



Babak Lami, M.D.
Carl N. Graf, M.D.
Spine Surgery

PATIENT INFORMATION				Date:			
Patient Name:				Referring Source/Doctor:		Ref. Source/Dr. Ph:	
Address:				Primary Doctor(PCP):		Primary Dr. Ph:	
City/State/Zip:		Employer/School		Employer/School Address:			
(H) Phone:		Cell Phone:		Work Phone:		Email Address:	
Social Security #:		Date of Birth:		Age:		Marital Status:	
Sex:		Emergency Contact:		Relationship:		(H) Phone:	
Cell Phone:		Pharmacy Name:		Town:		Pharmacy Phone:	
Pharmacy Fax:		DOB:		SSN:			
INSURANCE INFORMATION							
Responsible Party:				Relationship:		DOB:	
Responsible Party Address:				City/State/Zip:		Phone#:	
Primary Insurance:		Employer:		Secondary Insurance:		Employer:	
Insurance ID #:		Insurance Group #:		Insurance ID #:		Insurance Group #:	
Insured Name:				Insured Name:			
Address:				Address:			
City/State/Zip:				City/State/Zip:			
Insured DOB:		Insured Social Security #:		Insured DOB:		Insured Social Security #:	

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION:

I consent to evaluation and treatment of the condition for which I, or my dependent, have come to ILLINOIS SPINE INSTITUTE (ISI), and authorize the physicians and other health care providers affiliated with ISI to provide such evaluation and treatment. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by ISI. I also consent my physician(s) to check my external Rx history. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at ISI.

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to ILLINOIS SPINE INSTITUTE all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above names insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Guardian of Personal Representative

Medicare # (if applicable)

Date

Please print name of patient, Guardian or Personal Representative

Relationship to Patient

Illinois Spine Institute, S.C.

Surgical and Non Surgical Spine Care

Payment Policy

PATIENT NAME: _____

DATE OF BIRTH: _____

Thank you for allowing Illinois Spine Institute to be part of your spine care. The following information will help you understand your financial responsibilities.

CONTRACTED PPOs

Co-pays are required whenever seen by a physician and are due at the time of service.

CONTRACTED HMO/EPO/POS

Most of these plans require a referral from your primary care physician and also mandate that you have the referral at the time of the appointment. Without a referral, you will be responsible for all charges at the time of service. If you have your referral with you, your designated co-pay is your responsibility at the time of service.

INDEMNITY INSURANCE/OUT OF NETWORK PLANS

As a courtesy, we will submit claims to your insurance carrier for you, provided that you make available correct Insurance information. We require both the deductible and 20% of the billed charges at the time service is rendered.

WORKERS' COMPENSATION

At the time of your appointment, we require employer's verification that injuries are work related as well as all necessary carrier. Please remember that it is ultimately your financial responsibility for all services if your employer eventually denies your claim.

MEDICARE

Our practice accepts Medicare assignment. Your financial responsibility will include 20% of the Medicare allowable, annual deductible, and non-covered charges. We will submit all portions of your financial responsibility to your secondary insurance carrier, as long as you provide us with appropriate secondary Insurance information.

MOTOR VEHICLE ACCIDENTS (MVA)

For any motor vehicle accidents, automobile insurance must be submitted as primary. Our office submits to your health insurance as a secondary carrier, as long as you provide us with all necessary billing information.

SELF PAY

Payment is due at the time service is rendered. For your convenience, we accept cash, check, money orders and credit cards.

We understand that under unusual circumstances payment in full at the time of service may not be possible. To assist you in payment of the balance, ISI offers the following options:

- Payment plans are available for balance greater than \$500. A processing fee of \$100 will be assessed and complete payment must be made within twelve (12) months. Failure to comply with your payment plan will result in immediate transfer to a collection agency.
- For balance less than \$500, ISI will extend credit for 30 days only. Failure to pay within 30 days will result in a processing fee of \$100.

It is your responsibility to follow the specific instructions of your particular insurance plan. Furthermore, you are responsible for payment of your account, not your insurance company. In case of divorce, the parent who brings the child in for treatment will be responsible for payment and collecting from all other parties. In the event the account must be referred to collection, I agree to be responsible for the cost of collection, including responsible attorney fees, if any.

A representative from our financial department is always available to assist you.

Signed Patient, or (Parent of Guardian if Minor)

Date



PATIENT RECORD OF DISCLOSURES

500 West Golf Road, Suite 101, Schaumburg, IL 60195
415 Congress Parkway, Unit E, Crystal Lake, IL 60014
Phone: 847-519-9700 Fax: 847-519-9760

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

ILLINOIS SPINE INSTITUTE HAS MY PERMISSION TO DISCLOSE MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE:

Patient Name: _____

D.O.B.: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

It is the patient's responsibility to notify Illinois Spine Institute, in writing, of any changes to this list of people that are approved for disclosure regarding my medical information.

I WILL BE CONTACTED IN THE FOLLOWING MANNER:

I authorize Illinois Spine Institute to contact me on my cell phone, home phone, or any other telephone number I have provided. Illinois Spine Institute has my permission to leave a message to contact us on any of the phone numbers I have provided.

I authorize Illinois Spine Institute to send any written communication to any address I have provided for you.

It is the patient's responsibility to notify Illinois Spine Institute, in writing, of any change of phone numbers or address change.

ACKNOWLEDGEMENT RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that Illinois Spine Institute has provided me with a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

I consent to medical treatment and diagnostic procedures by the physicians at Illinois Spine Institute and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary in their professional judgment.

Patient Signature: _____

Date: _____

Print Name: _____

Date of Birth: _____

Signature of Representative/Legal Guardian: _____

Relation to Patient: _____



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SPINE PATIENT HISTORY QUESTIONNAIRE

Date: _____

Patient Name: _____

Primary Doctor: _____ City: _____ Phone #: _____

Referring Doctor: _____

Date of Birth: _____ Age: _____

Occupation: _____ Right /Left Handed

Description of the problem:

Duration of symptoms: _____

Do you have any bowel or bladder problems? _____

Do you have any difficulty with walking? _____

Do you drop objects, or have difficulty hand writing or fine manipulations? (such as buttoning a shirt)

If so, has this changed recently? _____

If this is a workman's compensation claim, then please answer the following:

How did the injury occur? _____

When? _____

Where? _____

When was your supervisor notified? _____

If you were seen at an acute care / occupational health center – which one and where?

Have you ever had a similar problem in the past? (If so how was it treated, did it resolve, etc.)

Have you had any treatments for this problem? (medication, physical therapy, chiropractor treatments, etc.)

Does anything make the pain better or worse?

Please circle the appropriate number below showing how bad your pain was **INITIALLY** after the injury:

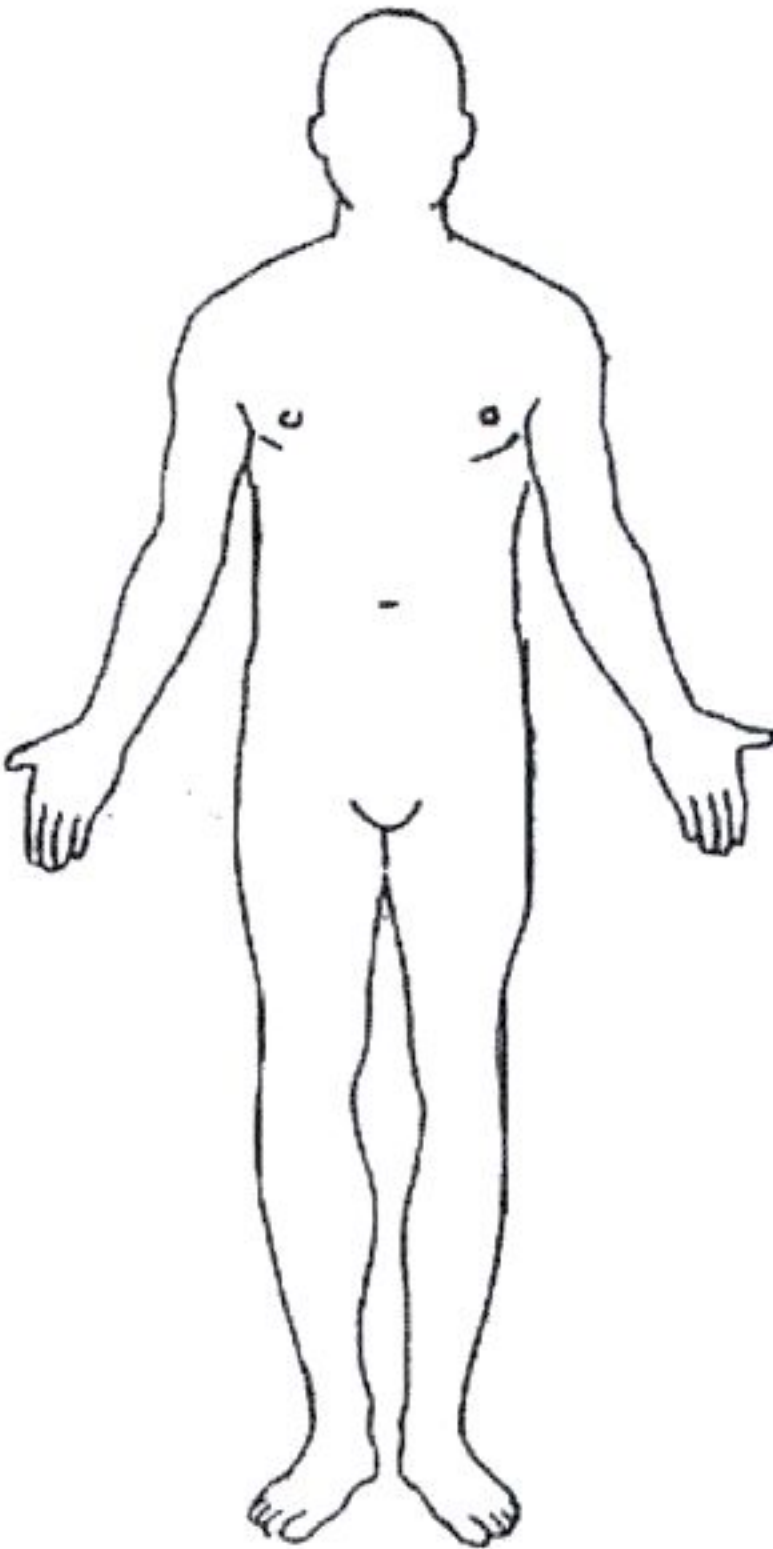
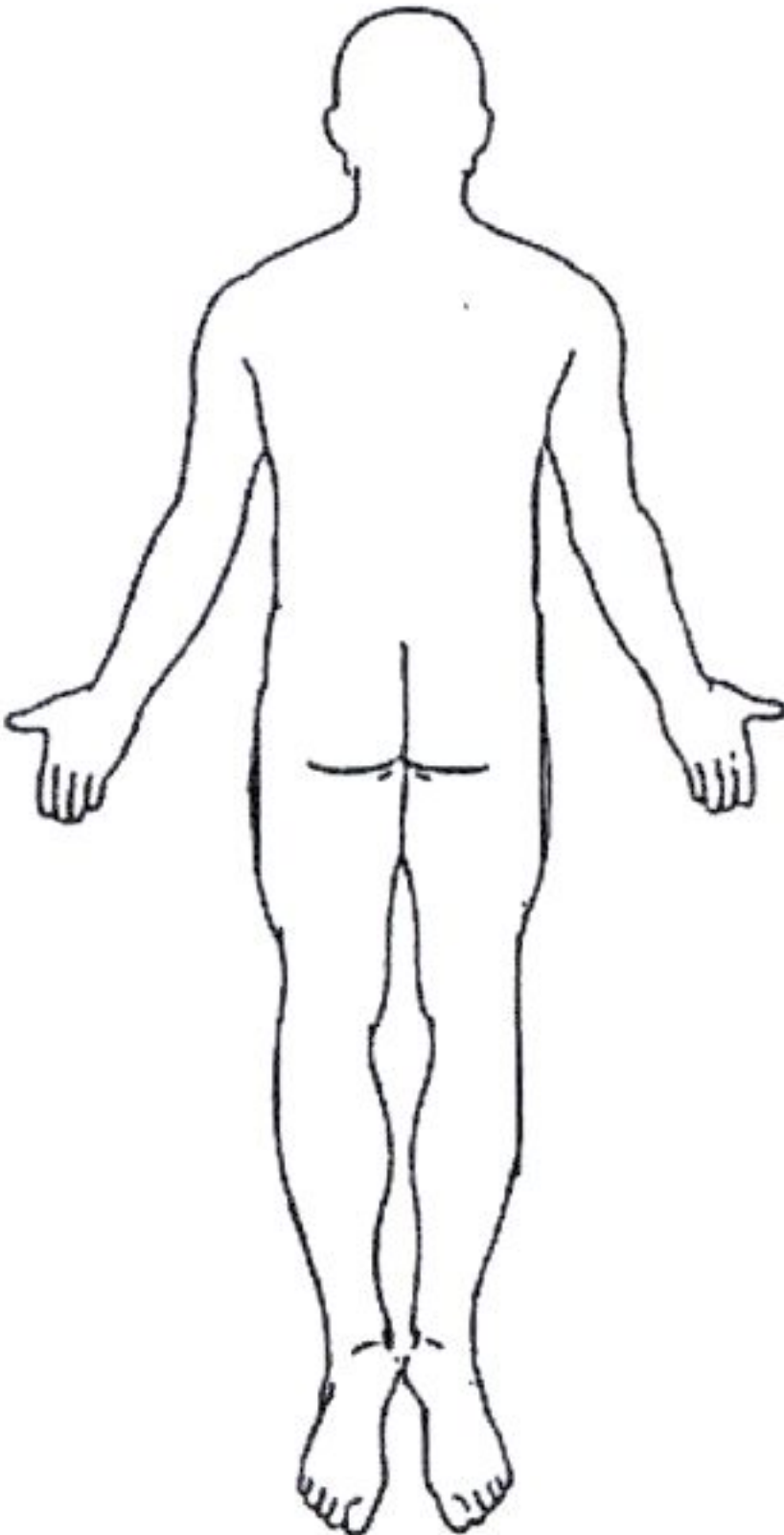
No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Please circle the appropriate number below showing how bad your pain is **NOW**:

No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Patient Name: _____

Pain Diagram (Please draw where your pain is)

R	L		L	R
		Numbness 		
		Pins and Needles 0 0 0 0 0		
		Burning x x x x x		
		Stabbing 		
		Ache A A A A		

Past Medical History:

- | | | |
|---------------------------------------|---|--|
| ☐ Diabetes | ☐ Hypertension | ☐ Heart Disease |
| ☐ Heart Attack | ☐ Renal/Kidney Disease | ☐ Cancer |
| ☐ GI/Stomach | ☐ Recent Weight Loss | ☐ Epilepsy |
| ☐ Arthritis | ☐ Gout | ☐ Sexual Difficulties |
| ☐ Hepatitis | ☐ HIV | |

Other: _____

Past Surgical History:

Current Medications and Dose:

Allergies to Medications:

Family History: (arthritis, medical problems, or adverse reactions to anesthesia)

Patient Name: _____

Social History: (Do you use any of the below?)

Tobacco products or Nicotine Patch (Type and frequency) _____

Alcohol (how much/frequency) _____

Street Drugs _____

REVIEW OF SYMPTOMS (Circle all that apply)

1. CONSTITUTIONAL

Depression Anxiety

2. EYES

Blurred Vision Trouble Seeing

3. EARS, NOSE, MOUTH, THROAT

Sore Throat Trouble Hearing

4. Cardiovascular

Heart Racing Chest Pain

5. RESPIRATORY

Breathing Difficulty

Shortness of Breath

6. GASTROINTESTINAL

Diarrhea Constipation

7. GENITOURINARY

Blood in Urine Urinary Stones

8. INTEGUMENT

Skin rash Birth Marks

9. NEUROLOGIC

Seizures Headaches

Dizziness

10. PSYCHIATRIC

Schizophrenia Bipolar Illness

11. ENDOCRINE

Goiter Thyroid Disease

12. HEMATOLOGIC/LYMPHATIC

Anemia Bleeding Problems

13. Allergies

Hay Fever Iodine IV Contrast

Any other concerns or questions for the doctor: _____

**Patient section stops here. Thank you, the doctor
will be with you shortly.**

Patient Name: _____

Spine Physical Examination Form

Vital Signs: Pulse _____ RR _____ BP _____ Weight _____ Height _____

General

The patient is a well developed, well nourished **MALE/FEMALE**, who appears **OLDER/YOUNGER/AGE APPROPRIATE** than the above stated age. **HIS/HER** body habitus is **APPROPRIATE/OBESE**.

The patient has a **NORMAL ANTALGIC TRENDELENBERG** gait.

The patient **HAS/HAS NO** difficulty with toe or heel walking, tandem gait, or squatting and raising from a squatting position.

Cervical Spine

The patient has **FULL/NORMAL/LIMITED/PAINFUL** range of motion of the cervical spine.

-There is pain with **FLEXION EXTENSION LEFT/RIGHT LATERAL BENDING ROTATION**.

There **IS IS NO** pain to palpation of the neck. Specific distribution of pain is: _____.

There is a **POSITIVE NEGATIVE** Spurling's sign (if positive☺ producing radicular pain down the **LEFT RIGHT** upper extremity.

UE Motor Strength:

Left: Deltoid /5; Supraspinatous /5; Biceps /5; Triceps /5; Wrist Extension /5; Wrist Flexion /5; Hand Intrinsic /5

Right: Deltoid /5; Supraspinatous /5; Biceps /5; Triceps /5; Wrist Extension /5; Wrist Flexion /5; Hand Intrinsic /5

Deep Tendon Reflexes:

Left: Biceps 0/1/2, Brachioradialis 0/1/2, Triceps 0/1/2

Right: Biceps 0/1/2, Brachioradialis 0/1/2, Triceps 0/1/2

Hoffmans sign +/- on **LEFT** and/or **RIGHT**

Sensation is **NORMAL ABNORMAL** in the left upper extremity.

Sensation is **NORMAL ABNORMAL** in the right left upper extremity.

- Specific distribution of abnormal sensation is _____.

Rapid movements of the hands are **NORMAL DIFFICULT**.

SHOULDER EXAM:

Muscular atrophy is **ABSENT / PRESENT**. Location _____.

Subacromial crepitation + / -

ROM – Forward Flexion _____ Abduction _____ IR/ER in abduction _____

ER at side _____ IR _____ Subscapularis lift off + / -.

Other:

Patient Name: _____

Thoracic/Lumbar/Sacral Spine

General

The overall spinal alignment is **NEUTRAL, KYPHOTIC, LORDOTIC, SCOLIOTIC.**

A list **IS/IS NOT** present.

There **IS/IS NOT** paraspinal musculature spasm present.

Pain to palpation is **PRESENT ABSENT** in :

Left / Right Paraspinal musculature

Midline over _____.

Left / Right SI joint.

Forward bending is to _____.

Extension is to _____.

Other:

Motor Strength

Left LE: Hip Flexion ____/5; Quadriceps ____/5; Hamstrings ____/5; Ankle Dorsiflexion ____/5;
EHL ____/5; Ankle Plantarflexion ____/5; Foot eversion ____/5; Foot inversion ____/5.

Right LE: Hip Flexion ____/5; Quadriceps ____/5; Hamstrings ____/5; Ankle Dorsiflexion ____/5;
EHL ____/5; Ankle Plantarflexion ____/5; Foot eversion ____/5; Foot inversion ____/5.

Neurologic Examination

Left LE: Patellar 0/1/2; Achilles 0/1/2; Clonus + / - beats ____; Babinski: toes ↑ ↓

Sensation **NORMAL / ABNORMAL:**

Right LE: Patellar 0/1/2; Achilles 0/1/2; Clonus + / - beats ____; Babinski: toes ↑ ↓

Sensation **NORMAL / ABNORMAL:**

Sitting straight Leg raise is **NEGATIVE POSTITIVE**

Supine straight leg raise is **NEGATIVE POSTITIVE**

Left Hip ROM: **FULL / LIMITED IR ER / LIMITED FLEXION / EXTENSION**

Left LE: +/- SI joint pain (figure of 4 position); +/- Femoral nerve stretch.

Right Hip ROM: **FULL / LIMITED IR ER / LIMITED FLEXION / EXTENSION**

Right LE: +/- SI joint pain (figure of 4 position); +/- Femoral nerve stretch.

Radiologic Studies:

Assessment:

Plan: