

California NeuroInstitute, Inc.
Premier Brain & Spine Institute, Inc.

(All information MUST be completed in order to bill your insurance company)

Patient Name Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Patient Social Security: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

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

Email: _____

Marital Status (Circle One): Married Single Divorced Widowed Separated

Sex (Circle One): Male Female

Primary Language Spoken: _____

Ethnicity (Circle one): Hispanic/Latin American Not Hispanic or Latino Other Refuse to Report

Race: (Circle all that apply) American Indian or Alaska Native Asian Native Hawaiian or Other Pacific

White Black or African American Hispanic Other Race Other Pacific Islander Refuse to Report

Employer: _____

Person to notify in an Emergency: _____ Relation: _____

Phone number: _____

Preferred Pharmacy: Name: _____ Phone Number: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance Company (Please Provide Copy of Card) : _____

Subscriber (if other than patient)

Last Name: _____ First: _____ MI: _____

Subscriber's Birth date: _____ Social Security Number: _____

Subscriber's Employer : _____

Subscriber's Identification Number: _____

Group Number: _____

Relationship to Patient: _____

I understand that I am liable for expenses incurred which are not covered under my plan. I understand that all co-payment, deductibles and/ or non covered services are to be paid in full at the time of service. I hereby authorize the release of any information to my insurance company necessary claims. I hereby authorize my insurance company to make payments directly to the physician. I have read and agree to the policies and will abide by them.

Signed: _____ Date: _____

Reason for today's visit:

Is this the result of a specific injury or accident? Yes NO

Are you involved in litigation regarding this condition? Yes NO

Date of accident: _____ Type of accident: _____

It is important for us to communicate with your physician about the result of your evaluation. Please provide the names and **full addresses** of all your individuals authorized to receive reports from us. Please also sign the space below to indicate your consent to release your medical information to these individuals.

If you wish to revoke your authorization to send copies of this evaluation and subsequent visits to any or all individuals listed below, please send a written letter to the clinic revoking consents to release this information and specify which individuals you are referring to.

1. Referring Physician: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

2. Primary Care Physician: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

3. Name: _____ Indicate primary care or subspecialty: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

4. Name: _____ Indicate primary care or subspecialty: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

Past Medical History:

Have you ever been **diagnosed** with any of the following conditions or had any of the procedures listed below? Circle Yes or No. If yes, please give an explanation.

System	Patient Comments	Physician Comment
<p><u>CARDIOVASCULAR</u> Atrial fibrillation Blood clotting disorder Carotid artery disorder Congestive heart failure Elevated cholesterol Heart murmur Heart attack/angina Heart surgery/angioplasty High blood pressure Prosthetic/artificial heart value Blockage of arm or leg blood vessels</p>	<p>YES NO YES NO YES NO YES NO Level _____ Date _____ YES NO YES NO YES NO YES NO YES NO YES NO YES NO</p>	
<p><u>GASTROINTESTINAL/ GENITOURINARY/RESPISTORY</u> Stomach ulcers Liver disease/hepatitis Kidney/bladder disease Lung disease Tuberculosis Asthma COPD</p>	<p>YES NO YES NO YES NO YES NO YES NO YES NO YES NO</p>	
<p><u>NEUROLOGICAL</u> Brain tumor Convulsions/seizure disorder/epilepsy Head injury Migraine headaches Parkinson's disease Stroke or TIA Nerve or muscle disease Other neurological disease</p>	<p>YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO</p>	
<p><u>OTHER</u> Alcohol dependency Cancer Diabetes Drug abuse Immune system disorder Thyroid disease Toxic exposure Sexually transmitted disease</p>	<p>YES NO YES NO Type: _____ YES NO YES NO YES NO YES NO YES NO YES NO</p>	

Other Medical Problems/History: (Please list all medical conditions not listed above)

Previous Operations/Hospitalizations

Date	Hospital	Problem/Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications

Please list any medication (prescriptions and non-prescription) you are currently taking (including vitamins & aspirin)

Medications	Dosage	Number taken daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List of Herbal medications & Vitamins:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any blood thinners? (Coumadin, Warfarin, Plavix, Aspirin, etc.) Yes No
Please list, including dosage: _____

Allergy History

Have you ever had an allergic reaction to any medication? YES NO if yes, please list medication & reaction.

Are you allergic to latex, x-ray dye or iodine? YES NO If yes, please explain? _____

Other Treatment

Please list other recent treatment for pain other medical condition. (e.g., physical therapy, acupuncture, hypnosis, psychiatric counseling, etc.) _____

Social History

Birthplace: _____ Highest grade completed in school: _____

Are you currently working? YES NO

Employer: _____

Occupation: _____

Who currently lives with you? _____

Have you ever smoked cigarettes? YES NO

If yes, how much do you currently smoke per day? None 1/2 pack 1 pack >1 pack

If you previously smoked, how long ago did you quit? <1 yr. 1-5 yrs. >5 yrs.

How many years did you smoke? _____

Have you had significant exposure to: Pesticides? YES NO Toxic Waste? Yes NO

Do you drink alcohol? YES NO Type: _____

How often/much do you drink alcohol? _____

Do you exercise? YES NO

If yes how much? Rarely Occasionally >3 times per week

Family History

(Please Circle)

Family Members

Age (or age at death):

Sex:

Living:

Medical Problems:

Grandparents –	Paternal:	_____	M	F	Yes	No	_____
	Paternal:	_____	M	F	Yes	No	_____
	Maternal:	_____	M	F	Yes	No	_____
	Maternal:	_____	M	F	Yes	No	_____
	Father:	_____			Yes	No	_____
	Mother:	_____			Yes	No	_____
	Siblings:	_____	M	F	Yes	No	_____
		_____	M	F	Yes	No	_____
		_____	M	F	Yes	No	_____
		_____	M	F	Yes	No	_____
Children:	_____	M	F	Yes	No	_____	
	_____	M	F	Yes	No	_____	
	_____	M	F	Yes	No	_____	

PAIN SCALE

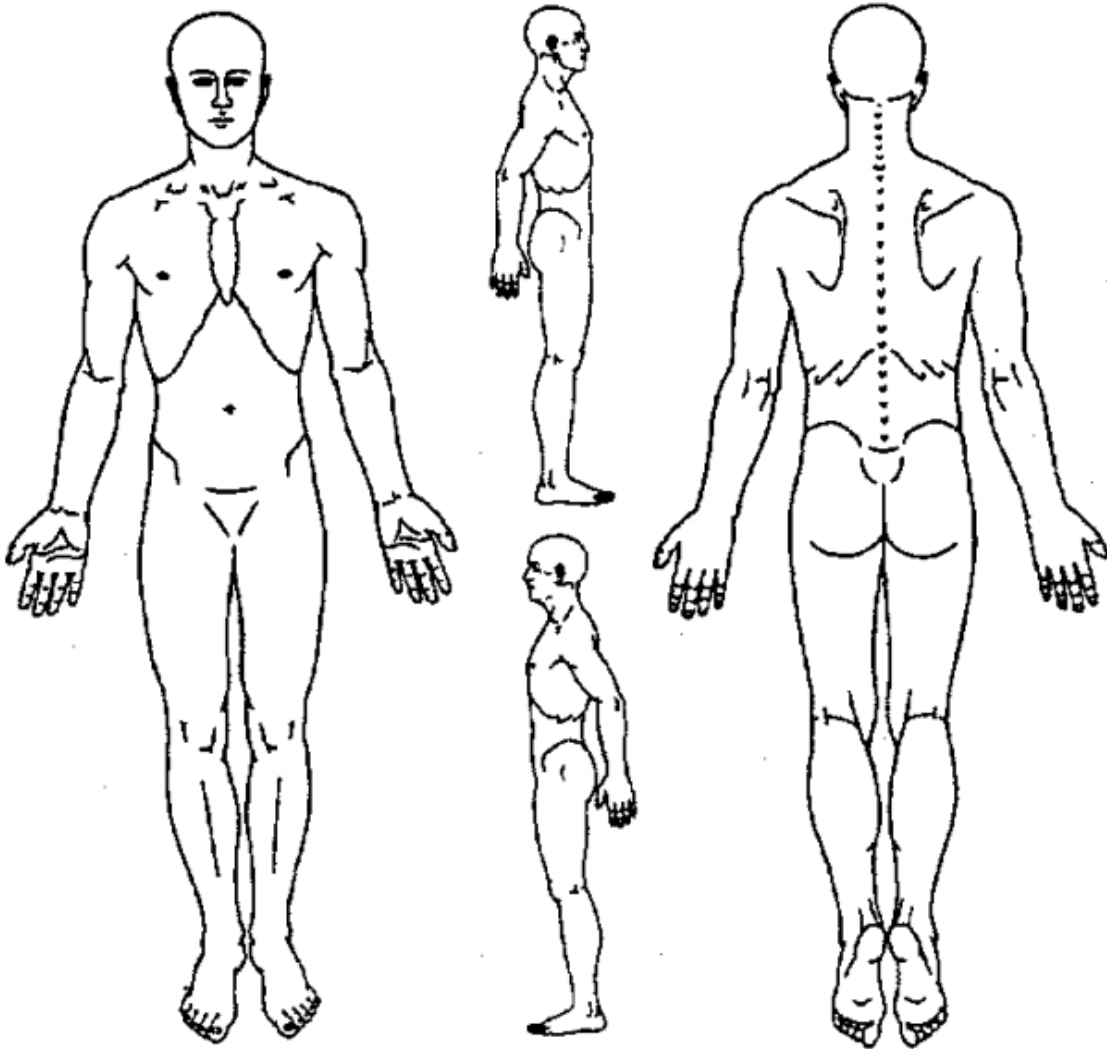
Rate the severity of your pain by checking one box on the following scale.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

- Key: A – ACHE B – BURNING N – NUMBNESS
P – PINS & NEEDLES S – STABBING O - OTHER



If **Other** please explain?

Review of Systems: Have you experienced any of the following symptoms? Please circle yes or no.

<u>ALLERGY/IMMUNOLOGY</u>	<u><i>Circle One</i></u>	<u>MUSCULOSKELETAL</u>	<u><i>Circle One</i></u>
Low resistance to infection	YES NO	Joint swelling	YES NO
Environmental allergies	YES NO	Difficulty walking	YES NO
<u>CARDIOVASCULAR</u>		<u>NEUROLOGICAL</u>	
Chest pain or angina	YES NO	Headaches	YES NO
Irregular heart rhythm	YES NO	Numbness/tingling sensation	YES NO
<u>CONSTITUTIONAL</u>		Weakness or paralysis	YES NO
Recent weight change	YES NO	Convulsions or seizures	YES NO
Good general health lately	YES NO	Change in memory/concentration	YES NO
Recurrent fevers, chills, sweats	YES NO	Loss or blurry vision/double vision	YES NO
Extreme fatigue	YES NO	Black outs/dizziness	YES NO
Frequent nausea, vomiting	YES NO	Memory loss or confusion	YES NO
Difficulty sleeping	YES NO	Other neurological problems	YES NO
<u>EARS, NOSE, MOUTH, THROAT</u>		<u>PAIN</u>	
Change in hearing	YES NO	Joint stiffness or pain	YES NO
Ringing in the ears	YES NO	Muscle pain	YES NO
Recent nose bleeds	YES NO	Neck pain	YES NO
Chronic sinus problems	YES NO	Back pain	YES NO
Voice changes	YES NO	Other pain (please specify)	YES NO
<u>EYES</u>		<u>PSYCHIATRIC</u>	
Change in vision	YES NO	Nervousness	YES NO
Glaucoma	YES NO	Depression	YES NO
<u>ENDOCRINE</u>		Other	YES NO
Heat or cold intolerance	YES NO	<u>RESPIRATORY</u>	
Excess thirst or urination	YES NO	Breathing problems/shortness of breath	YES NO
<u>GASTROINTESTINAL</u>		Coughing up blood	YES NO
Change in appetite	YES NO	Chronic cough	YES NO
Severe heart burn	YES NO		
Vomiting blood	YES NO		
Frequent diarrhea	YES NO		
Constipation	YES NO		
Black or bloody stools	YES NO		
Abdominal pain	YES NO		
<u>GENITOURINARY</u>			
Blood in urine	YES NO		
Burning with urination	YES NO		
Difficult/frequent urination	YES NO		
Lack of bladder control	YES NO		
Sexually transmitted disease	YES NO		
Change in sexual function	YES NO		
<u>HEMATOLOGICAL/LYMPHATIC</u>			
Easy bruising	YES NO		
Frequent bleeding	YES NO		
Enlarged lymph nodes	YES NO		
<u>INTEGUMENTARY (SKIN & BREAST)</u>			
Unusual or prolonged rashes	YES NO		
Breast pain or lump	YES NO		
Change in hair or nails	YES NO		

Please read this document carefully.

California NeuroInstitute/Premier Brain & Spine Institute

requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. **TERM OF AGREEMENT.** I understand that the terms and conditions in this outpatient agreement will remain in effect for one year from the date of signature and that I will be asked to sign this agreement annually. I understand I will be asked to confirm that my demographic and insurance information is correct at each clinic visit. If my insurance or demographics information has changed, I will inform the clinic staff.
2. **MEDICAL CONSENT.** I, the undersigned, consent to the general treatment and procedures that may be limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I also authorized California NeuroInstitute/Premier Brain & Spine Institute to use and/or dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during an operation, procedure or treatment, for research that maybe conducted by California NeuroInstitute/Premier Brain & Spine Institute or unaffiliated academic or commercial third parties if allowed under legal requirements and California NeuroInstitute/Premier Brain & Spine Institute policies. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.
3. **PHOTOGRAPHY.** I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for purposes permitted by law. Under specific circumstances, I may be asked for separate consent prior to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment and the use of those pictures, videotapes or electronic reproductions. If the image could be directly used to identify the patient, I will be asked for authorization to use or disclose the image, unless it is for treatment, internal teaching activities, institutionally approved research in specific cases, or limited other activities consistent with applicable privacy laws.
4. **FINANCIAL AGREEMENT.** For the services to be rendered, I agree to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of California NeuroInstitute/Premier Brain & Spine Institute. This includes financial responsibility for all deductibles and co-payment that may be required by the patient's insurance or health plan, including Medicare and Medi-Cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection. I further agree to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, paragraph 6 (Contracted Health Plan Patients and Other Sources) and/or 7 (Assignment of Insurance Benefits will also apply).
5. **Notice Regarding Disclosure of Physician Ownership Interests.**
Please be advised that Edward Rustamzadeh, M.D., holds ownership interest in the following and may refer you to one or more of these services in connection with your care and treatment: Advanced EP Diagnostics, Inc. is a California Professional Corporation which is owned in whole or in part by Edward Rustamzadeh, M.D., and provides Neuromonitoring to patients of Dr. Rustamzadeh. Please note that you have the right to obtain Neuromonitoring services from any provider of your choosing unless your ability to choose the provider of such services is limited by the terms of your health insurance coverage. If you do not wish to obtain Neuromonitoring services from Advanced EP Diagnostics, Inc. please let Dr. Rustamzadeh or his staff know and Premier Brain & Spine Institute, Inc. will endeavor to help seek to refer you to another provider of Neuromonitoring services. By your signature below you acknowledge your understanding that Dr. Rustamzadeh holds an ownership interest in Advanced EP Diagnostics, Inc. and your consent to receiving Neuromonitoring services provided by Advanced EP Diagnostics, Inc.
Dr. Fahd Khan is a shareholder at Spine Sports Surgery Center, LLC in Campbell, CA. Your surgery may be performed at this center, but patients can also elect to have their surgeries performed at multiple local hospitals instead. You will not be treated differently if you choose an alternative facility. Dr Khan would be happy to discuss this with you if you have any concerns.

6. **CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.** I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which California NeuroInstitute/Premier Brain & Spine Institute contracts, or through some other source (e.g., clinical trial sponsor, employer's worker's compensation insurance). I agree to be responsible under paragraph 4 contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other source; (d) for services not covered and/or paid by the patient's health plan or other source to the extent allowed by law or contract.
7. **ASIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** I authorize direct payment to California NeuroInstitute/Premier Brain & Spine Institute of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services at a rate not to exceed the actual institutional and professional charges. I understand and agree that I am financially responsible under paragraph 4 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, I further attest that information given to California NeuroInstitute/Premier Brain & Spine Institute to assist the patient in applying for payment under Medicare or Medi-Cal is correct.

The undersigned certifies that he/she has read both pages of the Terms and Conditions of Services and is the patient or responsible person is duly authorized by or on behalf of the patient to execute and accept its terms.

Patient or Responsible Person Signature

Print Name

Date/Time

Please indicate relationship of person signing this document:

Patient Authorized Consent

Patient with Legal Custody

Legal Guardian/Temporary Legal Guardian

Explain type of guardianship: _____

Person with written Authorization (e.g. Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney)

Explain type of written authorization: _____

Documentation of written authorization received

If interpreted: _____

Interpreter Signature

Print Name

Language

Position/Relationship to patient

Date/Time

FINANCIAL RESPONSIBILITIES AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (4) and, if applicable, Contracted Health Plan and Other Sources (6) and Assignment of Insurance Benefits (7) above.

Financial Responsible Party

Relationship to Patient

Date/Time