ Phone: _____

Address: _____

Reason For Visit

Main Complaint: _____

Date of Injury: _____ Duration of Symptoms: _____

Location of Pain: _____

Does pain spread to other area(s)? _____

Quality of the pain: ☐Burning ☐Cramping ☐ Sharp ☐Pressure ☐Pins/Needles ☐Numbness

☐Dull/ Aching ☐Other: _____

What makes the pain worse? _____

What makes the pain better? _____

Are you limited in the following due to pain? ☐Work ☐Chores ☐Recreation ☐Exercise

☐Shopping ☐Other: _____

What treatments have you received? ☐Physical Therapy ☐Pool Therapy ☐Chiropractic Therapy

☐Steroid injections ☐Epidural Steroid injections (☐Neck ☐ Lower Back) ☐Acupuncture

☐Surgery ☐Other: _____

Previous Tests (Please indicate approximate date and results):

	Test	**Date**		**Test**	**Date**
MRI:			CT:		
X-rays:			EMG:		
Other:			Other:		
Other:			Other:		

Allergy to Latex: ☐ Yes ☐ No

Allergies (are you allergic to any to any medications or foods): _____

Current Medications (or attach list):

Name	Dose	How Often?	Reason for Medication?

Are you taking any blood thinners? (examples: Plavix, Coumadin, other): _____

Medical History (Choose from below or List any medical problems):

☐Diabetes (Insulin-dependent ☐Yes ☐No) ☐Kidney Problems ☐High Cholesterol
☐High Blood Pressure ☐Heart Attack ☐Anemia ☐Blackouts/ Fainting
☐Heart Disease ☐Heart Stents ☐Repeated Infections ☐Bleeding Disorder
☐COPD ☐Pacemaker ☐Arthritis ☐Anxiety
☐Lung Disease ☐Asthma ☐Thyroid Disease ☐GERD (Acid Reflux)
☐Depression ☐Seasonal Allergies ☐Mental illness ☐Gout
☐Cancer: _____
☐Other: _____ _____ _____
_____ _____ _____

Past Surgeries (list approximate date and type of operation):

Operation	Date	Operation	Date

Family History (has any blood relative had any of the following)?

☐High Blood Pressure ☐Heart Disease ☐Heart Attacks ☐Stroke ☐Cancer
☐Epilepsy ☐Tuberculosis ☐Rheumatic Fever ☐Bleeding Tendency ☐Asthma
☐Arthritis and/or gout ☐Psychiatric illness ☐Diabetes ☐Kidney Disease ☐Alcoholism
☐Other _____ _____ _____

Social Background:

Employed? (what type of work) _____ ☐Retired (when?): _____ ☐Student?
Disabled? ☐Yes: Why? _____
When did you last work? _____
Status: ☐Single ☐Married ☐Divorced ☐Widowed
Living situation: ☐Alone ☐Spouse ☐Children ☐Parents ☐Other: _____
Exercise: ☐Daily ☐1-3x per week ☐4-6x per week ☐Inactive: _____
Special Interest or hobbies: _____

Do you drink alcohol? ☐Yes ☐ No How many drinks per day? _____ Per Week? _____ How long? _____
Do you smoke? ☐Yes ☐ No How much per day? _____ Per Week? _____ How long? _____
Previous smoker? ☐Yes ☐ No How much per day? _____ Per Week? _____ How long? _____
Street drugs? ☐Yes ☐ No Substance: _____ How long? _____
Work related injuries? ☐Yes ☐ No Date of Injury: _____ Location: _____
If YES, please list employer and insurance company:
Employer: _____
Insurance: _____

Is there any litigation pending: ☐Yes ☐ No
Are you applying for disability benefits: ☐Yes ☐ No

Review of Systems (ROS):

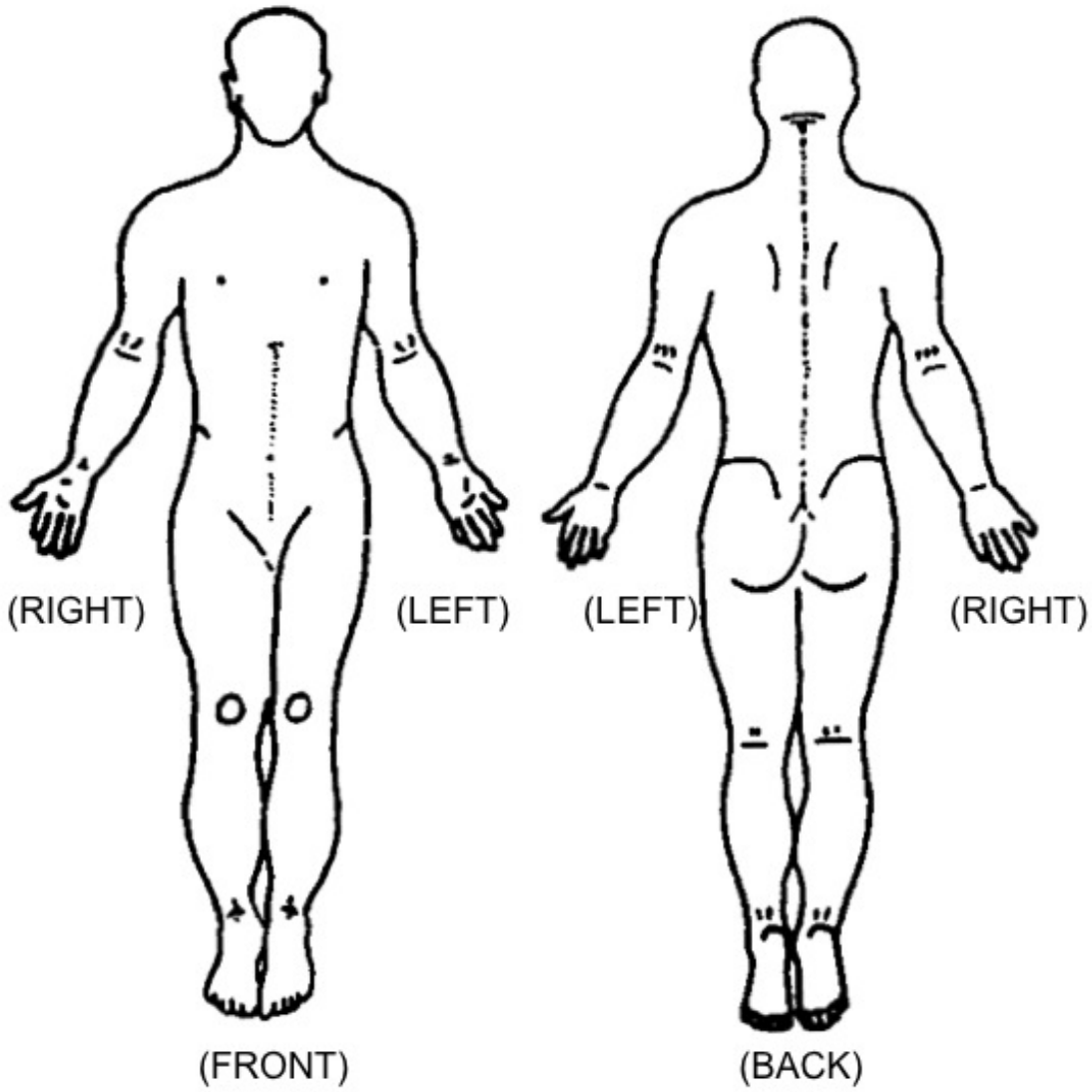
Are you easily fatigued?	☐YES	☐NO	Are you coughing up blood?	☐YES	☐NO
Unexplained weight loss or gain?	☐YES	☐NO	Are you unable to control your urine?	☐YES	☐NO
Do you have a fever?	☐YES	☐NO	Do you ever lose control of your bowels?	☐YES	☐NO
Do you have chills?	☐YES	☐NO	Do you feel sick to your stomach?	☐YES	☐NO
Unexplained decreased appetite?	☐YES	☐NO	Had diarrhea or constipation recently?	☐YES	☐NO
Do you have an irregular heart rate?	☐YES	☐NO	Have you passed blood with bowel movements?	☐YES	☐NO
Have you ever had a heart murmur?	☐YES	☐NO	Have you ever had tarry stools?	☐YES	☐NO
Difficulty exercising due to weakness?	☐YES	☐NO	Have you ever had ulcers?	☐YES	☐NO
Do you have chest pains?	☐YES	☐NO	Have you ever been jaundice?	☐YES	☐NO
Do your ankles swell constantly?	☐YES	☐NO	Have you ever had gallstones?	☐YES	☐NO
Do you feel like you might faint or feel light-headed?	☐YES	☐NO	Do you have or have you had blood in your urine?	☐YES	☐NO
Do you have unusual headaches?	☐YES	☐NO	Do you have difficulty moving any limb?	☐YES	☐NO
Have you ever had a seizure?	☐YES	☐NO	Do you have morning stiffness?	☐YES	☐NO
Have you ever been paralyzed?	☐YES	☐NO	Do you have joint swelling, redness or pain?	☐YES	☐NO
Do you feel short of breath?	☐YES	☐NO	Is your pain worse at night or awaken you from sleep?	☐YES	☐NO
Do you have trouble breathing with exercise?	☐YES	☐NO			

Patient Signature

Date Completed

SHOW BY MARKING AND DRAWING ON THE BACK AND FRONT OF THE FIGURES BELOW WHERE YOU ARE HAVING MOST OF YOUR PAIN:

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
^^^^	XXXX	OOOO	= = = =	/ / / /



Pain Scale (circle)											
No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain

Date:_____

MEDICAL RECORDS REQUEST

Patient Name: _____ Date of Birth: _____

Date(s) of Service Requested: _____

Provider or Department Requested: _____

I authorize the release of the following health information:

☐ Consultation	☐ History & Physical	☐ Lab Report	☐ Office Note
☐ ER Report	☐ X-ray Report	☐ Operative Report	☐ Other: _____
☐ Nurse's Note	☐ Physician Progress Note	☐ Discharge Summary	☐ Other: _____

Term: this authorization is effective immediately and will remain in effect for 1 year unless otherwise specified. I understand that all record requests require my authorization and that I may receive a copy of the authorization upon request.

Alternative expiration date:_____ Copy of authorization requested ☐

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS or mental health will be disclosed:

_____

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified below, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare provider. Any revocation will be effective immediately upon my healthcare provider in reliance on this Authorization before the provider received my written notice of revocation.

Fees: Federal and state laws permit a fee to be charged for the copying of patient records. I understand that any applicable fees for copies of records must be paid before records are mailed or picked up.

Photocopy: A photocopy, fax or electronic copy of this Authorization shall be considered as effective and as valid as the original.

Please forward records to:

_____
Patient Signature (Or legal guardian if patient is a minor)

_____
Date

_____
Physician Name/ Hospital Name/ Other

_____
Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the current Notice of Privacy Practices and understand a current Notice of Privacy Practices is available at www.mariolunamd.com under office information.

Patient Name: _____ Date of Birth: _____
Signature: _____
Relationship to Patient if not "Self": _____
Date: _____

Instructions for Communicating Personal Health Information (PHI)

Please indicate which of the following numbers and/or email address we should use to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call. Please specify if a message can be left on voicemail or with a designated person.

Home	_____	Message: *Yes / No*
Work	_____	Message: *Yes / No*
Cell	_____	Message: *Yes / No*
Other	_____	Message: *Yes / No*
Email	_____	Message: *Yes / No*

My PHI may be communicated to:	Do not communicate my PHI to:
_____	_____
_____	_____
_____	_____

Initials: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date:_____

Reason:_____

_____

Employee Initials:_____

MEDICAL HEALTH COVERAGE

Financial Responsibility

- Insurance billing by Luna Spine and Orthopaedic Surgery is provided as a courtesy
- Any charges not covered by health care benefits are the patient's responsibility.
- It is my responsibility to notify the office of any changes in my health care coverage.
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill, or balance of the bill, or balance of the bill, as determined by the office and/or my health care insurer if the submitted claims or any part of them are denied of payment.

Authorization of Release of Information

I authorize the release of medical or any other information to the health Care Financing Administration, my insurance carrier(s) or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Luna Spine and Orthopaedic Surgery. A copy of this authorization will be sent to the health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file.

My insurance remains the same from my last visit. □ Yes □ No

OR

My new insurance is:_____

Primary Care Physician:_____

New Medical Group:_____

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

_____

Patient/Insured Name (Please Print)

_____ _____

Patient/Insured's Signature Date

ePRESCRIBE & MEDICATION HISTORY CONSENT FORM

ePrescribe Program

ePrescribing is a process for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality.
  Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at *Luna Spine and Orthopaedic Surgery* as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at *Luna Spine and Orthopaedic Surgery* may request / send and use your prescription medication history from other healthcare providers and / or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to *Luna Spine and Orthopaedic Surgery* to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Patient Name _____Patient DOB

_____Signature of Patient or Guardian _____Today's Date

_____Relationship to Patient

Financial Policy

This is a statement that _____ is acknowledging you understand that you are obligated to ensure that *Luna Spine Orthopaedic Practice* fees are paid in full. *Luna Spine Orthopaedic Practice* staff may verify your coverage at the time of your visit and inform you whether or not Dr. Mario Luna is "In-Network or Out of Network" with your particular plan and then bill your insurance carrier on your behalf as a courtesy. However, <u>you are ultimately responsible for payment of your bill.</u> By signing this agreement you are agreeing that you will be responsible and pay any deductible, co-payment, co-insurance, and out of pocket or out of network expense as determined by your insurance plan. This includes and denials for "Not Medically Necessary" and or "Diagnosis does not meet Medical Coverage" denials you may receive on your Explanation of Benefit's (EOB).
_____ (Patient or Guarantor Initial)

You are in agreement that many insurance companies have additional requirements or stipulations that may affect your coverage; it is your responsibility to understand these stipulations by contacting your insurance carrier and receiving acknowledgement of these potential stipulations.
_____ (Patient or Guarantor Initial)

You are in agreement that all Office Visit Co-Pays are always due at the time of visit "no expectations" and can be paid by cash, check, or credit card. _____ (Patient or Guarantor Initial)

You are in agreement that there is a thirty or sixty dollar ($30 or $60) fee for appointments not kept without a twenty-four (24) hour notification. _____ (Patient or Guarantor Initial)

You are in agreement that you are responsible for checking to make sure the potential Hospital or Ambulatory Surgery Center (ASC) for any surgery procedure to be performed outside of *Luna Spine Orthopaedic Practice* is a covered with your insurance carrier or plan, as In-or-Out of Network and any additional Deductibles or Out of Pocket expenses that may be applied. _____ (Patient or Guarantor Initial)

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Patient Signature: _____ Date: _____

(Use if patient is a minor or otherwise has an authorized representative.)

Signature: _____ Date: _____

Authorized Representative for *Luna Spine Orthopaedic Practice*.

Signature: _____ Date: _____