AA Spine Center

Ahmed Amayem, MD, FIPP
Board Certified Anesthesiologist
Diplomate American Academy of Pain Medicine
Master Degree of Physical Medicine and Rehabilitation

1145 S.W. 74th, Building I, Suite 100
Oklahoma City, OK 73139
Phone: (405) 632-1783
Fax: (405) 631-0508
www.aaspinecenter.com

PATIENT INFORMATION

Legal
Name:_____Address:_____

City:_____State:_____Zip:_____MALE or FEMALE

SS#:_____Date of Birth:_____Age:_____Marital Status:_____

Home Phone:_____Work Phone:_____Cell:_____

Employer:_____Address:_____

PERSON RESPONSIBLE FOR BILL: (If minor parent or guardian information)

Name:_____Date of Birth:_____SS#:_____

Relationship to Patient: _____Address:_____

Home Phone:_____Work Phone:_____Cell:_____

Employer:_____Address:_____

INSURANCE INFORMATION:

Name of Insured:_____SS#:_____Date of Birth:_____

Relationship to Patient:_____Employer:_____

Name of Ins. Company:_____Address:_____

Group #:_____Policy ID#:_____

PLEASE GIVE INSURANCE CARD(S) TO RECEPTIONIST FOR COPYING
Authorization: My signature indicates that I have read above and grant authorization of treatment and am responsible for payment of fees.
I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to the physician.

_____ _____

DATE PATIENT OR LEGAL GUARDIANS SIGNATURE

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HEALTH HISTORY

Date:_____ Referring physician:_____
Name:_____ Age:_____
Chief complaint:_____

Describe your pain: sharp, dull, burning, shooting.
Site:_____ Referral pattern: (legs,arms)_____

When did your pain start?_____
Rate your pain on 0-10 scale in an average day _____, and in a bad day:_____
What makes your pain worse:_____
What makes your pain better:_____

Previous treatment:

Surgery:_____
Medical:_____
Any nerve block, epidural block: (yes, no)_____
P.T., other treatment:_____

Medical conditions. Check conditions you have or have had in the past:

*AIDS	*Epilepsy	*Kidney Stones	*Stroke
*Alcoholism	*glaucoma	*Kidney infection	*Ulcers
*Anemia	*Goiter	*Kidney failure	*venereal disease
*Arthritis	*Gonorrhea	*Liver hepatitis	*Veins, varicose
*Asthma	*Gout	*Liver cirrhosis	*veins, Clots
*bleeding disorder	*Heart disease	*liver gall bladder	*weight gain, recent
*Breast lump	*Hepatitis	*Migraine headache	*weight loss, recent
*bronchitis	*hernia	*Multiple sclerosis	*Others:
*cancer	*Herpes	*Pacemaker	
*Cataract	*Hypertension	*Pneumonia	
*Diabetes	*Hemiplegia	*Prostate problem	
*Drug addiction	*Hyperthyroidism	*Psychiatric care	
*Emphysema	*Hyperthyroidism	*Sleep problems	

Past surgical history:_____

Recent hospitalization:_____

Social history:

Do you smoke (Y,N) How much _____
Alcohol drinking more than 1 drink/day: _____
History of alcohol or drug abuse (Y,N)_____
Marital status:_____number of hose hold:_____

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Allergies:_____

Medication:_____
_____
_____

Mention any blood thinner**:**_____

Family history:

Father Illnesses:_____
Mother Illnesses:_____
Siblings illnesses:_____

Review of systems: Check symptoms you currently have

GENERAL
Chills
Depression
Difficulty sleeping
Dizziness
Fainting
Fever
Headache
Nervousness

Pain, Weakness
Arms
Hands
Legs
Feet
Neck
Back

Upper extremities
Numbness
Tingling
Joint pain
Joint swelling
Joint stiffness

Lower extremities
Numbness
Tingling
Joint pain
Joint stiffness
Joint swelling

Gastrointestinal
Bloating
Bowel change
Constipation
Diarrhea
Hemorrhoids
Indigestion
Nausea
Vomiting

Cardiovascular
Chest pain
Hypertension
Irregular heart beat
Poor circulation
Rapid heart beat
Swelling of ankles

Skin
Bruise easily
Hives
Change in moles
Itching
Rash
Sores won't heal

Eye*Ear*Nose
Bleeding gums
Blurred vision
Difficulty swallowing
Double vision
Ear discharge, pain
Hoarseness
Loss of hearing
Nosebleeds
Ringing in ears
Sinus problem
Vision, flashes
Vision, problems

Men only
Erection difficulty
Sore, lumps testicles

Women only
Breast lump
Abnormal bleeding
Menstrual pain
Vaginal discharge

Other problems

ST. JUDE MEDICAL

Pain Assessment

Name: _____ Date: _____

Rate the pain levels you experience as you perform the activities listed (on a scale of 1 to 10, with 10 being the worst possible pain).

_____ Sitting

_____ Standing

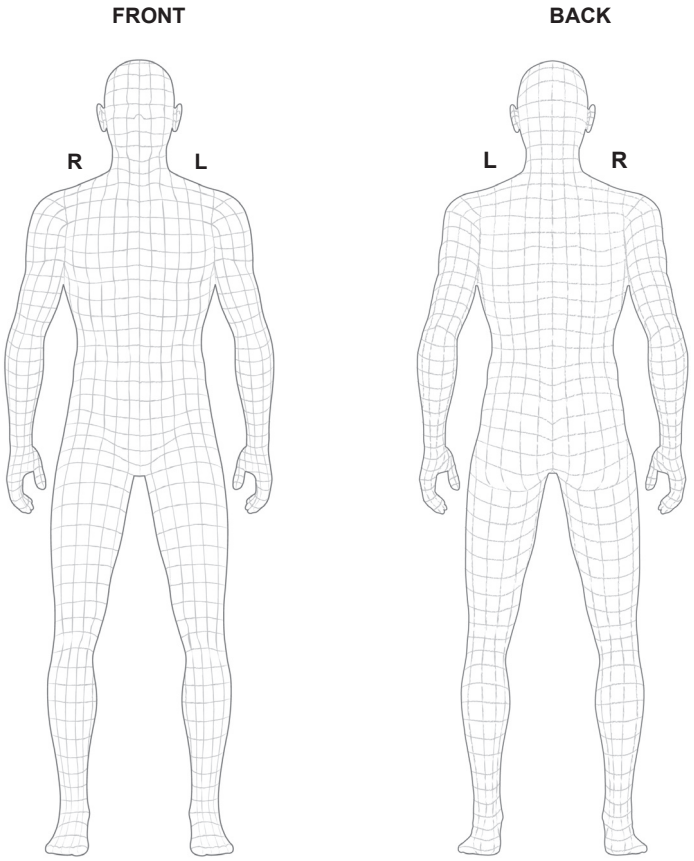
_____ Walking

_____ Sleeping

Shade in the area(s) where you feel pain.
Circle the area(s) of worst pain.

= Pain

= Worst Pain



On a scale of 1 to 10, please indicate with an "X" the level of pain you are experiencing right now:

(Least Intense) (Most Intense)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the frequency at which you experience this level of pain:

Rarely Once a month Once a week Once a day More than once a day Constant pain

Comments: _____

_____

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OFFICE POLICIES

1. Co-pays and office visit charges are due in full before you see the doctor. If you are unable to pay your co-pay we will reschedule your appointment. The only exception will be if you have spoken with the office manager prior to your appointment and made arrangements for payment. We accept cash, personal checks, Visa and MasterCard. If you should have a check returned from your bank for any reason, there will be a $25 charge in addition to the amount of the check which must be paid in cash or with a money order prior to your next visit. We will file claims with your insurance company for office visits and procedures, however, if your insurance does not pay within 90 days, you will be responsible for the bill. If it becomes necessary to send your account to an outside collection agency, there fees will be added to your balance.

2. If you need to cancel or reschedule your office visit, please call 24 hours in advance. If you fail to cancel and do not keep your appointment you will be charged $25. This will be due from you at your next visit and cannot be billed to your insurance. If your appointment is for a procedure either at a hospital or here in the office, you must give 48 hours notice or there will be a $50 charge.

3. Please limit phone calls to the office to 1 call and 1 message. If you are waiting to be scheduled for a procedure, we will call you as soon as we have the authorization from your insurance company. As you can see, we are very busy but your call is very important to us. Unless it is an emergency, please allow 24 hours for a return call. Return calls are a priority with our staff.

4. If you have a form to be filled out for FMLA or disability there will be a $25 charge for a single page and $50 for multiple pages. Please do not expect these forms to be filled out during your visit. Allow at least 3 days for the staff and Dr. Amayem to complete your forms properly.

5. If you require a copy of your medical records, you will be required to sign a release and allow two weeks for copying. There is a charge of $1.00 for the first page and $0.50 for each additional page. We will not fax records to anyone other than another physician who requests them with a signed release.

6. Your children are welcome in the office but must remain seated and quiet al all times. If they are disruptive or destructive you will be asked to reschedule your appointment for a time when you will not have to bring them with you.

7. We do not treat people for injuries from motor vehicle accidents. We will only treat patients with Workers' Compensation injuries with prior authorization from the insurance carrier. You must also provide us with the correct billing information at your first appointment. If you do not give us correct information and your claims are denied, you will be responsible for the entire bill.

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Patient Name:_____

Date:_____

I give Dr. Amayem and his staff permission to speak with the following people regarding my condition, medications, treatment, possible procedures and billing.

Name:_____

Relationship:_____

Date of Birth:_____

Name:_____

Relationship:_____

Date of Birth:_____

Name:_____

Relationship:_____

Date of Birth:_____

_____ _____

Patient Signature Date

_____ _____

Witness Date

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HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to this health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as require by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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AA Spine Center
Informed Consent

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:
You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

POSSIBLE SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Nausea/Vomiting
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Sleepiness or drowsiness
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS< INCLUDING ALCOHOL.

RISKS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

Runny nose	*Difficulty sleeping for several days*
Diarrhea	*Abdominal cramping*
Sweating	*'Goose bumps'*
Rapid heart rate	*Nervousness*

- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more drugs to get the same effect.
- Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

_____

Patient Signature Date

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PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on the Agreement. I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines. In this case, the doctor will taper off the medicine over a period of several days, as recommended. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. In addition:

- I will not use any illegal controlled substances.
- I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants or anxiety medication from another doctor.
- I will safeguard my medicine from loss or theft. Lost or stolen medicines will not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit. No refills will be called in.
- I agree to use _____Pharmacy located at _____ _____Phone number_____ for filling prescriptions of all of my pain medicine.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Oklahoma's Board of Pharmacy, In the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive all applicable privileges or right of privacy or confidentiality with respect of these authorizations.
  I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of medicine at a greater rate will be reported immediately to my doctor.
- I will bring all unused medication to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into this _____day of _____, 20_____.

_____

Patient Signature Printed Name

Physician Signature_____

Witnessed by: _____

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Office Procedure Instructions

Name:_____

You're having a _____ done in Dr. Amayem's office.

Arrive on: _____ @ _____AM/PM

Nothing to eat or drink after _____AM/PM

Follow up with the Doctor on _____ @ _____AM/PM

Office Preoperative Instructions

1. You will need to bring a driver with you. **NO SOONERIDE, TAXI, OR BUS!** Unless you have a trusted friend/family member to ride with you.
2. You need to bring or wear pants with an elastic band if possible. If you're having a Radiofrequency, please bring or wear shorts with an elastic band.
3. You ***MUST*** stop any **BLOOD THINNER** such as Coumadin, Plavix, Aspirin, or other ***FIVE*** days prior to your procedure.
4. Take your regular medications in the morning with a small amount of water. For Insulin Dependant Diabetics, take half your insulin dose in the morning before your procedure. Be sure to take your heart or blood pressure medicine if you have it.
6. If you have a temperature above 100 degrees F or an upper respiratory infection, please call the office to reschedule your procedure.
7. If you need to cancel or reschedule, you ***MUST*** give us a 48 *business hour* notice or there will be a $50.00 charge. This is **NOT** paid by your insurance.

If you have any other questions, please call our office prior to your procedure
Office phone is 632-1783