Practice Care Policies

Patient: ____ DOB: ______________________

We are pleased to have been asked to consult on your condition and care for you. Be assured that we devote our best professional efforts to your care. We are committed to providing quality care and want to help our patients reach the highest level of health possible. Our goal is to provide a patient and practice partnership focused on communication and cooperation. As part of this partnership, we believe our patients should understand our policies and make the following commitments:

1. Treat each patient and staff member with courtesy, dignity, and respect always.
2. Patients should provide the practice with all relevant, prior medical records and diagnostic tests (radiology reports and discs of radiology images) at each appointment.
3. Medications prescribed by Dr. Mallik must be taken as directed. Patients having surgery, may be prescribed medication up to three months following surgery. All prescription requests and/or refills will be handled within a timely manner.
4. Schedule and keep appointments regularly. A no-call, no-show appointment will result in a $75 fee that must be paid before another appointment will be scheduled. After two no-call, no-show appointments Dr. Mallik will then decide if you will continue to be a patient of the practice. Cancellations require a 48-hour notice.
5. Patients are responsible for all payments of insurance co-pays, deductibles, and fees non-covered services at the time of service. For questions regarding fees or coverage items, contact Business Dynamics at 1-888-337-8220.
    a) Per your health insurance plan, all co-insurance and deductible amounts remaining must be paid in full prior to, or at the first scheduled post-operative appointment.
    b) There will be a $10 fee for any checks or credit cards that are denied.
6. Any forms requiring completion by Dr. Mallik, including but not limited to disability, FMLA, insurance, etc. regardless of length will be $100, only if a letter provided by our office including all of the same information is not accepted. This letter will be free of charge. If the letter is not sufficient and specific disability paperwork is required, only then will the fee will be $100.00. Forms will not be completed until after surgery is completed.

My signature below acknowledges that I have read and understand the Practice Care Policy.

____ ___________________________

Patient Signature Date

Acknowledgement of Privacy Practices

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

Patient Name: ____

____ ____________________________

Patient Signature Date

If personal representative's signature appears above, please describe their relationship to that patient:

____

Names of Relatives, Friends, Etc. (if any) we may discuss your medical information with:

____ ___________________

Name Relationship

____ ___________________

Name Relationship

____ ___________________

Name Relationship

For Office Use, Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please specify) ____

____ ___________________________

Staff Signature Date

Patient Demographics

Today's Date: ________________________

____ ________ ______________________________
Last Name M.I. First Name

SSN: ______-______-________ Date of Birth: _________________ Age: __________

Please Circle:

Gender: Male Female

Marital Status: Single Married Widowed Divorced Separated

Employment Status:

Employed Unemployed Full-time Student Part-time Student Retired Child Other: _______

Home #: _________________ Cell: _________________ Work: ____________________

At which number, can we leave a detailed message? Home Work Cell

Address ____

City ______________________________ State _________ Zip___________

Email Address ____@_____________________

Referring Physician ______________________________________Phone ____________________

Other Referral Source: Patient Friend/Family Internet Other: __________

Family Physician ____________________________________ Phone ________________________

Emergency Contact __________________________________ Phone ________________________

Emergency contact's relation to you ____

Is it okay to leave a detailed message at your emergency contact's number? Yes No

Chief Complaint/History of Present Illness

Patient Name: ______________________________________ DOB: ______________ Date: _______________

Reason you are here: ____

____

____

Describe your symptoms: ____

____

____

Please rate your pain on scale of 0-10 (0=no pain, 10=worst pain) __________________________________

What caused your symptoms? How long have you had them? _____________________________________

____

____

Previous treatments for your current symptoms? ____

____

____

What relieves the symptoms? What makes them worse? ____

____

____

Any other signs or symptoms?____

____

Past Medical History

Name: ____ DOB: ______________ Date: _________________

Allergies to any medications, foods, latex or contrast? If yes, include reaction ____________________________

____

____

List all medications you are currently taking:

Name of Drug/Dosage	How Often	Reason for Taking	Doctor Prescribing
____________________	_____________	__________________	______________________
____________________	_____________	__________________	______________________
____________________	_____________	__________________	______________________
____________________	_____________	__________________	______________________
____________________	_____________	__________________	______________________

Please circle the following:

Seizures/Headache	NO	YES	Ulcer/GERD/Bowel Problem	NO	YES
Stroke/TIA	NO	YES	Arthritis: Osteo or Rheumatoid	NO	YES
Glaucoma/Cataracts	NO	YES	HIP Problems/Knee Problems	NO	YES
Blurred/Double Vision	NO	YES	Fibromyalgia/Connective Tissue Disorder	NO	YES
Glasses/Contact Lenses	NO	YES	Thyroid Problems/Diabetes	NO	YES
Asthma/Emphysema	NO	YES	Hepatitis/Liver Diseases/Kidney Problems	NO	YES
Bronchitis/Pneumonia	NO	YES	Anemia/Blood Transfusions	NO	YES
Sleep Apnea (CPAP?)	NO	YES	Cancer/HIV/AIDS	NO	YES
Heart Attach/Angina	NO	YES	Depression/Anxiety	NO	YES
Murmur/irregular beat	NO	YES	Claustrophobia/Panic Attacks	NO	YES
Mitral Valve Prolapse	NO	YES	Pregnant/Nursing/Birth Control Pills	NO	YES
Pacemaker or AICD	NO	YES	On Special Diet	NO	YES
High Blood Pressure	NO	YES	Metal anywhere in body ___________________	NO	YES

Surgical History and Dates:

____ _________________________________

____ _________________________________

____ _________________________________

Past Medical History (Continued)

Name: ____ DOB: ______________ Date: ______________

Hospitalizations; Please List **Date**

____ ________________

____ ________________

____ ________________

____ ________________

Social History/ Family History

Please circle the following:

Do you smoke?	NO	YES	
Did you smoke in the past?	NO	YES	When did you stop? ______________
Do you consume alcohol?	NO	YES	
Do you use recreational drugs?	NO	YES	
Have you ever had trouble with general anesthesia?	NO	YES	If yes; please describe_____________

Do any of your relatives (parents, grandparents, aunts, uncles, brothers, sisters, children, etc.) have any of the following?

Heart Disease	NO	YES	Lung Disease	NO	YES
High Blood Pressure	NO	YES	Liver Disease	NO	YES
Cancer	NO	YES	Kidney Disease	NO	YES
Diabetes	NO	YES	Bleeding Disease	NO	YES
Arthritis	NO	YES	Depression/Anxiety	NO	YES

____________________________________ ______________________

Patient Signature Date

____________________________________ ______________________

Physician Signature Date

Data Sheet

Name: ____ DOB: ______________ Date: _______________

Please indicate if you have had any testing for your current problem:

Test	Location	Date	Ordering Physician
MRI	______________________	______________	___________________________
CT	______________________	______________	___________________________
Myelogram	______________________	______________	___________________________
X-Ray	______________________	______________	___________________________
EMG/NCS	______________________	______________	___________________________
Discogram	______________________	______________	___________________________
Cisternogram	______________________	______________	___________________________
Spinal Tap	______________________	______________	___________________________
EEG	______________________	______________	___________________________

____ ______________________

Patient Signature Date

Physician Notes:

Impression: ____

____

____

____

____

Plan:____

____

____

____

O Advice for Normal Activities O Advice Against Bed Rest

____ ______________________

Physician Signature Date