INOVA

2PSMHX

Welcome to the Neurosciences Department at Inova. We are committed to making your experience with us as pleasant and stress-free as possible. To enhance our service to you, please fill out this information sheet prior to arriving for your appointment. Let us know if there is anything we can do to improve your visit with us. We would like you to have an excellent experience with us and our team.

Date of Appointment: _____

Age: _____ Sex: ☐ Male ☐ Female Dexterity: ☐ Right Handed ☐ Left Handed

Patient Address: _____

_____

Primary Care Physician: _____

Who referred you to our office? _____

Preferred Pharmacy: _____ (phone): _____

(address): _____

History of Present Illness

Chief Complaint – What is the problem for which you are here today? _____

_____

_____

When and how did this problem begin? _____

_____

_____

What are your symptoms? _____

How long have you had these symptoms? _____

What makes your symptoms better? _____

What make your symptoms worse? _____

Was the problem the result of an accident? ☐ Yes ☐ No

If yes: Date of Accident: _____ / _____ / _____ Briefly describe the nature of the accident: _____

_____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Physician Enterprise

Medical Condition and History – Neurosurgery Spine

CAT # 20911DT / R080320 • PKGS OF 50

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History of Present Illness (continued)

Did this accident happen at work?	☐ Yes	☐ No	☐ Not Applicable
Have you been out of work because of the accident?	☐ Yes	☐ No	☐ Not Applicable
Is this accident part of a legal claim?	☐ Yes	☐ No	☐ Not Applicable
Are you currently on or have you applied for disability?	☐ Yes	☐ No	

Attempted Treatments

Treatments	Not Applicable	**Medications** (check all that apply)		
Anticonvulsants	☐	☐ Lyrica/Pregabalin ☐ Keppra/Levetiracetam	☐ Neurotin/Gabapentin ☐ Other:	☐ Topomax/Topiramate
Antidepressants or anxiolytics	☐	☐ Ativan/Lorazpam ☐ Xanax/Alprazolam	☐ Elavil/Amitriptyline ☐ Other:	☐ Klonopin/Clonazepam
Anti-inflammatory medications	☐	☐ Advil/Ibuprofen ☐ Mobic/Meloxicam ☐ Voltran/Dicolofnac Sodium	☐ Aleve/Naproxen ☐ Naprosyn/Naproxen ☐ Other:	☐ Celebrex/Celecoxib
Oral steroids	☐	☐ Cortisone ☐ Other:	☐ Medrol Dose Pack/MethylPrednisolone	
Muscle relaxants	☐	☐ Flexeril/Cyclobenaprine ☐ Valium/Diazepam	☐ Skelaxin/Metaxalone ☐ Other:	☐ Soma/Carisoprodol
Narcotic medications	☐	☐ Oxycontin/Oxycodone ☐ Tylenol #3/Tylenol-Codeine ☐ Other:	☐ Percocet/OxycodoneHydrochloride ☐ Vicodin/Hydrocodene/Acetaminophen	
Non-narcotic medications	☐	☐ Tylenol/Acetaminophen ☐ Ultram/Tramadol	☐ Ultracet/Acetaminophen Tramadol ☐ Other:	
Other:				

Interventions (check one for each intervention)

Intervention	**Indicate effect of intervention on your condition**			
Acupuncture	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Bedrest	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Brace or corset	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Chiropractic manipulation	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Exercise	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Injections	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Physical Therapy	☐ Better	☐ Worse	☐ Same	☐ Not Applicable
Other:	☐ Better	☐ Worse	☐ Same	☐ Not Applicable

Previous Spine Surgeries ☐ **Not Applicable**

Date	**Location**	**Surgeon**

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Physician Enterprise

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Answer the following section if you have neck, shoulder, or arm pain: ☐ **Not applicable**

On a scale from 0 to 10 (0 being no pain and 10 being the worst pain of your life), how would you rate your:

Neck pain: _____ / _____ (Usually / Today) Right arm pain: _____ / _____ (Usually / Today) Left arm pain: _____ / _____ (Usually / Today) Shoulder pain: _____ / _____ (Usually / Today)

What percentage pain is in your neck versus your shoulder/arms (total 100%):

Neck pain: _____ % versus Shoulders/arm pain: _____ % = 100%

Pain worsens with: _____

Pain improves with: _____

Answer the following section if you have back, hip, or leg pain: ☐ **Not applicable**

On a scale from 0 to 10 (0 being no pain and 10 being the worst pain of your life), how would you rate your:

Low back pain: _____ / _____ (Usually / Today) Right leg pain: _____ / _____ (Usually / Today) Left leg pain: _____ / _____ (Usually / Today) Hip pain: _____ / _____ (Usually / Today)

What percentage pain is in your low back versus your buttocks/hips/legs (total 100%):

Low back pain: _____ % versus Buttocks/hips/legs pain: _____ % = 100%

Pain worsens with: _____

Pain improves with: _____

Answer the following section if you complain of weakness: ☐ **Not applicable**

Where is your weakness? _____

When did your weakness begin? _____

Answer the following section if you complain of sensory symptoms: ☐ **Not applicable**

(check all that apply): ☐ Numbness ☐ Pins & Needles ☐ Tingling ☐ Burning ☐ Other: _____

Where are your sensory symptoms? _____

When did your sensory symptoms begin? _____

Do you have hand clumsiness? ☐ Yes ☐ No

Do you have difficulty with balance? ☐ Yes ☐ No

Do you have difficulty walking long distances? ☐ Yes ☐ No

How far can you walk before you must stop? _____

Why must you stop? ☐ Low back pain ☐ Leg pain ☐ Leg numbness ☐ Leg weakness ☐ Other: _____

Do you have any bowel or bladder dysfunction? ☐ Yes ☐ No

Do you have any difficulty with sexual functioning? ☐ Yes ☐ No

Is your sleep affected by your condition? ☐ Yes ☐ No

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Physician Enterprise

Medical Condition and History – Neurosurgery Spine

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Review of Systems

System	Do you currently have, or have you had (check all that apply):
Constitutional	☐ Activity change ☐ Chills ☐ Face swelling ☐ Fatigue ☐ Fever ☐ Sweating
Ear/Nose	☐ Ear ringing ☐ Hearing loss ☐ Nasal discharge ☐ Nose bleed ☐ Postnasal drip
Eyes	☐ Blurry vision ☐ Double vision ☐ Eye discharge ☐ Eye pain ☐ Light sensitivity
Gastrointestinal	☐ Abdominal pain ☐ Bloody stool ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting
General	☐ Appetite change ☐ Headaches ☐ Recent weight gain ☐ Recent weight loss
Genitourinary	☐ Discharge ☐ Frequent urination ☐ Incontinence ☐ Urgency ☐ Urinary retention
Heart	☐ Chest pain or tightness ☐ Fainting ☐ Palpitations ☐ Other heart trouble
Hematologic	☐ Easy bleeding ☐ Easy bruising ☐ Swollen nodes
Lungs	☐ Chronic cough ☐ Cough ☐ Shortness of breath ☐ Sleep apnea ☐ Wheezing
Musculoskeletal	☐ Fractures ☐ Joint pain ☐ Joint swelling ☐ Leg swelling ☐ Muscle pain
Neurologic	☐ Dizziness ☐ Memory loss ☐ Seizures ☐ Speech difficulty ☐ Tremors
Psychiatric	☐ Anxiety ☐ Depression ☐ Excessive stress ☐ Hallucinations ☐ Suicidal thoughts
Skin	☐ Color change ☐ Enlarged glands ☐ Infection ☐ Moles or skin lesions ☐ Rash
Additional Comments:	

Allergies (check "No Known Allergies" or indicate allergies below): ☐ No Known Allergies

Medical History (check all that apply)

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood transfusion
☐ Cancer
☐ Cataracts
☐ Congestive heart failure
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Gastroesophageal Reflux Disease (GERD)
☐ Glaucoma
☐ Heart murmur
☐ Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)
☐ Hypertension
☐ Kidney disease
☐ Meningitis
☐ Muscle disease
☐ Myocardial infarction
☐ Nerve disease
☐ Osteoporosis
☐ Seizures
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Other: _____

Surgical History (check all that apply)

☐ Appendectomy
☐ Brain surgery
☐ Coronary Artery Bypass Graft (CABG)/Heart bypass surgery
☐ Carotid endartectomy
☐ Cholecystectomy
☐ Colon surgery
☐ Cesarean section
☐ Hernia repair surgery
☐ Hysterectomy
☐ Joint replacement surgery
☐ Prostate surgery
☐ Small intestine surgery
☐ Spine surgery
☐ Tubal ligation
☐ Valve replacement
☐ Other: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Physician Enterprise

Medical Condition and History – Neurosurgery Spine

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Medications – If you need more space, please provide a list of your medications with this form

Medication	Dose	Frequency	Medication	Dose	Frequency

Family Medical History

_____

_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Domestic partner ☐ Divorced ☐ Widowed ☐ Other: _____

Occupation: _____

Number of Children: _____ Children live with: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ Never have

If yes, what kind(s): ☐ Wine ☐ Beer ☐ Liquor

How many per week? _____

Do you smoke cigarettes or used tobacco products? ☐ Yes ☐ No ☐ Never have

If yes, how many packs per day? _____ How many years? _____

Do you vape? ☐ Yes ☐ No ☐ Never have How many years? _____

If you have quit smoking or using tobacco products, when did you quit? _____

Do you use recreational drugs? ☐ Yes ☐ No ☐ Never have

If yes, what kind(s): ☐ Prescription drugs ☐ Marijuana ☐ Methamphetamine ☐ Cocaine

☐ Heroin ☐ Other: _____

My signature verifies that the information provided is correct to the best of my knowledge.

_____ _____ _____

Patient or Designated Decision Maker (signature) Date Time

_____ _____

If Designated Decision Maker (print name) Relationship

Reviewed by Physician (signature): _____ Date: _____ Time: _____

Physician (print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Physician Enterprise

Medical Condition and History – Neurosurgery Spine

CAT # 20911DT / R080320 • PKGS OF 50

INOVA

1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

Authorization for Claims Payment and Reviews - Ambulatory

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:
I understand that if my insurance carrier or administrator of benefits does not consider any service rendered a covered service or has not authorized these services, they will not pay and I agree to pay for these services. I also understand and acknowledge that in the case of out of plan/network, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing; have had the opportunity to ask questions and have them answered and accept the above conditions and terms; **have read the notice regarding assignment of medical expense benefits for automobile accident patients, if applicable;** and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. I understand and agree this document will remain in effect for my present visit and any future outpatient or physician office visits to Inova, unless specifically rescinded in writing by me.

_____ _____
PATIENT (GUARDIAN, ETC.) DATE / TIME

_____
RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

_____ _____
WITNESS DATE / TIME

Notice: patients are not required to execute this assignment of benefits form. If you do not execute this form, all charges will be billed to you directly instead of to your Insurance Plan.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

INOVA HEALTH SYSTEM

AUTHORIZATION FOR CLAIMS, PAYMENT, AND REVIEWS - AMBULATORY

CAT #20083DT 1PT / R042515 • PKGS OF 25

INOVA®

1HIPAA

I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova's health care operations. The Notice also describes my rights and Inova's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.** I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova's web site listed above to view the most current version.

_____ _____

Patient or Personal Representative (signature) Date Time

_____

Patient or Personal Representative (print name)

_____

Description of Personal Representative's Authority

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R052516
PKGS OF 100

INOVA®

1ROI

The Health Insurance Portability and Accountability Act (HIPAA) **Privacy Rule** gives you the right to request how and where your healthcare provider communicates with you. We invite you to share your preferred place and manner of communication. You may change, update or revoke this information at any time, though it must be done in person. The information on this form will remain in effect for one year. You may revoke it at any time.

Print Name:_____ **Date of Birth:** _____

I prefer to be contacted in the following manner (check all that apply):

☐ **Patient Portal**: MyChart
☐ **Phone Contact:** Use the following numbers to contact me:

Home Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only
Cell Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only
Work Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only

☐ **Written Communication:** ☐ Mail to my home address ☐ Other: _____

☐ **Other:** _____

Preferred Contacts:

We respect your right to indicate who you prefer to involve in your treatment decisions and/or with whom your information is shared. Please note, however, that we may share your information regarding services we have provided with other persons (such as insurance plan) as needed for your care or treatment, and as set forth in our Notice of Privacy Practices.

Please indicate the person (s) you prefer we share your information with below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient (signature): _____ Date: _____ Time: _____

Patient (print name): _____

Parent or Guardian (if patient is a minor or otherwise not competent):

(signature): _____ Date: _____ Time: _____

(print name): _____ Relation to Patient: _____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Medical Group

Patient Record of Disclosure-Preferred Contacts

☐ Specialty (location): _____
☐ Primary (location): _____

CAT # 20749DT/R082819 • PKGS OF 50

INOVA

1HEAR

Inova Staff:
1. **If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.**
2. **A new form should be used at every visit and any time a change in accommodations is requested.**

Name of Person Requesting/Declining Accommodations: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

Do you and/or your companions have any special needs that require accommodations? ☐ **YES (complete boxes A and B)** ☐ **NO (complete box B)**

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing:
☐ Sign language interpreter ☐ Notepad and pen ☐ Speak loudly
☐ Sound amplifier (ex. PockeTalker® or disposable Posey®)
☐ Uses hearing aid(s): ☐ Left ☐ Right ☐ Bilateral
☐ Amplified phone with flasher (if admitted)
☐ Video Remote Interpreter (VRI) (where available)
☐ Other: _____

Vision:
☐ Magnifying sheet ☐ Request an escort
☐ Braille phone ☐ Documents read out loud
☐ Other: _____

Mobility:
☐ Uses service animal ☐ Walking escort
☐ Wheelchair escort ☐ Extra-wide wheelchair escort
☐ Accessible exam table ☐ Accessible weight scale
☐ Other: _____

Speech:
☐ Point-to-Speak cards ☐ Point-to-Speak alphabet ☐ Notepad and pen
☐ Other: _____

Other or Special Instructions: _____

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

☐ Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature)	**Patient/Representative/Companion** (print name)	Date	Time

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other: _____

Staff Witness (signature)	**Staff Witness** (print name)	Date	Time	Contact #	Department

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID# (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova

Americans with Disabilities Act (ADA)/ Special Needs Assessment

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____ ☐ Other: _____

CAT # 20328DT/R022420 • PKGS OF 50

As a patient, you are responsible for: (continued)

- Following the care, service or treatment plan developed for you.
- Understanding that patients may not photograph, videotape, record or film any person or practice on Inova property without prior permission from Inova. This applies to your visitors as well.
- Recognizing that all medications you will take while in the facility will be prescribed by your doctor, dispensed by the facility Pharmacy and administered by a nurse or therapist.
  - Patients may not take their own medications, unless allowed by facility protocol.
  - Patients may not keep medications at their bedside.
- Telling your doctor if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan.
- Providing the facility with accurate contact and billing information.
- Having detailed knowledge of your health insurance coverage including deductibles co-pays and network coverage.
- Being respectful to staff. This applies to your visitors as well.
- Being respectful of other patients and facility property and following facility rules and regulations. This applies to your visitors as well.
- Recognizing that the facility cannot accept responsibility for any personal property.

Notice of Deemed Consent for Infectious Disease Testing:

Virginia Code Section 32.1-45.1 provides that when either a person providing health care or a patient is directly exposed to the bodily fluids of the other in a way that may transmit human immunodeficiency virus (HIV) or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Consent for Treatment:

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care of the care of my minor child or the patient named below.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety. Laboratory tests may include testing for HIV and I understand that I have the right to decline testing for HIV.
- I understand that Inova utilizes an electronic medical record system.
- I authorize the release of my prescription history to my Inova physician from any pharmacy or drug monitoring agency.
- By signing below, I acknowledge and accept the patient rights and responsibilities outlined above and consent to treatment.

Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

Relationship to Patient (if not signed by patient)

Witness (signature)	**Witness** (print name)	Date	Time

Interpreter Information (To be completed by Inova staff, if applicable): ☐ **No Interpreter Required**

☐In person ☐Telephonic ☐Video Interpreter name/ID number (if applicable) _____

☐Patient/Designated Decision Maker was offered and refused interpreter ☐Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova

Patient Rights and Responsibilities

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