GOODMAN CAMPBELL
BRAIN AND SPINE

PATIENT MEDICAL HISTORY

CONTACT INFORMATION

Prefix: _____ Patient name: _____ Suffix: _____
Nickname: _____ Last four digits of Social Security #: _____
Date of birth: _____ Gender: ☐Male ☐Female ☐Other_____
Home address, City, State, and Zip: _____
Phone number (Please circle best daytime number): ☐Home_____ ☐Cell_____
If applicable, parent/guardian phone number: ☐Home_____ ☐Cell_____
Email address: _____

EMERGENCY CONTACT INFORMATION

Marital status: ☐Divorced ☐Legally separated ☐Single
☐Domestic partner ☐Married ☐Widowed
If applicable, name of spouse: _____Spouse's best phone: _____

Please list an emergency contact not living with the patient.

Name: _____Relationship: _____
Phone number: _____Address, City, State, and Zip: _____

DEMOGRAPHICS

Race: ☐Alaska Native ☐American Indian ☐Asian
☐Black or African American ☐Hispanic ☐Multi-Racial
☐Native Hawaiian or Other Pacific Islander ☐White ☐Other _____

1. Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
2. Preferred language: _____

PHYSICIANS & PHARMACY

Name of referring doctor: _____
Name of family doctor: _____
Preferred pharmacy: _____ Pharmacy phone number: _____

PRIMARY BILLING INFORMATION

Insurance name: _____ Policy holder's employer: _____
Policy holder's name: _____ Relationship to patient: _____
Policy holder's date of birth: _____

HOW DID YOU HEAR ABOUT US?

☐Physician referral ☐Print ad ☐Brain Bolt 5K/Other event
☐Friend/family ☐News/TV ☐Social media
☐Online search ☐Radio ☐Other

FAMILY HISTORY

Have your mother, father, brother or sister experienced any of the following?

☐Unknown family history ☐Heart disease ☐Diabetes ☐Stroke ☐Cancer ☐Other: _____

Father - ☐Living, age: _____ ☐Deceased, age at death: _____ Cause of death: _____

Mother - ☐Living, age: _____ ☐Deceased, age at death: _____ Cause of death: _____

Brothers - Number living: ____ Number deceased (cause of death): _____

Sisters - Number living: _____ Number deceased (cause of death): _____

PAST MEDICAL HISTORY

Please check all conditions you have or have had in the past.

☐NONE; none of the conditions below apply to me.

- ☐ Heart disease
- ☐ Heart attack (year: _____)
- ☐ Stent (year: _____)
- ☐ Pacemaker (year: _____)
- ☐ High blood pressure
- ☐ Stroke (year: _____)
- ☐ Seizures/convulsions
- ☐ Parkinson's Disease
- ☐ TBI (year: _____)
- ☐ Asthma
- ☐ Bleeding difficulties
- ☐ COPD
- ☐ Osteoporosis
- ☐ Thyroid dysfunction
- ☐ HIV
- ☐ Hepatitis
- ☐ TB
- ☐ Glasses/contacts
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2

If so, how do you treat it?

- ☐ Insulin dependent
- ☐ Pills
- ☐ Diet controlled
- ☐ Cancer (type/treatment): _____ _____ _____
- ☐ Arthritis (name/type): _____ _____ _____

☐Other conditions, please explain: _____

_____

ALLERGIES

☐NONE; I do not have any known drug allergies.

☐Latex ☐Tape ☐Other (please specify below)

	Allergy/Reaction		Allergy/Reaction
1.	_____	4.	_____
2.	_____	5.	_____
3.	_____	6.	_____

PRESCRIPTION MEDICATIONS

☐NONE; I do not take any prescription medications.

☐I have an active Pain Contract with a provider - physician's name: _____

☐***I am on a blood thinner (such as Coumadin, Plavix, Aspirin)***

	Medicine/Dose/Number per Day		Medicine/Dose/Number per Day
1.	_____	6.	_____
2.	_____	7.	_____
3.	_____	8.	_____
4.	_____	9.	_____
5.	_____	10.	_____

NON-PRESCRIPTION MEDICINE

☐NONE; I am not taking any non-prescription medicines.

	Herbal Supplement/Preparations		Over-the-counter drugs/Vitamins
1.	_____	1.	_____
2.	_____	2.	_____
3.	_____	3.	_____
4.	_____	4.	_____
5.	_____	5.	_____

PAST SURGICAL HISTORY

☐NONE; I have not had any previous surgeries.

Surgery/Date	Surgery/Date
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

REVIEW OF SYSTEMS

For Females:

Are you pregnant? ☐Yes ☐No

Menstrual irregularity? ☐Yes ☐No

Date of last period: _____ ☐N/A

For Males:

Erectile problems? ☐Yes☐No

For ALL Patients:

Flu shot? ☐No ☐Yes (Date:_____)

Pneumonia shot?☐No ☐Yes (Date:_____)

Shingles shot? ☐No ☐Yes (Date:____)

REVIEW OF SYSTEMS – PLEASE CHECK ANY OF THE FOLLOWING YOU ARE EXPERIENCING

Constitutional
- ☐ Fatigue
- ☐ Fever/chills
- ☐ Loss of appetite
- ☐ Weight gain
- ☐ Weight loss

Cardiovascular
- ☐ Chest pain
- ☐ Fainting
- ☐ Feet swelling
- ☐ Murmur
- ☐ Palpitations

Musculoskeletal
- ☐ Back/neck pain
- ☐ Fibromyalgia
- ☐ Gait problems (walking)
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint swelling
- ☐ Muscle pain/weakness

Psychological
- ☐ Anxiety ☐ Depression
- ☐ Insomnia ☐ Panic attacks
- ☐ Severe stress

Eyes & ENT
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Light sensitive
- ☐ Vision loss
- ☐ Hard of hearing
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Sore throat

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Change in, or pain with, bowel movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Reflux
- ☐ Ulcers
- ☐ Vomiting

Skin/Breast
- ☐ Abscess
- ☐ Itching
- ☐ Lesion discharge
- ☐ Rash
- ☐ Sores

Genitourinary
- ☐ Flank pain
- ☐ Incontinence
- ☐ Painful urination
- ☐ Urinary frequency
- ☐ Urinary hesitation
- ☐ Sexual difficulties

Endocrine
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Overly cold
- ☐ Overly hot

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing

Neurological
- ☐ Confusion
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Headache
- ☐ Memory impairment
- ☐ Head injury
- ☐ Numbness
- ☐ Seizures
- ☐ Slurred speech
- ☐ Tingling
- ☐ Tremors

Hematologic/Lymphatic
- ☐ Bleeding tendencies
- ☐ Blood clots
- ☐ Easy bruising
- ☐ Excessive bleeding during procedures
- ☐ Lymph node swelling

SOCIAL HISTORY

Tobacco Use
- ☐ Never
- ☐ Chewing tobacco
- ☐ Pipe
- ☐ Cigars
- ☐ Cigarettes (packs/day: ___)
- ☐ Vaping
- ☐ Quit smoking (when?_____)

Alcohol Use
- ☐ None
- ☐ Socially
- ☐ Daily (# per day:_____)
- ☐ Treated for alcoholism? If yes, when?_____

Illegal Drug Use
- ☐ None
- ☐ Marijuana
- ☐ Cocaine
- ☐ Amphetamines
- ☐ Other: _____
- ☐ Treated for drug addiction? If yes, when?_____

I currently live in a:
- ☐ House
- ☐ Apartment
- ☐ Mobile home/trailer
- ☐ Retirement facility

Hand Dominance:
- ☐ Right
- ☐ Left
- ☐ Ambidextrous

EDUCATIONAL HISTORY

Level of education: ☐Less than high school ☐High school diploma or GED
☐Two-year college degree ☐Four-year college degree
☐Post-college degree

ACTIVITY LEVEL

Did you participate in activities outside the home before your current problem developed (i.e. gardening, golf, walking, cycling, or volunteering)?

☐ No ☐ Yes (If yes, were the activities…☐ Sedentary or light, ☐ Moderate, ☐ Strenuous)

Did you participate in activities inside the home before your current problem developed (i.e. vacuuming, cooking, general housework)?

☐ No ☐ Yes (If yes, were the activities…☐ Sedentary or light, ☐ Moderate, ☐ Strenuous)

OCCUPATIONAL HISTORY

Current employment: ☐ **EMPLOYED** ☐ **UNEMPLOYED** ☐ **ATTENDING SCHOOL**

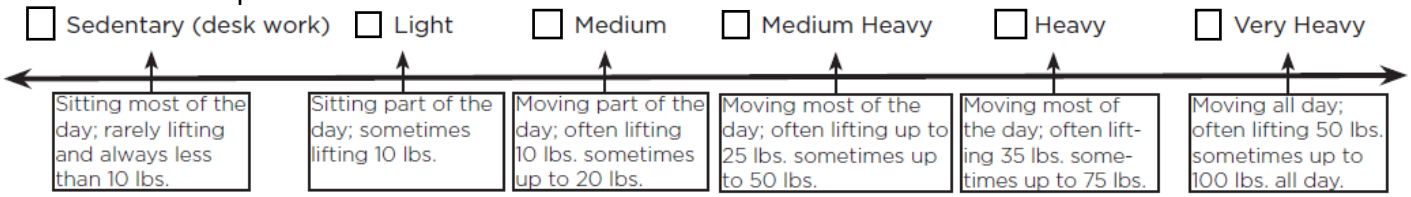
☐ Full-time
☐ Part-time

☐On disability
☐Retired (prior occupation: _____)
☐Homemaker
☐None of the above

Employer: _____Occupation:_____

Have you altered your job as a result of the problem that brought you here today? ☐Yes ☐No
If yes, explain:_____

Describe Your Occupation:



If the problem that brought you here today requires surgery, do you plan to return to work after your surgery?
☐Yes ☐No ☐Unknown

If employed but not working or unemployed on disability, is it due to? ☐Spine problems ☐Other problems

Are you actively under FMLA leave? ☐Yes ☐No If "Yes", physician's name: _____

Workers Compensation Claim: ☐Yes ☐No If "Yes", Work Comp Carrier: _____

Liability or Disability Insurance Claim: ☐Yes ☐No ☐Unknown

Form Completed By: _____ Relationship: _____ Date: _____

I hereby authorize the physicians and/or employees of Goodman Campbell Brain and Spine, PC to release any current reports or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force until revoked by me in writing (IN Code 16-4-8) (1-11).

I authorize and request insurance companies to pay directly to Goodman Campbell Brain and Spine, PC the surgical and/or medical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services. Attorney fees and court costs incurred by Goodman Campbell Brain and Spine, PC in the collection of my account balance will be my responsibility.

Signed: _____ Date: _____

NOTE: This authorization MUST be signed and dated by the patient unless the patient is a minor or has a legal guardian. In this case, a parent or legal guardian must sign and date.

GOODMAN CAMPBELL
BRAIN AND SPINE

ACCIDENT INFORMATION

Name: Date of Birth:

IS THIS VISIT THE RESULT OF AN ACCIDENT? ☐YES ☐NO
If yes, please continue filling out this form.

Nature of Accident:

☐Car accident ☐Fall ☐Sporting accident ☐Assault (a fight or beating) ☐Gunshot ☐Other: _____

Where were you injured?

☐In my own home

☐At work

Is this a worker's comp injury? ☐Yes ☐No
Date of injury: _____
Your employer's worker's comp carrier name:_____
Address of carrier: _____ Phone: _____
City/State: _____ Zip: _____ Claim #: _____
Case manager name: _____ Phone: _____ Fax: _____

☐In a motor vehicle accident

Date of accident: _____ Location of accident: _____
Have you contacted the other driver's car insurance company? ☐Yes ☐No

☐At a business

Date of accident: _____ Have you filed an insurance claim? ☐Yes ☐No
What is the name of the business? _____
What is the owner's name? _____ Phone: _____
What is the address of the business? _____

☐At someone's house

Date of accident: _____ Have you filed a homeowner's insurance claim? ☐Yes ☐No
What is the name of the person that owns the home? _____
What is the address? _____

☐Other

Regardless of the cause of the accident, please complete the questions below:

Is there litigation pending (suing in a court of law)? ☐Yes ☐No
Are you considering litigation (suing)? ☐Yes ☐No
If yes to either question, what is the name and phone number of your attorney?_____
_____

Please describe the accident: _____

_____

_____

_____

_____

_____

Had you ever experienced your symptoms before the accident? ☐Yes ☐No

If the accident was due to a fall, how did you fall? _____

If this was a bicycle, motorcycle or ATV accident, were you wearing a helmet? ☐Yes ☐No ☐N/A

If this was a car accident, did you have your seat belt on? ☐Yes ☐No ☐N/A

Did you have a shoulder strap on? ☐Yes ☐No

Did the air bag deploy or go off? ☐Yes ☐No

How fast was your car driving? _____

How fast was the car that hit you driving? _____

Where were you sitting in the car?

☐Driver's seat ☐Front passenger seat ☐Back seat, driver's side

☐Back seat, passenger side ☐Other: _____

When did you first seek medical treatment? _____ Where? _____

What tests were done? _____

What was your diagnosis? _____ Who was your doctor? _____

Were you taken to a hospital by ambulance? ☐Yes ☐No

If you were in the hospital, for how long? _____ Hospital name: _____

Doctor's name: _____

What kind of work do you do? _____

What was the last day you worked? _____

Please list anything else you would like your doctor to know about the accident and its effects on you:

_____

_____

_____

_____

_____

GOODMAN CAMPBELL
BRAIN AND SPINE
317.396.1300 • 888.225.5464
www.goodmancampbell.com

For staff use only - please do not write in this space

Name:

Date of Birth:

FINANCIAL POLICY

Please read this policy carefully. Payment is expected at the time of service unless other arrangements have been made prior to the appointment. Our Patient Accounts representatives are available Monday through Friday from 8:00 AM to 4:30 PM to discuss financial arrangements. For your convenience, we accept MasterCard, Visa, Discover, American Express, and CareCredit. Please call (317) 396-1300 or toll free 888-363-8762.

Goodman Campbell Brain and Spine contracts with patients for their medical care; any arrangements made by the patient with attorneys, insurance companies, or other third party payers will not be considered in the collection of your account.

Charges for Professional Services – Every professional service and associated expense rendered will be charged to the patient according to a fee schedule prospectively determined by the clinic. Contractual discounts to third parties prospectively agreed to by the clinic will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator, billing manager, or his or her designee. An estimate of these fees can be requested prospectively.

Insurance – Health insurance is primarily a contract between the patient and the insurance company; however, Goodman Campbell Brain and Spine also has mutually agreed contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Goodman Campbell Brain and Spine will make available substantial resources to facilitate insurance payment and will dedicate resources towards contractual obligations with these entities.

Payment – Payment for services rendered is due on the date of service and is part of the professional relationship. Goodman Campbell Brain and Spine reserves the right to request payment of the total negotiated fee on the date due unless directed otherwise by contract.

All co-payments will be collected at the time of service. All past-due balances or balances in collection must be paid prior to seeing a Goodman Campbell Brain and Spine practitioner.

Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient non-compliance with this financial policy. Only the administrator, billing manager, or their designated representative can amend this policy.

Down-Payment for Non-Urgent Surgical Procedures – Patient will be responsible for paying any deductible, coinsurance, and co-pays prior to receiving non-urgent surgical services from Goodman Campbell Brain and Spine physicians. Benefits will be verified prior to scheduling the surgery, and patient will be notified via telephone and mail of financial obligations. Down payment must be received prior to scheduled surgery. Failure to pay required down-payment may result in cancellation of surgery.

Patient Referrals and Out of Network – If patient is enrolled with an insurance carrier with network benefits, patient is entitled to full benefits of said plan when certain guidelines are followed. If patient does not obtain a referral from his/her Primary Care Physician (PCP) for services rendered by Goodman Campbell Brain and Spine physician or provider, patient may be responsible for all or a portion of charges incurred. Patient will be responsible for charges incurred when choosing to go out of the designated managed care network.

Collection Agencies – Goodman Campbell Brain and Spine will use all reasonable means to collect owed funds. Defaults in payment of agreed amounts will be referred to a collection agency for payment. Patient will be responsible for collection agency fees incurred while account is in collection.

Non-Sufficient Funds (NSF) – Goodman Campbell Brain and Spine will charge a $25 fee for all checks returned by the bank for non-sufficient funds.

Medicare Patients - Goodman Campbell Brain and Spine physicians are participating providers and accept the Medicare assignment of benefits. Medicare patients will be responsible for deductibles, 20 percent coinsurance and/or non-covered charges when applicable. By signing this policy, the Medicare recipient requests payment of authorized Medicare benefits be made on patient's behalf for any services furnished by Goodman Campbell Brain and Spine, including physician services.

Medigap/Secondary Insurance Authorization – Medicare recipient authorizes Goodman Campbell Brain and Spine or its agent to release medical or other information to supplemental insurance in order to process all medical claims. A copy of this authorization may be used in place of the original. Medicare recipient requests payment of medical insurance benefits to Goodman Campbell Brain and Spine for services provided.

_____ _____

Patient or Responsible Party Date

_____ _____

Witness Patient's Name

_____

For office use only

Goodman Campbell Account # _____ Witnessed by: _____

GOODMAN CAMPBELL
BRAIN AND SPINE

For staff use only - please do not write in this space

Name:

Date of Birth:

GOODMAN CAMPBELL BRAIN AND SPINE (the "Practice")
NOTICE OF PRIVACY PRACTICES
IMPORTANT NOTICE TO OUR PATIENTS

As required by HIPAA, all Patients who receive health care services from GOODMAN CAMPBELL BRAIN AND SPINE (the "Practice") must:

- **Receive** or at least be offered the attached "Notice of Privacy Practices" Form; and
- **Sign** the "Acknowledgement" Form below and return it to our front desk for our records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our Patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our Patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions last year.

Please Sign the Acknowledgement Form below and return it to our front desk for our records.

Thank you very much.

ACKNOWLEDGMENT FORM

I hereby acknowledge that I have received (or was at least offered) a current copy of Practice's Privacy Notice.

_____
Patient or Personal Representative* Signature

Date_____

(*) If signed by Personal Representative, please state your relationship to Patient:

_____

GOODMAN CAMPBELL
BRAIN AND SPINE

317.396.1300 • 888.225.5464
www.goodmancampbell.com

Name:

Date of Birth:

To Our Patients:

Goodman Campbell Brain and Spine believes strongly that well-informed patients are an integral part of the medical care process.

In support of this belief, Goodman Campbell Brain and Spine's physicians wish to inform our patients that our neurosurgeons maintain ownership, or limited investment interests, in commercial businesses that provide important benefits to our patient care. A summary of these are listed below:

Various Goodman Campbell Brain and Spine physicians act as neurosurgical consultants for:

- Medtronic stimulators and pumps
- Sofamor Danek spine instruments

Various Goodman Campbell Brain and Spine physicians maintain some ownership in the following:

- Various Outpatient Surgery Centers
- Proscan Imaging
- Novalis radiosurgery at St. Vincent Hospital
- Lanx Inc. (a surgical medical device company)

Various Goodman Campbell Brain and Spine physicians participate in multiple clinical trials:

- For all such clinical trials, specific patient informed consent is obtained for participation.

Goodman Campbell Brain and Spine physician participation in the above entities allows Goodman Campbell Brain and Spine physicians to demand the highest standards of care. Goodman Campbell Brain and Spine physicians will only accept the highest quality products for our patients.

Nevertheless, as with all medical decision-making, the choice of where and from whom a patient receives services is ultimately the patient's decision. Goodman Campbell Brain and Spine physicians will fully discuss with our patients any concerns that might exist regarding health care business ventures or products in which Goodman Campbell Brain and Spine physicians may have a financial interest.

Any questions regarding these matters should be directed to your Goodman Campbell Brain and Spine physician.

Please sign below so that our records indicate that you have received a copy of the above statement and understand the contents.

_____ Date ___/___/___

Thank you very much,

Goodman Campbell Brain and Spine