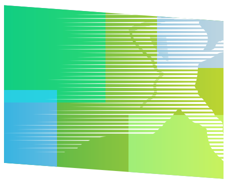


MARIN
ORTHOPEDICS
& SPORTS MEDICINE

Spine Patient History Questionnaire

Name: ______________________________ Date: ______________

Birthdate: ______________ Height: ________ Weight: _________ Sex: ☐ Male ☐ Female

Referring Provider: ________________________ Primary Care Physician: ____________________

How would you like to be addressed? ______________________________

Please explain the reason for your visit, including a description of your problem and the duration of your symptoms. Be as detailed as possible and attach extra pages if necessary:

____

____

____

____

Are your symptoms due to a work-related injury? ☐ Yes ☐ No

Are your symptoms related to a motor vehicle accident? ☐ Yes ☐ No

Is there litigation pending or anticipated regarding your current injury? ☐ Yes ☐ No

Have you had previous injuries or surgeries to this area? ☐ Yes ☐ No

If yes, please describe: ____

____

Have you seen another physician for this problem? ☐ Yes ☐ No

If yes, please list previous providers and dates treated: ______________________________

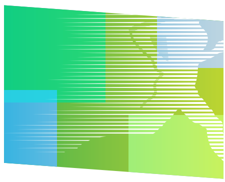
____

Have you had previous imaging (X-rays/MRI/CT scans) of the area? ☐ Yes ☐ No

If yes, please list the type of imaging and the date/location performed: ____________________

____

____



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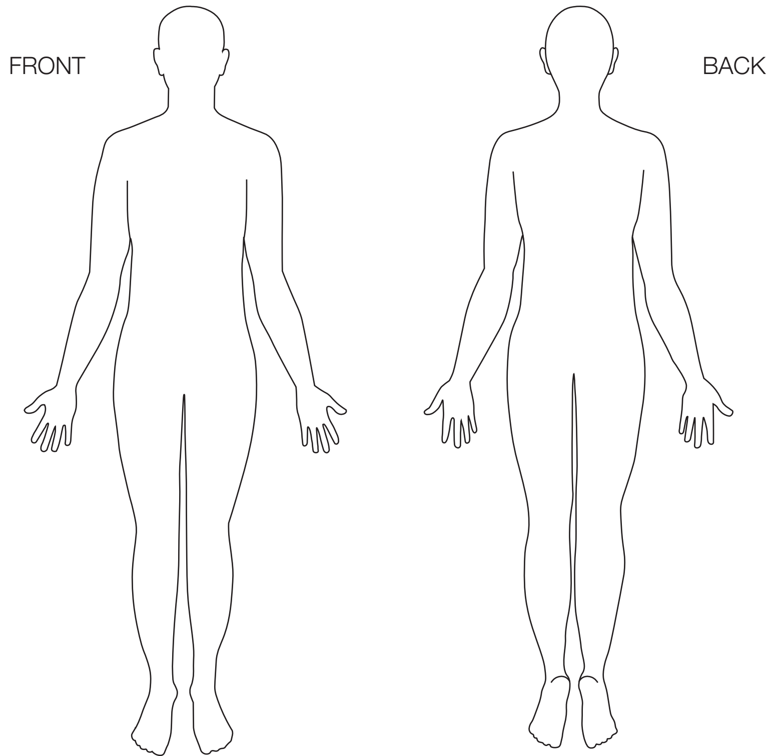
Spine Patient History Questionnaire (cont.)

Please use the diagram below to indicate the areas of your body that are affected by your symptoms:



Please check all of the following descriptions that apply to your current symptoms:

- [ ] Pain
- [ ] Numbness
- [ ] Loss of Motion
- [ ] Radiating
- [ ] Tingling
- [ ] Clicking
- [ ] Sharp
- [ ] Weakness
- [ ] Popping
- [ ] Stabbing
- [ ] Swelling
- [ ] Catching/Locking

Please use the following 0–10 pain scale to answer the following questions:

My current pain level is (0–10): ________________

The worst pain level I experience in a day is (0–10): _____________ **The least is (0–10):** _____________

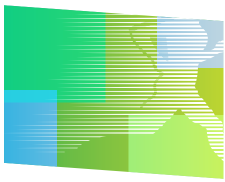
My symptoms are ***least*** in the (check one): ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

My symptoms are ***worst*** in the (check one): ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Please list the daily activities, sports activities, or hobbies that you are having difficulty performing due to your current symptoms: ____

____

____



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Spine Patient History Questionnaire (cont.)

Please answer the following regarding other treatments you have tried for this problem:

Type of Treatment	Check One	Helpful?	Dates Tried
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	
Chiropractic	☐ Yes ☐ No	☐ Yes ☐ No	
Acupuncture	☐ Yes ☐ No	☐ Yes ☐ No	
Massage	☐ Yes ☐ No	☐ Yes ☐ No	
Other: ______________	☐ Yes ☐ No	☐ Yes ☐ No	

Please list all medications you are **currently taking for this problem.** Include the dosage and frequency as well as the prescribing physician's name, if applicable (attach extra pages if necessary):

____

____

Please list all medications you have **previously tried for this problem** and the reason for discontinuation. Include the dosage and frequency as well as the prescribing physician's name, if applicable (attach extra pages if necessary):

____

____

Please provide a list of all other medications you are currently taking (attach extra pages if necessary):

Medication	Dosage	Frequency	Prescribing MD

Please list any other supplements/vitamins that you regularly use: ______________________________

____

If you have allergies to any medication(s), please list the medication(s) and type of reaction: ______________

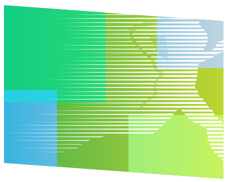
____

Please list all other medical conditions with which you have been diagnosed: ______________________

____

Please list all previous surgeries: ____

____



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Spine Patient History Questionnaire (cont.)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Smoking History: ☐ I Currently Smoke ☐ I Used to Smoke ☐ I Have Never Smoked

If you currently smoke, how many packs per day do you smoke? ___________________

If you are a prior smoker, when did you quit? ___________________

Alcohol History: I drink alcohol ☐ Daily ☐ Most Days ☐ 2–3x/Week ☐ Occasionally ☐ Never

If you currently drink alcohol, how many drinks do you have per week? ___________________

Have you ever been diagnosed with a substance abuse problem? ☐ Yes ☐ No

If yes, please describe: ____

Are you currently suffering from any of the following symptoms? Check **all** that apply.

☐ Fevers	☐ Chills	☐ Sweats	☐ Loss of Bladder Control
☐ Loss of Bowel Control	☐ Chest Pain	☐ Heart Palpitations	☐ Shortness of Breath
☐ Heartburn	☐ Abdominal Pain	☐ Fatigue	☐ Weakness
☐ Abdominal Cramping	☐ Insomnia	☐ Muscle Cramps	☐ Loss of Balance
☐ Recent Falls	☐ Leg Swelling	☐ Unintended Weight Loss	☐ Unintended Weight Gain
☐ Rashes	☐ Diarrhea	☐ Constipation	☐ Migraine Headaches
☐ Other Headaches	☐ Stress	☐ Anxiety	☐ Depression

Is there any additional information you would like to share with us regarding your current condition or medical history that you feel will be helpful to our medical staff?

____

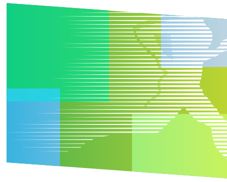
____

____

____

____

Patient Signature: ____



MARIN ORTHOPEDICS & SPORTS MEDICINE

Mark Lawler, MD
Orthopedic Surgery
& Sports Medicine

Holly Kelly, MD
Physical Medicine
& Rehabilitation

Daniel Solomon, MD
Orthopedic Surgery
& Sports Medicine

Kevin Holman, PA-C
Physician Assistant

Amy Jones, PA-C
Orthopedic
Physician Assistant

Patient Information and Treatment Contract

At Marin Orthopedics & Sports Medicine, we strive to provide the most up-to-date treatment options that will benefit you. The following document helps prevent confusion about your responsibilities in treating your medical condition. Please read the following information carefully.

FINANCIAL RESPONSIBILITY

You are responsible for all of the costs of your treatment. Your insurance may or may not cover all of the costs associated with the plan of care pursued by you and your physician. All copays are due at the time of service. As a courtesy to you, we will bill and collect the amount allowed by your insurance contract for your treatment. We are not responsible for insurer's inadequate payment, unreasonable payment delays, or claim denials. We do our best to make sure planned treatments are preauthorized for payment but advise that you make sure of your insurance benefits as well **before** undergoing treatments/procedures/surgical intervention. Please be aware that certain services are not typically covered under the scope of a routine office visit by your insurance and, as such, are billed as follows:

Forms and Letters:	**$25.00 per page**
Pharmacy Medication Authorizations/Appeals:	**$50.00 per medication**
Office Visit No-Show:	**$75.00**
Procedure/Surgery No-Show:	**$250.00**
Return Check Fee:	**$25.00**

LATE ARRIVAL POLICY

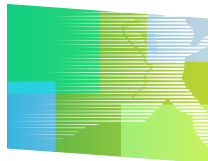
Please be aware that if you are late to your appointment, you may be asked to reschedule your visit or wait until we can fit you in after on-time arrivals have been seen.

PHONE CALL POLICY

Our office receives a tremendous number of phone calls each day. In order to devote the appropriate care and attention to each patient in the office, our physicians typically will return phone calls during the lunch hour or after regular business hours. The Medical Board of California discourages physicians from providing treatment information over the phone; therefore, if you are experiencing a new problem, please reschedule a return visit to discuss this issue in person. If you are having a life-threatening emergency, please call 9-1-1. In general, we are not available to rediscuss issues over the phone with multiple family members. If you believe you will have difficulty remembering the treatment recommendations discussed during your office visit, please bring a family member to the visit to assist with note taking for your recollection.

MEDICATION REFILL POLICY

You are responsible for keeping track of your own medications. No prescription refills for lost medications will be issued. No routine controlled substance prescription refills will be authorized after hours or on the weekends. Please allow 72 hours' notice for routine medication refill requests. Refill requests are most easily made by calling your pharmacy or sending a request through the Patient Portal located on our website. By signing below, you are giving Marin Orthopedics & Sports Medicine providers authorization to communicate verbally, electronically, or in writing to your pharmacy or other providers regarding your current medications.



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PAIN MEDICATION POLICY

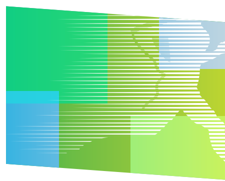
In addition to the above Medication Refill Policy, these further guidelines apply to controlled substances: all controlled substance prescriptions must be picked up in person with a photo ID. All prescriptions for controlled substances must be filled by one medical office at one pharmacy. Evidence of obtaining a controlled substance by more than one medical office or using multiple pharmacies without prior disclosure is grounds for discontinuation of controlled substance refills. By accepting a prescription for a controlled substance, you are agreeing to random urine drug screens and any possible associated costs of these screens so that we may confirm appropriate use of the prescribed medication(s). Presence of unauthorized substances or absence of your prescribed medications in a urine drug screen is grounds for discontinuation of medication refills. By accepting a controlled substance prescription from our office, you grant our physicians and staff permission to discuss aspects of your care and medications with all involved physicians, hospitals, and pharmacies as medically necessary.

Print Name: ____ **Date:** ______________

Patient Signature: ____

Physician Signature: ____

www.marinorthopedics.com
7100 Redwood Blvd, Ste 200, Novato, CA 94945
P: (415) 492-1600 • **F:** (415) 493-2542



MARIN ORTHOPEDICS & SPORTS MEDICINE

Notice of Privacy Practices (Medical)

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.

The Health Insurance Portability and Accountability Act of 1996 HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute non-identifying health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Patient Name: ______________________________ **Relationship to Patient:** ____________

Signature: ____ **Date:** ____________

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W., Washington DC 20201
(202) 619-0257 • Toll Free: 1(800) 696-6775