JAGANNATHAN NEUROSURGERY

Patient Intake Form

Your appointment has been scheduled on: **DATE:** _____ **TIME:** _____

Your appointment has been scheduled at: **LOCATION:** _____

PLEASE READ THE INFORMATION LISTED BELOW

It is very important that you bring your MRI or CT Myelogram disk(CD) and report to your appointment. The physician needs this information to better help and treat you at your visit.

If you are relying on the facility where you had your scan done or another office to send these directly to our practice, we ask that you call our office 2 days before your scheduled appointment to confirm that the office has received them.

Thank you for your cooperation and thank you for choosing us to serve your health care needs at Jagannathan Neurosurgery Institute.

Every effort will be made to honor your appointment time. Please note, however, that due to the nature of our practice, occasionally there are delays with appointments. We apologize in advance for any inconvenience this may cause you.

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DEMOGRAPHIC INFORMATION

Name: _____ D.O.B: ____/____/_____ Age: ____S.S. #_____
Last First

Address: _____
Number Street City State Zip Code

Cell: (____) _____ Home: (____) _____ Email: _____

Primary Care Physician: _____
Name of physician Location Phone Number

Who Referred You to Our Office? _____
Name Phone Number

Emergency Contact: _____
Name Relationship Phone Number

ADDITIONAL INFORMATION

Sex: Male Female Marital Status: Married Single Widowed Divorced

Are you Pregnant? Yes No Last menstrual period: _____

Race: _____ Primary Language Spoken: _____

Occupation: _____ Employer: _____

Does this visit pertain to a workers' compensation, Auto or a personal injury? Yes No

Date of Injury:_____Claim No.: _____ Adjuster: _____

Adjuster Phone:_____Lawyer: _____ Phone: _____

Is there a lawsuit planned, relating to your problem or injury, whether it be from a Workers Compensation Claim or Motor Vehicle Accident? Yes No

INSURANCE INFORMATION

Primary Insurance: _____ ID: # _____Group: # _____
Primary Card Holder: _____
Name Date of Birth Relationship

Secondary Insurance: _____ ID: # _____ Group: #_____
Secondary Card Holder: _____

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Patient Name: _____

I authorize Jagannathan Neurosurgery to contact me by the following means:

Cell Phone Text Messages Home Phone Regular Mail Email

RELEASE OF INFORMATION TO OTHERS (HIPPA)

I acknowledge that I have received a copy of "Notice of Privacy Practices." _____

Signature of patient/guardian

I authorize Jagannathan Neurosurgery and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release? All information No information whatsoever

Other: _____

To whom can we release this information to?

Name	Phone #	Relationship

TREATMENT CONSENT AND AUTHORIZATION

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

I understand that as part of my healthcare, this organization maintains all health records in accordance with state requirements describing my health history, symptoms, examinations, test results, diagnosis and treatment plans for my future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-□-party payer can verify that billed services were provided.
- A tool for routine healthcare operations including quality care, reviewing the competence of Healthcare professionals.

I hereby authorize Jagannathan Neurosurgery to furnish to any designated attorney or insurance company all information necessary to file a health insurance claim form or to obtain reimbursement. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plans to Jagannathan Neurosurgery.

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Jagannathan Neurosurgery. My signature below authorizes to disclose information such as treatment during hospitalization and/or outpatient care information. The forgoing information is true and correct to the best of my knowledge. I authorize Jagannathan Neurosurgery to provide medical treatment to me in the office and/or in the hospital.

I understand that anesthesia services provided at Jagannathan Neurosurgery are administered and billed separately by providers of Conquest Pain Management, LLC. I understand that if my insurance or any other payer fails to pay for the services rendered by Conquest Pain Management, LLC, I personally guarantee payment. If collection action regarding my outstanding balance occurs I agree to reimburse Conquest Pain Management, LLC for attorney's fees and costs, court costs and prejudgment and any applicable interest.

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DISABILITY

It is the policy of Jagannathan Neurosurgery to grant disability for no more than three months following surgery.

CONSENT TO BE TREATED BY MIDLEVELS INCLUDING PHYSICIAN ASSISTANTS AND/OR NURSE PRACTITIONERS

Jagannathan Neurosurgery may utilize Physician Assistants and/or Nurse Practitioners to assist in the delivery of medical care. Physician Assistants and Nurse Practitioners are not doctors. Physician Assistants and Nurse Practitioners are graduates of a certified training program and are licensed by the State Board. Under the supervision of a physician, Physician Assistants/Nurse Practitioners can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and responsibility for the medical services provided.

A Physician Assistant and/or Nurse Practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic intervention
- Assisting with surgery
- Offering counseling and education
- Writing prescriptions (as permitted by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of a Physician Assistant and/or Nurse Practitioner for my health care needs. I understand that their services are directed by the physician. I understand that at any time I can refuse to see a Physician Assistant and/or Nurse Practitioner and request to see a physician.

_____ _____

Signature of patient/Guardian Date

Patient Name: _____

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Please tell us the reason for your visit: _____

_____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

MEDICATION ALLERGIES

No known drug allergies

No other allergies

Yes I have known drug allergies (please list the drug and reaction)

_____

_____

Yes I have other allergies such as latex, contrast or adhesives (Please list allergy and symptoms)

_____

CURRENT MEDICATIONS

List all current medications you are taking

NAME:	DOSE:	FREQUENCY:	REASON PRESCRIBED:
Example: Benadryl	*25 mg*	*Two capsules a day*	*Allergies*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Dr. Jagannathan only prescribes pain management for post-- operative patients who sign the agreement & informed consent for opioid therapy if deemed a surgical candidate. All other prescriptions will have to be filled by your primary care doctor.

Signature of Patient/Guardian: _____ Date: _____

JAGANNATHAN NEUROSURGERY

Patient Name:

REVIEW OF SYSTEMS AND PAST FAMILY/SOCIAL HISTORY									
Review of Systems: Does the patient currently have any of these issues? Please Circle "yes" or "no"									
Constitutional	Fatigue	No	Yes	Fever/Chills	No	Yes	Weight Loss/Gain	No	Yes
Neurological	Seizures	No	Yes	Dizziness/Vertigo	No	Yes	Headaches	No	Yes
Musculoskeletal	Joint Pain	No	Yes	Back/Neck Pain	No	Yes	Morning Stiffness	No	Yes
Skin	Rash	No	Yes	Ulcers/Lesions	No	Yes			
Pulmonary	Shortness of Breath	No	Yes	Wheezing	No	Yes	Cough	No	Yes
Cardiology	Chest Pain	No	Yes	Palpitations	No	Yes	Irregular Heart Beat	No	Yes
	Swelling	No	Yes						
Gastrointestinal									
Genitourinary	Diarrhea	No	Yes	Nausea/Vomiting	No	Yes	Abdomen pain/blood in stool	No	Yes
Ears/Nose/Eyes	Frequent urination	No	Yes	Painful Urination	No	Yes	Burning with urination	No	Yes
Mouth/Throat	Loss of Hearing	No	Yes	Nasal Drainage	No	Yes	Change in Vision	No	Yes
Hematologic	Sore Throat	No	Yes	Tooth Ache	No	Yes			
Psychiatric	Easy Bleeding	No	Yes	Easy Bruising	No	Yes			
	Anxiety	No	Yes	Depression	No	Yes			

Past Family Social History: Has the patient or family member ever been diagnosed with any of the following medical conditions? Please circle "yes" or "no"

	Family Members		**Patient**		**If yes for patient, Please specify**
Heart Disease	No	Yes	No	Yes	
High Blood Pressure	No	Yes	No	Yes	
Stroke	No	Yes	No	Yes	
Cancer	No	Yes	No	Yes	*Type:
Coagulation Defects	No	Yes	No	Yes	
DVT(Blood Clots)	No	Yes	No	Yes	
Anemia	No	Yes	No	Yes	
Hepatitis	No	Yes	No	Yes	
Diabetes	No	Yes	No	Yes	
Kidney Disease	No	Yes	No	Yes	
Lung Disease/Asthma	No	Yes	No	Yes	

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Patients Name:

	Family	Members	Patient		If yes for patient, Please specify
Heart Attack	No	Yes	No	Yes	
Sleep Apnea	No	Yes	No	Yes	
Stomach Ulcers	No	Yes	No	Yes	
Colitis	No	Yes	No	Yes	
Rheumatoid/Osteoarthritis	No	Yes	No	Yes	
Autoimmune Disease	No	Yes	No	Yes	
Epilepsy or History of Seizures	No	Yes	No	Yes	
Depression/Anxiety	No	Yes	No	Yes	

If you circled "yes" to any of the above are you under treatment for these issues with a physician? No Yes

If so, please list the physician(s) treating you: _____

LIST ANY PRIOR SURGERIES (within past 5 years)	**PRIOR HOSPITALIZATIONS** (within this past year)

Hand Dominance: Right or Left **Height:** _____ **Weight:** _____

Alcohol Intake: (please circle all that applies): Never Socially Daily
Wine Beer Liquor

Smoking History: Have you ever smoked? No Yes If yes, How long ago? _____
Packs/day? _____
Have you ever quit smoking? No Yes If yes when? _____

Blood Products/Transfusions:
Do you have any objections to receiving blood or blood products? No Yes

OTHER HEALTH RELATED ISSUES NOT ALREADY COVERED

_____

_____

PHYSICIAN ONLY

I have reviewed the listed ROS/PFSH/Screening with the patient and noted the positive/negative findings for this visit.

SIGNATURE OF MD: _____ DATE: _____

_____ _____

Signature of patient/Guardian Date

JAGANNATHAN NEUROSURGERY

Patient Name: _____

Tobacco Utilization & Its Impact on Spinal Fusion

The bone is a living tissue dependent on the functions and support provided by the other body systems. When these systems are not able to perform normally, bone is unable to rebuild itself. Tobacco utilization clearly affects a multitude of these systems.

The success of a spinal fusion relies on the ability of the body to heal and grow new bone across the fusion segments of the spine. The screws, rods and plates only act as an internal brace until this fusion occurs. If a fusion does not occur, then these internal bracing technologies will eventually fail due to repetitive stress and metal fatigue – often ending in fracture of these components.

There is continued and growing evidence that tobacco utilization adversely affects spinal surgery:

- Studies have shown that patients who utilize tobacco and undergoing an anterior cervical fusion have and increased rate of failed fusion (up to **47%**) in comparison to patients who do not use tobacco products.
- A similar study involving lumbar fusions suggested risk of failed fusion in up to **40%** (compared to **8%** in patients who do not use tobacco products).

Studies have shown that tobacco utilization is associated with an **increased risk of infection** following any spinal procedure.

- A failure of solid fusion following any spinal fusion procedure is associated with a very poor overall outcome. Repeat operations to address a failed fusion have a **success rate of only 50%.**

There are many other risk factors associated with poor spinal surgical outcomes and fusion rates and these include, but are not limited to, **diabetes, age, gender, chronic steroid medications and osteoporosis**. Therefore, the addition of tobacco utilization in patients with other risk factors will further increase the overall risk of a poor outcome in these cases.

In addition, the risk of a failed fusion is proportional to the number of fused spinal segments in each operation and therefore all the above issues are extremely important regarding more extensive (multi-- -level) spinal fusions. Clearly, tobacco utilization is extremely detrimental to the overall success of a spinal fusion and patients should make every effort to stop smoking prior to any spinal procedure.

Patients are therefore strongly encouraged to discuss cessation medications and other options with their primary care physicians and to consider delay of elective fusion procedures if necessary.

I have read and fully understand the risks listed on this page and, by signing below, I agree that all my relevant questions have been answered to my satisfaction regarding these risks.

Patient/Guardian Signature: _____ Date: _____

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Random UDS (Urine Drug Testing)

Jagannathan Neurosurgery utilizes a third-□-party facility to pick up, drop off and process all specimens obtained in our office for urine drug testing. **We DO NOT TEST SUBMITTED SPECIMENS IN OUR OFFICE**. The specimens are picked up by a third-- -party courier and delivered to their lab for testing. **Results are usually received by our office 24 hours after the submitted specimen is received by their lab**.

If you do not live in this area and are unable to travel to this office for random urine drug screening when our office notifies you, you may choose to have your random UDS done at another facility. If you choose to have your random UDS done at another facility, please be aware that **results are usually received by our office within 48-□72 hours after specimen is submitted**.

Refer to our "Pain Medication Refill Policy" and be advised that it is the patient's responsibility to notify this office in enough time to allow for a possible urine drug screen (requested and performed at random), processing of that specimen, results to be received by our office and the prescription to be mailed to you. Please refer to "Pain Agreement & Informed Consent for Opioid Therapy" #12 for consequences of refusal to comply or positive results of illegal drugs and/or misuse of prescription medications.

Patients that utilize Marijuana – Although the use of Marijuana while being treated with pain management through Jagannathan Neurosurgery is prohibited (refer to our Marijuana policy), patients who used medical or recreational marijuana prior to being deemed a surgical candidate MUST submit to UDS testing EACH TIME they require a pain medication prescription refill.

I have read the above information (or it has been read to me) and all my relevant questions have been answered to my satisfaction.

_____ _____

Patient's signature Date

_____

Patient's printed name

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Medical Marijuana Policy

I. If the patient chooses to utilize post-□-operative pain management through Jagannathan Neurosurgical Institute, he/she must discontinue using marijuana (either medicinal or recreational) prior to surgery.

II. All patients who use marijuana, even legally prescribed medical marijuana, must submit a urine specimen for urine drug screen, and our staff must receive results negative for THC, before the patient can/will receive any required prescription refills for pain management. This urine drug test will be required prior to **every refill** and will **NOT** be at random.

III. If results received from urine drug screen, prior to pain medication prescription refill, reflect a positive THC result, the patient will be immediately discharged from pain management through Jagannathan Neurosurgery and will not receive any further prescription(s) through our office.

(Please refer to prescription refill policy and remember to alert staff in timely manner for a prescription refill to allow for test results to be received and prescription **mailed to you**)

By signing this policy, I understand that if I am deemed a surgical candidate I must immediately discontinue Marijuana use (even legally prescribed medical marijuana) pre-□operatively and will strictly adhere to all agreements within the medical marijuana policy as well as the opioid therapy contract to receive post-□operative pain management through Jagannathan Neurosurgery. I have read the above information (or it has been read to me) and all my relevant questions have been answered to my satisfaction.

Patient Printed Name: _____

Patient Signature: _____ Date: _____
Date

AKNOWLEDGEMENT OF PATIENT PRIVACY

By signing this form, you acknowledge receipt or review of the Notice of Privacy Practices of Jagannathan Neurosurgery. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read the entire document which is available in printed form and on our website.

Our Notice of Privacy is subject to change and we have reserved the right to change it. If we change our notice, you may obtain a copy of the revised document by contacting our office or you may review the updated document on our website.

If you have any questions about our Notice of Privacy Practices, please contact us directly at:

Jagannathan Neurosurgery

3290 West Big Beaver Road Troy, MI 48084 (P) 248-- -792-- -6527 (F) 248-- -792-- -9106	6255 Inkster Rd, Suite 206 Garden City, MI 48135 (P) 248-- -792-- -6527 (F) 248-- -792-- -9106	2333 Progress St. West Branch, MI 48661 (P) 989-- -701-- -2538 (F) 989-- -701-- -2540	309 W. 12 Ave. Suite 102 Sault Sainte Marie, MI 49783 (P) 906-- -253-- -1341 (F) 906-- -253-- -1331

I acknowledge receipt of the Notice of Privacy Practices of Jagannathan Neurosurgery.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

OR

I acknowledge receipt of the Notice of Privacy Practices of Jagannathan Neurosurgery on behalf of the patient:

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

Patient Agreement & Informed Consent for Opioid Therapy

I, _____, understand that my providers at Jagannathan Neurosurgery may initiate narcotic medication management. I have been informed and clearly understand the following issues regarding the treatment of pain with these medications, as well as our analgesic and sedative medications. I clearly understand that no pain medication refills may be called-□-in on Saturday, Sunday or Government Holidays. I understand that it is my responsibility to contact the office and request pain medications to allow enough time for the prescription request to be processed so that I do not run out of medication before the office processes my request. If it is an emergent situation, I agree to proceed to the emergency room for evaluation and treatment. I am fully aware that failure to abide by any of these conditions will be considered a breach of contract and may result in the termination of the patient-□-physician relationship.

1. **Sole providers:** The physicians at Jagannathan Neurosurgery will be the only providers to write narcotic prescriptions for a period of 12 weeks (3 months) following surgical procedures. **I will not obtain or accept** prescriptions for narcotic medications from any physicians outside of Jagannathan Neurosurgery during this period. Nor will I take medications prescribed to someone else or allow someone else to take medications prescribed to me. Prior to surgery, and after 12 weeks following my surgery, my narcotic pain medication management will be managed by my primary physician or pain specialist.
2. **Safekeeping:** I understand that I am responsible for the safekeeping of my prescriptions and medications. If I should lose them or if they are stolen, I will not be given replacements and I could experience the symptoms of withdrawal and/or pain to surgical site.
3. **Pharmacy:** I agree to use only one pharmacy in my town of residence.
4. **Medication Dosages:** I understand that my physician will prescribe my medications in dosages that he/she deems necessary. **I will not adjust the amount of medications I take without first contacting the prescribing physician.** If I should adjust the medication I am taking, and run out early, I will **not** be given additional medications to "get me through" until my next scheduled appointment. I understand that increasing my dose without medical supervision could lead to drug overdose, causing severe sedation, respiratory depression, cardiac arrest and death.
5. **Side Effects:** I am to notify my provider of any adverse effects that I might experience while taking narcotic medications. Adverse effects include but are not limited to: over-□-sedation, nausea, vomiting, constipation, euphoria, dysphoria, dizziness, sweating, itching, rashes, swelling, difficulty breathing, dysuria, dry mouth, insomnia, disorientation, decreased sex drive, and potency and abnormal jerking motions in the arms and legs. While on narcotic medications, I will not operate a ***motor vehicle*** of any type or any other form of machinery that could cause injury to others or myself.
6. **Physical Dependence:** It is clearly understood that the use of these medications may result in physical dependence.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

JAGANNATHAN NEUROSURGERY

SUMMARY NOTICE OF PRIVACY PRACTICES

Jagannathan Neurosurgery is required by Federal law to provide a Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under Federal and State privacy laws. This is a summary of that Notice. The full Notice will be provided to you upon your request for it.

USES AND DISCLOSURES

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- To provide information about your health condition to others who may treat you
- To provide information about the treatment that we provided to obtain payment from your health plan
- To report a communicable disease, domestic violence or criminal activity
- To comply with a court order requiring the discloser of your medical records

These are just a few examples. For full description of the uses and disclosures that we are to take, consult the Notice of Privacy Practices.

YOUR RIGHTS

While the records that we maintain about you belong to us, under the Federal privacy law, you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and copy the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of each disclosure that we have made of your health information. These rights are subject to some exceptions that are described fully in the notice.

OUR OBLIGATIONS

We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may amend the Notice from time to time. All amendment applies retroactively. Our full Notice of Privacy Practices is attached or enclosed. Please read it carefully. If you have any questions or require additional information, please contact us.

I have read and understand the information contained in this Summary Notice of Privacy Practices and all my relevant questions have been answered to my satisfaction.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Letter of Protection and Notice of Medical Lien

Patient Name: _____

Date(s) of service: _____

Attorney's Name: _____Phone No._____

County in which case is pending: _____

I do hereby authorize you _____(name of attorney) as my attorney to pay Jagannathan Neurosurgical Institute, PLLC (hereinafter "JNI") for medical services out of any proceeds that I receive as a settlement, judgment of verdict from my pending legal case.

I understand that the settlement or award amount may not cover part or all the medical services rendered by JNI. I fully understand that I am financially responsible for and agree to pay all charges which are not pain by the settlement, judgment or verdict in the case.

I hereby authorize and direct you as my attorney to pay directly to JNI such sums as may be due and owed to JNI for medical services rendered. I hereby further give a lien on my case to JNI against all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, because of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to JNI for all medical bills submitted by JNI for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify JNI of any charge or additional of attorney(s) used by me about this accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I have been advised that if my attorney does not wish to cooperate in protecting JNI's interest, JNI will not await payment, but will declare the entire balance due and payable. I have had an opportunity to review the terms and conditions of this lien and have had an opportunity to obtain advice of counsel. I enter this agreement knowingly and willingly.

Patient Signature: _____ Date: _____