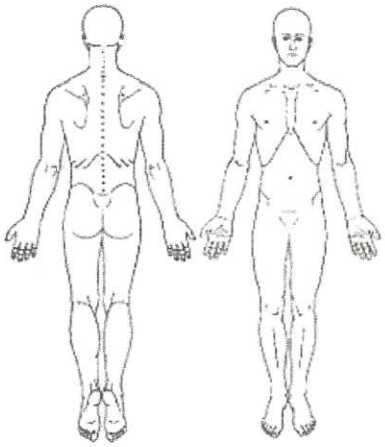
Yalamanchili Brain & Spine

Patient Name: _____
Date: _____ **Date of Birth:** _____ **Ht:** __'__" **Wt:** ____
Chief Complaint: _____
Indicate The Location Of Your Injury/Complaint:
_____

Is this visit a Workman's Compensation case? ❑ Yes ❑ No Due to an auto accident? ❑ Yes ❑ No

If Yes: date of accident: _____ claim/case #: _____



Please mark above the location of your symptoms.

Pain Level: (Mild) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Frequency: ❑ Occasional ❑ Frequent ❑ Constant

Do you experience numbness / tingling? ❑ Yes ❑ No
Does cough, sneeze, or strain increase pain? ❑ Yes ❑ No
Do you experience loss of bowel/ bladder control? ❑ Yes ❑ No
Previous neurosurgery history? ❑ Yes ❑ No

If yes, when? _____

Unintentional weight loss? ❑ Yes ❑ No How much? _____

Previous surgery on affected body part? ❑ Yes ❑ No If so, when? _____

What makes these symptoms: Worse?: _____ Better?: _____

Previous Testing: ❑ MRI ❑ CT Scan ❑ X-Ray ❑ EMG ❑ Other: _____ ❑ No Testing

Previous Treatment/When: ❑ Physical Therapy_____ ❑ Chiropractic _____ ❑ Acupuncture_____ ❑ Injections_____

❑ Anti-Inflammatory medications (please list) _____ ❑ No Treatments

Health Problems / Diagnoses: _____

Previous Surgeries/Procedures: _____

Over the Counter Medications/Supplements: _____

Preferred Pharmacy (Name and Location or Phone#): _____

Allergies: _____ Latex: ❑ Yes ❑ No Contrast Dye: ❑ Yes ❑ No

Social History: Marital Status ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed Alcohol Use: ❑Yes ❑No ❑Rarely
Illicit Drugs: ❑Yes ❑No Smoking: ❑Never ❑Quit ❑Current (__pack/day) Smokeless tobacco: ❑None ❑Chew ❑Vape

Race: _____ Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Decline to answer

Family History – Please indicate any health problems for the following family members:

Mother:	Father:
Sister(s):	Brother(s):
Daughter(s):	Son(s):

Review of Systems: Please check if you previously or currently have problems in the following areas:

Symptom	Y	N	Symptom	Y	N	Symptom	Y	N	Symptom	Y	N
AIDS/HIV			Bleeding disorder			Hypertension			Neck Injury		
Anemia			Cancer			Kidney Disease			Neurological Problems		
Aneurysm			Diabetes			Liver Disease			Stroke		
Anxiety/Depression			Epilepsy/Seizure			Lung Disease			Sleep Apnea		
Arthritis			Head Injury			MRSA			Thyroid Disease		
Asthma			Heart Disease			Meningitis					

Patient Signature: _____ **Date:** _____

FREDERICK
Integrated Healthcare
Network

MEDICARE SCREENING QUESTIONNAIRE - PREVENTATIVE MEDICINE

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

To verify/complete our medical records and to enhance your overall medical care, please complete the following questions.
Please give approximate date if exact date is unknown.
Note: Overdue/incomplete items may require a separate appointment for further clinical discussion.

Have you had 2 or more falls in the past year? *Yes* *No*
If yes, how many? _____

Did any of the fall(s) result in injury? *Yes* *No*

Over the past 2 weeks, have you felt down, depressed, or hopeless? *Yes** *No* Over the past 2 weeks, have you felt little interest or pleasure in doing things? *Yes** *No*

*(*Do PHQ-9 and: drug treatment referral suicide risk assessment additional evaluation other intervention or follow-up)*

Last Flu Vaccine
Date: _____ Location: _____ *N/A* *Never*

Last Pneumonia Vaccine
Date: _____ Location: _____ *N/A* *Never*

Last Mammogram
Date: _____ Location/Specialist_____ *N/A* *Never*

Most Recent Colon Cancer Screening / Colonoscopy:
Date: _____ Specialist Name: _____ *N/A* *Never*

(If you have diabetes, please complete the following:

Last Hemoglobin A1c blood test Value:_____ Date: _____

Last Diabetic Eye (Retinal) Exam Specialist Name:_____ Date: _____

_____ _____
Patient/Guardian Signature Date

Practice Staff Use Only: ☐ Information Abstracted By: _____ Date: _____

Yalamanchili Brain & Spine

Patient Financial Policy

Patient Name: _____ **DOB:** _____

Thank you for choosing **Yalamanchili Brain and Spine**! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our office at **301-846-0100**.

Payment is Due At the Time of Service

- We accept cash, debit, credit cards.
- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service.

Initial here

- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.

Initial here

- Patient-responsible balances (past due balances) are due when you check in for your appointment.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and co-insurance amounts.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of $25 for no-shows. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance, address and phone number.

Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance referral on file.
- Self-Pay patients, please be prepared to pay a minimum of $325 on the date of service. There may additional fees for DME or other supplies or services.

Initial here

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Financial Assistance

Our Practice treats patients regardless of financial status. We offer assistance in the form of a sliding scale discount of charges based on verifiable household income. The front desk receptionist will be happy to provide you an application.

Late Policy

Patients who arrive more than 15 minutes late for an appointment, without calling in advance, may need to be rescheduled. We strive to minimize the wait time for patients who arrive on time. We will offer you a later appointment on the same day if one is available. Our goal is to accommodate all patients as best as possible, but cannot compromise the quality and timely care provided to our other patients.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

Divorce and Child Custody Cases

- The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.
- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.

_____ Initial here — I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

_____ Initial here — I authorize my insurance benefits be paid directly to **Ravi Yalamanchili, MD, PA d/b/a Yalamanchili Brain and Spine.** In the event my claim is denied, I authorize **Yalamanchili Brain and Spine** to file an appeal on my behalf.

_____ Initial here — In order to properly treat me, I authorize **Yalamanchili Brain and Spine** permission to view my prescription medication records.

_____ Initial here — I authorize **Yalamanchili Brain and Spine**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

_____ Initial here — I authorize **Yalamanchili Brain and Spine** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

_____ Initial here — I authorize **Yalamanchili Brain and Spine** to contact or discuss my personal health information with:

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

Name: _____ Relationship: _____ Phone No: _____

X Patient/ Guarantor Signature _____ Date: _____

Acknowledgement of Yalamanchili Brain and Spine Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of **Yalamanchili Brain and Spine** Notice of Privacy Practices.

X Patient/ Guarantor Signature _____ Date: _____