KBS
KALRA
BRAIN & SPINE

Dear Patient:

We appreciate having you as a patient of Kalra Brain and Spine. It is our desire to provide you the best possible medical care. You may have questions regarding our clinic policies, and this letter is designed to answer some of your questions.

APPOINTMENTS: To facilitate your appointment process, please make sure you bring the following items:

1. All pages of paperwork completely filled out.
2. Driver's license and insurance card.
3. All radiological CD/films and reports (i.e. MRI, CT, X-Ray). **Failure to have these will result in rescheduling your appointment.**
4. Referrals if required by your insurance company. (Contact your primary care physician if unsure)

PLEASE ARRIVE 20 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

OFFICE HOURS: Our regular office hours are 8 a.m. to 5:00 p.m., Monday through Friday. Patient appointments are available Wednesday and Friday from 8:00 a.m. to 4:30 p.m. We know your time is valuable, as is ours, and we do our best to see you at your scheduled time. If you find it necessary to cancel an appointment, please give us at least 24 hour notice so that we can open that time slot for another patient. **Failure to do so may result in a $50.00 charge.**

TELEPHONE CALLS: We answer our telephones from 8 a.m. to 4:30 p.m. When you call with a question regarding your medical care, the office staff may find it necessary to take a telephone message as the doctor and physician assistant may be with other patients. The message will be given to the medical staff, and one of them will return your call within 24 hours. Please notify the office staff if your call is an emergency.

PRESCRIPTION REFILLS: Prescription refills will be done during regular office hours only. You will need to have your pharmacy send a refill request. If the physician approves the refill, it will be returned by fax to the pharmacy as soon as possible. **Please allow 1-3 business days for all medication refills. We do not refill requests after 2:00 p.m.**

RELEASE OF MEDICAL RECORDS: To protect your privacy, we require an authorized signature from you to release your medical records. In some instances where an attorney is involved, the attorney will need to obtain your authorized signature, which must be notarized, and the attorney's office will need to request the release of your medical records.

DISABILITY/FMLA PAPERWORK: Disability paperwork will be filled out after your surgery is complete if medically necessary. **There is a $25.00 fee for each set of paperwork. Please allow us 7-10 business days after receipt to complete your paperwork.**

Please feel free to call the office at (972) 905-9226 regarding any questions you may have. We look forward to meeting you and caring for your medical needs.

Sincerely,

Ricky Kalra, MD

PATIENT INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL SECURITY #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ CELL #: _____ WORK #: _____xt._____

EMAIL ADDRESS: _____ OTHER #: _____

EMPLOYER: _____ OCCUPATION:_____

EMERGENCY CONTACT/RELATIONSHIP: _____PHONE #: _____

WHO OR HOW REFERRED: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PHARMACY:_____ADDRESS_____

PHARMACY PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME: _____PHONE #: _____

CLAIMS ADDRESS: _____

INSURANCE POLICY HOLDER: _____ RELATION: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE CO. NAME: _____PHONE #: _____

CLAIMS ADDRESS: _____

INSURANCE POLICY HOLDER: _____ RELATION: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

The above information is true to the best of my knowledge. I have read the office policies provided and understand them fully. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kalra Brain and Spine or my insurance company to release any information required to process my claims.

_____

SIGNATURE **PRINTED NAME** **DATE**

MEDICAL HISOTRY QUESTIONNAIRE

Thank you in advance for taking the time to complete the detailed confidential questionnaire.

Name: _____ Referring Physician: _____

Date: _____ Height: _____ Weight: _____ Age: _____ Handedness: ◯ Right ◯ Left

Chief Complaint (reason for visit):

_____

Past Medical History: (check all previous or current medical conditions)

Cancer Type:	Diabetes Type:	High Cholesterol ☐	High Blood Pressure ☐	Sleep Apnea ☐
COPD ☐	Seizure ☐	Thyroid Disease ☐	Kidney Disease ☐	Blood clots ☐
Arthritis ☐	Arrhythmia ☐	History of Stroke ☐	Heart Disease ☐	Reflux ☐

Other:

Previous Surgeries (list dates):

Family History: (List any medical conditions that run in your family and how he/she is related to you)

Current Medications:

Medication	Dose	Frequency	Reason

Medication allergies:

Social History

Marital Status (check one)**:** ◯ Single ◯ Partnered ◯ Married ◯ Divorced ◯ Widowed

Do you live in a: ◯ House ◯ Apartment ◯ Other: _____ **Are there stairs?** _____

Do you smoke? ◯ No ◯ Yes **If yes, how many packs/day?** _____ **Date Quit:**_____

Do you chew tobacco?_____ **Recreational drug use:** ◯ No ◯ Yes **Type of Drug use**:_____

Do you drink alcohol? ◯ No ◯ Yes **If yes, how much per day?** _____

HEALTH QUESTIONNAIRE

Select **yes** for items you have had / **no** for items you have not had recently

General

Fever	◯ yes	◯ no	Cataracts	◯ yes	◯ no	Organ Transplant	◯ yes	◯ no
Night Sweats	◯ yes	◯ no	Arthritis	◯ yes	◯ no	Atherosclerosis	◯ yes	◯ no
Weight Loss	◯ yes	◯ no	Glaucoma	◯ yes	◯ no			
Weight Gain	◯ yes	◯ no	HIV/AIDS	◯ yes	◯ no			

Neurological

Blackouts	◯ yes	◯ no	Seizures	◯ yes	◯ no	Migraine Headaches	◯ yes	◯ no
Concussions	◯ yes	◯ no	Hit in Head	◯ yes	◯ no	Lyme Disease	◯ yes	◯ no
Brain Surgery	◯ yes	◯ no	Unconscious	◯ yes	◯ no	Epilepsy	◯ yes	◯ no
Dizziness	◯ yes	◯ no	Stroke	◯ yes	◯ no	Difficulty Walking	◯ yes	◯ no
Blurred vision	◯ yes	◯ no	Double Vision	◯ yes	◯ no	Difficulty Hearing	◯ yes	◯ no

Cardiovascular

Angina	◯ yes	◯ no	Palpitations	◯ yes	◯ no	Arrhythmia	◯ yes	◯ no
Lightheaded	◯ yes	◯ no	Fainting	◯ yes	◯ no	Bypass Surgery	◯ yes	◯ no
Hypertension	◯ yes	◯ no	Low BP	◯ yes	◯ no	Anemia	◯ yes	◯ no
Heart Disease	◯ yes	◯ no	Pacemaker	◯ yes	◯ no	AICD	◯ yes	◯ no
Mononucleosis	◯ yes	◯ no	Bleeding Tendency	◯ yes	◯ no	Mitral Valve Prolapse	◯ yes	◯ no

Respiratory

Hay Fever	◯ yes	◯ no	Bronchitis	◯ yes	◯ no	Lung Surgery	◯ yes	◯ no
Allergies	◯ yes	◯ no	Emphysema	◯ yes	◯ no	Pulmonary Edema	◯ yes	◯ no
Asthma	◯ yes	◯ no	Wheezing	◯ yes	◯ no	Pneumonia	◯ yes	◯ no
Short of Breath	◯ yes	◯ no						
Tuberculosis	◯ yes	◯ no	If yes, date of + ppd_____ or date of last chest x-ray					

Gastrointestinal

Reflux	◯ yes	◯ no	Nausea	◯ yes	◯ no	Persistent vomiting	◯ yes	◯ no
Diarrhea	◯ yes	◯ no	Hiatal Hernia	◯ yes	◯ no	Lactose Intolerance	◯ yes	◯ no
Constipation	◯ yes	◯ no	Peptic Ulcer	◯ yes	◯ no	Vomiting blood	◯ yes	◯ no

Genitourinary

Incontinence	◯ yes	◯ no	Discharge	◯ yes	◯ no	Painful Urination	◯ yes	◯ no
Frequency	◯ yes	◯ no	Bladder Infection	◯ yes	◯ no	Venereal Disease	◯ yes	◯ no
Kidney Disease	◯ yes	◯ no	Blood in urine	◯ yes	◯ no			

Type of birth control:_____ Are you claustrophobic? ◯ Yes ◯ No

Explain any yes answers:

HISTORY OF PRESENT ILLNESS

What caused your illness/pain? ☐ Disease ☐ Accident ☐ Surgery ☐ Other_____

Describe what happened

Pain onset: ◯ Sudden ◯ Gradual

The pain is: ◯ Constant ◯ Intermittent ◯ Occasional

Pain radiates/shoots: ◯ Yes ◯ No Where?_____

How many hours per day do you have pain? _____ Is the pain disturbing your sleep? ◯ Yes ◯ No

How many hours per night do you sleep?_____

What relieves your pain?

What aggravates your pain?

What activities are most affected by the pain?

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Today _____ Average day _____ Good day _____ Bad day_____

What diagnostic test have you had? ☐ Xray ☐ CT Scan ☐ MRI ☐ EMG ☐ Other _____

What treatments have you received? ☐ Physical Therapy ☐ TENS ☐ Surgery ☐ Acupuncture

☐ Steroid Injections ☐ Manipulation ☐ Other:_____

Have you had any previous work related injuries? ◯ No ◯ Yes

Explain_____

Is there a lawyer involved in your case? ◯ No ◯ Yes Name:_____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU WERE INJURED ON THE JOB OR IN AN ACCIDENT

Is this a work related injury? ◯ No ◯ Yes Is this an accident injury? ◯ No ◯ Yes

Date of injury/accident _____

When did you first notice pain? _____

When did you first seek medical help? _____ Where? _____

Are you currently working? ◯ No ◯ Yes Full duty ☐ Light duty ☐

IF YES, how many hours/day _____

Describe your job duties:

Sitting _____ hours Standing _____ hours Lifting _____ hours

Overhead work? _____

Climbing? ◯ No ◯ Yes Repetitive upper extremity use? ◯ No ◯ Yes

IF NO, how long have you been out of work?

Why did you stop? _____

Job satisfaction? ◯ No ◯ Yes Why? _____

Have you tried to return to work? ◯ No ◯ Yes

How long did you work at this job before this injury? _____

If you were injured in a car accident, were you? ◯ Driver ◯ Passenger

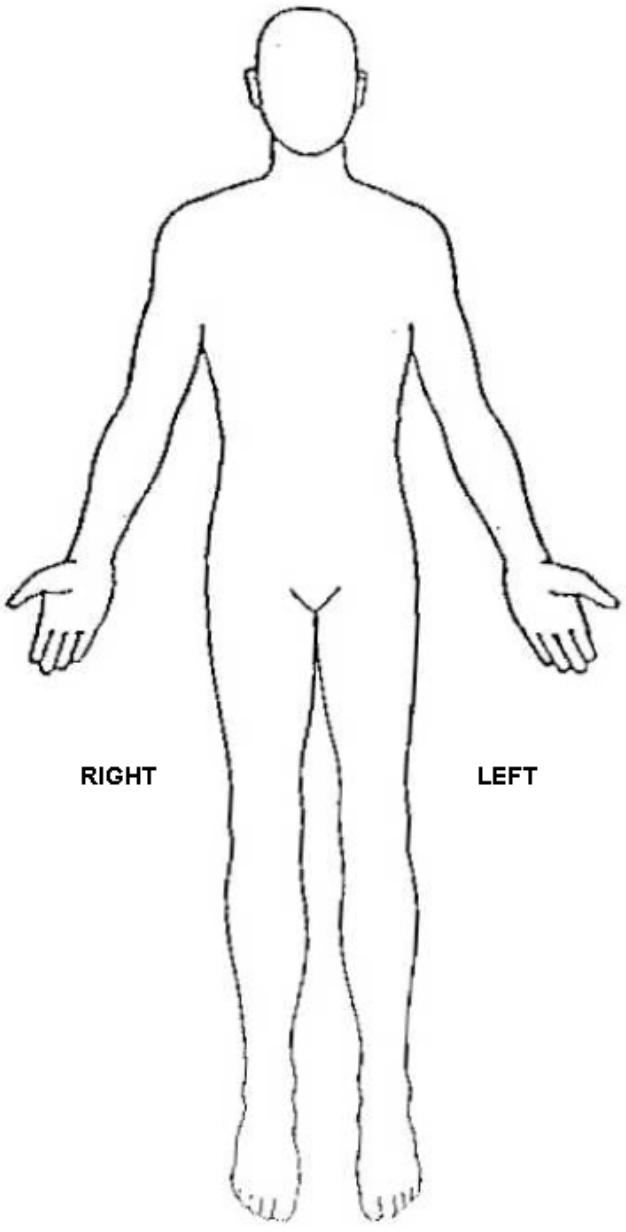
☐ Rear ended ☐ Side-swiped ☐ Broad-sided

Was seat belt on? ◯ No ◯ Yes

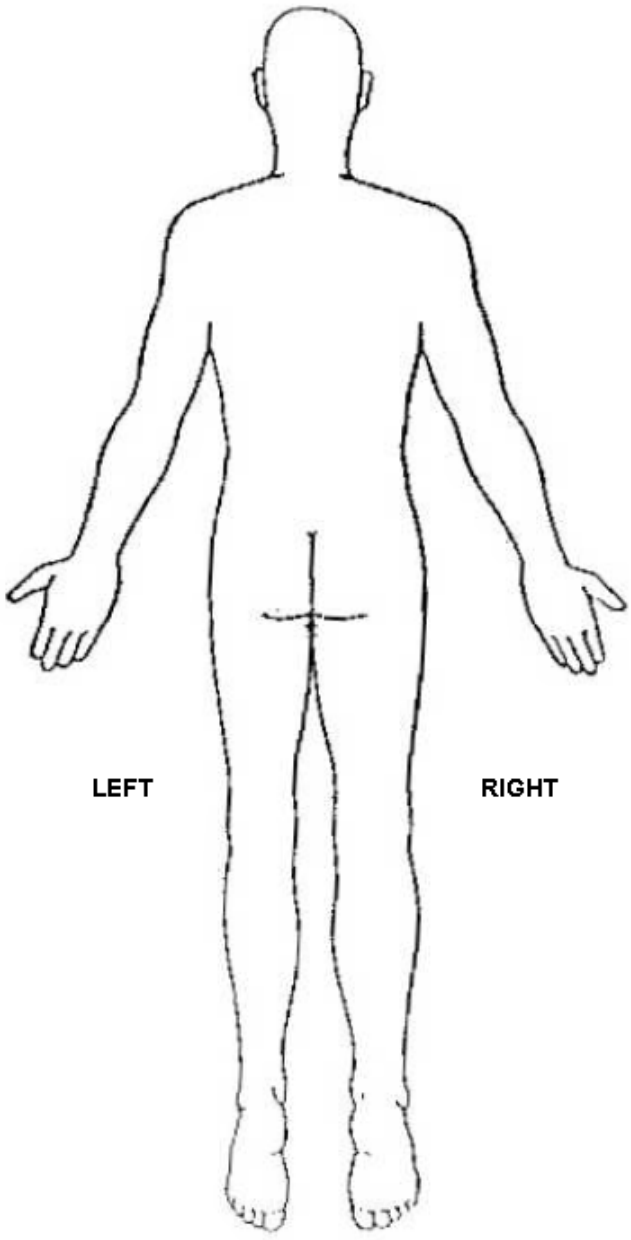
WHERE IS YOUR PAIN NOW?

Using the 'space bar' and 'enter key' mark the area(s) of your body where you feel the described sensations with the appropriate symbol(s). Include all affected areas.

ACHES	^^^^^ ^^^^^ ^^^^^	**NUMBNESS**	0 0 0 0 0 0 0 0 0 0 0 0	**PINS &** **NEEDLES**	- - - - - - - - - -	**BURNING**	XXXX XXXX XXXX	**STABBING**	/ / / / / / / / / / / /



FRONT



BACK

NOTICE OF PRIVACY PRACTICES

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

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Kalra Brain and Spine. (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims, and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address and claims information. We use this information to provide service to you, to process your claims and to bring your health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate, or not current, please call or write us at the telephone number or address listed below. We will take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why – information is shared

We limit who receives information and what type of information is shared.

* Sharing *information within **the Practice***. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

* sharing *information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and

companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

* *Other*. Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE FORM INSTRUCTIONS

A physician with a direct patient relationship with an individual is not required to obtain the consent of the patient prior to using protected health information (or disclosing it to third parties) for purposes of carrying out treatment, payment or health care operations. While the modifications to the final Privacy Rule reduced the necessity for a mandatory consent form, it provided for an acknowledgement of receipt of a Notice of Privacy Practices. This consent form accomplishes that purpose. A consent form should be signed prior to or during initial paperwork for each new patient and as soon as possible for existing patients. This form does not require a witness; however, we recommend that the form be witnessed whenever possible as it may help prevent misunderstandings at a future date.

REFERENCE

Policies & Procedures: Permitted Uses and Disclosures without Authorization
Minimum Necessary Use and Disclosure of Protected Health Information
Uses and Disclosures of PHI by and for Personal Representatives, Minors and Deceased
Incidental Uses and Disclosures

PATIENT CONSENT AND ACKNOLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Kalra Brain and Spine, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc. and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

PATIENT'S NAME PRINTED DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) SOCIAL SECURITY # (FOR ID PURPOSES ONLY)

_____ _____

WITNESS (Optional) DATE

FINANCIAL POLICY ACKNOWLEDGEMENT

I understand and agree that I will be charged $50.00 for any missed office appointments, not rescheduled or cancelled with a 24-hour notice.

Furthermore, I understand that I am responsible for any/all surgical deductibles and co-insurances. All surgical fee estimates are due and payable prior to the patients' surgical pre-operative appointment. An estimate of surgical fees will be presented to the patient at the time of scheduling.

I have read and understand the financial policy for the office of Kalra Brain and Spine, and agree to adhere to the terms of this policy. I also understand that such terms may be amended by the practice from time to time. I understand that a written copy of the financial policy will be provided to me upon request.

Signature	*Printed Name*	*Date*

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORAMTION

Patient Information:

Name: _____ SS# _____ DOB _____

I, the above-mentioned person, release that the following medical information be sent from Dr. Kalra's office.

☐ All Medical Records ☐ All Billing Records

I, the above-mentioned person, release Dr. Ricky Kalra, and staff from any liability concerning the above mentioned records. Information can be released and sent to:

Who is authorized to receive information:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

By signing this form, I the above named person release the physician and his staff from any liability concerning my medical records.

_____ _____ _____

Printed Name Signature Date

PAIN MEDICATION NOTICE

This office does not prescribe hydrocodone on initial visit for pain control or prior to any planned or scheduled surgical procedures.

Patients, who are undergoing surgery, will be limited to two 30 day prescriptions after their surgical procedure. After, the patient will be switched to another medication if needed for pain control. Patients will not receive this medication in office prior to a surgical procedure or for pain management.

Lost or misplaced medication or their prescriptions will not be refilled at any early date.
Do not drink alcohol while on narcotics.
Pain medication prescriptions should be obtained only from one physician. If you currently have a pain management doctor you may be referred back to them for current medication management.
Fill your prescription medication at only one pharmacy.
Early medication: We will not refill medications prior to their scheduled due date. If you run out of medication for any reason prior to scheduled due date, they will not be refilled.

_____ _____

Patient signature Date