SARATOGA SPINE
NEW PATIENT PACKET

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Saratoga Office
31 Myrtle Street
T:518-587-7746

Glens Falls Office
7 Murray Street
T: 518-587-7746

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16 DeGrandpre Way Ste 100
T: 518-587-7746

INITIAL PATIENT VISIT:

Name: _____ DOB: _____
Address: _____
Age: ____ Sex: ____ Weight: _____ Height: _____
Phone: Home: _____Work: _____ Mobile: _____
Social Security Number:_____
Email address_____
Local Pharmacy name_____Address_____
Mail Order Pharmacy_____
Employer_____Occupation_____
Who referred you to Saratoga Spine?

Referring Physician Name_____ Referring Physician Telephone #_____

Referring Physician Address City State Zip Code

Who is your Primary Care Physician? _____

Please describe your main problem/complaint:_____

CURRENT MEDICAL CONDITION:

Do you have: ___ Only Back Pain ____Back And Leg Pain ____ Only Leg Pain
___ Only Neck Pain ____Only Shoulder/Arm Pain
___ Neck, Shoulder and Arm Pain ___ Other _____

Which is worse: ___Back Pain ___Leg Pain ___ Neck Pain ____ Shoulder/Arm Pain

I have had back/neck pain: ____Less than 1 month ___1-3 Months ____ 3-6 Months ___ 6 Months- 1 Year
____1-3 Years ___3-5 Years ____ Greater than 5 Years

My pain came on: ____Gradually, over time ____Quickly

Saratoga Spine

Patient name _____

My pain was brought on by: ____No specific incident ____Following an accident or incident at work
____ Following an accident or incident **NOT** at work _____Motor vehicle accident?
_____ Date of accident/injury
Describe the accident/incident: _____

_____

Do you have: ____Numbness: Where_____
____Tingling: Where_____
____Weakness: Where_____
What time of the day is your pain worse ____Morning ___Late in the day ___The middle of the night

My Pain pattern is: ___A single attack of pain ___Attacks of pain with pain free intervals
___Continuous Pain ___Continuous pain with attacks of severe pain

I experience pain: ___The entire day ___A fair amount of the day (2-7 hours)
___Most of the day (16-20 Hours) ___A small amount of the day (1 hour or less)
___A good part of the day (8-15 Hours) ___Less than once a day

How long does the pain attack last: ____Seconds ___Minutes ___Hours ___Constant
For how long can you walk: ___ <15 minutes ____15-30 Minutes ___ 30-60 Minutes ___NO Restrictions
How long can you stand: ___< 15 minutes ___15-30 Minutes ___30-60 Minutes ___ NO Restrictions
Do you need assistive device (walker/crutches etc.)_____ How long using assistive device?
Do you need help getting dressed Personal hygiene? Y/N Are you able to self transport? Y/N

What position/activity make the pain worse or better?

	Standing	Sitting	Walking	Stairs	Lying Down	Bending	Lifting	Coughing	Bowel Mov't	General Activity
Better:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Worse:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Pain Rating Scale: How would you rate your pain today: **(check One Number)**

0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__9__ 10__

None Moderate Moderate Severe Worst Possible Pain

Name, Date, and ***Location*** of office you have sought help for your pain: (Fill out all that apply)

Family Doctor:_____
Orthopedist:_____
Spine Surgeon:_____
Physical Therapist:_____
Chiropractor:_____
Pain Management:_____
Physiatrist:_____
Neurologist:_____
Psychiatrist/Psychologist:_____

Have any of the above treatments decreased your pain: ___ NO ___ YES, describe below
_____
Which medications do you take for your pain:_____
My pain now seems to be: ___ Getting better ___ Staying the same ___ Getting worse
Have you noticed any change in your bowel or bladder habits? ___ NO ___ YES, describe:
_____

Saratoga Spine

Patient name _____

Have you seen a spine surgeon for this issue? _____NO ____YES
What was recommended?_____

Have you Previous Spine Surgery?___NO ___YES When: ___/___/_____
Doctor:_____

TYPE OF SPINE SURGERY:

_____

_____

If you had previous spine surgery, did the surgery make the pain better: ____YES ___NO
Have or are you planning to apply for Disability or Worker's Compensation: ____YES ___NO
Is there a lawsuit or litigation pending in relationship to your pain? ____YES ___NO
Date of Injury: _____

REVIEW OF SYSTEMS:

Primary Reason for Today's Visit:

_____

Do you presently have any problems with the following areas? If YES, give explanation and date

Fever	____YES____NO	Weakness of Upper or Lower extremities	__ YES___NO
Chills	____YES____NO	Gait imbalance	___YES___NO
Weight loss	____YES____NO	Dropping objects	___YES__ NO
H/O Falls	____YES____NO	Bowel or Bladder Incontinence	___YES___NO

Eyes(eye pain, vision loss)	____YES ____NO
Ears, Nose, Mouth, Throat:	____YES ____NO
Cardiovascular, (heart, blood vessels)	____YES ____NO
Respiratory (lungs/breathing)	____YES ____NO
Gastrointestional (stomach/intestines)	____YES ____ NO
Genitourinary (genitals/kidney/bladder)	____YES ____NO
Musculoskeletal (muscles/joints)	____YES ____NO
Integument (skin/breast)	____YES ____NO
Neurological	____YES ____NO
Psychiatric (depression, anxiety, bipolar, substance abuse)	____YES ____NO
Endocrine (hormones, glands)	____YES ____NO

Hematologic/Immunologic (blood) ____YES ____NO
Do you have blood clotting problems?___YES ____NO
Excessive bleeding? ____YES ____NO
Blood loss during surgery? ____YES ____NO
Seasonal Allergies (hay fever) ____YES ____NO
Diabetes _____YES _____NO if yes, Last A1c level?_____ Date _____

Saratoga Spine

PAST MEDICAL HISTORY:

Check below if you have had any of the following:

_____ Heart Disease	_____ High Blood Pressure	____ Diabetes
_____Cancer	_____ Fibromyalgia	____ Tuberculosis
_____Migraine Headaches	_____ Hepatitis	____ Kidney Disease
_____Emotional Disorder	_____ Asthma	____ HIV

Other_____

PAST SURGERIES: (Procedure and date):_____

_____

FAMILY HISTORY (Muscle or nerve problems, Diabetes, or Bleeding Disorders):

_____

CURRENT MEDICATIONS and DOSAGE: (Dates started meds and include non-prescription)

_____

_____

****ALLERGIES TO MEDICINE/SUBSTANCES/LATEX:** (Include reaction)

WORK STATUS:

Employer Name and Address_____

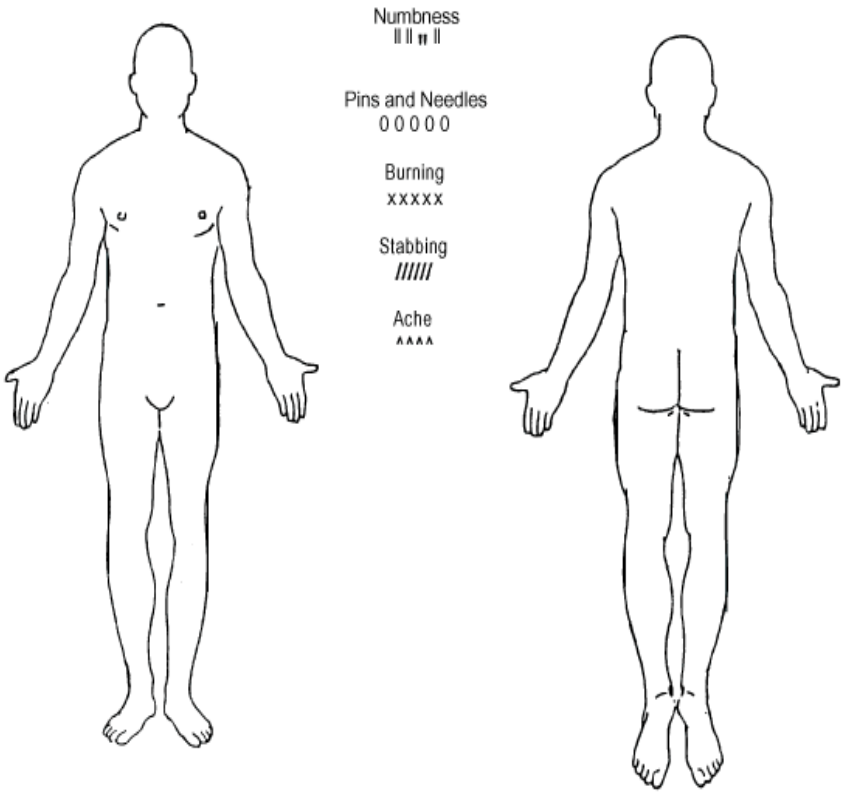
Occupation_____ Duties _____

Are you currently?

_____ Working Full Time	_____Working Part time
_____ Unemployed	_____ Retired
_____ Disabled, Temp	_____ Disabled, Perm
_____ Housewife	
_____ Other	

If you are currently NOT working: How long have you been off work due to your back/neck pain?

_____



PAIN DIAGRAM:

If you have the ability to download, draw, and scan to email, please use the following diagrams to show us where you are experiencing pain and numbness. If you do not, please describe :_____

_____

_____

Check any/all of following that describe pain.

DULL___ BURNING___ COLD___

TIGHT___ THROBBING___ SHOOTING___

ELECTRIC TINGLING___

Saratoga Spine

Patient name_____

SOCIAL HISTORY:

Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed

Highest Education Level Completed:
____ Grade school ____ High School ____ College, Technical ____ Graduate, Professional

Do you currently use Tobacco? ___Yes ___No _____ Started Age/Total years _____Stopped
Have you ever used tobacco products? ____Yes ____No If yes, what tobacco products?_____
Indicate quantity per day: Cigarettes____ Cigars____ Chewing Tobacco_____

Do you currently consume Alcohol? _____Yes _____No If yes, how much?_____ Amount Per day

Do you have any history of recreational drug use? Current use _____Yes _____No What drug(s)_____
Past use _____Yes _____ No What drug(s)_____

Patients with known Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS/ KYPHOSIS

Year deformity was first noticed: _____

Your age at the time deformity was first noticed: _____

Family history of Scoliosis / Kyphosis: ____ Parent _____Brother/Sister
____Cousin _____None
_____Other

Previous non-operative treatment: _____None _____Observation Only
_____ Exercise _____Brace ___ Other _____

First operative event: ___/___/_____ Second operative event: ___/___/_____

Current concerns: ____ None ____Feel imbalance
____ New or increased back pain ____Painful rod
____ Unhappy with my appearance

If you have back pain, then where: ___Upper Back ___Mid Back ___Lower Back

Do you feel that your curves have increased or decreased over time: ___Yes ___No

Do you feel you have lost height in the last few years: ___Yes ___No

Saratoga Spine

PATIENT NAME_____

INSURANCE
Insurance policy holder? _____
Relationship to patient: (self, wife, etc.)_____
Policy holder's employer_____
Birth date: _____ SS# _____
Health Insurance company :_____
ID# _____ Group # _____

Is patient covered by secondary insurance? Y/N (If yes, Please Complete the Following)
Insurance company name: _____
ID#: _____ Group #_____

***WORKER's COMPENSATION or NO FAULT INFORMATION ***
This information is Mandatory if you are filing a claim thru Workers Comp or No Fault insurance

Is patient covered by No-Fault insurance? Y/N _____
Is patient covered by Workers Compensation? Y/N _____
Onset date of Injury or accident_____
WC or NF Insurance company name: _____ Policy #_____
WC Case ID# _____Group # _____
Case worker's name and phone/fax #: _____
_____

Employer Name:_____
Employer Address:_____City_____State_____Zip_____
Job Title: _____
Job Activity (ie; sit, stand etc)_____

Saratoga Spine

Patient Name _____

I certify that I have insurance with the above company and assign Saratoga Spine all insurance benefits, if any, otherwise payable to me for services rendered. I authorize use of my signature on all insurance submissions.
The offices of Saratoga Spine may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits and the benefits payable to related services.
MEDICARE AUTHORIZATION:
I request that payment of authorized Medicare benefits be made to Dr. John Herzog for their services. I authorize any holder of medical or other information about me to be released to Medicare or Medicaid services and their agents any information needed to determine these benefits related to services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Print Name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILTY TO INFORM SARATOGA SPINE IF I OR MY MINOR CHILD, EVER HAVE A CHANGE IN ANY OF THE ABOVE INFORMATION

_____ _____
Signature of Patient, Parent or Guardian Date

Saratoga Spine

Patient Name _____

HIPPA PRIVACY STATEMENT

This notice describes how health information about you, if you decided to become a patient of this practice, may be used, disclosed and how you can get access to your health information. This is required by the Privacy Regulations used as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Commitment to your privacy:

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the integrity of your health information. We realized these laws are complicated, but we must provide you with the following information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or of another individual of the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the US Military forces and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

Rights regarding your health information:
You can request that our practice communication with you about your health in a particular manner. We will accommodate reasonable requests.

1. You can request a restriction in our use or disclosure of your health information for treatment and payment of health care operations.
2. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician's name to 7 Murray Street, Glens Falls, NY 12801. We will respond within ten (10) business days.
3. You may ask to amend your health information if you believe it is incorrect or incomplete, as longs as the information is kept by our practice. To request and amendment, your request must be made in writing and submitted to this office. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice.
5. Right to file a complaint if you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosure that are not identified by this notice or permitted by applicable law.

This practice shares an electronic medical record database. We do cover each other and your medical records will be accessed when necessary.

Additional person(s) authorized to speak with regarding appointment messages and/or medical information:

Name:_____ Relationship:_____ Phone _____

Name:_____ Relationship:_____ Phone _____

Signature_____Date_____

Saratoga Spine

Patient Name _____

Financial Responsibility

You must present a valid insurance card and photo ID such as a valid Driver's license at each visit. It is your responsibility to report any insurance changes to the office as soon as possible. Any information that is inaccurate or received after the date of service may not be billable to the insurance carrier and may become the responsibility of the account guarantor.

All co-payments and past due balances are due at time of check-in. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

If your insurance pays you directly for services rendered by us, you agree to forward the payment to us immediately.

There is a $25 service charge for all returned checks.

There is a $25.00 fee for all visit cancelled with less than 24-hour notice.

.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at (518) 743-1010.

Acknowledgment that I have received that above policy:

Name_____
Signature_____Date_____

SARATOGA SPINE

PAIN MEDICATION AND CONTROLLED SUBSTANCE POLICY

Pain medication will be prescribed when necessary, in the immediate post-operative period only. Narcotics are usually prescribed for no longer than 6-8 weeks for a non-deformity surgery such as Laminectomy, Discectomy or Cervical Fusion. Narcotics will usually be prescribed for no longer than 12 weeks for a lumbar spinal fusion.

Most research has shown worse outcomes for patients who are on chronic narcotics. However, some pain specialists still routinely prescribe these medicines for prolonged periods of time. This requires specialized expertise and close follow up by a pain management specialist.

All Prescription refill requests must be made by the patient only and will be processed Monday thru Thursday only, during normal business hours. All requests made on Fridays will be processed on Monday. We require at least 48 hours notice. Please plan ahead.

Controlled substance medications may not be renewed if stolen or lost until the prescription has expired.

All prescriptions will be electronically transmitted to your pharmacy. When requesting a medication refill, please state the pharmacy you would like the prescription electronically sent to along with your name, date of birth, medication name requested. Your request will be reviewed by our providers and you will get a return phone call notifying you of the status of your request.

I agree to the following and understand that I may be discharged from Saratoga Spine if I break any of these conditions:

I will not attempt to get pain medication from any person or healthcare provider not authorized my Saratoga Spine provider.
I will not use medication in a way that is not prescribed.
I will not exhibit deceitful behavior nor provide false information
I will not make calls after hours to obtain medication.
I will not sell or give my medications to any other person.
I will sign and follow the "Patient Understanding for Opioid Treatment Form"
I will sign and follow the "Patient Informed Consent for Opioid Treatment form"
I am aware that I may be subjected to random testing including but not limited to: urine screening and random pill counts.

I _____, Acknowledge that I have read the all the pages and agree to comply with Saratoga Spine's Pain Medication and Controlled Substance Policy. I understand that failure to follow these policies may result in my being discharged from Saratoga Spine and I could risk prosecution as directed by state and federal agencies.

Patient or Guardian Signature_____ Date:_____

Oswestry Low Back Pain Scale

Name_____ Signature_____Date_____

Please rate the severity of your pain by circling a number below:

No pain 0__ 1__ 2 __3__ 4 __ 5__ 6__ 7 __ 8__ 9__ 10__ *Unbearable pain*

Please read: This questionnaire has been designed to give the doctor information on how your back pain has affected your ability to manage in everyday life. Please answer every question, and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking

0. I have no pain walking.
1. I have some pain walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

NECK DISABILITY INDEX

Name_____Signature_____Date_____

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Please read: This questionnaire has been designed to give the doctor information on how your neck pain has affected your ability to manage in everyday life. Please answer every question, and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I can if they are conveniently positioned, e.g. on the table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

Section 5 – Headache
0. I have no headache at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches most of the time.

Section 6 – Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7 – Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 8 – Driving
0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9 – Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 - Recreation
0. I am able to engage in all recreational activities with no pain in my neck.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of my neck pain.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

Name_____ Date_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all
Somewhat difficult
Very difficult _____
Extremely difficult _____

NAME_____ **DATE** _____

PATIENT HEALTH QUESTIONAIRE (phq-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
…	…	…	…

PATIENT AUTHORIZATION TO OBTAIN

SUMMARY PLAN DESCRIPTION & 5500 FORM

Patient Name _____

Employer _____

Employer address _____

_____

I hereby direct you to forward to **Saratoga Spine** the following governing plan documents for the purpose of applicability of compliance with PPACA:

1. **Summary Plan Description (SPD)**
2. **5500 Form (Plan Annual Report)**
3. **Certified Copy of Certificate for PPACA Grandfathered Plan.**

Please forward to the below address immediately:

Saratoga Spine
7 Murray St.
Saratoga Springs, NY 12866

DATED: _____

_____
Patient Name (Please Print)

_____
Patient Signature

Identification No:_____

Designation Of An Authorized Representative

An Authorized Representative is a person you authorize to act on your behalf, in pursuing a claim or an appeal of a denied claim. This authorization may be either (1) granted for a particular event or date of service, after which time the authorization approval is revoked, or (2) granted for any present or future claim for health care benefits you may have. Designation of Authorized Representative status granted for a particular event or date of servicer are most appropriate when being granted to a health care provider or an attorney that may be representing you in connection with a claim. Designations of Authorized Representative status for any present or future claim for health care benefits are more appropriately made to family members or other trusted persons who you may wish to authorized to assist you in the future with health care claim matters.

I,_____, hereby appoint Saratoga Spine_____

As an Authorized Representative, to act on my behalf in the filing or pursuance of claim and pursuance of appeals in connection with the following health care claims (check one):

☒ _____; or
(Description of claim(s) issue, date(s) of service, providers(s) of service, and any other pertinent information available)

☒ And present or future claim for health care benefits.

I understand that as a result of this authorization, Saratoga Spine_____ may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the individual/ Health Care Provider named above.

_____
Print Name of patient

_____ _____
Signature of patient Date