

SAN DIEGO CENTER FOR SPINAL DISORDERS MEDICAL GROUP, INC.
Behrooz A. Akbarnia, M.D. and Ramin Bagheri, M.D.
4130 La Jolla Village Dr., Ste. 300
La Jolla, CA 92037
Phone (858) 678-0610
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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.
We will validate up to 1 hour of parking for patients with a scheduled appointment.

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

If yes, when did they begin? _____ / _____
(month/year)

**San Diego Center for Spinal Disorders
PEDIATRIC HEALTH HISTORY FORM**

Child Name: _____

Date: _____

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.			

SRS-22r† Patient Questionnaire

Patient Name: _____ Date of Birth: _____
Mo Day Year

Today's Date: _____ Age: _____
Years Months

Medical Record #: _____

Instructions: We are carefully evaluating the condition of your back, and it is **IMPORTANT THAT YOU ANSWER EACH OF THESE QUESTIONS YOURSELF. PLEASE CIRCLE THE ONE BEST ANSWER TO EACH QUESTION.**

1. Which of the following best describes the amount of pain you have experienced during the past 6 months?

None
Mild
Moderate
Moderate to severe
Severe

2. Which one of the following best describes the amount of pain you have experienced over the last month?

None
Mild
Moderate
Moderate to severe
Severe

3. During the past 6 months, have you been a very nervous person?

None of the time
A little of the time
Some of the time
Most of the time
All of the time

4. If you had to spend the rest of your life with your back as it is right now, how would you feel about it?
- Very happy
 - Somewhat happy
 - Neither happy nor unhappy
 - Somewhat unhappy
 - Very unhappy
5. What is your current level of activity?
- Bedridden
 - Primarily no activity
 - Light labor, such as household chores
 - Moderate manual labor and moderate sports, such as walking and biking
 - Full activities without restriction
6. How do you look in clothes?
- Very good
 - Good
 - Fair
 - Bad
 - Very bad
7. In the past 6 months, have you felt so down in the dumps that nothing could cheer you up?
- Very often
 - Often
 - Sometimes
 - Rarely
 - Never
8. Do you experience back pain when at rest?
- Very often
 - Often
 - Sometimes
 - Rarely
 - Never
9. What is your current level of work/school activity?
- 100% normal
 - 75% normal
 - 50% normal
 - 25% normal
 - 0% normal

(CONTINUED ON NEXT PAGE)

15. Are you and/or your family experiencing financial difficulties because of your back?
Severely
Moderately
Mildly
Slightly
None
16. In the past six months, have you felt down hearted and blue?
Never
Rarely
Sometimes
Often
Very Often
17. In the past three months, have you taken any sick days from work/school due to back pain and, if so, how many?
0
1
2
3
4 or more
18. Does your back condition limit your going out with friends/family?
Never
Rarely
Sometimes
Often
Very often
19. Do you feel attractive with your current back condition?
Yes, very
Yes, somewhat
Neither attractive nor unattractive
No, not very much
No, not at all
20. Have you been a happy person during the past six months?
None of the time
A little of the time
Some of the time
Most of the time
All of the time

(CONTINUED ON NEXT PAGE)

21. Are you satisfied with the results of your back management?

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Unsatisfied
- Very unsatisfied

22. Would you have the same management again if you had the same condition?

- Definitely yes
- Probably yes
- Not sure
- Probably not
- Definitely not

Thank you for completing this questionnaire. Please comment if you wish.

Refined 1/1/04

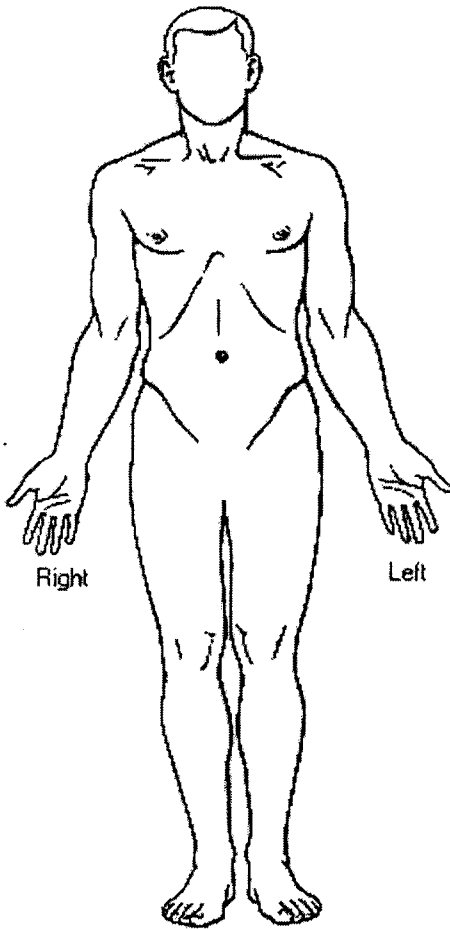
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END

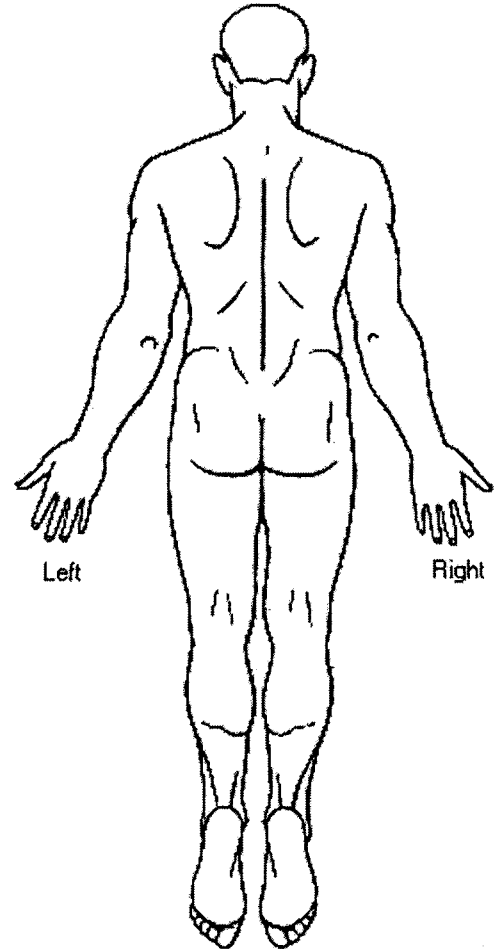
Spine New Patient Questionnaire

WHERE IS YOUR PAIN NOW?

Front



Back



Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	%

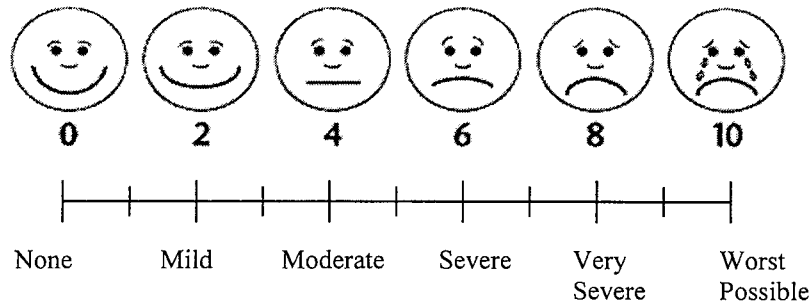
Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.

Use the body diagrams to show where you feel the following sensations.

<u>Ache</u>	<u>Numbness</u>	<u>Burning</u>	<u>Stabbing</u>
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///
<u>Pins And Needles</u>			
≡ ≡ ≡			

Grade your overall Pain

Please place an X on the hash mark that most accurately describes your overall degree of pain now.



**SAN DIEGO CENTER FOR SPINAL DISORDERS MEDICAL GROUP, INC.
PATIENT REGISTRATION**

NAME OF PATIENT: _____ HOME PHONE: _____

ADDRESS: _____
City State Zip

BIRTH DATE: _____ SOCIAL SECURITY#: _____

IS PATIENT: Single Married Male Female
 Employed Retired Unemployed

EMERGENCY INFORMATION: (Relative/Friend not living with you)

NAME: _____ PHONE: _____ RELATIONSHIP: _____

WHO REFERRED YOU TO THIS
OFFICE: _____

HAS THE PATIENT BEEN SEEN BY THIS PHYSICIAN PREVIOUSLY: YES NO

If YES, please indicate where and when: _____

PATIENT'S EMPLOYER: _____ WORK PHONE: _____

EMPLOYER'S
ADDRESS: _____
City State Zip

PERSON RESPONSIBLE: _____ RELATIONSHIP: _____
FOR PAYMENT

DOB: _____ SS# _____ EMPLOYER: _____

PRIMARY
INSURANCE: _____ GROUP#: _____

CERTIFICATE# / ID#: _____ INSURED'S NAME: _____

SPECIALISTS VISIT COPAY, DEDUCTIBLES AND/OR CO-INSURANCE: _____

SECONDARY
INSURANCE: _____ GROUP#: _____

CERTIFICATE# / ID#: _____ INSURED'S NAME: _____

SPECIALISTS VISIT COPAY, DEDUCTIBLES AND/OR CO-INSURANCE: _____

IS THIS A LEGAL CASE: YES NO ATTORNEY: _____ PHONE: _____

I HEREBY AUTHORIZE THE ATTENDING PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS MEDICAL TREATMENT, AND HEREBY ASSIGN TO SAN DIEGO CENTER FOR SPINAL DISORDERS MEDICAL GROUP, INC., ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE COVERED BY INSURANCE.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

SDCSD PERSONNEL: _____ DATE: _____

ELIGIBILITY ACKNOWLEDGEMENT

I, _____ hereby certify that I am eligible for _____
(Patient Name) (Health Plan Name)

effective _____.
(Date)

I have chosen a surgeon at the San Diego Center for Spinal Disorders Medical Group, Inc. to be my medical provider. I understand that if I am **NOT ELIGIBLE** under the terms of my health plan, as stated above, I am liable for all charges for services rendered. I agree to pay in full for all services rendered upon receipt of statement from the noted providers.

Signature of Member / Guardian: _____

Print Your Name: _____ Date: _____

Subscriber's Social Security Number: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

San Diego Center for Spinal Disorders
4130 La Jolla Village Drive; Suite 300
La Jolla. CA 92037

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices either in person or from the website. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by email at:

_____.

Signed: _____ Date: _____

Print Name: _____ Telephone: : _____

If not signed by patient, please indicate:

Relationship:

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

Name of Patient: _____

**SDCSD SAN DIEGO CENTER FOR SPINAL DISORDERS MEDICAL GROUP, INC.
PATIENT ACCEPTANCE OF FINANCIAL RESPONSIBILITY**

The San Diego Center for Spinal Disorders Medical Group, Inc. will bill your primary and secondary insurance company(s) as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we will require that you remit payment to the San Diego Center for Spinal Disorders (SDCSD). Additionally, if your insurance company does not remit payment in a timely manner (within 90 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to SDCSD for all outstanding insurance balances over 90 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments
- Annual deductibles
- Services that are not covered by your health plan
- Administrative charges for co-pays not paid at the time of service
- Interest charges for overdue balances

To prevent this, we suggest that you stay in communication with your insurance company to assure they are paying for the services we have provided. Often insurance companies are more responsive when they are contacted by their policyholders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls will also assist us. Our billing service can be reached at (760) 724-9014 and is there to assist you in obtaining payment on your claims

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. We will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers. We may request your assistance in following up on our authorization requests delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment and expedite payment for your services.

Phone consultations between the patient/parent and doctor may be subject to a consultation fee. Your insurance will be billed for this consultation, based on the length of the phone conference.

We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement.

In the event you miss an appointment or fail to provide our office 24 hours notice for a cancellation, you will be directly charged a "Missed Appointment" charge of \$50.00 for a new patient and \$25.00 for an established patient. If you need to cancel your appointment, please make note of the name of the person you spoke with as well as the date and time.

Your co-payment is required at the time you check-in for your appointment. If you fail to bring your co-payment and we must bill you for it, an administrative charge of \$15.00 will be added to your bill. All patients that are past due (greater than 30 days) will accrue an interest charge of 5% of your outstanding "patient-due" balance.

I understand and agree that I (or the person named below who is financially responsible for me) am financially liable for all services provided and will pay my outstanding balance within 15 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay San Diego Center for Spinal Disorders Medical Group within 90 days of services billed, the balance will be transferred to my responsibility and payment will be due at that time.

Patient Printed Name Date

Responsible Party's Printed Name Date

Patient's Signature (age 18 or older)

Responsible Party's Signature

**SAN DIEGO CENTER FOR SPINAL DISORDERS MEDICAL GROUP, INC.
IMPORTANT INFORMATION AND POLICIES FOR PATIENTS**

Due to the rapidly changing horizon of health care, many insurance carriers are changing group, employee and individual benefit packages almost yearly. Please be advised that if diagnostic testing, outpatient procedures (physical therapy, injection therapy, etc.), or surgery is necessary, it will be the patient's responsibility to make sure that they have that benefit available through their insurance carrier. If you have a new insurance plan, you must notify our staff immediately.

This office will routinely obtain any necessary medical authorization for surgery and diagnostic tests when they are ordered through this office. Individual benefits for these procedures and tests are not verified by this office, so please be sure to verify your benefits with your insurance carrier by calling your plan's member services department or your employer's human resource department. In the process of our office obtaining approval, we are regularly informed by insurance medical management departments that authorization is not a guarantee of benefits, or of payment. Please be advised that this office will not take responsibility for the refusal of an insurance company to pay for testing or treatment due to lack of insurance benefits. **PLEASE CONSULT THE BENEFITS DEPARTMENT OF YOUR INSURANCE COMPANY ANY TIME YOU REQUIRE MEDICAL TREATMENT FROM THIS OR ANY OFFICE.** (The telephone number is often found on the back or front of your insurance card, or, look in your insurance benefits handbook that you received at the time of your enrollment.)

Effective April 1, 2007, this office has a **"MISSED APPOINTMENT"** Policy. If you fail to keep your appointment, or cancel less than 24 hours before your appointment, a \$50.00 charge for new patients and \$25.00 for established patients will be billed to you directly, not your insurance company (see the attached form "Patient Acceptance of Financial Responsibility)

Effective April 1, 2007, no patient will be seen by the doctor without first signing an arbitration agreement. If you have not yet signed, please refer to the physician explanation regarding arbitration to assist you.

Medications prescribed by this office are refilled electronically and not by phone. Please advise your pharmacy to fax all medication refill requests to our office. We will attempt to process all requests within 24 hours of receiving the request (except on weekends and holidays)

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Also, in order to protect your privacy, this office will no longer leave detailed messages to our patient's home or work phone numbers, unless you permit us to do so. By signing below, you give the San Diego Center for Spinal Disorders staff and associates permission to leave messages on your home and/or work numbers in reference to your appointments, treatments, etc. I give the San Diego Center for Spinal Disorders Medical Group, Inc. permission to leave detailed messages on my **(circle all that apply)** HOME / WORK / CELL phone
List phone number to call: _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

As a part of our commitment to assure that you are fully informed, and in accordance with the Office of the Inspector General for the Department of Health and Human Services and as defined in section 65.42 of the California Business and Professions Code, we are required to inform you that Behrooz Akbarnia, M.D. and Ramin Bagheri, M.D. may maintain an investment in the Orthopedic Surgery Center of La Jolla.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

The physicians of the San Diego Center for Spinal Disorders are faculty members of the San Diego Spine Fellowship, which provides advanced medical training for orthopedic spine fellows and international visiting surgeons. Your care will be provided by your doctor, however, you may also be seen by a fellow as part of your spine evaluation and care.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Print Name _____ Relationship if not patient _____



Behrooz A. Akbarnia, M.D.
Ramin Bagheri, M.D.

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 suit 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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