Executive Medical and Surgical

900 E. Washington Street, Suite 300

Colton, Ca 92324

Phone # (909) 824-2422 Fax # (909) 824-8234

PATIENT CONSENT FORM

Authorization for treatment and release of information:

1. **I consent for this provider to render the treatment set forth as ordered by my physician**
2. **I give authorization, for treatment to be provided in the areas not totally isolated from other patients and personnel.**
3. **This authorization, or photocopy of same, authorizes the release of any medical information necessary for treatment and/or to process claims for series rendered by this provider.**

Signature of Patient/Guardian: _____Date: _____

Guardian Name (please print)_____Relationship:_____

Reimbursement Coverage:

4. I request and authorize my insurance and/or Medicare to make payments for benefits on my behalf to Executive Medical & Surgical.

Signature of Patient/Guardian: _____Date: _____

If policyholder is other that the patient, please complete the following. I, The policyholder, request and authorize my insurance company and/or Medicare to make payments for benefits on behalf of the patient to Executive Medical & Surgical.

Signature of Policyholder: _____Date:_____

PLEASE PROVIDE PROOF OF INSURANCE COVERAGE UPON COMPLETION OF THE FORM

Assignment and Authorization: I authorize the release of any medical information necessary to process insurance claims on my behalf. I authorize payment of medical benefits directly to Executive Medical & Surgical for services and supplies provided to me. A copy of this authorization shall be considered as valid as the original and valid for the duration of my care. I understand I am liable for all charges incurred should my insurance not pay for these services (Except for Worker's Compensation).

Signature: _____Date_____

Please Print Name: _____

Executive Medical and Surgical

Darren L. Bergey, MD

Spinal Surgeon

REFERRED BY_____

PATIENT NAME_____SEX_____

PATIENT ADDRESS_____CITY_____

PATIENT ZIP_____HOME PHONE_____CELL_____

PATIENT OCCUPATION_____

INJURY DATE_____

DATE OF BIRTH_____

SS NUMBER_____

CLAIM NUMBER_____

INSURANCE CARRIER_____

INSURANCE ADDRESS_____

INSURANCE CITY, STATE AND ZIP_____

INSURANCE PHONE_____

EMPLOYER_____

EMPLOYER PHONE_____

ATTORNEY_____

ATTORNEY ADDRESS_____

_____

ATTORNEY PHONE_____FAX_____

CONTACT_____

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Patient Name: _____

PATIENT QUESTIONNAIRE

1. My chief problem is: _____

   _____

2. This has been going on for:_____

   Ever since my: _____

3. Describe the location of your pain:_____

   _____

4. Describe the nature of your pain:_____

   _____

5. Location and description of numbness or tingling:_____

   _____

6. Location and description of weakness:_____

   _____

7. How have these symptoms changed your life, or your ability to perform your usual functions?

   _____

   _____

8. What makes these symptoms better? _____

   _____

9. What makes these symptoms worse?_____

   _____

10. What have you tried for these symptoms?_____

    _____

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11. Do you have problems controlling your bowel or bladder?_____

_____

12. Do you have trouble walking?_____

_____

13. Do you have other medical problems?_____

_____

_____

_____

_____

_____

14. Please list any and all surgeries that you have had:_____

_____

15. What medication, vitamins, herbs or supplements do you take?_____

_____

_____

_____

16. Do you have any allergies to medications?_____

_____

17. Please list any medical problems that run in your family:_____

_____

18. Do you smoke?_____If so, how much and how long?_____

19. Do you drink alcohol?_____If so, how much and how long?_____

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20. What is your weekly activity like? (i.e., list exercises, physical activity, etc.) _____

    _____

    _____

21. Are your symptoms related to a work related injury?_____

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REQUEST FOR CONSULTATION:

Aside from the problem for which you are seeking help from Dr. Bergey, do you have any of the following? (Please circle the items and explain below)

GENERAL/CONSTITUTIONAL

Fever, chills, nauses, vomiting, lethargy, fast or slow heart beat, lapses of consciousness or memory.

SKIN/BREAST

Rashes, lumps under the skin, easy bruising, easy bleeding.

EYES/EARS/NOSE/MOUTH/THOAT

Sore throat, difficulty swallowing or getting food down, stuffed nose or sinuses, hoarseness.

CARDIOVASCULAR

Chest pain, skipped or irregular heart beats

RESPIRATORY

Trouble breathing, frequent coughing, production of sputum, blood in sputum.

GASTROINTESTINAL

Bloating, abdominal pain, pain after eating, trouble with bowel movements.

GENITOURINARY

Trouble starting or stopping urine flow, leakage of urine, impotence, incontinence, blood in the urine or burning on urination.

MUSCULOSKELETAL

Pain in the joints, limitation of range of motion, cramping in the muscles

NEUROOLOGIC/PSCHIATRIC

Problems controlling mood, loss of appetite or sleepiness, sleeping too much, trouble with balance or walking, problems with vision, hearing, taste, and/or smell.

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What tests, Xrays, MRI's have you had?_____

_____

_____

_____

Who is your primary physician?

Name:_____

Address:_____

_____

Phone:_____

Who is your referring physican:

Name:_____

Address:_____

_____

Phone:_____

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MEDICAL INFORMATION RELEASE

I hereby authorize (name and address of healthcare provider)

_____

_____

to release/disclose my Personal Health Information for purposes of payment, health care operations and treatment. The information and records, which may be released to any medical, psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records and/or information, which he/she may have regarding.

_____, _____

(Patient's Name) (Date of Birth)

Examples of these types of uses and disclosures include:

PAYMENT: We use and disclose your PHI in order to process claims and seek reimbursement for your health expenses covered by and insurer.

TREATMENT: We may disclose your PHI to assist in your health care (doctors, pharmacy and others) in your diagnosis and treatment.

OTHER PREMITTED OR REQUIRED DISCLOSURES OF YOUR PHI:

AS REQUIRED BY LAW: We may disclose your PHI when required to do so by law (i.e., Workers' Compensation).

PUBLIC HEALTH ACTIVITIES: We may disclose PHI to public health agencies for reasons such as preventing or controlling disease, medical injury or disability, and/or enable product recalls, repairs or replacements.

BUSINESS ASSOCIATES: There are some services provided by us through contracts with business associates and PHI disclosure may be necessary to perform the job we have asked them to do. To protect PHI, we require the business associates to abide by the appropriate privacy measures.

1. The information and PHI/Medical Records, which may be released, are limited to all medical, psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records or other information obtained by (healthcare provider) _____, through his/her interviews with the patient: _____, and/or through his/her inquires and/or review of records concerning the patient_____, and/or other persons , and includes all medical, psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records which are in the possession or control of:_____.

2. The purpose of such disclosure is for use in connection with:_____

_____

_____

3. The consent is subject to revocation at anytime except to the extent that action has already been take in reliance thereon. If not preciously revoked, the consent will terminate on (date):_____

4. I understand that I may receive a copy of this consent.

_____ _____

Patients Signature Date Signed

If the patient is deceased:

_____ _____

Signature of Beneficiary or Date Signed

Personal Representative of Deceased patient

If the patient is a minor, or has been judicially determined to be incompetent:

_____ _____

Signature of the Legal representative of The patient, Date Signed:

Such as a Conservator of the person, and individual

Granted A Durable Power or Attorney, or a Parent with

Legal custody of a minor patient