IMPORTANT

Notice of Medical Visit

St Charles Spine Institute
550 St. Charles Drive, Ste 208
Thousand Oaks, CA 91360
Telephone: (805) 379-2322 Fax: (805) 435-0259

www.stcharlesspine.com

Appointment Date: _____ Time: _____

All attached forms need to be completed by your appointment date.

Please arrive 20 minutes prior to your appointment with your paperwork completed.

****You will be rescheduled if forms are not completed.****

Please bring the following:

- Picture ID such as Driver's License and Insurance Cards
- X-Rays , MRI, CT Scans with CD/Films and Reports (within 2 years)
- Past EMG and Operative Reports
- Current Medication List
- Health Advance Directive

Should you need to cancel this appointment for any reason, please call our office at 805-379-2322 OPTION 2 at least 48 hours in advance.

Thank you for your cooperation in this matter.

ST CHARLES SPINE INSTITUTE
550 St Charles Drive Suite # 208
Thousand Oaks, CA 91360
(805) 379-2322 option 2

PATIENT INFORMATION

Name: _____ Date of birth: _____
Age: _____ Sex: _____ Marital Status: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
E-Mail Address: _____ Social Security #: _____

EMERGENCY CONTACT
Name: _____ Relationship: _____ Phone: _____

HOW DID YOU HEAR ABOUT US? _____

PHYSICIAN INFORMATION

Primary Care Physician (**FIRST NAME LAST NAME**) _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
Referring Physician: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Address: _____
Subscriber/Policy #: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____ Subscriber SS# _____

Secondary Insurance Name: _____
Address: _____
Subscriber/Policy #: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____ Subscriber SS# _____

AUTHORIZATION OF BENEFITS AND INFORMATION RELEASE

I hereby authorize that medical and/or surgical benefits otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize St Charles Spine Institute and my physician to release any information required by my insurance company to process claims.

_____ _____
Patient/Guarantor Signature **Date**

St. Charles Spine Institute

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION

Patient Name:		**Date:**
Date of Birth:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? O Neck O Back O Other _____

II. Which side is affected? O Right O Left O Bilateral

Are you? O Left handed O Right handed

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV. Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other:_____

V. Pain Calculation: Questions A and B should total 100%

A. What percentage of your problem is due to back/neck pain?

O 0% O 25% O 50% O 75% O 100%

B. What percentage of your problem is due to leg/arm pain?

O 0% O 25% O 50% O 75% O 100%

VI. General Questions

How would you rate your pain? Place a circle on the pain level below:

No pain 0 1 2 3 4 5 6 7 8 9 10 very severe pain

Have you had any change in bowel or bladder function? O Yes O No

Does your pain disrupt your sleep? O Yes O No

Does pain or weakness keep you from doing your regular activities? O Yes O No

Did you attend physical therapy for greater than 6 weeks? O Yes O No

Did you experience relief from physical therapy for greater than 3 weeks? O Yes O No

Does your pain radiate? O Yes O No If so, where _____

VII. Pain medications?

Anti-inflammatory agent O Yes O No Drug Name:_____

Pain Medication O Yes O No Drug Name:_____

Tylenol O Yes O No

Have you had any injections/epidurals? O Yes O No

How many in the last 12 months?_____ Date of most recent injection: _____

Did you get any relief? O Yes O No

If Yes, how much? O > 50% O > 80%

VIII. Have you had any testing? O MRI O EMG/NCS O X-ray O CT Scan

Medical History

Do you have or have you had:	Yes	No		Yes	No
Asthma/COPD	O	O	Cancer	O	O
Diabetes	O	O	High Blood Pressure	O	O
Acid Reflux Disease	O	O	Heart Attack	O	O
Osteoporosis	O	O	Hypertension	O	O
Emphysema	O	O	Seizures	O	O
Stroke	O	O	Arthritis	O	O
Gout	O	O	Thyroid Disease	O	O
Kidney Problems	O	O	Blood Clots	O	O

Social History

Marital status: O Single O Married O Widowed O Divorced

Do you smoke? O Yes O No O Have Previously

If yes,

How many packs/ day? O <1 O 1-2 O >2

How many years have you smoked? O 1-4 O 5-10 O >11

Do you consume alcohol? O Yes O No

How often do you consume alcohol? O Daily O Social O Never

Do you exercise regularly? O Yes O No

In the past did you consume alcohol? O Yes O No

Working status: O Full time O Part Time O Student O Unemployed

Family History

Father	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease
Mother	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease
Siblings	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease
Grandparents	O Arthritis	O Cancer	O Diabetes	O Stroke	O Heart Trouble	O Lung Disease

Review of Systems

Constitutional Fatigue O Yes O No

Weight change	O	Yes	O	No
Fever	O	Yes	O	No
Neurological				
Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No
Coordination Problems	O	Yes	O	No
Neck Pain	O	Yes	O	No
Respiratory				
Shortness of Breath	O	Yes	O	No
Chest Pain	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No
Coughing up Blood	O	Yes	O	No
Cardiovascular				
Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No
Spine				
Severe Back Pain	O	Yes	O	No
Spine Curvature	O	Yes	O	No
Back Problems	O	Yes	O	No
Musculoskeletal				
Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No
Gastrointestinal				
Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No
Skin				
Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No
Hematologic				
Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No
Women ONLY:				
Are you pregnant or could possibly by pregnant?	O	Yes	O	No

Allergies

Are you allergic to any medications? O Yes O No

If yes, please list: _____

Are you allergic to food or environmental substances? O Yes O No

If yes, please list: _____

Medications (Please list name of medication and dosage)	
Hospitalization (Please list)	**Surgeries (Please list surgery type and year)**

Patient Signature _____ Date _____

St. Charles Spine Institute
550 St. Charles Drive, Suite 208
Thousand Oaks, CA 91360

Current Medication List

Patient Name: _____ **DOB:** _____
Today's Date: _____

Medication Name	Strength	How many tablets per day?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

If the space provided is not sufficient, please continue list on the back.

St. Charles
Spine Institute

Patient/Provider Assessment

Name: _____ Date: _____
First Last

Gender: _____ Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Primary Insurance : _____

Please answer the following questions to the best of your ability. Mark yes with a "X" in the box.

Section A:

Have you ever been diagnosed with or do you experience:

- ☐ Numbness or a feeling of pins and needles in hands or feet?
- ☐ Diabetes Type I with tingling in your feet or toes?
- ☐ High blood pressure?
- ☐ Peripheral neuropathy (normally a result of damage to your nerves often causing weekness, numbness and pain in hands and feet)?
- ☐ Gangrene?
- ☐ Raynaud's Syndrome or your fingers and toes feel numb and cold often?
- ☐ Abdominal pain?
- ☐ Often feel fatigued?
- ☐ Have pain in your neck?
- ☐ Rapid heart rate?
- ☐ High cholesterol?
- ☐ Diabetes Type II with tingling in your feet or toes?
- ☐ Low blood pressure?
- ☐ Circulation issues or Perpheral Vascular Disease?
- ☐ An irregular heart beat or arrhythmia?
- ☐ Buerger's Disease?
- ☐ Dizziness when standing?
- ☐ Excessive sweating ?
- ☐ Pain in your upper back?
- ☐ Get dizzy or light headed when you stand up or ever faint?

Section B:

Do you have or do you ever experience:

- ☐ Ataxia (lack of coordination)?
- ☐ High triglycerides?
- ☐ Pain in your lower back?
- ☐ Swelling in your hands or feet?
- ☐ Numbness or tingling in your hands or feet?
- ☐ Hyperlipidemia?
- ☐ Carpal tunnel?
- ☐ Family history of heart disease?
- ☐ Pain in your arms and/or legs?
- ☐ Excess weight?

Section C:

- ☐ Are you pregnant?
- ☐ Do you have a pacemaker or defibrillator?
- ☐ Do you have a pain or insulin pump?
- ☐ Do you have any electrical or metal implants or sensors of any kind? If yes, what kind? _____

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimize your quality of care through access to your healthcare data. as part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines.

Patient Signature Provider Signature

_____

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St Charles Spine Institute
Lana Louie A. Wania-Galicia, M.D
550 St Charles Drive, Suite # 208
Thousand Oaks, CA 91360
Tel 805-379-2322 Fax 805-435-0259

Pain Management Treatment Agreement

This document is an agreement between _____, the patient, and Dr. Lana Louie A. Wania-Galicia. Patient agrees to the policies as listed below to manage chronic pain. Patient acknowledges the fact of habituation on the opioid medication as a direct consequence of its use. Because of the controlled nature of these medications, strict accountability is required. The following policies are necessary for continued treatment:

- **Regularly monthly visits for patient with scheduled II medication must be made to assess response and observe complications**

- **ALL pain medications will be prescribed by ONE physician, which in case, Dr. Lana Louie A. Wania-Galicia.**

- **ALL pain medication prescriptions will be filled at one pharmacy, patient chooses:**

Pharmacy Name: _____

Address: _____

Phone: _____

- Physician has complete liberty to discuss treatment details with the pharmacist at the dispensing pharmacy, and may ask the pharmacy for information about other medications, which have been prescribed for the patient.

- Random urine drug screens will be requested at any time. Urine must be given before given medication prescription

- Prescribed medication will be closely guarded. Please note these medications could be hazardous or lethal to another person, who is not tolerant to their effect. Patient will take as much care with medications, and written prescription, as they would their driver license or credit cards.

- Medications WILL NOT be replaced (if they are lost, fall in the toilet, eaten by pets, etc. If your medications are lost or stolen an INCIDENT REPORT must be filed at the local police station or by a police officer. Once a hard copy of the police report is obtained, ONE exception may be made. Be sure to ask officer for turnaround time.

- Early refills will not be given. If a patient uses a month supply of medications within three weeks, the last week will be without medications.

- All confidentiality of prescription and medication records is waived if there is any request from legal authorities for the information concerning inappropriate or unlawful use of controlled substances. Failure to adhere to these policies will result in permanent cessation of pain medication prescribed by Dr. Lana Louie A. Wania-Galicia. Patient understands that he/she will not take medications or substances (prescription or recreational), which have not been disclosed to the physician.

St Charles Spine Institute

Lana Louie A. Wania-Galicia, M.D

550 St Charles Drive, Suite # 208

Thousand Oaks, CA 91360

Tel 805-379-2322 Fax 805-435-0259

▪ Pursuant to Health and Safety Code section 11165.4(a), the mandatory consultation requirement requires health care practitioners to consult the CURES database to review a patient's controlled substance history under both of the following circumstances:

1. Before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time; and
2. At least once every four months thereafter if the substance remains part of the treatment of the patient.

▪ "First time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

Signature:	Date:
Print Name:	Witness:
Physician:	Date:

ST. CHARLES SPINE INSTITUTE

550 St. Charles Drive, Suite 208
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OFFICE POLICY & INFORMATION

Financial Policy:
Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. You bear full financial responsibility for the services rendered and products provided by St. Charles Spine Institute and agree to pay at the time of service. Additionally, you authorize and request that insurance payments be made directly St Charles Spine Institute should we elect to receive such payments.

Payments that you are responsible for include, but are not limited to, any and all copayments, coinsurance, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like orthopaedists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though St Charles Spine Institute will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company St Charles Spine Institute. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due, you will receive a statement. If a refund is a due, we will be happy to mail it to you.

Authorization for Treatment/Referrals (POS PLANS):
You are responsible for obtaining an authorization for examinations & treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Otherwise, the insurance company will not pay for your visit. Without a referral, you have the option to receive services on a fee for service basis.

Keeping Your Account Up-To-Date:
It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies give us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

Delinquent Accounts:
Accounts turned over to a collection agency will be assessed a $25.00 fee. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

Lab/Diagnostic Testing Results:
It is the patient's responsibility to contact this office for the results of any lab work or diagnostic testing.

Please note:

The surgeons at St. Charles Spine Institute may hold the patents or have worked on the development of some implants purposed for your spinal surgery. They do NOT receive any financial compensation for implanting these devices. If you have questions, please discuss this with your Surgeon during your appointment.
The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Returned Checks: There will be a $25.00 charge for all returned or cancelled checks.

Release of Medical Records
There will be a $15 clerical fees, plus up to $.25 cents per page for medical records. If you need any insurance forms completed by our office, there will be a $20.00 charge on each form. You authorize us to release all medical records to the referring and family physicians and to your insurance company, if applicable. You allow fax transmittal, telephone and by mail of your medical records, if necessary.

All copayments, coinsurances, deductible fees, and outstanding balances must be settled before seeing the physician.
We reserve the right to immediately cancel your care for conduct, non-cooperation, or non-payment.
You will be responsible for your Medicare Co-Insurance if you don't have secondary insurance.

YOUR SIGNATURE represents your consent to treatment necessary for the patient named, your acknowledgement of full financial responsibility, and your understanding and acceptance of our policies detailed above.

Name Of Patient: _____ **DOB:**_____

Signature: _____ **Date:** _____

SPINE

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998
("HIPAA"), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Advanced Directive Status

St. Charles Spine Institute

I have been informed of my right to formulate an Advanced Directive, and I have been provided with information regarding the execution of an Advanced Directive.
Please Select One:

☐ I have previously completed an Advanced Directive and have provided a copy of inclusion in my medical record

☐ I will provide a copy of my previously executed Advanced Directive to St. Charles Spine Institute for Inclusion in my medical record

☐ A copy of my Advanced Directive is on file with: _____
Name of Provider or Health Care Facility

☐ I have not executed an Advanced Directive and I am not interested in any further information

☐ I am interested in formulating an Advanced Directive and will discuss my options with my primary care physician

Patient Signature: _____ **Date:** _____

Patient Name (Print): _____

Comments: Include steps taken to obtain a copy of Advanced Directive

_____

_____

_____

☐ A copy of the Advanced Directive has been requested

Signature of Group Representative: _____ Date: _____

St. Charles Spine Institute
Dr. Lana Wania Galicia
TAX ID: 474299199 NPI: 1730166406

ASSIGNMENT OF BENEFITS AGREEMENT
Direct Payment to Doctor

I hereby authorize _____ Insurance Company to pay by check made payable to and mailed directly to St. Charles Spine Institute for medical expense benefits allowable, and otherwise payable to, under my current insurance policy, as payment towards charges for professional services rendered.

Financial Responsibility

I understand that I am financially responsible to reimburse St. Charles Spine Institute for any charges not covered by health care benefits. It is my responsibility to notify St. Charles Spine Institute of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

Assignment of Benefits

I hereby assign all medical benefits, to include any surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance or any other health/medical plan, to issue payment directly to St. Charles Spine Institute I have requested medical services from St. Charles Spine Institute on behalf of myself and/or my dependents and understand by making this request that I become fully financially responsible for any and all charges incurred during the course of treatment authorized.

Name of Person Financially Responsible (Print): _____

Relationship to Insured: _____

Signature of Insured: _____

Today's Date: _____