Metro Spine, P.C.

6188 Oxon Hill Road, Suite 100, Oxon Hill, MD, 20745, Ph: 301-856-5860, Fax: 301-856-5864

Welcome! And thank you for choosing Metro Spine, P.C..
Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel welcome to contact any member of our team with questions or need any information.

Patient Information

Office Hours/Appointments
Our offices are open generally between 8:30 a.m. and 5:00 p.m., Monday through Friday. Please see the specific office location information to confirm the hours of operation. Patients are seen by appointment only.

Registration
For initial appointments with our practice, patients should arrive at the office 15 minutes prior to their scheduled appointment time. If you are a new patient, we ask that you complete a New Patient information sheet. This form provides valuable information for the physician and will enable us to establish a history and administrative file for you. If you have any questions regarding the information requested, please ask for assistance to complete the form as soon as possible. After arriving, please check in with the front desk. If you are an established patient and information concerning your insurance, your address, or phone number has changed, please let us know so that we may update our records accordingly.

> **Note: It is very important that you come with copies of your MRI or X-ray films on your initial visit to see the doctor. By doing this you will avoid unnecessary visits and COPAYMENTS.**

Referrals
If a patient's insurance company requires a referral from his or her primary care physician to see one of our specialists, it is the patient's responsibility to provide our office with all required referral documentation. If your insurance requires and electronic referral please be sure to get the referral number from your primary care doctor. Please note that patient's must have this referral information with them on their initial appointment to be seen.

Insurance Copays
Insurance copays are expected at the time of service. The payment can be made with cash or credit card. At the request of your insurance we cannot waive or bill you for your copay. We except checks for bill payments only. A $35 charge is added to any returned check.

Non-covered services: (Prolotherapy, Platlet Rich Plasma Kit) must be paid for at the time of service.

Appointment Cancellations/Missed Appointment
Appointments should be cancelled within 24 hours to allow other patients an opportunity to be seen. Any patient that fails to show up for their scheduled appointment will be charged a NO SHOW FEE of $25 for follow up visits and $250 for Injection Procedures. We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.

Tardiness
Please call if you are running late. We will allow you to arrive 10-15 minutes past you appointment time. Patients arriving 20 minutes late may be asked to reschedule their appointment.

Medications
Prescriptions and refills will only be issued on an appointment. To ensure that your medication needs are met in a timely manner we request you to set-up your next appointment at checkout or call at least 2 weeks prior to the date your medication is scheduled to run out.

Drug Screenings
All new patients and patients taking opiate medications will be subjected to a urine drug screening and will need to sign a **Medication Management Contract**. All urine drug screenings will be done randomly.

Forms/Medical Records
For forms there will be a $5 fee for each page completed by the doctor, with the exception FMLA forms, the fee regardless of the pages will be $35. The fee for medical records will be .73cents per page. The turn around time for both of these request will be 48 to 72 hours.

Note: No Food and **Drinks** are allowed in the office. You are discouraged from bringing family members especially kids to the office due to limited space.

_____ _____

Signature of Patient or Responsible Party Date

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CONFIDENTIAL PATIENT INFORMATION

First Name _____ Social Security# _____
Last Name _____ Sex M F
Middle Initial _____ Martial Status: S M D W Sep
Address Line _____ Email Address _____
City, State, Zip _____
Home Phone (__)_____
Work Phone (__)_____
Birth Date _____

Primary Insurance
Company Name _____
Address Line _____
City, State, Zip _____
Phone# _____
Policy/Group# _____
ID# _____
Relation Self Spouse Child

Secondary Insurance
Company Name _____
Address Line _____
City, State, Zip _____
Phone# _____
Policy/Group# _____
ID# _____
Relation Self Spouse Child

If relation is other than Self, **PLEASE** provide this information for the insured person.

Insured Person _____
Address Line _____
City, State, Zip _____
Employer Name _____
Home Phone _____
Work Phone _____
Social Security# _____
Birth Date _____
Sex M F
Employer Name _____
Attorney's Name _____
Attorney's Address _____
City, State, Zip _____

Insured Person _____
Address Line _____
City, State, Zip _____
Employer Name _____
Home Phone _____
Work Phone _____
Social Security# _____
Birth Date _____
Sex M F
Employment Status: FT PT Retired
Attorney's Phone _____

Is injury due to _ Auto Accident _ Worker's Comp _ Other Date of Injury _____
State where happened ____
If MVA, put your Auto Insurance Comp information in **PRIMARY** Insurance Area above. Put Medical Insurance in SECONDARY Area.
Claim Adjuster_____ Claim# _____ Phone# _____

I, the undersigned, certify that the above information is correct and assign directly to Metro Spine, c/o G. Hudson Drakes, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Furthermore, I understand that the statute of limitations in this State is three (3) years from the time services are rendered. In the event that a claim is filed against me by reason of unpaid bill for which I am responsible, I agree to waive the statute of limitations as a defense. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature: _____ Date: _____

Health Summary List

Allergies to:

Allergies Y N

Adv.react. To anesthesia Y N

Pregnant or could be? Y N

- [ ] Cardiovascular
  - [ ] Heart Attack
  - [ ] Coronnary artery disease
  - [ ] High blood pressure
  - [ ] chest pain
  - [ ] Murmur
  - [ ] Congestive heart failure
  - [ ] Heart rhythm problem
  - [ ] Rheumatic artery ds.
  - [ ] Angina
  - [ ] Valve disease
- [ ] Respiratory
  - [ ] Asthma
  - [ ] Emphysema
  - [ ] Tuberculosis
  - [ ] Bronchitis
  - [ ] Sleep Apnea
- [ ] Gastrointestinal
  - [ ] Heartburn
  - [ ] Ulcers
  - [ ] Hepatitis
  - [ ] Liver dx
  - [ ] Reflux
  - [ ] IBS
  - [ ] Jaundice
- [ ] Psychiatric
  - [ ] Depression
  - [ ] Bipolar DX
  - [ ] Alcohol dependence
  - [ ] Substance abuse/depen
  - [ ] Anxiety
- [ ] Endocrine
  - [ ] Thyroid
  - [ ] Diabetes
- [ ] Renal
  - [ ] Renal insufficiency
  - [ ] Chronic renal fail.
  - [ ] Dialysis
  - [ ] Kidney/blad. Stones
- [ ] hematologic
  - [ ] Anemia
  - [ ] Cancer
  - [ ] Hemophilia
  - [ ] Bleeding dx.
  - [ ] blood clots
  - [ ] Sickle cell Dx
- [ ] Exposures
  - [ ] Syphilis
  - [ ] Gonorrea
  - [ ] Lyme disease
  - [ ] Herpes Zoster
  - [ ] Chemotherapy
  - [ ] Solvents
  - [ ] Heavy metals
  - [ ] pesticides
  - [ ] Radiation
  - [ ] Hiv
  - [ ] Aids
  - [ ] Rabies
- [ ] neuromuscular
  - [ ] Carotid artery dx
  - [ ] Stroke
  - [ ] TIA
  - [ ] Motor neuron Dx
  - [ ] Polio
  - [ ] ALS
  - [ ] Neuropathy
  - [ ] Myopathy
  - [ ] Musculardistrophy
  - [ ] Radiculopathy
  - [ ] dementia
  - [ ] Alzheimer's
  - [ ] TBI
  - [ ] head injury
  - [ ] Seizures
  - [ ] Glaucoma
  - [ ] Arthritis
  - [ ] Fractures
  - [ ] Fibromyalgia
- [ ] Other
- [ ] None

Patient Name : _____ Signature: _____ Date: ____/____/____

Patient Name: ______________________ date: ____/____/____

Social History

- [ ] Working
- [ ] Medical leave
- [ ] regular exercice
- [ ] Tobacco
- [ ] Alcohol
- [ ] Recreational or IV drug

Family History

- [ ] Heart Dx
- [ ] Diabetes
- [ ] High blood pressure
- [ ] neuromuscular DX
- [ ] chronic pain
- [ ] mental illness
- [ ] Alcohol/drug depend.
- [ ] Stroke
- [ ] Cancer

Injection procedures

- [ ] Trigger points
- [ ] botox
- [ ] Joint injection
- [ ] epidural steroid
- [ ] Nerve Blocks
- [ ] Sympathetic Nerve blocks
- [ ] Facet joint
- [ ] Medial branch blocks
- [ ] Spinal cord stimulator
- [ ] Intrathecal Pump

Conventional Therapy

- [ ] Physical therapy
- [ ] Therapeutic exercice
- [ ] Ice
- [ ] Streches
- [ ] Traction
- [ ] heat
- [ ] Electrical stimulation
- [ ] Chiropratic care
- [ ] massage
- [ ] Occupation therapy

surgery

- [ ] Lumbar fusion
- [ ] Lumbar laminectomy
- [ ] Lumbar Discectomy

- [ ] cervical fusion
- [ ] Cervical laminectomy
- [ ] Cervical discectomy

Head and neck

- [ ] Tosillectomy
- [ ] Thyroidectomy
- [ ] Catract

Chest/heart

- [ ] Coronary bypass graft
- [ ] stent placement
- [ ] Pacemaker

Abdominal

- [ ] Cholectomy
- [ ] Appendectomy
- [ ] Hernia repair

urologic

- [ ] Vasectomy
- [ ] Bladder suspension
- [ ] Prostatectomy

Gynecologic

- [ ] Tubal ligation
- [ ] Hysterectomy
- [ ] D&C

Orthopedic

- [ ] hip replacement
- [ ] Knee replacement

- [ ] ***Plastic***

- [ ] Brest enhancement
- [ ] Breast reduction
- [ ] Rhinoplasty

- [ ] ***Vascular***

- [ ] ***other***

Medications

Name	dose	frequency

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EMERGENCY NOTIFICATION:

Person to be notified in case of emergency:

Name: _____

Address: _____

Telephone: Home _____ Work _____

Relationship to you? _____

REFERRAL SOURCE:

Who referred you to this office? _____
Who is your primary care physician? _____
What is the date of your last physical? _____ Where? _____

Any other comments/information you feel may be important or something that you want the physician to know about: _____
_____

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AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize_____Insurance company to pay by check and mail directly to:

Metro Spine, P.C.
6188 Oxon Hill Road, Suite 100
Oxon Hill, MD 20745
(301) 856-5860

Metro Spine, P.C.
9001 Woodyard Road Suite A
Clinton, MD 20735
(301) 856.5860

The medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy. As payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to this assignee, and I agree to pay in a current manner any balance of said professional service charges above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check payable to me and mail to:

Metro Spine, P.C.
6188 Oxon Hill Road, Suite 100
Oxon Hill, MD 20745
(301) 856-5860

Metro Spine, P.C.
9001 Woodyard Road Suite A
Clinton, MD 20735
(301) 856-5860

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment will be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, billing service or attorney involved in this case.

DATE: _____

SIGNATURE OF POLICY HOLDER: _____

SIGNATURE OF CLAIMANT: _____

WITNESS: _____

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Financial Policy

Thank you for selecting the Metro Spine, P.C. as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

For patients who are responsible for your own health coverage, we expect full payment for professional services. We accept cash or credit. Under certain circumstances, we may be willing to arrange a weekly/monthly payment plan. Our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered.

We require you to make your payment at time of service so that we do not have to send you a bill. Prompt payment allows us to control cost which ultimately keeps our fees to a minimum. Patients with a standard co-payment amount per visit should render that payment at the time of service. This payment will be applied toward your ultimate responsibility. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible. We require you to pay your deductible at the time of service.

If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier.

Please be aware that few insurance companies attempt to cover all medical cost. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the cost. Our practice is committed to providing the best treatment to you and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

You are responsible for obtaining the necessary referral, if required by your insurance company and bringing the completed form to your appointment. In the event that you are seen without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment for all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with you insurance carrier regarding your policy guidelines and regulation.

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balances and pay for each visit in full at the time of the appointment before additional services/care will be provided. Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, coverage issues are best addressed by your employer or group plan administrator. Your insurance policy is a contract between you and your insurance carrier. Metro Spine, P.C. is not a party to that contract and cannot act as a mediator with the carrier or your employer.

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to contact your Patient Account Representative at (301) 856-5860.

I have read the above Financial Policy and agree to it's terms and conditions.

_____

Patient Name (please print)

_____ _____

Signature of Patient or Responsible Party Date

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You and the HIV Virus

We are all concerned with minimizing the risk of exposure to the HIV virus.

We are very conscientious about this at Metro Spine, P.C. We have very careful Protocols that comply with government regulations for safety (monitor by the Occupational Health and Safety Administration). We'd like you to know that we use disposable needles and that you are at no time exposed to the blood or bodily fluid of any other patient.

We are obligated to provide a safe workplace. This ensures a safe treatment environment for you. There may be occasions when we accidentally come in contact with your blood or other bodily fluids. Maryland's laws authorize that if such an incident occurs, we may test your blood for HIV. The same laws require that you be informed of this.

Again, these precautions are taken in the interest of safety for you and our staff members.

Please sign below indicating that you understand this information.

_____

Patient signature Date

Standard Authorization of Use and Diclosure of Protected Health Information

I hereby authorize the use of disclosure of my individually identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I further understand that I may see and copy the information described on this form if I may ask for it, and that I get a copy of this form after I sign it.

Information to Be Used or Disclosed

The information covered by this authorization includes:

_____

_____

_____

_____

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If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Office Manager
Metro Spine, P.C.
6188 Oxon Hill Road, Suite 100
Oxon Hill, MD 20745
(301) 856-5860

Effective Date

This notice is effective on or after April 14, 2003.

Privacy Notice Acknowledgement

I have received the Privacy Standards Notice of Health Information Practices of Metro Spine, P.C.

Print Name: _____

Signature: _____

Date: _____

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INFORMATION CONCERNING YOUR PRESCRIPTION REFILL

Q: **If I am running out of medication, what should I do?**

A: You should call us two (2) weeks before your medication is due to run out if your prescription is filled locally. If you use a mail order company, please call 14 days before your medication is due to run out.

Q: **How long will it take to get my prescription refilled?**

A: It takes three (3) business days because your medical record needs to be reviewed and your doctor's signature is needed to authorize the refill. **Please Plan Ahead**. In addition, some medications require periodic lab tests to monitor the effectiveness of the medication. You will be notified if lab tests are needed, and you'll be referred to the facility most convenient to you.

Q: **Why are refills for opioid medications different from other drugs?**

A: Very strict controls are in place for all drugs containing an opioid substance. Some opioids cannot be called into a pharmacy. These types of medications require an original written prescription which can be picked up from our office one the physician has signed it. Also, it is important that the patient who takes opioid medications be aware that **THESE DRUGS CANNOT BE REFILLED UNTIL THE CURRENT PRESCRIPTION IS FULLY EXPIRED.** In addition, patients taking opioid medications need to have a follow-up visit with the physician at least every 90 days.

Q: **What if I need a refill that was prescribed by another physician?**

A: The refill must be authorized by the prescribing doctor and cannot be authorized by a physician at Metro Spine, P.C.

Q: **What if I am going out-of-town and need my medication and cannot wait 48 business hours?**

A: Many of our patients are on medication treatment plans. Due to our high refill volume process, please plan ahead.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONN ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Metro Spine, P.C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

- The right to amend or submit corrections to your protected health information

- The right to receive an accounting of how and to whom your protected health information has been disclosed

- The right to receive a printed copy of this notice

Metro Spine Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: