Troy I. Mounts, M.D.
Orthopaedic Spine Surgeon

Welcome,

I want to thank you for placing your trust in me first as your doctor and second as your surgeon. I hope the experience you have leaves you feeling well treated and well informed.I am excited to bring new ideas, new approaches, new technology and a fresh perspective to all of your spine related needs. You have dealt with your pain long enough, it's time to let someone else bear the burden. I'm ready to help you get BACK your freedom, get BACK on track and get BACK your life.

As a new patient I need your assistance with the information that will be used to establish your account and medical chart. Attached is paperwork for you to completePRIOR to your appointment. If a question does not apply to you please write N/A (not applicable) in theappropriate space.

TO HELP THE FLOW OF YOUR CARE AND TO MAXIMIZE THE VALUE OF YOUR VISIT PLEASE BRING THE FOLLOWING ITEMS FOR YOUR INITIAL APPOINTMENT:

- PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT
- FILMS (AND/OR CD) AND REPORTS (MRI, X-RAY, CT SCANS, ETC.)
- ALL COMPLETED FORMS SENT TO YOU FROM OUR OFFICE
- CURRENT INSURANCE CARDS

MEDICATION REFILL POLICY: I am often out of the office due to my surgical schedule.Please allow 72 hours for refill requests to be processed. If you need a refill on an existing prescription, please call your pharmacy and they will fax a request to our office.

I really appreciate your assistance in helping my office staff care for your needs in an efficient and timely manner.

Sincerely,
Troy I. Mounts MD

Troy I. Mounts, M.D. Orthopaedic Spine Surgeon

PATIENT INFORMATION (REQUIRED)			
NAME (LAST, FIRST)			
PHYSICAL ADDRESS (ADDR WHERE YOU CURRENTLY RESIDE)		CITY, STATE, ZIP	
MAILING ADDRESS (ADDR WHERE YOU RECEIVE YOUR MAIL)		CITY, STATE - ZIP	
HOME	WORK	CELL	EMAIL(Responsible Party) (I do not wish to receive updates: _____)
SSN	DOB	SEX **M F**	Marital Status **S M D W**
EMPLOYMENT STATUS (CIRCLE ONE) F/T P/T Retired Disabled Other _____	EMPLOYER NAME **OR** SCHOOL (IF STUDENT)		OCCUPATION
PRE RETIREMENT EMPLOYER/OCCUPATION	PRIMARY MD		REFERRING MD

FINANCIALLY RESPONSIBLE PARTY INFORMATION (PERSON **"LEGALLY"** RESPONSIBLE TO PAY)			
NAME	RELATIONSHIP TO PATIENT	SSN	DOB
MAILING ADDRESS		CITY, STATE - ZIP	
HOME	WORK	CELL	

PRIMARY INSURANCE (REQUIRED)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER	OCCUPATION		
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX **M F**
ADDRESS OF INSURED	CITY	STATE	ZIP	

SECONDARY INSURANCE (IF APPLICABLE)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER	OCCUPATION		
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX **M F**

EMERGENCY CONTACT		
NAME	PHONE #	RELATIONSHIP

- I am responsible for payment due at time of service (ie: co-pay, co-ins, ded, non-covered/denied services, and/or cash pay)
- 1.5% per month (18% per yr) interest charge and/or late fee may be added to unpaid balances over 30 days.
- $25.00 non-sufficient funds (NSF) fee will be charged for all returned checks.
- $50.00 may be charged for appointments cancelled or missed without 24 hours notice.
- $15.00 **minimum** charge may be charged for completion of forms.
- $15.00 may be charged for providing inaccurate, outdated, and/or incomplete insurance information that result in additional billing.
- There may be a charge for copying medical records.
- I authorize payment of medical benefits to Troy I. Mounts, MD for services provided.

_____ _____

Patient/Responsible Party Signature Date

TROY I. MOUNTS, M.D.

PATIENT NAME: _____**DATE**: _____

Dr. Mounts is **required by federal regulations to request the following demographic information:**

ETHNICITY: (PICK ONLY ONE)

___ Hispanic or Latino

___ Not Hispanic or Latino

___ Unknown

___ Unreported/Refused

RACE: (PICK ONLY ONE)

___ American Indian or Alaska Native

___ Asian
- ___ Indian
- ___ Cambodian
- ___ Chinese
- ___ Japanese
- ___ Korean
- ___ Laotian
- ___ Vietnamese

___ Black or African American

___ Native Hawaiian/Other Pacific Islander
- ___ Filipino
- ___ Guamanian
- ___ Samoan

___ White

___ Other Race

___ Unknown

___ Unreported/Refused

PREFERRED LANGUAGE: ____ English ___ Spanish ___ Other: _____

Troy I. Mounts, M.D., Inc.

Orthopaedic Spine Surgery

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize Troy Mounts, M.D. to obtain any and all medical records pertinent to my care from any physician, hospital, or other health care professional.

I also hereby authorize Troy Mounts, M.D. to release any medical records belonging to them concerning my care to any physician, hospital, or other health care professional. These may include but not be limited to mental health records protected by Lanterman Pertis Short Act, drug and alcohol abuse records and HIV test results to any except as specifically follows: _____

This authorization is effective now and will be in effect for the time that I am a patient of Troy Mounts, M.D., or until I revoke it in writing.

Troy Mounts, M.D. reserves the right to modify the privacy practices outlined in the notice.

Signature (Patient/Responsible Party): _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

A copy of the HIPPA guidelines for the office of Troy Mounts, M.D. was made available to me to read at the front desk. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results and chart notes.

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Signature (Patient/Responsible Party): _____ Date: _____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" on _____.
The acknowledgement was not obtained because:

___ The patient was undergoing emergency treatment.
___ The patient declined to sign the acknowledgement.
___ Other _____

Name of Staff Member: _____ Date: _____

Consent to Photograph/Videotape/Film/Interview Individuals

I give Troy Mounts, M.D., Inc. permission to photograph, videotape, film and/or interview myself, and to publish said photographs, videotapes, films, written testimonials and/or interviews on the internet, Dr. Mounts' web site and all other forms of media. The photographs, videotapes, etc. shall constitute the exclusive property of Troy Mounts, M.D., Inc. and may be reproduced by Troy Mounts, M.D., Inc., without compensation or payment to the individual concerned or any other person. I also hereby release Troy Mounts, M.D., Inc. and his employees from all claims, demands, and liabilities whatsoever in connection with the above.

Patient Name: _____ Signature: _____ Date: _____

Responsible party: _____ Signature: _____ Relationship to Patient: _____

Troy I. Mounts, M.D., Inc.

Orthopaedic Spine Surgery

ORIGIN of PAIN

(This information is required by all insurance companies)

Under the provisions of the contract with your private insurance for you and your dependent (s), liability may be an exclusion of your policy. So that your private insurance company can determine if they are correct in accepting liability for the services provided for this problem/injury, they will need the following information:

BODY PART FOR THIS VISIT: _____ (Right or Left)

1. **Is your pain/concern due to: (Circle one of the below)**

   A. Gradual onset = skip to #'s 3& 4
   B. Accidental injury =complete #'s 2, 3, & 4

2. **Briefly describe the onset of your current symptoms:** _____

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3. **Where did injury/accident occur:** **Work** **Home** **Auto** **Other:** _____

4. **Date symptoms started:** _____

5. **Do you think your problem is related to work?** **YES or NO** (IF YES, ANSWER #6)

6. **Have you filed a workers' comp claim with your employer?** **YES or NO**
   If "yes"
   A. Have you notified our office? **YES or NO**
      a. If "NO", **immediately** call our office **at 544-2500.**
      b. If "YES", bring a copy of your claim form to your appointment.
   B. Has your claim been denied or put in delay? **YES or NO**
      a. If "YES", bring a copy of your denial/delay letter to your appointment.

I CERTIFY THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Name: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible Party: _____ Relationship to Patient: _____

Troy I. Mounts, M.D.
Medicare Coverage Information

DO YOU HAVE MEDICARE COVERAGE? ☐ **Yes** ☐ **No If "NO" & 65 or over, please explain why you do not have Medicare:** _____

(FAILURE TO DISCLOSE ALL INSURANCE PLANS CAN CAUSE DENIAL/DELAY OF CLAIM PAYMENT!)

This form must be completed by patients with Medicare coverage (primary or secondary)

Medicare requires that providers determine whether Medicare is the primary or secondary payer for each claim for a Medicare beneficiary. The MSP form is used as a guide during the registration process to help identify other payers which may be primary to Medicare.

- Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation?
  ☐ Yes ☐ No

  If yes, please provide the following information:
  Date of accident; _____/_____/_____
  Nature of accident: ☐ Auto ☐ Workers Compensation ☐ Liability
  Claims address (Auto/Work Comp/Liability): _____
  _____

  Claim Number: _____

- If under age 65, is your Medicare coverage due to disability? ☐ Yes ☐ No

  Are you covered by a large Employer Group Health Plan based on your current employer or your spouse's current employer (20 or more employees)? ☐ Yes ☐ No
  (if yes, Medicare is secondary and primary information must be obtained)

- If 65 and over, are you covered by Employer Group Health Plan based on your own or spouse's current employer? ☐ Yes ☐ No
  (if yes, Medicare is secondary and primary information must be obtained)

SIGNATURE SECTION

Patient Name: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

Review of Systems

Name:_____

Allergic/ Immunologic

- ☐ seasonal allergies
- ☐ allergic reaction to foods/environment
- ☐ immunosuppresion

Cardiovascular

- ☐ chest pressure
- ☐ Cardiovascular Problems or chest symptoms
- ☐ chest pain
- ☐ elevated blood pressure
- ☐ Edema
- ☐ foot swelling
- ☐ heart attack
- ☐ palpitations
- ☐ heart murmur

Constitutional/ Symptom

- ☐ chills
- ☐ fever
- ☐ headache
- ☐ nausea
- ☐ dizziness
- ☐ night sweats
- ☐ sleep problems
- ☐ weight gain
- ☐ weight loss, intentional
- ☐ unexpected weight loss

ENT & Mouth

- ☐ difficulty with hearing
- ☐ cough
- ☐ difficulty with swallowing
- ☐ ear pain
- ☐ gum problems
- ☐ hoarseness
- ☐ sinus problems
- ☐ loss of hearing
- ☐ nose bleeds

Endocrine

- ☐ Change in Thirst or Appetite
- ☐ dry hair
- ☐ dry skin
- ☐ unusual fatigue
- ☐ weight change
- ☐ thyroid disease

Eyes

- ☐ corrective lenses
- ☐ eye or vision problems
- ☐ glasses
- ☐ loss of vision
- ☐ resent change in vision

Gastrointestinal

- ☐ bloody/tarry stools
- ☐ constipation
- ☐ diarrhea
- ☐ hemorrhoids
- ☐ nausea
- ☐ stomach problems
- ☐ vomiting
- ☐ ulcers

Genitourinary

- ☐ blood in urine
- ☐ difficulty empting
- ☐ inability to empty bladder
- ☐ painful urination
- ☐ urinating frequently at night
- ☐ urine retention
- ☐ stress incontinence
- ☐ urinary incontinence
- ☐ difficulty in starting
- ☐ incontinence[1]

Hematologic / Lymphatic

- ☐ anemia
- ☐ ankle edema, swelling
- ☐ bleeding problems
- ☐ easy bruising
- ☐ recent night sweats
- ☐ sweats

Integumentary

- ☐ dry scaly skin
- ☐ itching
- ☐ non healing wound
- ☐ rash

Musculoskeletal

- ☐ back pain
- ☐ decreased ROM
- ☐ difficulty getting out of a chair
- ☐ episodic weakness
- ☐ joint pains
- ☐ arm pain
- ☐ leg pain
- ☐ neck pain
- ☐ weakness

Neurological

- ☐ black outs
- ☐ balance problems
- ☐ difficulty walking
- ☐ dizziness
- ☐ headaches
- ☐ migraine
- ☐ paralysis
- ☐ seizures
- ☐ numbness
- ☐ trouble balancing
- ☐ paresis (muscle weakness)
- ☐ uncontrolled movements
- ☐ weakness
- ☐ stroke

Psychiatric

- ☐ anxiety
- ☐ Binging and purging
- ☐ claustrophobia
- ☐ depression
- ☐ generally satisfied with life
- ☐ paranoia
- ☐ psychiatric care
- ☐ nervous exhaustion
- ☐ OCD

Respiratory

- ☐ asthma
- ☐ breathing difficulties
- ☐ chest pain with inspiration
- ☐ shortness of breath
- ☐ sleep apnea
- ☐ coughing up excess sputum

Alerts

- ☐ premedication prior to procedures
- ☐ pacemaker
- ☐ rheumatoid arthritis
- ☐ RSD
- ☐ allergy to shellfish/iodine
- ☐ allergy to latex
- ☐ allergy to adhesive
- ☐ under pain management
- ☐ pregnant or planning preganancy
- ☐ blood thinners
- ☐ defibrillator

Vaccines

___ Flu Shot
___ Pneumonia Vaccination

Advance Care

Do you have a living will? YES NO

___ Do Not Intubate
___ Do Not Resuscitate

Do you have a health care proxy in the event you are unable to make a medical decision? YES NO

Proxy Name _____

Proxy Phone _____