San Diego Center for Spinal Disorders

Ramin Bagheri, MD • Gregory Mundis, MD

Thank you for scheduling an appointment with our Center.

Please complete the attached paperwork in advance of your appointment so we will be able to get it processed quickly on the day of your first appointment.

As a new update, with internet access these forms can be completed and saved on your computer. We ask that you print your completed forms and bring them with you to your appointment along with all spine x-rays, MRI or CT spine scans and their reports, along with your current health insurance card.

1. **NOTICE TO PATIENTS:** Effective April 1st, parking validation will no longer be provided. We apologize for any inconvenience this may cause.

2. All co-payments are due at the time of check in.

3. Late Policy: We make every effort to be on time for all our appointments **Patients arriving more than 15 minutes after their appointment time will be asked to reschedule**.

4. No Show Policy: In an effort to serve you better, we ask for proper notice for any cancellation. **Patients failing to provide at least a 24-hour notice will be charged $50 for any missed appointment.**

5. Surgery Cancellation Policy: A lot of time is put into scheduling of a surgery with many parties involved. In light of that, if you decide to cancel your surgery for non-medical reasons, you will be charged $300.

   If you have any questions concerning this notice, please feel free to ask your physician or any staff representative. We welcome you as a patient and value our relationship with you.

We look forward to serving you!

Ramin Bagheri, M.D. Gregory M. Mundis, Jr., M.D.

San Diego Center for Spinal Disorders
Ramin Bagheri, M.D. - Gregory Mundis, M.D.

PATIENT INFORMATION

Name: _____ _____ _____ _____/_____/_____ _____ Gender: M / F
Last First Middle Date of Birth Age

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Phone: Home ( )_____-_____ Cell ( )_____-_____

Address:_____City:_____Zip:_____

Social Security Number: _____-_____-_____ Email: _____ Driver's License: _____

Primary/Referring Physician: _____

Current Employer: _____Occupation:_____ Phone ( )_____-_____ ext.____

Work Address: _____City:_____Zip:_____

Pharmacy:_____ Phone ( ) _____-_____ Location:_____
Electronic Medicine will be sent to this pharmacy

SPOUSE/PARENT OR EMERGENCY CONTACT

Name: _____ Relationship: _____ Date of Birth: _____/_____/_____

Address:_____City:_____Zip:_____

Phone: Home ( )_____-_____ Cell( )_____-_____ Work ( )_____-_____ / _____

Social Security Number: _____-_____-_____ Email Address: _____

Current Employer: _____Occupation:_____

Work Address: _____City:_____Zip:_____

INSURANCE INFORMATION

Name of Insured (If not Patient) _____Date of Birth(If not patient):_____/_____/_____ _____

_____ _____ _____
Insurance Company Name Policy Number Group Number

Claims Mailing Address: _____City:_____Zip:_____

Phone: ( )_____-_____/_____ Contact Name:_____+

SECONDARY INSURANCE INFORMATION

Name of Insured(If not Patient):_____Date of Birth(If not patient):_____/_____/_____

_____ _____ _____
Insurance Company Name Policy Number Group Number

Claims Mailing Address: _____City:_____Zip:_____

Phone: ( )_____-_____/_____ Contact Name:_____

*__Authorization to pay Benefits to physician:__ I hereby give authorization for payment of medical and/or surgical benefits directly to Ramin Bagheri, M.D. and/or Gregory M. Mundis, Jr., M.D., for services described on the insurance claim forms. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to, deductibles, co-pays, co-insurances, and services not covered under my plan. It is my responsibility to know the coverage of benefits for my insurance policy.

***Authorization to release information**: I hereby authorize the release of any medical or other information to my insurance company to process claims for services rendered.

***HIPAA Policy**: I hereby acknowledge that I have been offered the Notice of Privacy Practices of Ramin Bagheri, M.D. and Gregory M. Mundis, Jr., M.D.

***Notice to Consumers:** Medical doctors are licensed and regulated by the Medical Board of California 800) 633-2322 www.mbc.ca.gov

I hereby certify that the above information is correct and accurate to the best of my knowledge. I understand that San Diego Center for Spinal Disorders will assist me in obtaining benefit verification and authorizations as required; I also understand that this does not guarantee payment from my insurance company. I also authorize San Diego Center for Spinal Disorders to submit claims on my behalf and obtain any and all records they determine necessary for my treatment and to obtain payment. In the event that San Diego Center for Spinal Disorders is unable to collect any portion of my bill from my Insurance company, I will be personally responsible for any and all charges and balances allowed by law. I also assign to San Diego Center for Spinal Disorders any and all insurance benefits and ask that payment for services rendered to me will be made payable and directed to San Diego Center for Spinal Disorders .

_____ _____ _____/_____/_____
Patient/Representative Signature Printed Name Date

San Diego Center for Spinal Disorders

Ramin Bagheri, MD • Gregory Mundis, MD

4130 La Jolla Village Dr., Ste. 300
La Jolla, CA 92037
Phone (858) 678-0610
Fax (858) 678-0007
www.sandiego-spine.com

DRIVING DIRECTIONS FROM 5 AND 805 FREEWAYS

I-5 Northbound:

Exit at La Jolla Village Drive; turn right
Turn left on Regents Road; immediately turn right onto Regents Park Row
Our Building is on the right (3 story red brick building with 4130 at the top left corner)
Turn right immediately **after** our building at the Ace Parking Booth; park under our building (on the right)

I-5 Southbound:

Exit at La Jolla Village Drive; turn left
Turn left on Regents Road; immediately turn right onto Regents Park Row
Our Building is on the right (3 story red brick building with 4130 at the top left corner)
Turn right immediately **after** our building at the Ace Parking Booth; park under our building (on the right)

I-805 North and Southbound:

Exit at La Jolla Village Drive/Miramar Rd exit.
Merge onto the La Jolla Village Drive ramp (westbound only).
Turn right on Regents Road; immediately turn right onto Regents Park Row
Our Building is on the right (3 story red brick building with 4130 at the top left corner)
Turn right immediately **after** our building at the Ace Parking Booth; park under our building (on the right)

DISABLED PARKING ONLY: Park on the Orthopedic Surgery Center parking lot in front of our building.

All other patients and visitors: please park in the underground parking beneath our office building.

Please visit our website for driving directions: www.sandiego-spine.com

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

At the time of your new patient appointment, you will be given an arbitration agreement. By signing this agreement both patient and physician are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suite in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. The method of resolving disputes by arbitration is one of the fairest systems for both patient and physician. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patient and physician. This is because the time it takes to conduct an arbitration hearing is far less than a jury trial. Further, both parties are spared some of the rigors of trial and the publicity, which may accompany judicial proceedings.

The goal of course, is to provide medical care in such a way as to avoid any such dispute. We know that the most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

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PEDIATRIC HEALTH HISTORY FORM

Date: _____

Child Name: _____ Age: _____ Sex: ☐ Female / ☐ Male

1. When was the Scoliosis / Kyphosis problem first discovered? _____/_____ (month/year)
2. Was this discovered because of (check one):

☐ School Screening Exam ☐ Your Child's Doctor

☐ Someone Noticing A Curve ☐ Someone Noticing Roundback

☐ Someone Noticing Poor Posture ☐ Back Pain

☐ Other

3. Does anyone else in your family have Scoliosis or Kyphosis? ☐ Yes ☐ No
   If yes, what relation are they to the patient? (i.e.: sister, aunt, cousin)_____
4. Has there been any previous back treatment? ☐ Yes ☐ No
   If yes, what treatment was given? _____
5. Is there currently any of the following symptoms? (check all that apply)

_____ Back Pain _____ Easily Tired

_____ Heart Trouble _____ Other _____

_____ Breathing Problems _____ None

6. Would you say your child's health is: (check one)

☐ Good ☐ Fair ☐ Poor

7. Has your child ever had any problems with: (check all that apply) _____ None

_____ Heart _____ Lungs _____ Allergies

_____ Kidneys or Bladder _____ Muscles of Arms or Legs _____ Headaches

_____Stomach or Intestinal Tract _____ Eyes, Ears, Nose or Throat

_____ Other (If checked, please describe): _____

Child Name: _____ Date: _____

8. Female patients only: Have your child's periods started? ☐ Yes ☐ No
   If yes, when did they begin? _____/_____
   (month/year)

SPINE Surgical History:

Date	Surgery	Complication

Other Surgical History:

Date	Surgery	Complication

Medication Allergies **Is your Child Allergic to Latex:** YES ☐ NO ☐

_____

_____

_____

Medication and Dosage:

	Medication	Strength	# of doses per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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Early Onset Scoliosis 24-Item Questionnaire (EOSQ-24)

Center for Pediatric Orthopedic Research
Columbia University Medical Center

Morgan Stanley Children's Hospital of NewYork-Presbyterian
Columbia University Medical Center
Columbia Orthopaedics
Pediatric Orthopaedic Surgery

OFFICE USE ONLY **Study ID:** **Date:** / /

General Health: During the past 4 weeks				
1. In general, you would say your child's health has been:				
Poor ○	Fair ○	Good ○	Very good ○	Excellent ○
2. How often has your child been sick?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○

Pain/Discomfort : During the past 4 weeks				
3. How often has your child had pain/discomfort?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○
4. How severe has your child's pain/discomfort been?				
Very Severe ○	Severe ○	Moderate ○	Mild ○	No Pain ○

Pulmonary Function: During the past 4 weeks				
5. How difficult has it been for your child to cry/babble/speak (appropriate for age) without experiencing shortness of breath?				
Difficult ○	Somewhat Difficult ○	Neutral ○	Somewhat easy ○	Easy ○
6. How often has your child experienced shortness of breath during activities?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○

Transfer: During the past 4 weeks				
7. How often has your child's health condition limited his/her access to places?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○

PLEASE SEE NEXT PAGE TO CONTINUE

Physical Function: During the past 4 weeks				
8. How difficult has it been for your child to move his/her upper body?				
Difficult ○	Somewhat difficult ○	Neutral ○	Somewhat easy ○	Easy ○
9. How difficult has it been for your child to sit up on his/her own?				
Difficult ○	Somewhat difficult ○	Neutral ○	Somewhat easy ○	Easy ○
10. How difficult has it been for your child to keep his/her balance while crawling, walking, or running?				
Difficult ○	Somewhat difficult ○	Neutral ○	Somewhat easy ○	Easy ○

Daily Living: During the past 4 weeks				
11. How difficult has it been for your child to dress him/herself or assist with dressing? **(examples: helping remove/ putting-on clothing, pushing arms and legs through shirts and pants, or assisting with fasteners, zippers, snaps, buttons, velcro)**				
Difficult ○	Somewhat difficult ○	Neutral ○	Somewhat easy ○	Easy ○
12. My child needs more time than a healthy child to eat the same amount of food.				
Strongly agree ○	Inclined to agree ○	Neither ○	Inclined to disagree ○	Strongly disagree ○

Fatigue/Energy Level: During the past 4 weeks				
13. How often has your child had fatigue?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○
14. How difficult has it been for your child to keep up his/her energy all day?				
Difficult ○	Somewhat difficult ○	Neutral ○	Somewhat easy ○	Easy ○

PLEASE SEE NEXT PAGE TO CONTINUE

Emotion: During the past 4 weeks				
15. How often has your child felt anxious/ nervous due to his/her health condition?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○
16. How often has your child felt frustrated due to his/her health condition?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○

Parental Impact: During the past 4 weeks				
17. How often have you felt anxious/nervous about his/her health condition?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○
18. How often has your child's health condition interfered with family activities?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○
19. How much has your child's health condition affected your energy level?				
Extremely ○	A lot ○	Some ○	A little ○	Not at all ○
20. How often have you missed or have you been late for work or social events due to your child's health condition?				
All of the time ○	Most of the time ○	Some of the time ○	A small amount of the time ○	None of the time ○
21. Have you been able to spend enough time with your family/partner/spouse despite your child's health condition?				
None of the time ○	A little of the time ○	Some of the time ○	Most of the time ○	All of the time ○

Financial Impact: During the past 4 weeks				
22. How much of a financial burden has your child's diagnosis of Early Onset Scoliosis been?				
Extreme burden ○	Quite a burden ○	Moderate burden ○	A little bit of a burden ○	No burden ○

Satisfaction: During the past 4 weeks				
23. How satisfied is your child with his/her ability to do things?				
Very dissatisfied ○	Dissatisfied ○	Neutral ○	Satisfied ○	Very satisfied ○
24. How satisfied are you with your child's ability to do things?				
Very dissatisfied ○	Dissatisfied ○	Neutral ○	Satisfied ○	Very satisfied ○

PLEASE SEE NEXT PAGE TO CONTINUE

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Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

☐ **I give Permission for my physician/staff to speak with the following family member or significant other regarding confidential health information, only when medically necessary, or in my best interest:**

Name: _____

Name: _____

Name: _____

☐ **Phone**

I want you to contact me by telephone at _____

☐ Do ☐ Do not leave messages on my answering machine.

☐ Do ☐ Do not leave messages with any other person.

☐ **Mail**

I want you to contact me at the following address _____

_____

☐ **E-mail**

I want you to contact me at the following e-mail address: _____

☐ **Fax**

I want you to contact me at the following fax number: _____

☐ **Other**

_____

_____

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate:

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Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian of conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

Name of patient: _____

****

For office use only:

Date Granted: _____

Date Terminated of Modified: _____

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Print File

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AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: ____/____/____

Last First Middle

Authorization for Use / Disclosures of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below:

Name of the Provider: _____
Address of Provider: _____
_____

Fax Number: _____

Recipient and Address for Delivery of Records:

Ramin Bagheri, M.D. / Gregory M. Mundis, Jr, M.D.
4130 La Jolla Village Drive; Ste. 300
La Jolla, CA 92037
Phone: 858-678-0610 / Fax: 858-678-0007

Purpose: I understand that the specific purpose of this Authorization is:

_____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment receive by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information.

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation:

_____

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Terms: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guaranteed that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign / right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have nay effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have a right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as a effective and as valid as the original.

_____	___/___/___	_____
Signature	Date	Signature of Witness

Name: _____
(Please Print)

If Individual is unable to sign this Authorization, please complete the information below.

_____	_____	___/___/___	_____
Signature of Personal Representative	Legal Relationship	Date	Witness Signature

Name: _____
(Please Print)

Save File

Print File