

California Spine Care
Santi Rao MD
SPINAL DISORDERS & SURGERY

www.SantiRaoMD.com

Tel: 925 691 1700

Fax: 925 691 1707

Date: _____

Dear: _____

This letter is to remind you of your appointment at the office in:

Concord

Vallejo

On: _____ at: _____.

To fully evaluate and diagnose your problem, it is extremely important to have all pertinent information available. Please bring the following with you to the appointment:

- Insurance cards
- Co-payments (Cash or Check only at the **Vallejo** Office)
- Completed forms and questionnaire (Enclosed)
- X-rays, MRI's, CT reports and films
- Any other special tests including: bone scans, EMG/Nerve Conduction studies
- List of current medications (**must be brought**)
- Any medical records and reports

Kindly notify our office at least 24 hours in advance if you must cancel or reschedule your appointment.

Please excuse us if an emergency necessitates our changing your appointment.

We look forward to meeting you!

Sincerely,

2291 Pacheco Street
Concord, CA 94520

100 Hospital Dr., #110
Vallejo, CA 94589

Santi Rao, MD

Spinal Disorders and Surgery

www.SantiRaoMD.com

Today's date _____

Patient Name:

[Last Name] _____ [First Name] _____

Your Age: _____ Date of Birth: ____/____/____

Mailing Address: _____ City: _____
State: _____ Zip Code: _____

Calif. Driver's License: _____ Social Security#: _____

Home Phone: (____) _____ **Work Phone:** (____) _____

Cell Phone: (____) _____ **Email address:** _____

Name of Spouse: _____ if under 18, name of parents: _____

Emergency Contact: _____ Phone (____) _____

Employer and address: _____

Your Occupation: _____

Your family physician: _____ Phone (____) _____

Would you mind telling us who referred you? / How did you hear about this office?

Private Insurance Information (please present all insurance cards to receptionist)

Name of insurance company _____ Subscriber _____

ID# _____ Social Security # _____

If there is a second health plan, please include:

Name of insurance company _____ Subscriber _____

ID# _____ Social Security # _____

Work Related / Car Accident Related Problems:

Do you have an attorney? ---- - ---- - ---- - ---- - ---- - YES NO

Attorney name _____ Phone (____) _____

Have you filed a claim for a work-related injury? YES NO

If you are claiming a *work related injury* – please give us your information -

Insurance company: _____ Date of injury _____

Claims examiner name: _____ Phone (____) _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process this claim

Print and sign name (patient or authorized person)

Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby instruct my insurance company, or attorney to pay directly to my physician any benefits allowable for the professional services rendered to me.

Print and sign name (insured or authorized person)

Date

ASSIGNMENT OF SECONDARY INSURANCE BENEFITS

I hereby instruct my secondary insurance company to pay directly to my physician any benefits allowable for the professional services rendered to me.

Print and sign name (patient or authorized person)

Date

LIABILITY OF UNPAID BALANCE

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance.

Print and sign name (patient or authorized person)

Date

PERMISSION TO TREAT A MINOR

I/We grant consent to have my/our child receive the necessary medical treatment as prescribed by the physician.

Print and sign name (parent or guardian)

Date

THANK YOU!

If you develop leg pain with walking, does leaning forward and supporting your upper body on something relieve your leg pains –

() yes () no () do not develop leg pain with walking

NECK PROBLEM: (if this applies to you)

How many years / months / weeks ago did it start? _____

What date (approximately) did your problem begin? ____/____/____

Please circle how you injured yourself / how the pain started
Slip / direct impact / jerk / lift / twist / fall / bend / other car accident

Comments _____

- Your pain began () gradually () suddenly () from an injury
 - Your pain is in () front of neck () back of neck () back and front
 - It has lasted () weeks () months () years
 - You have pain () occasionally () off and on () constantly
 - The pain radiates () R arm () L arm () does not radiate
 - You have tingling / numbness () R / L arm
 - You have muscle weakness () R / L arm
 - You have () headaches () blurred vision () changed hearing
 - Your pain is (check box)
- | Worse | no different | better with |
|-------|--------------|--------------------------|
| () | () | () coughing or sneezing |
| () | () | () straining at stools |
| () | () | () sitting straight |
| () | () | () sitting reclined |
| () | () | () standing |
| () | () | () sexual activity |
| () | () | () turning to R side |
| () | () | () turning to L side |
| () | () | () looking up |
| () | () | () looking down |

PLEASE DESCRIBE ANY OTHER SYMPTOMS YOU ARE HAVING:

TREATMENT

How long have you been treated so far? _____ months _____ years

You are () improved () no different () getting worse

With whom have you had your treatment so far –

<u>Providing source</u>	<u>Treatment given</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

INVESTIGATIONS PERFORMED

please list the tests done

Test	approximate date	Center / Doctors office
SPINE X-RAYS	_____	_____
CT SCAN	_____	_____
MYELOGRAM	_____	_____
MRI SCAN	_____	_____
EMG NERVE TEST	_____	_____
ARTHRITIS BLOOD TESTS	_____	_____
OTHER TESTS	_____	_____

MEDICATIONS: you currently take _____ for your (whatever) medical problem

_____	for your _____
_____	for your _____
_____	for your _____
_____	for your _____
_____	for your _____
_____	for your _____

ANY PAST NECK/BACK PROBLEMS () Yes () No () different

Previous motor vehicle accidents () Yes () No

Previous work injuries – describe when () Yes () No

and who treated you.

PAST MEDICAL HISTORY:

What serious medical problems do you suffer from? Please list any surgeries you may have had for any problem.

COUNSELING: have you had or are you having any counseling, psychological or psychiatric treatment?

From date _____ till _____ For what reason?

JOB DESCRIPTION:

Have you had to take time off from work for this problem? () yes () no

Duration of time off from _____ to _____

Your job title _____

You are currently () working () not working () unemployed

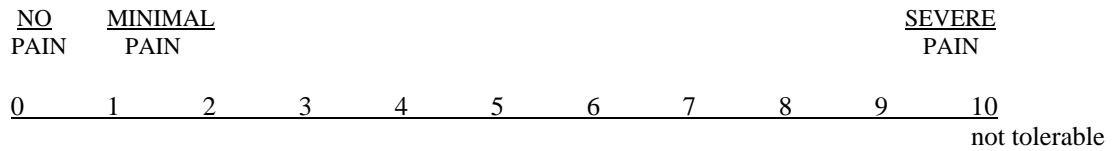
Your last day worked _____

You are on () regular duty () modified duty

() full time () part time

Please see the other side

PLEASE DRAW A LINE OR MARK WHERE YOU THINK YOUR PAIN LEVEL HAS GENERALLY BEEN FOR THE LAST FEW DAYS:

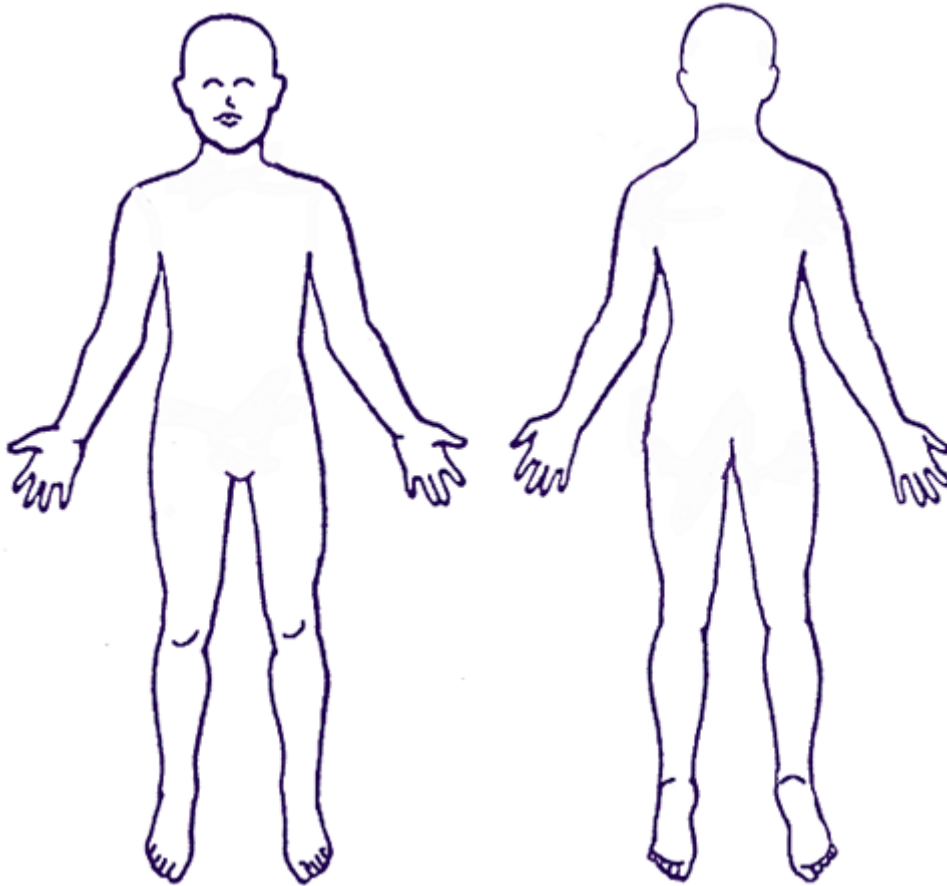


Your pain is: once / few hours once / few days once / few week or two
 once / few weeks occasional almost constant constant

PAIN DIAGRAM:

Please draw in wherever you are feeling any of the following symptoms – use the following symbols:

PAIN (+) NUMBNESS (=) TINGLING (0) BURNING (X)



(Signature) _____

California Spine Care
Santi Rao MD
SPINAL DISORDERS & SURGERY
 Tel: 925 691 1700 Fax: 925 691 1707

I authorize California Spine Care to disclose the following information from the health record of:

PATIENT INFORMATION	Patient Name _____		Date of Birth _____	MR# _____
	Address _____		Phone Number _____	
	City _____	State _____	Zip _____	
	Dates of Service: From _____ To _____			
INFORMATION REQUESTED	All Pertinent Records Assessment(s) Consultation Discharge Summary ER Report EKG Report History & Physical	Operative Report Pathology Report X-Ray Films X-Ray Reports Billing Record Photos Specify:	Home Care/Hospice Records Nursing Assessment Plan of Care Therapy Evaluation Visit Notes Itemized Billing Statements Specify:	
PURPOSE	Self _____ Other (specify reason) _____	Continuing Medical Care _____	Attorney Request _____	
INFORMATION TO BE GIVEN TO	Company, Person, Facility _____		Phone Number _____	
	Address _____	City _____	State _____	Zip Code _____
	Company, Person, Facility _____		Phone Number _____	
	Address _____	City _____	State _____	Zip Code _____
INFORMATION NOT TO BE GIVEN TO	Company, Person, Facility _____		Phone Number _____	
	Address _____	City _____	State _____	Zip Code _____

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse; my signature authorizes release of any such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the release of medical and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I may refuse to sign this authorization form. I understand that California Spine Care will not condition or deny treatment on my signing this authorization. This form is good for 1 years from the date sign.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. California Spine Care requires revocation of this release in writing.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release California Spine Care, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient _____

Date _____

2291 Pacheco Street
 Concord, CA 94520

100 Hospital Dr., #110
 Vallejo, CA 94589

Please fax back to = California Spine Care – Fax # 925 691 1707

Patient Name:

Attorney Name:

Attorney Fax #:

Today's Date:

ASSIGNMENT OF BENEFITS/ MEDICAL LIEN AND SECURITY AGREEMENT

1. Provider's Lien. I, **Patient's Name**, (hereinafter referred to as PATIENT), hereby grant to Santi Rao, M.D. (hereinafter PROVIDER) all rights to payment from PATIENT'S claim for personal injury which occurred on or about **Date of Injury**, (hereinafter CLAIM), in an amount equal to gross fees for medical services performed by Provider, to PATIENT or PATIENT'S minor children.

PATIENT gives authority and instructs the attorney of record, **Name of Attorney** _____ (Hereinafter ATTORNEY) to make payment directly and immediately to PROVIDER from the amount obtained by ATTORNEY in his settlement, award or judgement of the above-mentioned claim. PATIENT understands this notice constitutes a lien in favor of PROVIDER, on the proceeds of PATIENT'S claim. PATIENT further authorizes ATTORNEY to withhold such sums as may be necessary to adequately protect PROVIDER against any and all creditors.

PATIENT fully understands that he/she is directly and fully responsible to PROVIDER for all medical bills submitted by him/her for services rendered. PATIENT acknowledges that this agreement is made solely for PROVIDER'S additional protection and consideration of his/her awaiting payment. PATIENT further understands that such payment is not contingent on any settlement, judgement or verdict, which PATIENT eventually may recover.

PATIENT hereby instructs that in the event another ATTORNEY is substituted or associated in this matter, the new ATTORNEY honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. This lien constitutes a notice to any attorney responsible for this claim. For purposes of this contract, ATTORNEY shall refer to the attorney named herein, or any attorney who is subsequently substituted or associated in the handling of PATIENT'S CLAIM.

2. Assignments. PATIENT understands that all of PROVIDER'S rights under this contract, including the lien are freely alienable, and PROVIDER may assign these rights in full to a third party, herein ASSIGNEE, of PROVIDER'S choosing. PATIENT expressly authorizes PROVIDER to furnish ASSIGNEE with all medical bills, medical records and other documents which are the subject of this lien; PATIENT expressly waives her right of privacy with regard to all medical information provided to ASSIGNEE.

PATIENT understands, and ATTORNEY acknowledges, in the event of such an assignment, all of PATIENT'S and ATTORNEY'S duties and obligations associated with this contract, including but not limited to the duty to pay, as well as the duty to inform, will be enforceable by ASSIGNEE.

3. Revocation. PATIENT herein expressly agrees not to revoke, modify, or alter this agreement and the same shall remain a lien, not to be discharged until such time as PROVIDER or PROVIDER'S ASSIGNEE is fully compensated for services rendered to PATIENT and other persons pursuant to the PATIENT/PROVIDER contract.

4. Substitution of Attorney. PROVIDER has agreed, under the terms of this medical lien, to provide medical services to PATIENT upon the basis that PATIENT has retained an attorney acceptable to PROVIDER duly licensed to practice law in the state where jurisdiction lies, and that PROVIDER is relying on PATIENT'S continued attorney-client relationship with PATIENT'S chosen ATTORNEY. In the event that PATIENT, for any reason, terminates the attorney-

client relationship with PATIENT'S chosen ATTORNEY, then:

- A. PATIENT shall immediately notify PROVIDER; and
- B. PATIENT agrees to retain another attorney, who will execute this agreement; and
- C. In the event PATIENT fails to retain counsel within fourteen (14) days, chooses an ATTORNEY not acceptable to PROVIDER or the ATTORNEY fails or refuses to execute this document, PATIENT shall be in default of this agreement and subject to all remedies including acceleration of all debts making them immediately due and payable and subject to monthly interest at the rate of one percent (1%) per month, from the date of default.

PATIENT ACKNOWLEDGES that this agreement is made for the PROVIDER'S protection and in consideration of PROVIDER'S agreement to provide services on a lien basis.

5. Restriction to Disburse. PATIENT and PATIENT'S ATTORNEY specifically agree not to disburse any funds from PATIENT'S settlement (including to PATIENT or ATTORNEY) until this lien has been satisfied.

6. Attorney's Fees/collection. Should litigation become necessary to enforce any of the rights of this agreement, the prevailing party of such litigation shall be entitled to all reasonable costs, including ATTORNEY'S fees. Furthermore, in the event of any collection activities being necessary, PATIENT agrees to pay any and all collection fees.

7. Modification. This Agreement may be supplemented, amended, or modified only by the mutual agreement of the parties. No supplement, amendment, or modification of this Agreement shall be binding unless it is in writing and signed by both parties.

8. Word Usage. Unless the context clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limited.

9. Entire Agreement. This Agreement constitutes the final, complete, and exclusive statement of the terms of the agreement between the parties and supersedes all prior and contemporaneous understandings or agreements of the parties. No party has been induced to enter into this Agreement by, nor is any party relying on, any representation or warranty outside those expressly set forth in this Agreement.

10. Severability. If a court or an arbitrator of competent jurisdiction holds any provision of this Agreement to be illegal, unenforceable, or invalid in whole or in part for any reason, the validity and enforceability of the remaining provisions, or portions of them, will not be affected, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision.

11. Ambiguities. Each party and its counsel have participated fully in the review and revision of this Agreement. Any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in interpreting this Agreement.

12. Counterparts. This agreement may be executed by the parties hereto in separate counterparts, each of which shall be deemed to be an original and all of which when taken shall constitute but one and the same agreement.

13. Applicable Law. This agreement shall be governed by the Law of the State of California.

14. Execution. I have had an opportunity to be, and have been, represented in the above agreement by counsel of my own choosing. I have read the agreement, my counsel has fully explained its contents to me, and I am aware of its legal effect. I consent to the agreement and agree to be bound by it. PATIENT understands that this document is not effective, nor shall any monies be obligated or paid until the signatures of both PATIENT and ATTORNEY are affixed hereto.

PATIENT _____ **Date** _____

By: _____

On this ____ day of _____, 2010

The undersigned being the ATTORNEY of record for the above patient does hereby agree to observe all of the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdicts as may be necessary to adequately protect PROVIDER. ATTORNEY agrees that an equitable distribution will be considered in the event funds received from any settlement are inadequate to cover all lienholders.

ATTORNEY _____ **Date** _____

By: _____

On this ____ day of _____, 2010

ATTENTION:

YOU **MUST** BRING THE FILMS OF ANY MRI SCANS, CT SCANS, OR X-RAYS YOU HAVE HAD DONE OF YOUR NECK AND / OR BACK.

While the radiologist's interpretations are helpful, the actual films and / or CD's are necessary.

If you do not bring your films and / or CD's **YOU MAY NOT BE SEEN** and will have to reschedule your appointment. You can obtain the MRI, CT scans, or X-Rays at the facility where they were taken. Please keep in mind most facilities have a wait period of several days before they can have your films ready for pick up.

In addition, please complete all forms enclosed in this packet prior to your appointment and bring them with you.

THANK YOU FOR YOUR COOPERATION!!

PLEASE SEE BACK FOR DIRECTIONS!! →

Directions to *California Spine Care* Welcome!!

Vallejo Office / Located in the Cancer Center Concord Office (Main Office)

<p>100 Hospital Drive, #110 <u>Vallejo</u>, CA 94589</p> <p><i>Coming West on 80</i> Exit Right on Redwood St Right on Tuolumne Right on Hospital Drive Left first driveway into 100 Hospital Drive</p> <p><i>Coming East on 80</i> Exit Redwood West Right on Adm. Callaghan Lane Right on Redwood Right on Tuolumne Right on Hospital Drive Left first driveway into 100 Hospital Drive</p>	<p>2291 Pacheco Street <u>Concord</u>, CA 94520</p> <p><i>Coming South on 680</i> Take 4 East Take 242 South Exit Left on Solano / Grant This becomes East Street Turn Right at the light on Pacheco Street Little house on the corner of Pacheco & Colfax</p> <p><i>Coming North on 680</i> Take 242 North Exit Right on Solano / Grant This becomes East Street Turn Right at the light on Pacheco Street Little house on the corner of Pacheco & Colfax</p>
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2291 Pacheco Street
Concord, CA 94520

100 Hospital Drive, #110
Vallejo, CA 94589

**Acknowledgement of Receipt of Notice of Privacy Practices
Santi Rao M.D.**

I hereby acknowledge that a copy of the current notice of Privacy Practice will be posted in the reception area, and that I may be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Name of Patient: _____

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient