

Christopher Taleghani, MD
Neurosurgeon



Amy Bonner, PA-C
Physician Assistant

Dear New Patient: _____

Your New Patient appointment is scheduled for: _____

Location: _____ **Nashville Office:** _____ **Bowling Green Office**
3901 Central Pike Ste. 455 **1641 Scottsville Road**
Hermitage, TN 37076 **Bowling Green, KY 42104**

Welcome to Cumberland Brain & Spine. We look forward to your upcoming new patient appointment.

We have enclosed the new patient forms for your initial visit to our practice. Prior to your visit please fill out the following forms and bring them with you to your scheduled appointment. Completing the forms entirely will help us in serving you better.

Please bring any and all diagnostic films (MRI, CT scans, ect.) with you to your scheduled visit or we will not be able see you for your initial consultation. We need these films to accurately evaluate your condition.

Please note, if you need to reschedule, or cancel your appointment, please do so at least 24-48 hours in advance. Failure to notify our office of your absence will result in a delay of rescheduling.

REMINDER:
BRING ALL DIAGNOSTIC FILMS/CD's TO YOUR ABOVE SCHEDULED VISIT.

Directions to our Hermitage Tennessee office:
Address:

From I-65:

Follow I-65 South to Exit 90B (Briley Parkway). Continue East on Briley Parkway towards OpryLand Hotel and Opry Mills Mall. You will exit on 6A which will put you on Interstate 40 EAST (towards the Nashville International Airport). Once you are on I-40 you will need to get off at Exit 221A. As soon as you get off THE HERMITAGE exit, you will need to exit to your first right towards CENTRAL PIKE. At the end of the ramp take a right then an immediate left into our parking lot. We are on the fourth floor of the Summit Outpatient Building in suite 455.

Directions to our Bowling Green Office:
Address: 1641 Scottsville Road
Bowling Green, KY 42104

From I-65:

Take exit 22 (Bowling Green/Scottsville) Turn Left off the exit ramp if on 65 North and turn Right off the ramp if on 65-South. Look for stop light number "3". Turn left at stop light # 3, take an immediate right onto the first road on the right. You will pass a Century 21 building and Magma Chiropractic and we are the third building on the left. It is a white building with a green roof. We are located in the left wing of the building.

From US 31-W By-Pass:

Turn onto Broadway which turns into Scottsville Road and proceed to stoplight number 3. Turn right onto Westen Avenue. There will be a Steak & Shake your left. Turn right onto the first street. You are going to pass Century 21 on your left and a Chiropractic office. We are the third building on your left. It's a white building with a green roof. We are located in the left wing of the building.

Nashville Office:
3901 Central Pike Ste. 455
Hermitage, TN 37076
Phone: 615-884-0001
Fax: 615-884-0009

Bowling Green Office
1641 Scottsville Rd.
(Mailing) 1945 Scottsville Rd. B-2 PMB 395
Bowling Green, KY 42104
Phone: 270-781-1772 Fax: 270-781-2212

Chris Taleghani, M.D.
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Amy Bonner, PA-C
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PATIENT INFORMATION

Name: _____

Birth Date: _____

Address: _____

Social Security #: _____-_____-_____

City/State/Zip: _____

Marital Status: []Married []Single [] Divorced [] Other

Home Phone: () _____

Sex: []Female []Male

Mobile/Other: () _____

Referring Physician: _____

Work Phone: () _____

Primary Physician: _____

GUARANTOR (Person Statement will be mailed to)

[] Same as Patient

Name: _____

Birth Date: _____

Social Security #: _____-_____-_____

Address: _____

Home Phone: () _____

City/State/Zip: _____

Work/Other: () _____

PRIMARY INSURANCE

[] Same as Patient [] Same as Guarantor [] Other

Company: _____

Policyholder: _____

Phone Number: () _____

Relation to Patient: _____

ID Number: _____

Social Security #: _____-_____-_____

Group Number: _____

Birth Date: _____

SECONDARY INSURANCE

[] Same as Patient [] Same as Guarantor [] Other

Company: _____

Policyholder: _____

Phone Number: () _____

Relation to Patient: _____

ID Number: _____

Social Security #: _____-_____-_____

Group Number: _____

Birth Date: _____

EMERGENCY CONTACT

Name: _____

PATIENT EMPLOYMENT

[] Employed [] Retired [] Unemployed [] Other

Relationship: _____

Employer: _____

Address: _____

Address: _____

City/State/Zip: _____

City/State/Zip: _____

Home Phone: () _____

Work Phone: () _____

Work/Other: () _____

Position: _____

IS YOUR CONDITION CONNECTED WITH WORKMAN'S COMPENSATION? YES NO (Circle One)

If so, please include the following:

Name of Employer: _____

Employer's Phone: (____)_____ Date of Injury: _____

Contact: _____ Claim #: _____

How did accident occur? _____

IS THIS RELATED TO AN AUTO ACCIDENT? YES OR NO (Circle One)

If so, please include the following:

Insurance Company: _____ Address: _____

Phone #: (____)_____ Contact: _____

Policyholder's Name: _____ Relationship to Patient: _____

Date of Accident: _____ Policy #: _____

Claim #: _____ How did accident occur? _____

INSURANCE AUTHORIZATION (All patients must sign authorizing us to bill your insurance carrier)

I understand and authorize Cumberland Brain & Spine to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to the above practice. I authorized any holder of medical information about me to release to the health financing administration and its agents any information needed to determine these benefits. I understand that I am financially responsible for any information necessary to secure payment of benefits, which includes providing current insurance information. Without this current information, I understand that I will be billed for any services that are rendered by the above practice.

Signature: _____ Date: _____

PAYMENT POLICY (All patients must sign acknowledging copay responsibilities and returned check fees)

Co-payment is due at the time of service. If you do not have your co-pay, please let the receptionist know so she can reschedule your appointment. There is a \$25 returned check fee, and a \$20 fee for missed appointments or cancelled appointments the same day as your appointment.

Signature: _____ Date: _____

ATTORNEY AUTHORIZATION (Only patients with attorneys must sign)

Who is your attorney: _____ Atty phone number: _____

I understand and authorize my medical bills and records to be sent to the above listed attorney to these dates of treatment. If my case is not settled, or if the amount settled does not cover my medical bills, I will pay for these services.

Signature: _____ Date: _____

RELEASE OF INFORMATION/COLLECTIONS POLICY

I authorize, Christopher Taleghani, MD, to release my insurance company any information required for services provided. I also assign any insurance benefits to Christopher Taleghani, MD on any unpaid medical bills.

I understand that I remain responsible to Christopher Taleghani, MD for any and all charges not met by the insurance company.

I, the undersigned, hereby agree that in the event of default in payment of any amount due, and if his account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of the collection including the agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Signature: _____ Date: _____

By signing each of the above statements, I acknowledge that I fully understand the content, and agree to all of the above conditions.

Health History Form

Date: _____ HMC# _____

Name: _____ DOB: _____ Age: _____

Name of person completing form (if other than patient): _____
Relationship to patient: _____

Were you referred by another physician? YES NO

Physician: _____

Street
Address: _____

If you have any other primary care physician other than your referring physician, please complete the information below.

Physician: _____

Street
Address: _____

If you would like the information from today's visit sent to a physician other than those listed above, please complete the information below.

Physician: _____

Street
Address: _____

What is the reason for today's visit? _____

Is this the result of a specific accident or injury? YES NO

If "YES", please answer the following:

Date of Accident/Injury: _____ Type of accident: _____

Are you involved in litigation regarding this condition? YES NO

Are you applying for or receiving worker's compensation for this or any other condition? YES NO

Are you applying for or receiving disability for this or any other condition? YES NO

Health History Form

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Past Medical History

Do you have any other medical problems? YES NO

If "YES", please check below:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Other: _____ | | |

Please list all previous Hospitalizations and/or Operations

<u>Date</u>	<u>Hospital</u>	<u>Problem/Operation</u>

Do you or have you ever had?

Constitutional Symptoms

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Persistent fever chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Frequent nausea/vomiting | | |

Cardiovascular/Respiratory

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Shortness of breath at night | <input type="checkbox"/> Shortness of breath on stairs | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Blood in your sputum (spit) | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Irregular Heart Beat | |

Hematological

- | | | | |
|---|--|---------------------------------|--|
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Black or tarry stools | <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding/bruising |
|---|--|---------------------------------|--|

Neurological

- | | | |
|---|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blackouts or Dizziness | <input type="checkbox"/> Seizure or Epilepsy |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Headache | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Temporary weakness or numbness | <input type="checkbox"/> Temporary loss or blurring of vision | |

Genitourinary

- | | | |
|---|--|--|
| <input type="checkbox"/> Kidney or Bladder problems | <input type="checkbox"/> Difficulty/frequent urination | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Lack of bladder control | |

Gynecological

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Irregular Menstrual Periods |
|------------------------------------|---|--|

If premenopausal, please give date of last menstrual period: _____

Gastrointestinal

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Gastrointestinal Ulcers | <input type="checkbox"/> Liver Disease of Hepatitis | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation/Diarrhea |
|--|---|---|--|

Dermatological

- | | |
|---|--|
| <input type="checkbox"/> Unusual/Prolonged Rash | <input type="checkbox"/> Any prolonged Lesions/Lumps |
|---|--|

Endocrine

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hormone Replacement | <input type="checkbox"/> Thyroid Disease |
|-----------------------------------|--|--|

Musculoskeletal

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pain in legs with exercise | <input type="checkbox"/> Dry mouth or eyes | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Joint or muscle pain | <input type="checkbox"/> Rheumatoid Arthritis | | |

Other _____

Health History Form
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Medications

Please list any medications (Prescription and non-prescription) that you are currently taking:

Medication	Dosage	Number taken Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any allergic or unusual reactions after contact with adhesive tape, medications, food or drugs?

Yes No

Item	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Personal History

Occupation: _____ If no longer working, last day worked: _____

Marital Status: Single Married Divorced Separated

Who lives with you? _____

Have you ever smoked? Yes No

If "YES" how many packs per day? _____ For how many years? _____

If you discontinued, how many years ago? _____

Do you drink alcoholic beverages? Yes No

If "YES", what kind? _____ How Often? _____ How Much? _____

Do you use any recreational drugs? (Cocaine, marijuana, ect.) Yes No

If "YES", What kind? _____ How Often? _____ Lasttime used? _____

Family History

Does or did anyone in your family (parents, grandparents, siblings, children, etc.) suffer from any of the following:

Asthma Cancer Heart Disease High Blood Pressure

Which, if any, other diseases run in your family? _____

Is there anything else that would be helpful for us to know? _____



www.cumberlandbrainandspine.com

NOTICE OF PRIVACY PRACTICES

Chris Taleghani, M.D.

Amy Bonner, PA-C

TO OUR PATIENTS:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this Practice in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

NOTICE OF PRIVACY PRACTICES

Chris Taleghani, M.D.
Amy Bonner, PA-C
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You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information (our normal copying fee will be required)
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

PATIENT ACKNOWLEDGEMENT

I have received, read and understand your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that this Medical Practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the office at any time at the address noted in this notice to obtain a 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 or 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 of the *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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MEDICATION USAGE AGREEMENT

Anyone receiving chronic controlled substances from Cumberland Brain & Spine, LLC will have to sign a Medication Usage Agreement.

By signing this agreement I, _____, agree to abide by the following conditions and terms when using any and all medications prescribed to me by the staff at this practice.

1. I will take my medication(s) only as directed. Any changes in taking my medication(s) will need to be discussed with the office practitioners prior to the change.
2. I agree to take full responsibility for my medication(s) and understand that:
 - a. Lost or stolen medications will not be replaced.
 - b. I will not share my medication(s) with anyone.
 - c. Early refills will not be given if I have accelerated my medication usage and run out before I am due another refill.
3. State law prohibits obtaining medications under false pretenses. If this occurs, we are obligated to report these situations to local law enforcement agencies. Misuse or abuse of these medications is a Class D felony. If the below occurs we will be required to discharge you from the practice immediately. Such false pretenses include, but are not limited to:
 - a. "Doctor shopping" to obtain multiple prescriptions.
 - b. Multiple emergency room visits to obtain prescriptions and medications.
 - c. Use of false identification or any other subterfuge in order to obtain medications.
4. It is important that patients receive their medications from only one doctor. This is not only to prevent possible legal penalties, but also to avoid dangerous side effects and interactions that your medication can have with other medicines that we may not be aware that you are taking. Therefore if you receive any medication(s) from another treating physician, it is **imperative** that you let us know what these medications are.
5. Please be aware that it is not a medical obligation to prescribe controlled substances to a patient at any time.
6. We strongly encourage all of our patients to refrain from using tobacco and alcohol. We also strongly discourage the use of illicit drugs – either illegal substances or prescription medications that are bought from illegal sources.
7. I understand that random urine and/or serum drug testing is done at Cumberland Brain & Spine. I understand that failing a random drug test can be defined as:
 - a. The presence of illegal drugs in the sample.
 - b. The presence of legal drugs that should not be in the sample.
 - c. The absence of the drugs we prescribe when there should be evidence of that particular medication.
 - d. Attempting to pass off someone else's sample as my own.
 - e. Attempting to alter the sample that I leave in order to disguise the results.
8. I understand that refusing or failing a random drug screen may result in one or more of the following occurring:
 - a. I may be required to repeat the screen.
 - b. I may not be prescribed any medications.
 - c. I may be discharged as a patient.
 - d. I may be referred to a drug rehabilitation program.



**MEDICATION USAGE AGREEMENT
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9. I understand that requests for medications and/or refills are done as follows:
- e. Refills may be requested Monday through Friday from 8:30am until 4:30pm.
 - f. Refill requests generally take 3 business days to process.
 - g. No refills will be done on weekends, after normal business hours or on holidays. There will be no exceptions.
 - h. All controlled substances received from our office must be written on a prescription. These medications will not be called into pharmacies.
10. I agree to use _____ pharmacy, located at _____, phone number _____ for all of my controlled substances. If I change my pharmacy for any reason, I will notify the practitioner at the time I receive my prescriptions.

If you have any questions or concerns about this policy, please do not hesitate to discuss it with our practitioners.

I have read the above agreement and agree to abide by the terms set above.

Patient Name (Printed)

Date

Patient Signature

Date

Witness Signature

Date