Academic Pain & Spine

Today's Date:

Please complete this form in order to ensure proper billing of your services. **Please Print**.

Patient's Last Name	Patient's First Name	MI
DOB / /	Sex ☐ M ☐ F ☐	Social Security Number - -	Language ☐ English ☐Other
Race ☐ African American or Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Caucasian or White ☐ Hispanic ☐		
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other		
Address Line 1	Address Line 2	
City	State	Zip
Home Phone	Work Phone	Cell Phone
Email		
Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Disabled ☐ Homemaker ☐ Student ☐ Retired		
Employer	Occupation	
Employer's Address Line 1	Employers Address Line 2	
City	State	Zip

Please Complete if guarantor is other than self.

Guarantor's Last Name	Guarantor's First Name		
DOB / /	Sex ☐ M ☐ F	Social Security Number - -	Patient's Relationship to the Guarantor	Phone

Emergency Contact Information.

Emergency Contact's Last Name	Emergency Contact's First Name
Patient's relationship to the Emergency Contact	Phone

Insurance Information. *A separate form is required for worker's compensation or automobile liability*.

Please bring insurance cards & ID to your appointment and you can ***skip*** this field.

Primary Insurance Company Name			
ID#		Group#	
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	
Secondary Insurance Company Name			
ID#		Group #	
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	

How did you hear about our practice?_____

The Western Ontario and McMaster Universities Osteoarthritis Index

(WOMAC)

Name:_____ Date:_____

Instructions: Please rate the activities in each category according to the following scale of difficulty: 0 = None, 1 = Slight, 2 = Moderate, 3 = Very, 4 = Extremely

Circle **one number** for each activity

Pain	1. Walking	0	1	2	3	4
	2. Stair Climbing	0	1	2	3	4
	3. Nocturnal	0	1	2	3	4
	4. Rest	0	1	2	3	4
	5. Weight bearing	0	1	2	3	4
Stiffness	1. Morning stiffness	0	1	2	3	4
	2. Stiffness occurring later in the day	0	1	2	3	4
Physical Function	1. Descending stairs	0	1	2	3	4
	2. Ascending stairs	0	1	2	3	4
	3. Rising from sitting	0	1	2	3	4
	4. Standing	0	1	2	3	4
	5. Bending to floor	0	1	2	3	4
	6. Walking on flat surface	0	1	2	3	4
	7. Getting in / out of car	0	1	2	3	4
	8. Going shopping	0	1	2	3	4
	9. Putting on socks	0	1	2	3	4
	10. Lying in bed	0	1	2	3	4
	11. Taking off socks	0	1	2	3	4
	12. Rising from bed	0	1	2	3	4
	13. Getting in/out of bath	0	1	2	3	4
	14. Sitting	0	1	2	3	4
	15. Getting on/off toilet	0	1	2	3	4
	16. Heavy domestic duties	0	1	2	3	4
	17. Light domestic duties	0	1	2	3	4

Total Score: _____ / 96 = _____%

Comments / Interpretation (to be completed by therapist only):

Academic Pain & Spine

3070 Bristol Pike, Building 2 – Suite 130, Bensalem PA 19020. Tel 267-282-6680. Fax: 267-282-6677

Name: _____ Date: _____

Height: _____ Weight: _____

1. Are you experiencing pain in the ☐left knee, ☐right knee or ☐both knees?
2. Frequency of Symptoms: ☐ Constant ☐ Frequent ☐ Occasional ☐ Infrequent
3. Is your knee pain a result of an accident or injury that you incurred? ☐Yes or ☐No
4. Have you had any recent falls? **☐Yes or ☐No** – When _____.
5. Have you ever been diagnosed with arthritis of the knees or any type of osteoarthritis? ☐Yes or ☐No.
6. Are you experiencing any ☐ numbness, ☐tingling, ☐burning sensation, ☐ sharpness, ☐ shooting or ☐ radiating with the knee pain?
7. Have you ever experienced any buckling of the knees upon walking? **☐Yes or ☐No**
8. Does your current pain interfere with your ability to sleep well at night? **☐Yes or ☐No**
9. Does your current knee pain affect your quality of life? For example, does it prevent you from attending certain events or engaging in any physical activity? **☐Yes** or **☐No**. Please explain _____.
10. Have you attempted to lose weight because of the pain**? ☐Yes or ☐No**. If you have lost weight recently, how much have you lost, and has it helped to improve your pain symptoms**? ☐Yes or ☐No** _____.
11. Do you exercise? ☐ 5-7 x/weekly ☐ 3-4 x/weekly ☐ 1-2 x/weekly ☐ Occasionally ☐ None
12. Do you currently use assistive devices for ambulation? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches
13. Have you been fitted for a knee brace in the last 3 years? ☐Yes or ☐No
14. Have you had any X-Rays or MRIs done on your knees? ☐Yes or ☐No. If so, (○X-ray / ○MRI) where _____ _____ and when_____?
15. Have you ever had any knee surgeries? ☐Yes or ☐No. If yes, when was your last surgery? _____.
16. Have you ever had any knee injections? ☐Yes or ☐No- If yes, when was your last injection and by whom? _____.
17. If yes, name of injection and how many? _____.
18. Have you completed any Physical Therapy Programs? **☐Yes or ☐No.** If yes, within the last 6 months? **☐Yes or ☐No**
19. Have you used ○hot or ○cold therapies, ○PRP, ○Shockwave or ○Ablation to help with the pain? Did it help? _____.
20. Are you currently using opioids (pain medication) to assist with the pain? **☐Yes or ☐No**- If yes, how long have you been taking the medications? _____. If you do not use prescribed pain medication, what kind of medication do you use? _____
21. Do you experience any pain relief from the oral medications that you take? **☐Yes or ☐No**

Patient Health History Form

Name: _____ **Date:** _____
Primary Care Physician: _____ **DOB:** _____

Chief Complaint: What is the reason for your visit today (please describe problem in detail): _____

_____

_____

_____

Past Medical History: Please check all that apply to you:

- ❑ Arthritis
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Heart problems
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Psychiatric disease
- ❑ Stroke
- ❑ Thyroid
- ❑ Other: _____

Previous Surgeries: Please list past surgeries with approximate date: _____

_____

_____

_____

Serious Injury: Please describe any serious injuries you have had: _____

_____

Medications: Please list any medications you are taking with dose and frequency:

Drug	***Dose/Frequency***

Allergies: please list any allergies that you have _____

_____

Do you drink alcohol? ❑Yes ❑No If yes, how much/week? _____
Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day? _____ ☐ Never smoked
Do you consume caffeine? ❑Yes ❑No If yes, how many cups/week? _____
Do you use recreation drugs? ❑Yes ❑No If yes, what type and frequency? _____
Are you on a special diet? ❑Yes ❑No If yes, please describe? _____
Does your work activities mostly involve (circle) Sitting Standing Light Labor Heavy Labor N/A

Family History: Do you know of any blood relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Brain Tumor
- ❑ Cancer, Type:
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Arthritis
- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Comments:

Patient Health History Form

As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health
- ❑ Good general health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever/chills

Allergy
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever
- ❑ Other: _____
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Painful chewing
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ None
- ❑ Other: _____

Eyes
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Other: _____
- ❑ None

Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other: _____
- ❑ None

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: #pregnancies_____ #miscarriages_____
- ❑ Female: vaginal discharge
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Male: testicle pain
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention/ incontinence
- ❑ Other: _____
- ❑ None

Heart and Lungs
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Other: _____
- ❑ None

Muscles/Joints/Bones
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Black outs/loss of consciousness
- ❑ Difficulty speaking
- ❑ Difficulty walking
- ❑ Facial drooping
- ❑ Headaches
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines
- ❑ Mini stroke
- ❑ Neuropathy
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Other: _____
- ❑ None

Are you? ❑ right handed ❑ left handed ❑ Both

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Other: _____
- ❑ None

Pulmonary
- ❑ Asthma
- ❑ Blood in cough
- ❑ Cancer
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Color changes
- ❑ Other: _____
- ❑ None

Sleep
- ❑ Snoring
- ❑ Sleepwalking
- ❑ Nightmares

Do you sleep well? ❑Yes ❑No
Do you feel rested when you wake? ❑Yes ❑No
Do you fall asleep during the day? ❑Yes ❑No

Patient Signature: _____ Date:_____

Academic Pain & Spine

In order to assure that your care is coordinated with all of your physicians, please provide us with the names addresses and/or phone numbers of those physicians.

Referring Doctor:

Name: _____

Address: _____

Phone: _____

Primary Care Physician:

Name: _____

Address: _____

Phone: _____

Cardiologist:

Name: _____

Address: _____

Phone: _____

Orthopedist:

Name: _____

Address: _____

Phone: _____

Other:

Name: _____

Address: _____

Phone: _____

Academic Pain & Spine

Pharmacy Information

Pharmacy Plan/Benefit Information:

_____

_____

Pharmacy Name/Location: (i.e. CVS, Walgreens, etc.)

_____

_____

Laboratory/Radiology Information

Are your Laboratory and Radiology studies capitated to specific performing location? ☐ Y ☐ N

Radiology/Imaging Center: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Laboratory: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Academic Pain & Spine

HIPAA COMPLIANCE PRIVACY LAWS

Due to HIPAA Compliance Privacy Laws of the Federal Government,it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers:

Home Phone Yes / No

Cell Phone Yes / No

May we contact you at your place of employment? Yes / No If yes: Work Phone: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information , surgical and billing)? Yes / No

If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Is this person your Power of Attorney for medical purposes? Yes / No

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Is this person your Power of Attorney for medical purposes? Yes / No

I hereby authorize Academic Pain & Spine to obtain or release any and all pertinent information regarding my medical care as needed, to assist in my ongoing treatment to or from other healthcare providers, laboratories, radiology facilities or other institutions. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL REVOKED.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues stated above. I have reviewed the Academic Pain & Spine Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed By: _____

Academic Pain & Spine

PATIENT INFORMATION PACKET

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS: _____
Street City State Zip

TELEPHONE: CELL:_____ OTHER:_____

SSN: XXX-XX-_____ E-Mail ADDRESS_____

CONSENT FOR EVALUATION AND TREATMENT

Consent is hereby voluntarily given for medical evaluation and treatment as may be necessary for the opinion of the examining physician.

Signature: _____ Date: _____

AUTHORIZATION FOR DIRECT PAYMENT

The undersigned hereby authorizes payment directly to Academic Pain & Spine upon receipt of the itemized statement for services rendered to the patient benefits herein specified and otherwise payable to the undersigned, but is not to exceed the physician's regular charge for this service. (**In layman's terms, this says that you are giving the insurance company permission to pay us directly**.)

Signature:_____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION, MEDICAL AND PHARMACEUTICAL

I hereby authorize Academic Pain & Spine to release and/or obtain any necessary information related to my health insrunce, medical or pharmaceutical record as to be determined by the treating Medical Staff.

Signature:_____ Date: _____

Academic Pain & Spine

3070 Bristol Pike Bldg. 2-130 Bensalem, PA 19020, P:267-282-6680 F: 267-282-6677

ALL patients must complete the "Patient Information" form before seeing any physician in this office.

YOU are responsible for obtaining any necessary referrals from your PCP. Anyone who does NOT have their necessary referral will be responsible for payment in full at the time of service or will be rescheduled. Co-payments MUST be paid upon arrival in the office.

AUTO ACCIDENTS/WORKMAN'S COMPENSATION: ALL information regarding the insurance company, policy or claim numbers and the agent/case worker MUST be received in this office 48 hours prior to your visit so that we can confirm coverage.

REGARDING INSURANCE: In most cases, insurance is a contract between YOU and the INSURANCE CARRIER. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges etc, other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT.**

PAYMENTS FOR SERVICE PERFORMED: Our office accepts cash, check, Visa, MasterCard and American Express. All payments are expected at the time of service and any outstanding balances are due within 30 DAYS, unless prior arrangements have been made with the Billing Department. All balances that reach 121 DAYS past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future service.

MISSED APPOINTMENTS: We require 24-hour notice for cancellations. **You will be charged $35.00 for any missed (without 24-hour notice) appointments.** Three occurrences will result in dismissal from the office. Please help us to serve you better by keeping your scheduled appointments.

RETURNED CHECKS: A fee of **$35.00** will be charged for any checks returned to our office.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for charges to my account for ALL professional services rendered to me. I have read ALL of the information given to me and have completed all answers. I certify that this information is true and correct to the best of my knowledge. I will notify BAC Medical, PLLC of any and all changes in my health status or personal information.

Signed:_____

Date:_____

Academic Pain & Spine

Our "No-Cost, No-Obligation" Consultation

We are one of less than 50 healthcare clinics nationwide licensed to offer *The Advanced Arthritis Relief Protocol*™. The AARP program is a unique approach to the non-surgical treatment of Osteoarthritis of the Knee & Shoulder. Utilizing a variety of state-of-the-art medical devices such as digital x-ray, video fluoroscopy, custom engineered knee unloading braces, and more we are able to leverage the latest medical devices to assist in your treatment and care. At BAC Medical/Academic Pain & Spine, we strive to help our patients avoid surgery and regain their optimum function and quality of life.

Because of the unique nature of our facility and our treatment programs we offer a "No-Cost, No-Obligation" Consultation in which you can learn more about us, and we can better understand your condition and healthcare goals. Your consultation today will consist of:

- An explanation of our unique treatment protocol
- The ability for you to ask questions about your health related issues
- Tour of our facility
- A general opinion as to the ability of the services provided at this facility to possibly help you with your healthcare needs

Once you have received the above and we feel you are a candidate for our unique approach to your healthcare needs, the "No-Cost, No-Obligation" Consultation has ended. In order for you to then become a patient and receive care at our facility, a full examination by the treating clinician will be performed. The full exam and any treatment you may have at that time, including x-ray or other diagnostic tests as deemed necessary by the clinician will be billed to your insurance company.

By signing below you are acknowledging that you have received the "No-Cost, No-Obligation" Consultation and have expressed the desire to become a patient and understand the examination, treatment, and any diagnostics rendered at this point on this day, will be billed to your insurance company.

_____ _____

Patient Signature Date