Initials:_____

PATIENT INFORMATION						
DATE	LAST NAME		FIRST NAME			MIDDLE INITIAL
ADDRESS		CITY		STATE		ZIP CODE
DATE OF BIRTH	AGE	GENDER	HOME PHONE	CELL PHONE		WORK PHONE
EMAIL		SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER		

EMERGENCY CONTACT INFO		
EMERGENCY CONTACT (LAST NAME, FIRST NAME)	RELATIONSHIP TO PATIENT	
CONTACT'S HOME PHONE	CELL PHONE	WORK PHONE

INSURANCE INFORMATION			
RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	INSURED NAME (LAST NAME, FIRST NAME, M.I.)		
INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH	WORKER'S COMP? ☐YES ☐NO	
PRIMARY INSURANCE COMPANY	☐HMO ☐PPO	IF HMO, NAME OF MEDICAL GROUP	
MEMBER ID NUMBER			
SECONDARY INSURANCE COMPANY	RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
MEMBER ID NUMBER	INSURED NAME	INSURED DOB	

PROVIDERS			
WHO WERE YOU REFERRED BY? ☐ PRIMARY CARE PHYSICIAN ☐ NEUROLOGIST ☐ PAIN MANAGEMENT ☐ ONCOLOGIST ☐ CHIROPRACTOR ☐ FRIEND ☐ INTERNET ☐ INSURANCE ☐ OTHER _____			
REFERRING DOCTOR'S NAME	PHONE	FAX	
ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE PHYSICIAN	PHONE	FAX	
ADDRESS	CITY	STATE	ZIP CODE
CARDIOLOGIST	PHONE	FAX	
ADDRESS	CITY	STATE	ZIP CODE

Initials:_____

MAIN REASON FOR YOUR CLINIC VISIT TODAY
CONSERVATIVE THERAPIES TRIED : PHYSICAL THERAPY X____MONTHS, STEROID INJECTIONS X_____, PAIN MEDICATIONS X____ MONTHS , CHIROPRACTIC X_____MONTHS, ACUPUNCTURE X____MONTHS OTHER:

CURRENT MEDICATIONS	DOSE, ROUTE, AND FREQUENCY

ALLERGIES TO MEDICATION	TYPE OF REACTION

PREFERRED PHARMACY		
NAME	ADDRESS	PHONE

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)	
BACK PAIN / LEG PAIN / NECK PAIN / ARM PAIN	TREMOR / STIFFNESS / FALLS
LOSS OF CONSCIOUSNESS / SEIZURES	DIZZINESS / HEADACHES
NUMBNESS / WEAKNESS / TINGLING	BLURRED VISION / DOUBLE VISION
EAR PAIN / NOSE BLEEDS / SORE THROAT	CHEST PAIN / PALPITATIONS
SHORTNESS OF BREATH / COUGHING / WHEEZING	NAUSEA / VOMITING / DIARRHEA
URINARY / BOWEL INCONTINENCE	DEPRESSION / MANIA
FEVER / NIGHT SWEATS / CHILLS	OTHER:

Initials:_____

PREVIOUS SURGERIES (PLEASE LIST DATES IF POSSIBLE)

PREVIOUS HOSPITALIZATIONS, INCLUDING TRAUMATIC INJURIES (PLEASE LIST THE REASON)

CHRONIC MEDICAL CONDITIONS (*e.g.* DIABETES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL)

FAMILY MEDICAL HISTORY (*e.g.* CANCER, DIABETES, HEART ATTACK, STROKE)

SOCIAL HISTORY		
MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED	OCCUPATION	
EMPLOYED: ☐FULL TIME ☐PART TIME ☐HOMEMAKER ☐UNEMPLOYED ☐DISABLED		
DO YOU SMOKE? ☐YES ☐NO	HOW MANY PACKS PER DAY?	FOR HOW MANY YEARS?
DO YOU CHEW TOBACCO? ☐YES ☐NO		
ALCOHOL CONSUMPTION? ☐YES ☐NO	HOW MANY DRINKS PER DAY _____ PER WEEK _____ PER MONTH _____	
ANY DRUG USE? (*e.g.* marijuana, cocaine)		

Financial Policy

We are committed to your treatment being successful. 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 read and agree to prior to treatment. We accept cash, checks, and credit cards.

Insurance Billing

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form. If unable to make payment in full, contact us immediately to make payment arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney's fees. If your account becomes delinquent or is referred for collections, Brain and Elective Spine Treatment Center (B.E.S.T.) and/or any collection agent of B.E.S.T. has authorization to obtain your credit report to assist them in the collection of your bill.

HMO Plans (with which we are contracted): All co-payments must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collection of co-payments at every visit. You are responsible for obtaining authorization and approval for treatment with your medical group or primary care physician prior to treatment.

PPO Plans (with which we are contracted): We have negotiated rates with your insurance company. Your co-insurance, co-payments, and unmet deductibles are your responsibility and payment is due at time of service.

Medicare: We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance not paid by the insurance carriers.

In the event your insurance coverage changes to a plan with which we are not a participating provider, you will be responsible for any out-of-network deductible or co-insurance amounts.

Paperwork Fees: We do charge for completing paperwork on your behalf. This fee covers our costs and time involved in accessing your medical records, reviewing the documents, completing and signing the forms. We require a $35.00 fee for any document that is 3 pages or less. Any number of pages thereafter will be charged $15/page. These fees must be paid prior to the forms being completed.

Usual and Customary Rates: Our practice is committed to providing the BEST treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Returned Checks: A $25 fee will be charged for any returned checks. We will be unable to accept your checks for any services thereafter.

Patient name (printed): _____ Date signed: _____

Patient signature: _____ (parent or legal guardian, if applicable)

☐ Check if parent or guardian

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: Dr Devin Binder
BEST Center
9940 Talbert Ave Ste 201
Fountain Valley, CA 92708
Tel: 949-829-2378

PLEASE FAX to 714-769-6121

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse_____(initial)
HIV Diagnosis/Treatment _____(initial)
Psychiatric/Mental Health _____(initial)
Genetic Information _____(initial)
Tests for Antibodies to HIV _____(initial)

DURATION: This authorization shall be effective immediately and remain in effect for 1 year.

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative
Relationship *if other than patient*

_____ _____
Patient's Name (PRINT)
Date

_____
Patient's Date of Birth

DEVIN K. BINDER, M.D., PH.D.
Board-Certified Neurosurgeon
9940 Talbert Ave Suite 201
Fountain Valley, CA 92708
(949) 829-2378 (-BEST) (phone)
(714) 769-6121 (fax)
www.bestcenteroc.com
info@bestcenteroc.com

Controlled Substance Agreement

I understand that my provider is prescribing controlled medications (opioids, barbiturates, benzodiazepines) to assist me in managing my post-operative pain. These medicines are intended to decrease pain in order to improve function and allow progress in rehabilitation. I understand that I have important responsibilities regarding the care and use of these medications.

1. I understand that I should be receiving pain medication from only one doctor or practice at any one time. I understand that I will only be getting prescriptions for pain medicines from Dr. Binder or from a physician outside of the practice, but NOT BOTH. If I develop another condition that requires the prescription of a controlled medication, I will inform the clinic within one business day of receiving any new controlled medications.
2. I understand that Dr. Binder may only be prescribing my pain medications UP to **90 days** past the date of my surgery. At that point, if they are still necessary, I will receive them from my PCP or a dedicated pain management physician.
3. I will designate only one pharmacy where all my narcotic prescriptions will be filled.
4. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my provider's approval. Refills may not be given if I "run out early".
5. I understand that I am responsible for the care of my medications once I leave the office/hospital with my prescription. I understand that my narcotic medications may not be replaced if they are lost, stolen, or destroyed. Controlled medications should be locked up and secured.
6. Refill of a controlled medications will be made only during regular office hours Monday- Friday, 8:30 AM-5:00PM. No refills on nights, holidays, or weekends. I will allow 2-3 business days for my prescription to be ready for pick up. **No exceptions will be made.**
7. I understand that the medications prescribed are for the sole purpose of pain control and agree not to use if for any other purpose.
8. I will not share or divert my narcotic medications with any other person.
9. I understand that controlled medications can affect my thinking and judgement and may interfere with my ability to drive. I will not drive if I have this concern.
10. I understand these rules and that noncompliance may lead to the discontinuation of my medications and/or discharge from Dr. Binder's care.

I have read the contract and it has been explained to me. I fully understand the consequences of violating this agreement.

Signature: _____

Print name: _____ Date: _____

BRAIN & ELECTIVE SPINE TREATMENT CENTER
9940 TALBERT AVE SUITE 201
FOUNTAIN VALLEY, CA 92708
949-829-BEST
www.bestcenteroc.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices for Brain & Elective Spine Treatment Center.

Signature of Patient *(or Parent, if minor):* _____

Print Name: _____

Date: _____

If a personal representative signs this acknowledgement on behalf of the patient, please complete the following:

Name of Personal Representative:

_____

Relationship to Patient: _____