

Executive Medical and Surgical  
900 E. Washington Street, Suite 100

Colton, Ca 92324

Phone # (909) 824-2422 Fax # (909) 824-8234

### **PATIENT CONSENT FORM**

**Authorization for treatment and release of information:**

1. I consent for this provider to render the treatment set forth as ordered by my physician
2. I give authorization, for treatment to be provided in the areas not totally isolated from other patients and personnel.
3. This authorization, or photocopy of same, authorizes the release of any medical information necessary for treatment and/or to process claims for services rendered by this provider.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name (please print) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Reimbursement Coverage:**

4. I request and authorize my insurance and/or Medicare to make payments for benefits on my behalf to Executive Medical & Surgical.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

If policyholder is other than the patient, please complete the following. I, The policyholder, request and authorize my insurance company and/or Medicare to make payments for benefits on behalf of the patient to Executive Medical & Surgical.

Signature of Policyholder: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE PROVIDE PROOF OF INSURANCE COVERAGE UPON COMPLETION OF THE FORM**

Assignment and Authorization: I authorize the release of any medical information necessary to process insurance claims on my behalf. I authorize payment of medical benefits directly to Executive Medical & Surgical for services and supplies provided to me. A copy of this authorization shall be considered as valid as the original and valid for the duration of my care. I understand I am liable for all charges incurred should my insurance not pay for these services (Except for Worker's Compensation).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

# Executive Medical and Surgical

*Darren L. Bergey, MD*

*Spinal Surgeon*

REFERRED BY \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ SEX \_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

PATIENT ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_

PATIENT OCCUPATION \_\_\_\_\_

INJURY DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

SS NUMBER \_\_\_\_\_

CLAIM NUMBER \_\_\_\_\_

INSURANCE CARRIER \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

INSURANCE CITY, STATE AND ZIP \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER PHONE \_\_\_\_\_

ATTORNEY \_\_\_\_\_

ATTORNEY ADDRESS \_\_\_\_\_

ATTORNEY PHONE \_\_\_\_\_ FAX \_\_\_\_\_

CONTACT \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_

## **PATIENT QUESTIONNAIRE**

1. My chief problem is: \_\_\_\_\_  
\_\_\_\_\_
2. This has been going on for: \_\_\_\_\_  
Ever since my: \_\_\_\_\_
3. Describe the location of your pain: \_\_\_\_\_  
\_\_\_\_\_
4. Describe the nature of your pain: \_\_\_\_\_  
\_\_\_\_\_
5. Location and description of numbness or tingling: \_\_\_\_\_  
\_\_\_\_\_
6. Location and description of weakness: \_\_\_\_\_  
\_\_\_\_\_
7. How have these symptoms changed your life, or your ability to perform your usual functions?  
\_\_\_\_\_  
\_\_\_\_\_
8. What makes these symptoms better? \_\_\_\_\_  
\_\_\_\_\_
9. What makes these symptoms worse? \_\_\_\_\_  
\_\_\_\_\_
10. What have you tried for these symptoms? \_\_\_\_\_  
\_\_\_\_\_

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11. Do you have problems controlling your bowel or bladder? \_\_\_\_\_

\_\_\_\_\_

12. Do you have trouble walking? \_\_\_\_\_

\_\_\_\_\_

13. Do you have other medical problems? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Please list any and all surgeries that you have had: \_\_\_\_\_

\_\_\_\_\_

15. What medication, vitamins, herbs or supplements do you take? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Do you have any allergies to medications? \_\_\_\_\_

\_\_\_\_\_

17. Please list any medical problems that run in your family: \_\_\_\_\_

\_\_\_\_\_

18. Do you smoke? \_\_\_\_\_ If so, how much and how long? \_\_\_\_\_

19. Do you drink alcohol? \_\_\_\_\_ If so, how much and how long? \_\_\_\_\_

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20. What is your weekly activity like? (i.e., list exercises, physical activity, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. Are your symptoms related to a work related injury? \_\_\_\_\_

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## **REQUEST FOR CONSULTATION:**

Aside from the problem for which you are seeking help from Dr. Bergey, do you have any of the following? (Please circle the items and explain below)

### **GENERAL/CONSTITUTIONAL**

Fever, chills, nausea, vomiting, lethargy, fast or slow heart beat, lapses of consciousness or memory.

### **SKIN/BREAST**

Rashes, lumps under the skin, easy bruising, easy bleeding.

### **EYES/EARS/NOSE/MOUTH/THOAT**

Sore throat, difficulty swallowing or getting food down, stuffed nose or sinuses, hoarseness.

### **CARDIOVASCULAR**

Chest pain, skipped or irregular heart beats

### **RESPIRATORY**

Trouble breathing, frequent coughing, production of sputum, blood in sputum.

### **GASTROINTESTINAL**

Bloating, abdominal pain, pain after eating, trouble with bowel movements.

### **GENITOURINARY**

Trouble starting or stopping urine flow, leakage of urine, impotence, incontinence, blood in the urine or burning on urination.

### **MUSCULOSKELETAL**

Pain in the joints, limitation of range of motion, cramping in the muscles

### **NEUROLOGIC/PSCHIATRIC**

Problems controlling mood, loss of appetite or sleepiness, sleeping too much, trouble with balance or walking, problems with vision, hearing, taste, and/or smell.

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What tests, Xrays, MRI's have you had? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is your primary physician?

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Who is your referring physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

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## MEDICAL INFORMATION RELEASE

I hereby authorize (name and address of healthcare provider)

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to release/disclose my Personal Health Information for purposes of payment, health care operations and treatment. The information and records, which may be released to any medical, psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records and/or information, which he/she may have regarding.

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(Patient's Name)

(Date of Birth)

Examples of these types of uses and disclosures include:

**PAYMENT:** We use and disclose your PHI in order to process claims and seek reimbursement for your health expenses covered by and insurer.

**TREATMENT:** We may disclose your PHI to assist in your health care (doctors, pharmacy and others) in your diagnosis and treatment.

### OTHER PERMITTED OR REQUIRED DISCLOSURES OF YOUR PHI:

**AS REQUIRED BY LAW:** We may disclose your PHI when required to do so by law (i.e., Workers' Compensation).

**PUBLIC HEALTH ACTIVITIES:** We may disclose PHI to public health agencies for reasons such as preventing or controlling disease, medical injury or disability, and/or enable product recalls, repairs or replacements.

**BUSINESS ASSOCIATES:** There are some services provided by us through contracts with business associates and PHI disclosure may be necessary to perform the job we have asked them to do. To protect PHI, we require the business associates to abide by the appropriate privacy measures.

1. The information and PHI/Medical Records, which may be released, are limited to all medical, psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records or other information obtained by (healthcare provider) \_\_\_\_\_, through his/her interviews with the patient: \_\_\_\_\_, and/or through his/her inquires and/or review of records concerning the patient \_\_\_\_\_, and/or other persons, and includes all medical, psychiatric, psychological, psychotherapy, alcohol and/or drug abuse records which are in the possession or control of: \_\_\_\_\_.

2. The purpose of such disclosure is for use in connection with: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. The consent is subject to revocation at anytime except to the extent that action has already been take in reliance thereon. If not preciously revoked, the consent will terminate on (date): \_\_\_\_\_

4. I understand that I may receive a copy of this consent.

\_\_\_\_\_

Patients Signature

\_\_\_\_\_

Date Signed

**If the patient is deceased:**

\_\_\_\_\_

Signature of Beneficiary or

\_\_\_\_\_

Date Signed

Personal Representative of Deceased patient

**If the patient is a minor, or has been judicially determined to be incompetent:**

\_\_\_\_\_

Signature of the Legal representative of The patient,

\_\_\_\_\_

Date Signed:

Such as a Conservator of the person, and individual

Granted A Durable Power or Attorney, or a Parent with

Legal custody of a minor patient

