CHRISTIANA SPINE CENTER P.A.

Anthony L. Cucuzzella, M.D.**
Tony R. Cucuzzella, M.D.*
Anton Delport, M.D. ** **
Elva G. Delport, M.D.*
J. Rush Fisher, M.D.***
Ann Kim, M.D.*
Nancy Kim, M.D.*
Michael R. Murray, M.D. ***
Yong I. Park, M.D. **
Scott Roberts, M.D.*
Frank B. Sarlo, M.D.**

Medical Arts Pavilion 2
Suite 3302
4735 Ogletown-Stanton Road
Newark, Delaware 19713

Telephone: (302) 623-4144
Facsimile: (302) 623-4147

www.christianaspinecenter.com

***Fluoroscopic Spine Procedures**
Physical Medicine & Rehabilitation

****Electromyography**
Physical Medicine & Rehabilitation

*****Reconstructive Spinal Surgery**
Orthopedic Surgery

******Musculoskeletal Procedures**
Musculoskeletal Radiology & Ultrasound

Welcome to the Christiana Spine Center. The following appointment has been scheduled for you.
Date: ____________Time:____________with Dr.____

We hope that the following information will be helpful to you. We respect your time and would like to help make your visit as efficient as possible.

LOCATION: We are conveniently located on the Christiana Hospital Campus in Medical Arts Pavilion II. There is free parking in the front and the back of the building. We are wheelchair accessible.

MEDICAL INFORMATION: **YOU MUST BRING ALL YOUR IMAGING STUDIES (FILMS) ON DISC AT THE TIME OF A SURGICAL APPOINTMENT. FAILURE TO BRING YOUR STUDIES WILL REQUIRE US TO RESCHEDULE YOUR APPOINTMENT.** Please have your physician fax or mail your medical records to our office prior to your appointment. They would include MRI, CT Scans, plain films, and operative or hospital summaries. Our fax is (302)623-4147. Please hand carry all discs/films at the time of appointment. **A spinal injection will NOT be performed the same day of your initial evaluation.**

FORMS TO BE COMPLETED: Enclosed you will find various forms which must be reviewed, completed and signed. Please complete the registration forms, patient questionnaire and signatures on forms where indicated and bring them with you to your appointment.

FINANCIAL POLICY: We collect co-pays at the time you check in at our office, before seeing the Doctor. Failure to pay your co-pay at that time will result in having your appointment rescheduled. **PLEASE BRING ALL INSURANCE CARDS** at the time of your visit. If you will be filing a workman's compensation, motor vehicle accident or personal injury claim, please bring all billing information including address and claim number. We do require a copy of your primary insurance card for these claims, as well.

MEDICAL INSURANCE: Before your appointment, please verify that your health insurance allows treatment by our office. Your plan may require that your primary care physician write a referral/authorization. **PLEASE BRING THE REFERRAL AT THE TIME OF YOUR APPOINTMENT. FAILURE TO BRING YOUR REFERRAL MAY NECESSITATE YOUR APPOINTMENT BEING CANCELLED UNTIL YOU HAVE OBTAINED THE PROPER REFERRAL.** Your insurance reimbursement may not cover the full cost of your visit. Regardless of insurance, payment remains your personal responsibility.

INSURANCE FORMS: There be a fee for disability forms completed by our physicians. This does not include your private health insurance filing.

CANCELLATION: If, for any reason, you cannot keep this appointment, please call to reschedule at least **24** hours in advance at 302.623.4144. **A $25 fee will be charged if not cancelled 24 hours in advance. Failure to keep your appointment, we reserve the right to charge a fee of $30.00.**

Disclaimer

The Christiana Spine Center, LLC, is a separate name-only entity and does not have separate liability coverage. Physiatrist Associates, PA, employs all physicians and they are not considered partners, employees, agents and/or servants of the Christiana Spine Center, LLC.

CHRISTIANA SPINE CENTER
PATIENT PORTAL

Christiana Spine Center's Patient Portal is an online service that allows you to keep track of your personal medical information. It will also allow us to share and receive information easily with you.

You will be able to do the following, and more.

- Send and receive messages to and from our staff. These can address appointment and refill requests, billing and health questions, and general messages

- Access forms and educational material

- Keep your account up to date by reporting changes in general information, responsible party, employment information, insurance, emergency contacts, pharmacy, medications, allergies, and history information.

- View clinical summary information which is available after every office visit

- Get the results of your images or other tests securely delivered through the Patient Portal which can eliminate the inconvenience of phone calls

Feel free to contact us if you have any questions about how to use the Patient Portal.

CHRISTIANA SPINE CENTER
NEW PATIENT QUESTIONNAIRE

NAME ____ **Date of Birth** ___________________

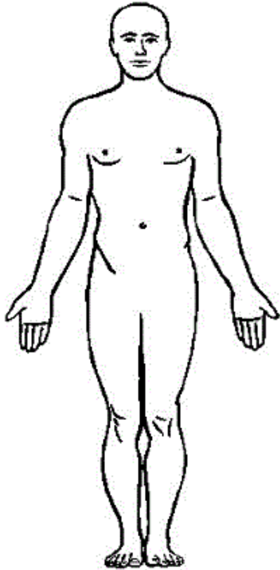
Today's Date ____________________________

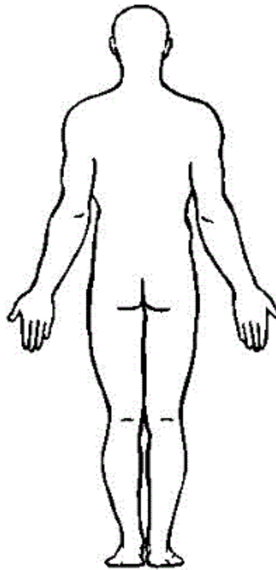
CHIEF COMPLAINT ____ ____

____

(Please use your pen to mark painful areas)

Front **Back**





When did the pain begin:

____

Allergies and reaction:

____

❑ dye/contrast allergy

❑ iodine allergy

Smoking History:

❑ never ❑ currently
❑ quit - when ____________
____ packs/day

____ years smoked

History of:

❑ Substance abuse

❑ Alcohol abuse

Currently working? ❑ No ❑ Yes Type _________________ ❑ Full-time ❑ Part-time ❑ Disability ❑ Retired

Is your pain accident related? ❑ No ❑ Yes Date_________ ❑ Motor Vehicle ❑ Industrial/Work

Do you have a lawyer representing you? ❑ No ❑ Yes Name _______________________________________

Previous Spine Surgery: ❑ No ❑ Yes **Surgeon Name and Date:** _________________________________

Physical Therapy: ❑ No ❑ Yes ❑ Aquatic Therapy ❑ Bracing ❑ TENS unit

Alternative Medicine: ❑ Chiropractic ❑ Acupuncture ❑ Massage Therapy

Hand Dominance: ❑ right ❑ left **Height**: __________________ **Weight:** __________________

Medications: (please list names and doses) ____

____

____

Past Surgical History: (please list surgeries and dates) ____

____

Past Medical History: ____

____

Past Family History: Medical problems: Mother _______________________________________ age _______

Medical problems: Father ____ age _______

NAME ____ **Date of Birth** ________________

REVIEW OF SYSTEMS

Please circle any medical concerns that you have TODAY:

Constitutions:	weight change, weakness, fatigue, fever
Eyes:	vision, glasses pain, tearing, double vision
Ears, nose, throat:	hearing, tinnitus, vertigo, pain, sinus, cold, sore throat
Cardiovascular:	high blood pressure, murmurs, shortness of breath, chest pain, palpations
Respiratory:	cough, sputum, coughing up blood, sneezing, asthma, chest pain, bronchitis
Gastrointestinal:	trouble swallowing, heartburn, vomiting, diarrhea, indigestion, pain blood in stool
Genitourinary:	pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence
Musculoskeletal:	joint pain/stiffness, cramps, back of neck ache, weakness, loss of range of motion, low back pain, thoracic pain
Skin:	rash, lumps, itching, dryness, color change, hair changes, nail changes
Neurological:	fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss
Psychological:	nervousness, tension, mood changes, depressions, anxiety
Endocrine:	heat or cold intolerance, sweating, thirst, hunger, changes in urination
Hematology:	bruising, bleeding, transfusion reactions
Allergy/Immune:	drug, product or allergies, immunizations

Provider Signature: ____

Anthony L. Cucuzzella, MD, Tony R. Cucuzzella, MD, Anton Delport, MD, Elva Delport, MD, J. Rush Fisher, MD, Ann Kim, MD, Nancy Kim, MD, Michael R. Murray, MD, Yong Park, MD, Scott Roberts, MD, Frank Sarlo, MD, Rebecca Barnett, APRN, Amy Bolstein, PA-C, Jennifer Brown, PA-C, Amanda Farina, APRN, Meghan Malloy, PA-C

Disclaimer

The Christiana Spine Center, LLC, is a separate name-only entity and does not have separate liability coverage. Physiatrist Associates, PA, employs all physicians and they are not considered partners, employees, agents and/or servants of the Christiana Spine Center, LLC.

Pharmacy name and address: ____

Pharmacy phone: ____

CHRISTIANA SPINE CENTER

PAIN MEDICATION CONTRACT

Our goal at the Christiana Spine Center is to treat patient's pain and to improve functional ability. We try to achieve these objectives without the use of narcotic medications. We attempt to avoid narcotic medications because these substances are highly addictive, commonly resulting in dependency. Furthermore, patients develop tolerance to these medications often requiring higher dosages. Our practice requires that you sign this Pain Medication Contract, in case you and your physician determine that narcotic medications will be used in your treatment. It is important that you have an understanding of the significant risks and responsibilities that go along with treatment with narcotic medications. Please **read each statement and sign** this agreement/contract below.

I, ____, understand that:

- I am aware that the use of pain medications has certain risks, including, but not limited to: addiction, impaired judgment, sleepiness and/or confusion, constipation, nausea, vomiting, allergic reactions, overdoses, breathing problems, dizziness, lowered blood pressure, sexual problems and possibly that the medication **will not** provide complete pain relief. The goal of treatment is to reduce my pain to a level that is tolerable and will allow me to function from day to day. This may require careful use of the pain medications together with a variety of other treatments. These may include other types of medications, nerve blocks, physical therapy, changes in my activity, TENS unit, or acupuncture.

- I will use one provider to prescribe medication for me. I will not attempt to obtain any pain medications, controlled stimulants or anti-anxiety medications from any other provider. If I seek a prescription for pain medications from another provider/facility, this will break my contract and this office will no longer prescribe my medications.

- I will use one pharmacy to have my prescriptions filled. I will use the following pharmacy:
  Pharmacy Name: ____ Phone number: __________________
  Address: ____

- I agree to participate in RANDOM DRUG SCREENING TESTS in order to determine effectiveness and compliance with my pain medications. If I decline to participate in this screening, this office will no longer prescribe my medications.

- Medications **will not** be replaced if they are lost, stolen, get wet, are destroyed, left somewhere, etc. I will take the highest possible degree of care with my medication and prescription.

- I agree that refills for pain medications will be made only at my office visit or on the medication refill line. There will be no early refills and refills will not be available during evening hours or weekends.

- I will communicate fully and honestly with my provider the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

- While this contract is in effect, I will not use any illegal substances, including marijuana, cocaine, heroin, etc. I will not sell, give my medications to others, misuse, or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent. If illegal substances are found during screening, I will be reported to the authorities.

- I understand that if I break this agreement/contract, my provider will stop prescribing these pain medications and that my treatment may be terminated.

Patient signature: ____ Date: ______________

<u>**CHRISTIANA SPINE CENTER**</u>

Patient Name: _______________________________________ Date: ____________________

Oswestry Disability Questionnaire (FOR BACK PAIN ONLY)

This questionnaire has been designed to give us information as to how your back pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity
☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing)
☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self-care
☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives me extra pain
☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed i.e. on a table
☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can only lift light weights
☐ I cannot lift or carry anything

Section 4: Walking *
☐ Pain does not prevent me walking any distance
☐ Pain prevents me from walking more than 1 mile
☐ Pain prevents me from walking more than 0.5 miles
☐ Pain prevents me from walking more than 0.25 miles
☐ I can only walk using a stick or crutches
☐ I am in bed most of the time

Section 5: Sitting
☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me sitting more than one hour
☐ Pain prevents me from sitting more than 30 minutes
☐ Pain prevents me from sitting more than 10 minutes
☐ Pain prevents me from sitting at all

Section 6: Standing
☐ I can stand as long as I want without extra pain
☐ I can stand as long as I want but it gives me extra pain
☐ Pain prevents me from standing more than 1 hour
☐ Pain prevents me from standing for more than 30 minutes
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me from standing at all

Section 7: Sleeping
☐ My sleep is never disturbed by pain
☐ My sleep is occasionally disturbed by pain
☐ Because of pain I have less than 6 hours sleep
☐ Because of pain I have less than 4 hours sleep
☐ Because of pain I have less than 2 hours sleep
☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
☐ My sex life is normal and causes no extra pain
☐ My sex life is normal but causes some extra pain
☐ My sex life is nearly normal but is very painful
☐ My sex life is severely restricted by pain
☐ My sex life is nearly absent because of pain
☐ Pain prevents any sex life at all

Section 9: Social Life
☐ My social life is normal and gives me no extra pain
☐ My social life is normal but increases the degree of pain
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests i.e. sports
☐ Pain has restricted my social life and I do not go out as often
☐ Pain has restricted my social life to my home
☐ I have no social life because of pain

Section 10: Traveling
☐ I can travel anywhere without pain
☐ I can travel anywhere but it gives me extra pain
☐ Pain is bad but I manage journeys over two hours
☐ Pain restricts me to journeys of less than one hour
☐ Pain restricts me to short necessary journeys under 30 minutes
☐ Pain prevents me from traveling except to receive treatment

<u>**CHRISTIANA SPINE CENTER**</u>

Patient Name: ______________________________________ Date: ____________________

Disability Questionnaire (FOR NECK PAIN ONLY)

This questionnaire has been designed to give us information as to how your neck pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity
- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing)
- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed i.e. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift light weights
- I cannot lift or carry anything

Section 4: Work
- I can do as much work as I want
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I can't do my ususal work
- I can hardly do any work at all
- I can't do any work at all

Section 5: Headaches
- I have no headaches at all
- I have slight headaches that come infrequently
- I have moderate headaches that come infrequently
- I have moderate headaches that come frequently
- I have severe headaches that come frequently
- I have headaches almost all the time

Section 6: Concentration
- I can concentrate fully without difficulty
- I can concentrate fully with slight difficulty
- I have a fair degree of difficulty concentrating
- I have a lot of difficulty concentrating
- I have a great deal of difficulty concentrating
- I can't concentrate at all

Section 7: Sleeping
- I have no trouble sleeping
- My sleep is slightly disturbed for less than 1 hour
- My sleep is mildly disturbed for up to 1-2 hours
- My sleep is moderately disturbed for up to 2-3 hours
- My sleep is greatly disturbed for up to 3-5 hours
- My sleep is completely disturbed for up to 5-7 hours

Section 8: Driving
- I can drive my car without neck pain
- I can drive as long as I want with slight neck pain
- I can drive as long as I want with moderate neck pain
- I can't drive as long as I want because of moderate neck pain
- I can hardly drive at all because of severe neck pain
- I can't drive my car at all because of neck pain

Section 9: Reading
- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want because of moderate neck pain
- I can't read as much as I want because of severe neck pain
- I can't read at all

Section 10: Recreation
- I have no neck pain during all recreational activities
- I have some neck pain with all recreational activities
- I have some neck pain with a few recreational activities
- I have neck pain with most recreational activities
- I can hardly do recreational activities due to neck pain
- I can't do any recreational activities due to neck pain

CHRISTIANA SPINE CENTER
PATIENT INFORMATION SHEET

DRS. ALC TRC EGD AK NK FBS YIP STR AGD JRF MRM

DATE: ___________________
NAME: (LAST)_______________________________ (FIRST)_____________________________ (MI)__________
SS#:___________________________ DOB:___________________ Gender: Male / Female
HOME ADDRESS:____ (APT#)______________
(CITY)_______________________________ (STATE)_______ (ZIP)____________
HOME PHONE:( )____________ WORK PHONE:( )____________ CELL:( )____________
E-MAIL:____

PLEASE CIRCLE:
RACE: Asian Black Hispanic White LANGUAGE: English Spanish Other ETHNICITY: Latino Not Latino

Referring Physician – Name, Address and Telephone Number:

____

Family Physician – Name, Address and Telephone Number (if different from above)

____

Employer – Name, Address and Telephone Number:

____

Employment Status: ____ Full-time ____ Part-time ____ Disability ____ Retired
Emergency Contact Name/Phone/Relationship to Patient:

____

Do you have an attorney: _______ **Attorney Name:** ___________________________ **Phone:** ___________________
Injury Result of Accident: ____ No ____ Yes Date of Accident: _______________________
Type of Accident: ______ Motor Vehicle ______ Industrial/Work ______ Other

Primary Insurance

Name of Insurance: ____ Phone: ___________________
Address: ____
Effective Date of Insurance: ________________ ID#: _______________________ Group#: _______________________
Subscriber's Name: __________________________ Relationship: _______________ Subscriber's DOB: ____________

Secondary Insurance

Name of Insurance: ____ Phone: ___________________
Address: ____
Effective Date of Insurance: ________________ ID#: _______________________ Group#: _______________________
Subscriber's Name: __________________________ Relationship: _______________ Subscriber's DOB: ____________

Auto/Workman's Compensation/Personal Injury Insurance Information

Name of Insurance Company: ____ Phone: __________________
Address: ____
Adjuster's Name: ___________________________ Claim: ______________________ Date of Accident: ____________
Insured Name:____________________________ Relationship: _______________ Insured's DOB: ___________ ______

Waiver of Responsibility and Release of Medical Information

I understand that if I am unable to obtain the proper referral/authorization from my primary care physician for my insurance, and/or in the event my workman's compensation/automobile or personal liability insurance defaults, I will be financially responsible for the services performed by Christiana Spine Center, in full. Our financial policy is as follows: We collect (payments & co-payments) at time of services are rendered. **PLEASE BRING ALL INSURANCE CARDS** at the time of your visit. If it is a workman's compensation, motor vehicle accident or personal injury claim, please have the correct insurance information, including name, address, and claim/file numbers. **PLEASE BE ADVISED THAT IF YOUR WORKMAN'S COMPENSATION COMPANY IS FROM A STATE OTHER THAN DELAWARE, YOU MAY BE BILLED THE BALANCE NOT PAID IN FULL BY ANOTHER STATE. It is our policy THAT WE DO NOT BILL LAWYERS for office visits and/or procedures.** We require having your personal health insurance information on file, and if needed, a referral/authorization from your primary care physician for the visit. If you have any questions regarding this policy, please call our billing department at 302-623-4144.

I authorize release of all health information to Christiana Spine Center, LLC and from all my previous and present treating physicians/hospitals concerning my care and treatment for the purpose of evaluating and administering my care. I also authorize Christiana Spine Center, LLC the ability to release my health information to requesting physicians/hospitals for the purpose of evaluating and administering my care. Also, administering claims for insurance benfits otherwise payable to me directly to Christiana Spine Center, LLC.

Signature of patient:____ **Date:** _____________________

Signature of parent/guardian: ____ **Date:** _____________________

Insurance Authorization and Assignment

I hereby authorize Christiana Spine Center, LLC to furnish information to insurance carriers concerning my illness and treatments, and I herebyb assign to the physician(s) all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance and/or if I fail to provide appropriate insurance information to process medical claims. In the event that I am in default of my account, Christiana Spine Center reserves the right to charge 25% of the total bill for collection agency fees. Christiana Spine Center reserves the right to charge for visits not cancelled within 24 hours. If patient is less than 18 years of age, guarantor must sign.

Signature of Financially Responsible Party: ____

Relationship to Patient: _________________________ **Date:** ________________________________

FOR MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Christiana Spine Center, LLC for any services furnished me by Christiana Spine Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services.

Signature of patient: ____ **Date:** _____________________

PATIENT CONSENT FORM
THIS FORM IS TO BE SIGNED AND BROUGHT
WITH YOU AT THE TIME OF YOUR APPOINTMENT

The Notice of Privacy Practices for Christiana Spine Center provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

This Consent allows the Practice to disclose my information to the following people:

Name:	Relationship:
____________________________	________________________________
____________________________	________________________________
____________________________	________________________________
____________________________	________________________________

Signature of patient: ____ **Date:** _____________________

Printed name: ____