NEW LIFE SPINE CENTER

1331 CONANT ST. #104
MAUMEE, OH 43537
Phone: 419-724-5433
Fax: 419-720-6994

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Social Security #:_____ □ Male □ Female

Marital Status: □ Married □Single □Divorced □Separated □Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation_____ Your Employer: _____

Referred to this Office by: □Friend/Family Member - Name? _____
□Yellow Pages □ Mail □Clinic Location □Other_____

Payment for Services will be by: □Cash □Check □Credit Card □Health Insurance
□Automobile Insurance □Worker's Compensation

Name of Insurance Co.:_____ Insured's Name: _____
Insured's Date of Birth: _____
Insured's Social Security/ID #:_____ Group# _____
Insured's Employer: _____ Employer's Phone #:_____

Are you covered by more than one insurance company? □Yes □No

Name of secondary Insurance Co.:_____ Insured's Name: _____
Insured's Date of Birth: _____
Insured's Social Security/ID #:_____ Group# _____
Insured's Employer: _____ Employer's Phone #:_____

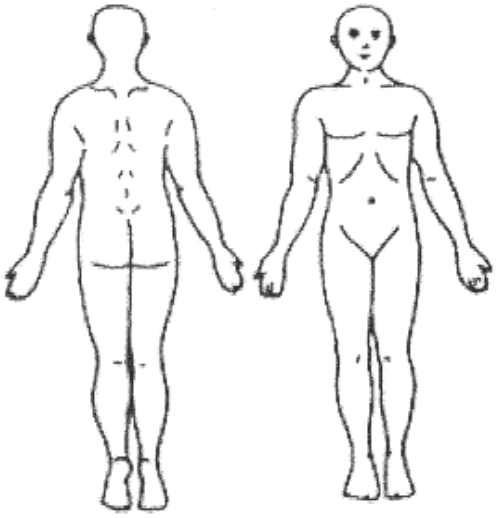
Unwanted Condition (Why you are here today?)**:**_____

Patient Name: _____
Date: _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No. When? _____
Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury
☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other
Explain: _____
_____
Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?
_____
_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No
Describe Condition: _____ Date of Last Physical Exam: _____
SURGICAL HISTORY:
1._____ Date: _____
2._____ Date: _____
3._____ Date: _____

Have you ever had a metal implant? ☐Yes ☐No Have ever had been gunshot? ☐Yes ☐No

ACCIDENT HISTORY: ☐Job ☐Auto ☐Other 1. _____Date:_____
☐Job ☐Auto ☐Other 2._____Date:_____
☐Job ☐Auto ☐Other 3._____Date:_____

Patient's Signature: _____ **Date:** _____

NEW LIFE SPINE CENTER

Dr. Thomas M. Baur
1331 CONANT ST. #104
MAUMEE, OH 43537
419-724-5433

*******************************Office Policies*****************************

There is **$20.00** no show fee for any appointments that are missed or cancelled without a 24 hour prior notice. This fee is your responsibility.

Our returned check fee is **$25.00**.

Any services/charges that your insurance does not cover will be billed to you as your patient balance. We accept Discover, MasterCard and Visa.

Reexaminations are performed after 90 days without care or after new injury or exacerbation of an old injury. Patients are considered inactive if they are not treated within ninety days.

Personal Injury cases must have a letter of protection from your attorney before any treatment can take place.

I have read and understand the office policies of New Life Spine Center.

Print Patient Name: _____

Signature: _____ Date: _____

NEW LIFE SPINE CENTER
1331 CONANT ST., #104 MAUMEE, OH 43537 ph: 419-724-5433 fax: 419-720-6994

HIPAA COMPLIANCE AND CONTACT INFORMATION

Patient Name: _____ *Date:* _____

Please read and initial the following statements:

___ I acknowledge receipt of NLSC's notice of Privacy Policy. (If not initialed, NLSC personnel should describe efforts to obtain and reason for failure to obtain such acknowledgment in the space below.)

- ☐ Refused to acknowledge
- ☐ Did not understand request to acknowledge
- ☐ Other (describe) _____

___ I consent to the disclosure of my Protected Health Information by NLSC for treatment, payment and health operations purposes in accordance with law.

___ I agree to the disclosure of my Protected Health Information by NLSC to_____, (a person directly involved in my health care, other than my physician). I understand that at any future point I can withdraw this agreement.

Patient Communication Details for Special Consideration:

HOME PHONE _____
- ___DETAILED MESSAGE
- ___CALL-BACK # ONLY
- ___DO NOT USE

WORK/OFFICE PHONE _____
- ___DETAILED MESSAGE
- ___CALL-BACK # ONLY
- ___DO NOT USE

CELL PHONE _____
- ___DETAILED MESSAGE
- ___CALL-BACK # ONLY
- ___DO NOT USE

WRITTEN COMMUNICATIONS
- __MAIL TO HOME ADDRESS
- ___FAX TO:_____
- __MAIL TO OTHER ADDRESS:_____
_____

NLSC has permission to coordinate my care with the following physicians (please list):

GENERAL PHYSICIAN:
ADDRESS:
PHONE #:

OB GYN:
ADDRESS:
PHONE #:

OTHER:
ADDRESS:
PHONE #:

OTHER:
ADDRESS:
PHONE #:

_____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

PRIVACY POLICY

NEW LIFE SPINE CENTER
Dr. Thomas M. Baur 1331 CONANT ST. #104 MAUMEE, OH 43537 PH: 419-724-5433 FAX: 419-720-6994

NEW LIFE SPINE CENTER IS AN OPEN AREA FACILITY.

NOTICE OF DOCTOR'S PRIVACY PRACTICE

Dr Thomas Baur's office, located at 1331 Conant Street, Suite 104, Maumee, OH 43537, is required by the Health Insurance Portability Accountability Act (HIPAA) to inform all patients regarding the Federal and State standards that exist to protect the privacy of all patients' identifiable and protected health information (PHI). Dr Baur has certain responsibilities to the patient that are outlined in this notice. This notice describes the various rights that patients have concerning PHI. If the patient wants a copy of this notice, simply ask Dr Baur for one and it will be provided (45 CFR Sect 164).

PATIENT RIGHTS REGARDING HEALTH-MEDICAL RECORDS

All medical records, including those that the patient and doctor generate, including intake forms, history, examination, diagnosis, treatment, tests, etc., as well as any records received from other sources become property of Dr Baur. The patient has the right to inspect and copy his/her health records, amend or change his/her records, and request restrictions on certain aspects of his/her medical records for a period of seven years or as long as the patient's records are maintained by Dr Baur's office. If the patient has any sensitive PHI he/she wants "restricted", the patient may request that the PHI be "restricted" unless specifically authorized by the patient or when mandated by a legal or court order. Dr Baur is not required to agree to any requested "restriction". If Dr Baur is unable to comply, the patient will receive a letter of explanation. The patient may ask for an accounting of every disclosure of his/her PHI to another party at any time. The patient may ask that disclosure of his/her PHI be communicated in a different manner, such as by fax instead of USPS. Dr Baur will not disclose any PHI without the patient's signed and dated authorization, unless mandated by law (such as court order), in an emergency situation, when providing treatment to the patient based on prescribed orders from another health care provider, or when compelled to do so in cases of potential harm/injury to a person, abuse, or crime as dictated by law. The patient may revoke any authorization, except in situations where actions have already taken place. All requests for amendments, viewing or copying records, restrictions, revocation or authorizations, or request for summary of disclosures or uses of patient records must be submitted in writing to Dr Baur. Please give Dr Baur enough time to process any requests. If requesting records, HIPAA laws allow for 30 days if records are maintained on-site and 60 days if stored off-site.

WHAT ARE DR BAUR'S RESPONSIBILITIES TO THE PATIENT?

Dr Baur is required to protect and maintain all written and electronic health information as well as maintaining confidentiality and privacy of anything that is verbally communicated, written down, or generated in any manner. If the patient has telephone numbers or a mailing address that is preferable, he/she has the right to indicate alternative means of communication. Any person/business who has access to any patient's PHI, including computer or equipment service, janitorial service, billing service, or other persons will have signed agreements that protect all PHI contained within Dr Baur's office. Dr Baur reserves the right to change his practices and make new provisions or disclosures. Dr Baur will make every reasonable effort to comply with protecting the patient's PHI and if Dr Baur's health information practices change, the patient will be mailed a copy of such changes to the most recent address on file.

HOW WILL DR BAUR USE YOUR PROTECTED HEALTH INFORMATION?

Your medical-health records that are generated each visit provide the basis for Dr Baur to determine the diagnosis, what treatment needs to be prescribed or modified, how the patient has responded to treatment, if consultation/referral is needed, and provides the means for the doctor to communicate relevant PHI with other health care providers or diagnostic facilities. Unless restricted or specified otherwise by the patient, Dr Baur will use the patient's PHI to obtain information to verify and process insurance billing, provide "minimum necessity" records to those third-party payers who are responsible to pay for service given, and to obtain authorization for treatment, services, procedures, or for supplies provided. The patient's PHI will be used to help determine the condition, diagnosis, treatment, and the need for consultation, referral, testing, or coordination with other health care providers. The patient's PHI may be used to respond to questions from insurance companies regarding the necessity of a service, test, or supplies or to verify services. Dr Baur will use the patient's PHI to return phone calls, make appointment reminders, mail billing statements or updates, and for sending other office related material. In cases where the patient has an attorney, Dr Baur needs to be able to communicate about various aspects of the patient's case and submit reports outlining the patient's response to treatment, diagnosis, and other relevant issues. If the patient has a friend, family member or other person in attendance at Dr Baur's office, the patient must provide written consent for any discussions that involve PHI. If Dr Baur is out of the office and has another doctor covering his practice, the patient's PHI is necessary for the doctor to provide treatment.

NOTE: All patients are encouraged to submit written recommendations directly to Dr Baur as your comments regarding privacy and security are greatly appreciated. If the patient believes that Dr Baur has violated his/her privacy rights he/she may file complaints with the US Department of Health and Human Services at 200 Independence Ave, SW, Room 509F, HHH Bldg, Washington, DC 20201. Our office will not retaliate in any manner of any complaints are made.