NMS Spine & Joint Institute
Dr. Carl Hiller
760 W. Lincoln Highway
Exton, PA 19340

Phone: 610-594-5502
Fax: 610-594-1017

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Presently Employed: Yes No Occupation or Previous: _____

Email Address: _____

Birth Date: _____ Gender: Male /Female SS #: _____

Marital Status: M S D Sep W Spouse Name: _____

Primary Physician: _____ Phone #: _____

Health Insurance Information

Name of Carrier: _____ ID #: _____

Subscriber of policy: Name _____

Relationship to Subscriber: _____ Date of Birth: _____

Auto Accident/Worker's Comp Insurance Information

Name of Carrier: _____ Claim #: _____

Address: _____ City: _____ Zip: _____

Adjuster's Name: _____ Phone #: _____

Date of Accident: _____

Medical Information

Medical reactions/Allergies: Substance and Reaction _____

_____

Anticoagulant Medication: _____ (Coumadin, Warfarin, Low Molecular weight Heparin, Lovenox, Frafmin, Innohep) _____ other _____ none

Antiplatelet Medications: _____ (Plavis, Platel, TICLID) ____ other ____ none

Medications: (list all current meications including over the counter Herbs/Doses/Schedules)

_____

_____

List Types of Surgeries & Year: _____

_____

List Non-surgical Hospitalizations: _____

_____

Patient Signature: _____ Date: _____

Dr. Carl Hiller
Neuromusculoskeletal Spine & Joint Institute
PH: 610.594.5502
Fax: 610.594.1017

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed and their phone numbers:

_____

_____

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices.

— Received Paper Copy
— Individual refused to sign copy

Signature: _____ Date: _____

If you are not the patient, please specify your relationship to the patient. _____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Financial Policy/ Agreement/ Insurance Coverage

Dr. Carl Hiller and NMS Spine & Joint Institute are dedicated to providing patients with exceptional care and service, while keeping costs to our patients reasonable without continually increasing. We provide several methods of payment for services rendered. Please read carefully and initial below as an acknowledgement of your understanding of the policies.

Insurance: If you have insurance that covers our services, per your plan, we will bill your insurance company and provide you a receipt. If your insurance company does not cover services rendered, you will be responsible for any charges and incurred costs. All co-payments, co-insurance and deductibles are the patient's responsibility, are governed by your insurance plan, and are due at the time of your visit. HMO insurances require referrals for services. It is the patient's responsibility to obtain the referral PRIOR to the time of service. If a referral was not obtained, electronically, the patient is responsible for the payment in full for that date of service or until a referral is presented.

It is important for you to understand your own insurance policy and your health insurance coverage. This is an agreement between you and your insurance company.

Motor Vehicle/ Workman's Compensation: We will bill your motor vehicle and/or workman's compensation insurance company. PIP forms are required for all auto claims. Please note, should your case be placed in review, for either personal injury, workman's compensation or motor vehicle and your insurance company determines care is not related and/or reasonable/necessary, or your employer denies your workman's compensation claim, we will bill your personal health insurance if it covers our services. If you do not have other health insurance coverage, you will be responsible for all services rendered. Should your benefits become exhausted respective to your motor vehicle insurance, we will bill your personal health insurance. You will be responsible for your co-pays, co-insurance, and deductibles as stipulated in the above insurance section. We do require a letter of protection that is to be signed on your first visit and subsequently signed by your attorney to cover any outstanding amounts on you r account related to your injuries.

Cash: Cash plans are available for patients who do not have coverage for our services. Doctor fees are to be paid at the time of service, unless prior arrangements have been approved by the billing manager only. All payments are expected at the time of service and any outstanding balances are due upon receipt of your statement. All balances that reach 90 days past due will incur 1.5% interest per month and will be sent to a collection agency. Should your account be sent to a collection agency, you will be responsible for any collection and legal fees that our office incurs through this process to collect outstanding and delinquent balances. In addition, payment in full will be expected at the time of service for any future accounts where the balances are continually overdue.

Initials: _____

Authorization

I certify that I have read and understand that all information to the best of my knowledge is correct. I authorize the Doctor to release any information including diagnosis and the records for treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

Medical History Name:_____, DOB: _____, Date:_____.
Check all that apply:

Head

— Trauma

Eyes

— Blindness
— Cataracts
— Glaucoma
— Wears glasses/contacts
— Visual disturbances

Ears

— Hearing aids
— Nose/Sinuses
— Allergic Rhinitis
— Sinus infections
— Tinnitus

Mouth/Throat/Teeth

— Dentures

Cardiovascular

— Aneurysm
— Angina
— DVT
— Dysrhythmia
— HTN
— Murmur
— Myocardial infarction
— Syncope
— Palpitations
— Pacemaker
— AICD
— Hypercholesterol
— Hypertension
— Other heart disease

Respiratory

— Asthma
— Bronchitis
— COPD/Bronchitis/ Emphysema
— Pleuritis
— Pneumonia
— TB
— Sleep Apnea
— Oxygen at Home
— DOE
— Asthma
— Orthopnea
— Hemoptysis
—

Gastrointestinal

— Cirrhosis
— GERD
— Gallbladder disease
— Heartburn
— Hemorrhoids
— Hepatitis
— Hiatal hernia
— Jaundice
— Ulcer
— Reflux
— Diverticulitis

Genitourinary

— Hernia
— Incontinence
— Nephrolithiasis
— Other kidney disease
— STDs
— UTI(s)

Musculoskeletal

— Arthritis
— Gout
— M/S injury
— Wheelchair/Cane
— Prosthesis
— DVT
— Scoliosis
— Osteoporosis
— Fibromyalgia

Skin

— Dermatitis
— Mole(s)
— Psoriasis
— Eczema
— Acne
— Skin condition(s)

Neurological

— Epilepsy
— Seizures
— Severe headaches, migraines
— Stroke
— Vertigo
— TIA
— Narcolepsy
— Paralysis

Psychiatric

— Bipolar disorder
— Depression
— Hallucinations, delusions
— Suicidal ideation
— Suicide attempts

Endocrine

— Goiter
— Hyperlipidemia
— Hypothyroidism
— Thyroid disease
— Thyroiditis
— Type I Diabetes
— Type II Diabetes
— Scleroderma
— Lupus
— Rheumatoid Arthritis
— Adrenal Problems
— Pituitary Problems

Heme/Onc

— Anemia
— Cancer Type: _____
— Infectious
— HIV
— STDs
— Tuberculosis (dz)
— Tuberculosis (exposure)

Name: _____ DOB: _____ Date: _____

Additional Medical Information:

Tobacco Use:

- — Current every day smoker
- — Current some day smoker
- — Former smoker
- — Heavy tobacco smoker
- — Light tobacco smoker
- — Never smoker

Alcohol Use:

- — Do not drink
- — Drink daily
- — Frequently drink
- — Hx of Alcoholism
- — Occasional drink

Street Drug Use:

- — IVDU
- — Illicit drug use
- — No illicit drug use

Cardiovascular:

- — Balanced Diet
- — Regularly Active

OB/GYN:

- — Possibility of Pregnancy

Additional Symptoms:

- — Dizziness
- — Memory Loss
- — Easy Bleeding
- — Easy Bruising
- — Appetite Change
- — Weight Change
- — Nausea/ Vomiting
- — Coughing

Please check the box if anyone in your family has the following and list family member:

Birth defects ☐ Yes ☐ No _____

Breast Disease ☐ Yes ☐ No _____

Cancer ☐ Yes ☐ No _____

Diabetes ☐ Yes ☐ No _____

Heart Attack ☐ Yes ☐ No _____

Heart Disease ☐ Yes ☐ No _____

High Blood Pressure ☐ Yes ☐ No _____

High Cholesterol ☐ Yes ☐ No _____

Osteoporosis ☐ Yes ☐ No _____

Stroke ☐ Yes ☐ No _____

Bleeding Disorder ☐ Yes ☐ No _____

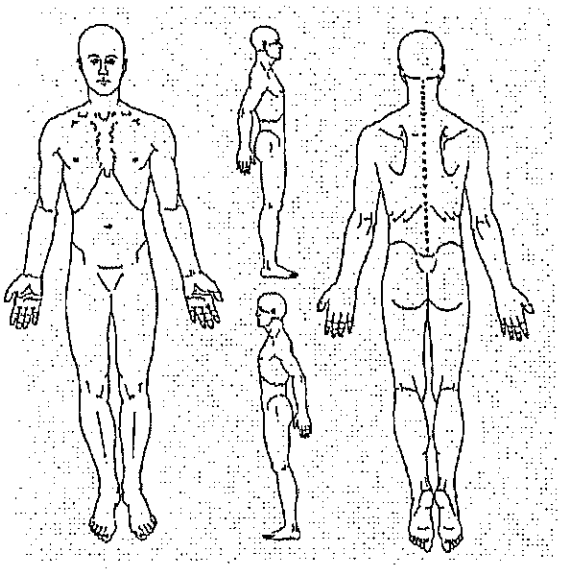
Other ☐ Yes ☐ No _____

For those listed indicate living or deceased

Deceased	Living		Deceased	Living	
☐	☐	_____	☐	☐	_____
☐	☐	_____	☐	☐	_____
☐	☐	_____	☐	☐	_____

Name:_____ Date:_____

Please mark on the diagram the location of the pain.



Please describe the type of pain or sensation you are currently experiencing (check all that apply)

□ Aching	□ Shooting
□ Burning	□ Stabbing
□ Cramps	□ Stiffness
□ Dull	□ Swelling
□ Numbness	□ Throbbing
□ Sharp	□ Tingling
□ Spasms	□ Weakness

□ Other, Describe _____

Please place a mark on the line that corresponds to your **current** pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

Please place a mark on the line that corresponds to your **average** pain.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

- When did the pain begin? _____ Since onset is pain getting better or worse?

_____

- What brought the pain on? Was it an event or injury?

_____

- The pain □ Is constant □ Intermittent □ Occasional. If it is intermittent or occasional, how often does the pain exist? And for how long?_____
- Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation
  □ Other_____
- Activities or movements that are painful to perform and/or increase pain:
  □ Sitting □ Standing □ Walking □ Bending □ Lying Down □ None
  □ Other_____
- What makes the pain better?

_____

- What medications are you taking for this pain?

_____

- Any prior injuries to the area of pain?

_____

- What if any treatments have you received for this pain?

_____