Date:____________

PATIENT INFORMATION

Patient Full Name: ______________________ Social Security Number: ______________
Mailing Adress: ____________________ City: ____________ State: ______ Zip: ____________
Birthdate: ______________ Age: ______ Gender: ________ Email: ______________________
Home Phone: ______________ Cell Phone: ______________ Work Phone: __________________
Employer: ______________________________Occupation: ______________________
Please circle one: Married Divorced Widowed Single Separated Other

EMERGENCY/HIPPA CONTACTS

Emergency Contact:
Name of Relative or Neighbor NOT Living With You:____________________ PHONE: ____________
HIPPA Contacts: Name of the Relative or friend we can discuss your medical needs with if necessary:
Name: ________________________ Relationship: ______________ Ph# ______________
Name: ________________________ Relationship: ______________ Ph# ______________
Name: ________________________ Relationship: ______________ Ph# ______________

REFERRING INFORMATION

Referring Physician: ______________________ Primary Physician: ______________________

INSURANCE INFORMATION

Primary Insurance:
Name of person ins. policy is under:________________________ Date of Birth: ______________
Primary Insurance: __________________________ ID # __________________________
Effective Date: ____________________ Social Security # __________-_____-__________

Secondary Insurance:
Name of person ins. policy is under:________________________ Date of Birth: ______________
Secondary Insurance: __________________________ ID # __________________________
Effective Date: ____________________

RESPONSIBLE PARTY (if patient is under 18 years old) / POWER OF ATTORNEY

Name: ________________________________ Relationship to patient: ________________
Address: ________________________ City: ____________ State: _____ Zip: ____________
Home Phone: ______________________ Social Security #: __________-_____-__________

______________________________________ ____________________
Patient/Legal Representative Signature Date

SUMMERS SPINE & NEUROSURGERY

Patient Health History Questionnaire

The information below is extremely important. Please fill out this form on the *back and front* of each page. Be sure to bring it with you to your appointment.

Patient Name: ______________________ Date: ____ / ____ / ____

Age: ______________________

How did you hear about our practice? ______________________

Please list all of the operations you have had: Date:

______________________ ____________

______________________ ____________

______________________ ____________

______________________ ____________

______________________ ____________

(Attach extra page if necessary)

Are you allergic to any medicines, x-ray, dye, or iodine? ☐ Yes ☐ No

I AM ALLERGIC TO: **What was your reaction?**

List all medications you take routinely, along with the doses: (Use additional page if needed)

Medication	Dose	Frequency

Are you taking any "blood thinning" medication? ☐ Yes ☐ No

☐ Aspirin or aspirin containing medication ☐ Anti-inflammatory medication

☐ Plavix ☐ Coumadin ☐ Other

On a scale of 1 to 10, with 10 being the worst pain you can imagine and 1 being essentially no pain, please rate the typical or average amount of pain you have during the day. Circle a number.

1	2	3	4	5	6	7	8	9	10

SUMMERS SPINE & NEUROSURGERY

Patient Health History Questionnaire (continued)

Do **you** have any of the following?

___ High Blood Pressure ____ Diabetes

___ Heart Disease ____ Osteoporosis

___ Bleeding disorder ____ Cancer

Please list all other health problems: ____

____

____

Do any of the following diseases run in **your family**?

___ High Blood Pressure ____ Diabetes

___ Heart Disease ____ Osteoporosis

___ Bleeding disorder ____ Cancer

Please list all other health problems: ____

____

____

Do you use any tobacco products? ______YES _____NO - Type: ____________________

If yes, how many per day? ______________ How many packs per day? ____________________

Have you ever used tobacco products? ____YES ___NO - if yes, when did you stop?______________

Do you drink alcohol? ______YES _____NO

Do you use "recreational" drugs? ______YES _____NO

Are you at risk for AIDS (e.g sexual orientation, drug abuse, previous blood tranfussion)?

______ YES, if yes please explain: ____

______ NO

For Females: Are you, or could you be pregnant? ______YES _____NO

SUMMERS SPINE & NEUROSURGERY

Patient Health History Questionnaire (continued)

1. If your current Condition is the result of an injury please describe in detail how that injury occured:
____
____
____

2. What other physicians have you seen for these conditions? ______________________________
____

3. Have you previously been treated for neck or back issues? ______YES ______NO

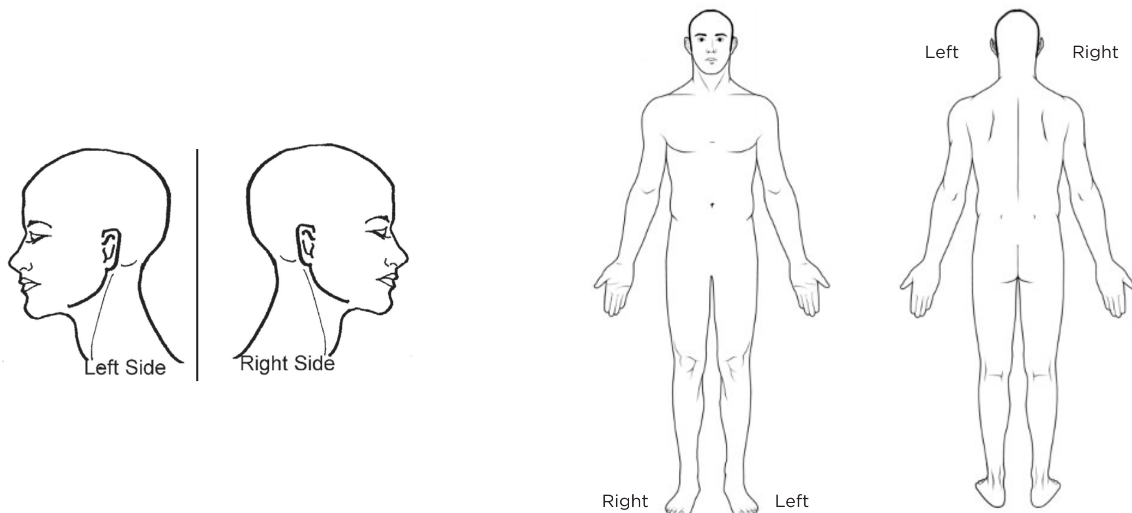
4. What gives you relief from your symptoms? ______________________________
____

5. Are you presently working? ______YES ______NO
If not, when was the last day you worked? ______________________________

6. Describe your working habits: (circle one:)

Heavy Labor | Light Labor | Sedentary | Professional
Homemaker | Retired | Unemployed

On the diagram below, indicate where your pain is usually located. Please shade the painful areas.



I give Summers Neurosurgery, LLC permission to pull my medication history from pharamcies for medical treatment. ______YES _____NO

The information on this form is accurate to the best of my knowledge.

_______________________________________ ____ / ____ / ____
Patient Signature Date Completed

I have reviewed the above information with patient:

_______________________________________ ____ / ____ / ____
Physician Signature Date Completed

_______________________________________ ____ / ____ / ____
Physician Signature Date Completed

_______________________________________ ____ / ____ / ____
Physician Signature Date Completed

In preparation for your appointment, please be sure:

- You have completed and signed this form.
- You have all pertinent medical records with you.
- If you have a cardiac history, please bring results of your last EKG and/or other tests.
- You have your actual x-ray films with you, not just reports.
- You have your insurance card.

Do not hesitate to call our office at (985) 419-7767 with any questions.

Review of Systems

Do you currently, or have you had, a problem with:

Constitutional:	Circle One	
Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Eyes:		
Wear glasses	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Ear, Nose, Throat & Mouth		
Wear hearing aid (s)	Yes	No
Hearing loss	Yes	No
Ear pain	Yes	No
Ear infections	Yes	No
Ringing in ears	Yes	No
If yes, circle one: Left Right Both		
Nose bleeds	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Inability to smell	Yes	No
Sinus problems	Yes	No
Balance disturbance (vertigo, spinning, etc.)	Yes	No
Cardiovascular		
Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in hands or feet	Yes	No
Leg pain while walking	Yes	No
Respiratory		
Asthma	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Lung cancer	Yes	No
Bloody sputum	Yes	No
Gastrointestinal		
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver disease	Yes	No
Jaundice	Yes	No
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon cancer	Yes	No
Endocrine		
Diabetes	Yes	No
Thyroid disease	Yes	No
Excessive thirst/urination	Yes	No

Genitourinary	Circle One	
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Difficult starting/stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Prostate cancer (male)	Yes	No
Uterine or cervical cancer (female)	Yes	No
Musculoskeletal		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No
Integumentary		
Skin disease	Yes	No
Skin cancer	Yes	No
Breast pain, tenderness (female)	Yes	No
Nipple discharge (female)	Yes	No
Neurological		
Fainting spells or "black outs"	Yes	No
Seizures	Yes	No
Problems with memory	Yes	No
Disorientation	Yes	No
Difficulty with speech	Yes	No
Inability to concentrate	Yes	No
Double or blurred vision	Yes	No
Weakness in arms and/or legs	Yes	No
Loss of sensation	Yes	No
Difficulty with balance	Yes	No
Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Other psychiatric disorder and/or treatment:	Yes	No

Hematological/Lymphatic		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding tendencies	Yes	No
Blood transfusion	Yes	No
Persistent swollen glands or lymph nodes	Yes	No
Allergy/Immunological		
Food allergies	Yes	No
Inhalant (nasal) allergies	Yes	No
Autoimmune disease (lupus, rheumatoid arthritis, etc.)	Yes	No

NARCOTIC PRESCRIPTION POLICY

Due to the alarming rate of narcotic pain medication abuse/dependence, it has become necessary for physician practices to closely manage patient use of prescription narcotic pain relievers, such as Vicodin, Vicoprofen, Hydrocodone, Tylenol w/codeine, oxycontin, Oxycodone, Dilaudid, Percocet, Percodan, Lorcet, Norco and Morphine products.

The *Narcotic Prescription Policy* of Summers Spine & Neurosurgery is as follows:

1. No narcotic medications will be prescribed at the time of the initial consultation. The referring physician should manage all pain medication until the time that a final treatment plan has been recommended by this office. It is unlikely that a final treatment plan can be recommended at the initial visit since most patients will not have had all of the necessary diagnostic tests required to form an accurate diagnosis (i.e. MRI, x-rays, CT scan, etc).
2. Once the final diagnosis has been made, this office will recommend a treatment plan that may or may not include the short-term use of narcotic pain medication.
3. In the event that surgery has been recommended, this office will render the post-operative pain management. Narcotic pain management is the post-operative period may not exceed 60 days.
4. In the event a non-operative treatment plan has been recommended, pain management can be rendered by either the primary care physician (PCP) or by the non-surgical specialist to whom the patient is referred for further care.
5. Regional pharmacies monitor patient use of narcotic pain medications and contact the prescribing physician(s) if a patient is receiving narcotic pain medication from more than one physician. If this office receives notification, form any source, that a patient is receiving narcotic pain medication from more than one physician, prescribing of such medication by this office will be immediately suspended.
6. At the discretion of the physician and/or advanced practitioner, narcotic pain medication may not be prescribed beyond a 60-day period. If narcotic pain management is required beyond 60 days, a referral to your primary care physician (PCP) or a Chronic Pain Specialist may be made.
7. In the event of suspected narcotic abuse, further prescriptions will not be made and the patient may be discharged from care.
8. In the event of documented narcotic abuse, further prescriptions will not be made and the patient may be discharged from care.
9. In the event of suspected narcotic dependence, a referral to a Dependency Treatment Specialist can be made, at the patient's request.
10. If a patient has not been seen in this office during the preceding 3 months, no prescriptions will be "called-in" to the pharmacy without reassessment of the patient.
11. At the request of this practice, saliva drug testing or urine drug testing may be requested periodically in compliance with DEA guidelines

If a request for prescription refill has been made by telephone, the physician must review your chart prior to contacting the pharmacist. Therefore, your request may not be processed immediately. It is the policy of this office to complete all legitimate requests within 72 business hours. Requests made on Friday may not be completed until the following week.

Prescriptions will not be filled as an "emergency".

No prescription will be refilled early and no sooner than the actual date the next prescription is due to be refilled.

Lost or stolen medication will not be replaced unless we have a copy of a police report.

We will only refill prescriptions written by a Summers Spine & Neurosurgery provider. For all other medication refill requests you will be asked to contact the prescribing physician.

We reserve the right to refuse to prescribe narcotic medication if a patient is verbally abusive to our staff and/or calls continuously within a 48-hour period for narcotic refills.

Prescriptions will only be filled during normal business hours (8am-4pm). Not during the evening, weekend, or holidays.

By signing below, I understand and agree to follow the rules of Summers Spine & Neurosurgery Narcotic Prescription Policy. This policy has been explained to me, my questions have been answered, and I have been given a copy for my review. I understand that if I do not follow these rules completely, the physicians of Summers Spine & Neurosurgery may stop my narcotics and discharge me from the practice.

Patient Signature: ______________________________ Date: ____________________

Staff Signature: ______________________________

Please select one pharmacy for filling your narcotic prescriptions. If you must change the pharmacy due to financial implications, or for any other reason, please notify our office.

Pharmacy: ______________________________

Pharmacy Phone Number: ____________________

Lori Summers, MD
Neurosurgeon

Summers Neurosurgery, LLC
1200 Derek Dr.
Suite 400
Hammond, LA 70403

Phone: (985) 419-7767
Fax: (985) 419-7771

To: ______________________________________ Date: ____________________
Patient Name

DISCLOSURE OF FINANCIAL INTEREST:

Louisiana law requires physicians to disclose to a patient, when the physician refers the patient to another health care provider or facility, that the physician has a financial interest in that entity. As part of your care you may be referred to Cypress Point Surgical Hospital for surgical, diagnostic or laboratory services, Northshore Spine Holdings that purchases medical implant devices from the manufacturer and sells them to the hospital in connection with their use in surgery, and Old Gretna Pharmacy, LLC.

The purpose of this disclosure is to notify you that Lori Summers, MD has an ownership/financial interest in Cypress Point Surgical Hospital, Northshore Spine Holdings and Old Gretna Pharmacy, LLC. If you are referred to one of these entities and have any questions, please discuss this with your physician directly. You have the right to choose a different entity or choose not to receive the services by letting the doctor know prior to the referral.

Physician: ________________________________
Lori E. Summers, MD

PATIENT ACKNOWLEDGMENT

I, the above named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

X ____
Signature of Patient or Patient's Representative

H2.6C NOTICE OF PRIVACY PRACTICES

Summers Neurosurgery, LLC

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Authorization
Your authorization is required for us to sell or to use and disclosure your protected health information for marketing purposes if we would receive financial remuneration for the marketing from a third party.
For other uses and disclosures not mentioned in this notice we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information including to not disclose information to your insurance plan if you paid out of pocket for the service or item. We are not required to agree to all restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a paper or electronic copy of your health information. There may be a small charge for the copies.
Fundraising Communications: You have the right to opt out of receiving fundraising communications from us should we decide to contact you to raise money for organizations such as The Colitis Foundation.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.
Breach Notification: You have a right to be notified of a breach of your unsecured protected health information

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. **Changes in Privacy Practices**
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and hallway. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Summers Neurosurgery, LLC

Tammy Graf

(985) 419-7767

Effective Date: June 17, 2016

I hereby acknowledge receipt of the Notice of Privacy Practices given to me today.

____

X Signature of patient

If not signed, reason why acknowledgement was not obtained: ______________________

____

Signature of Witness