COASTAL VIRGINIA SPINE & PAIN CENTER

прнр {ƨdzűK . ƨdzfŜØI·ℕŘ
Suite нлл
Virginia Beach, VA 234p2
Phone: 757-227-3820
Fax: 757-226-9021

Thank you for choosing Coastal Virginia Spine and Pain Center to provide you with health care services. We appreciate your trust in us, and we pledge to do all that we can to accommodate your needs and expectations.

On the day of your appointment please arrive approximately thirty (30) minutes early, so that we can ensure all necessary paperwork is in order.

Your initial visit will require that you be in our office for approximately ninety (90) minutes. Occasionally, due to unforeseen circumstances, this length of time may be longer.

We also would like to familiarize you with some record-keeping items that will facilitate your visit with us. Enclosed, you will find the following forms. **Please complete each of these forms prior to your scheduled appointment.**

- ☐ Patient Registration Form
- ☐ General Consent/Agreement to Outpatient Services
- ☐ In-Office Visit during Covid-19 Pandemic - Patient Authorization and Consent Form
- ☐ Headache Questionnaire
- ☐

The following documents are available for your review in our office or on our website www.CovaSpineandPain.com.

- Our Notice of Privacy Practices (HIPAA)
- Notice of Patient Rights and Responsibilities

On the day of your appointment, please bring your insurance card, a state-issued ID (driver's license, Virginia ID card) and your specialist co-pay in order to be seen.

The doctors and staff of Coastal Virginia Spine and Pain Center are dedicated to excellence in patient care, service and satisfaction. If you have any questions please do not hesitate to ask any staff member in our practice.

Sincerely,

Coastal Virginia Spine and Pain Center

COASTAL VIRGINIA SPINE & PAIN CENTER

PATIENT REGISTRATION

PLEASE PRINT

LAST NAME: _____ First:_____ MI: _____ Date of Birth: _____

Sex: ☐ M ☐ F ☐ Gender Neutral Transgender ☐ M ☐ F Social Security #:_____

Address:_____ City_____ State_____ Zip_____

PHONE: HOME:_____ CELL:_____ WORK:_____ E-MAIL: _____

Referring Physician: _____Patient PCP: _____

Preferred Pharmacy: _____ Phone: _____

Employer: _____Phone: _____

Marital Status: _____ If married, Spouse's Full Name:_____

EMERGENCY CONTACT: _____ Relationship to Patient: _____ Phone:_____

INSURANCE INFORMATION

(if Worker's Comp, please write W/C under Primary Insurance)

PRIMARY INSURANCE PLAN: _____

ID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** ☐ **OTHER**

If Other: Last Name:_____ First Name_____ MI_____

Relationship to Patient: _____Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

SECONDARY INSURANCE PLAN: _____

IID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** ☐ **OTHER**

If Other: Last Name:_____ First Name_____ MI_____

Relationship to Patient: _____ Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

The information below will be used to improve the quality of healthcare by granting us the ability to measure and minimize care disparities based on ethnicity, race and preferred language. It gives the practice an accurate estimate of our patient population, and accordingly assesses the need for different services such as interpreter services translated patient forms and cultural competency training for our staff.

RACE: (Please check one) ☐ DECLINED

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other Race

ETHNICITY: (Please check one) ☐ DECLINED

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

ASSIGNMENT and RELEASE

I hereby assign my insurance benefits to be paid directly to the physician.

I understand that I am financially responsible for all non-covered services

I authorize the physician to release any information required to process this claim

SIGNED: _____ DATE:_____

GENERAL CONSENT/AGREEMENT
OUTPATIENT SERVICES

1. **CONSENT TO TREATMENT:** I hereby consent to treatment by Coastal Virginia Spine & Pain Center (COVA), their associates, and/or assistants, and accept responsibility for payment of fees for such medical services. I understand that treatment may include injections, manipulations, medication management, medical appliances, and/or other procedures as deemed necessary and appropriate. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2. **PAYMENT FOR SERVICES**: I understand that COVA may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to COVA. If I should receive the payments, I understand that I will be responsible for paying COVA. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the physician or their associates/assistants, I will have to do so. I understand that COVA will hold me responsible in any one of the following situations:

   a. When I choose to have a service that my health plan covers, but I do not obtain the required referral or authorization from my health plan.
   b. When I choose not to use my health plan and agree to pay for services myself. *(Use Do Not Bill Insurance Form)*
   c. When my health plan does not participate with COVA for the services I want, or need, and I agree to pay for my care myself.
   d. When I receive services that are not covered under my health plan.

3. **ADVANCED DIRECTIVES**: COVA does not honor Advanced Directives. Unexpected complications due to procedures and/or treatment are not natural causes, and therefore will be treated. This means that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative, or other stabilizing measures, and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment, or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, Advanced Directive, or Health Care Power of Attorney. The admitting facility is not affiliated, or in partnership with COVA.

4. **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to COVA for the purpose of continued treatment.

5. **RELEASE OF INFORMATION**: I authorize COVA to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.

   If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim, or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, physical therapy notes and consultations.

   Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access by information; aggregating and comparing my information for quality

improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to blood borne diseases, such as HIV and AIDS.

6. **DISCLOSURE TO FAMILY AND FRIENDS**: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

7. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT**: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for COVA and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recordered messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent, I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of COVA. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

   You may be contacted via voicemail or text to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health information. I consent to receiving healthcare communications at the phone number provided. This request to receive text messages applies to future communications unless I request a change in writing.

   Home Phone: _____ Cell Phone: _____

   OR

   ____ (initials) _____ I decline to receive communications via text

8. **NOTICE OF PRIVACY PRACTICES**: I acknowledge that I have received/reviewed COVA's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

9. **AUTHORIZATION FOR RELEASE OF PRESCRIPTIONS**: I hereby authorize COVA Spine and Pain Center to release my prescriptions to the following in the event that I am unable to pick up my prescriptions.

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

I agree to the items as outlined in the Agreement,

Name (Print): _____

Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative):_____

COASTAL VIRGINIA SPINE & PAIN CENTER

HEADACHE QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Gender: ☐ M ☐ F Handedness: ☐ L ☐ R

Who referred you to COVA? _____

When did your headaches start? _____

_____

What was the initial cause? _____

_____

_Since your headaches began, have they changed? ☐ Yes ☐ No

Are there others in your family who have headaches? ☐ Yes ☐ No

☐ Immediate family ☐ Mother's side of family ☐ Father's side of family

My headaches are (check all that apply):

☐ More frequent	☐ Less frequent	☐ More severe	☐ Less severe
☐ More continuous	☐ Less continuous	☐ More predictable	☐ Less predictable
☐ Last longer	☐ Do not last as long	☐ Different in quality	

How many different types of headaches do you have per: day _____ week_____ month_____

How many severe/debilitating headaches do you have per: day _____ week_____ month_____

How many mild/moderate headaches do you have per: day _____ week_____ month_____

How long does each headache last? minutes_____ hours_____ days_____

Additional comment:_____

_____

PAIN DESCRIPTION: Please rate your pain on the following scale, where 0 is no pain and 10 is the worst pain possible.

0 1 2 3 4 5 6 7 8 9 10

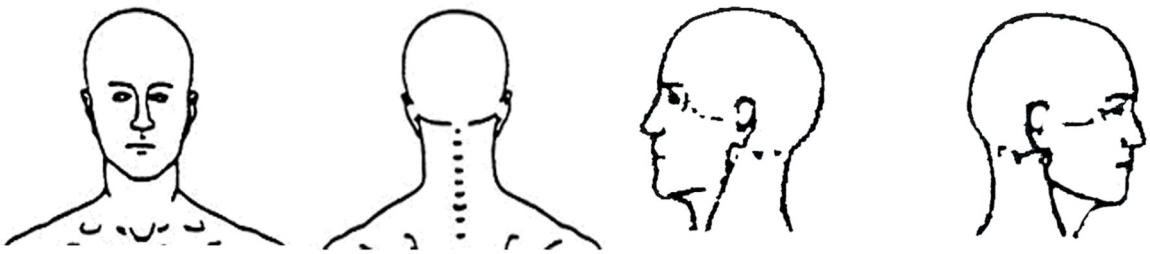
Your pain right now: ____ Your pain at its best: ____ Your typical headache: _____ Your headache at its worst: _____

On the body chart below:

Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensation.

Please number each painful area in order of the most troublesome, i.e., 1 – 10 on the diagram.

®	Shooting
////	Stabbing
XXX	Dull/Aching
***	Burning
∞	Throbbing
===	Numbness



EFFECTIVE: 1/2/2019
REVISED: 1/9/2024

Indicate when you have the symptoms listed above:

	Never	Occasionally	Frequently	Always	When severe
Shooting					
Stabbing					
Dull/Aching					
Burning					
Throbbing					
Numbness					

WHAT MAKES YOUR PAIN BETTER? (Please check all that apply)

- ☐ Lying down
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Medication
- ☐ Sleep
- ☐ Heat
- ☐ Massage
- ☐ Exercise
- ☐ Stretching
- ☐ Traction
- ☐ TENS
- ☐ Ice
- ☐ Biofeedback
- ☐ Compression

WHAT MAKES YOUR PAIN WORSE? (Please check all that apply)

- ☐ Standing
- ☐ Walking
- ☐ Bending
- ☐ Stress
- ☐ Reaching overhead
- ☐ Sitting
- ☐ Sneezing
- ☐ Weather
- ☐ Driving
- ☐ Lack of sleep
- ☐ Lying down
- ☐ Coughing
- ☐ Lifting
- ☐ Reaching
- ☐ Sexual activity

WHICH OF THE FOLLOWING SEEM TO BRING HEADACHES ON?

- ☐ Fatigue
- ☐ Stress/Tension
- ☐ Chewing/Clenching teeth
- ☐ Medications
- ☐ Lack of sleep
- ☐ Skipping meals
- ☐ Sinus problems
- ☐ Smells/Perfumes
- ☐ Oversleeping
- ☐ Hunger
- ☐ Weather
- ☐ Coughing
- ☐ Menstrual cycle
- ☐ Food allergies/Sensitivity
- ☐ Exercise
- ☐ Other_____

ASSOCIATED SYMPTOMS:

Please mark which of the following symptoms you have and their relationship to your headaches.

	Have Symptom	Before Headache	During Headache	When Severe		Have Symptom	Before Headache	During Headache	When Severe
Nausea					Cold hands or feet				
Vomiting					Balance Problems				
Dizziness					Memory Problems				
Sensitivity to light					Attention/Concentration				
Sensitivity to noise					Bladder Problems				
Sensitivity to smells					Bowel Problems				
Weakness					Jaw Pain				
Tiredness					Neck/Back Pain				
Swelling					Neck/Back Stiffness				
Nasal Congestion					Visual Abnormalities				
Sinus Drainage					Unusual Smell/Taste				
Numbness					Hearing Abnormalities				
Irritability					Unusual Sensations				
Sweating					Loss of sensation to limbs/face				
Anxiety					Loss of strength to limbs				

SLEEP

Do you have severe nightmares? ☐ Yes ☐ No

Do you have trouble falling asleep? ☐ Yes ☐ No

Average number of hours of sleep per night? _____

How many times per night do you wake up? _____

Do you wake up unusually early in the morning? ☐ Yes ☐ No

Do you wake up with a headache? ☐ Yes ☐ No

Do you grind your teeth at night? ☐ Yes ☐ No

Do you snore excessively loudly at night? ☐ Yes ☐ No

Do you stop breathing in your sleep? ☐ Yes ☐ No

Is your sleep restful? ☐ Yes ☐ No

PLEASE INDICATE HOW MUCH YOU AGREE WITH THE FOLLING STATEMENTS:					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I worry about my headaches					
My headaches are predictable					
I am concerned that something is seriously wrong with me					
I am a perfectionist					
There is never enough time to do the things I need to do					
I believe my headaches would be better if I could relax more					
I take medications as soon as possible to control my headaches					
I try to wait as long as possible before taking medications					
I sometimes take more medications that I am supposed to use					
I avoid medications because I am afraid of addiction					
I am concerned that I am addicted to my medications					
I try to get as much done before my headaches get severe					
There are many things I am unable to do because of my headaches					
I have trouble saying no to people					
I have trouble taking care of myself					

MEDICAL TREATMENT:

Current Treating Physician for Headaches: _____

Family/Primary Care Physician: _____

Other Physicians/Health Care Providers currently treating you: _____

_____

List any Physician/Health Care Providers who have treated you in the past for you headaches.

(If you do not know their names, please provide their specialty instead): _____

_____

REVIEW OF SYSTEMS

CONSTITUTIONAL	☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Weakness ☐ Fatigue ☐ Difficulty Sleeping ☐ Chills ☐ Night Sweats
EYES	☐ Visual Problems ☐ Glaucoma
HENT	☐ Headaches ☐ Sinus Problmes ☐ Hearing Problems ☐ Sleep Apnea
CARDIOVASCULAR	☐ Heart Trouble ☐ Swelling of feet ☐ Hypertension ☐ Lower Extremity Swelling
RESPIRATORY	☐ Cough ☐ Shortness of Breath
GASTROINTESTINAL	☐ Liver Disease ☐ Hepatitis ☐ Gall Bladder Problems ☐ Reflux ☐ Bowel Problems ☐ Consitpation ☐ Diarrhea
GENITOURINARY	☐ Kidney Stone ☐ Kidney Disease ☐ Bladder Problems ☐ Blood in Urine ☐ Reduced Libido (desire for sex)
INTEGUMENT	☐ Dry Skin ☐ Rashes
NEUROLOGICAL	☐ Seizures ☐ Stroke ☐ Peripheral neuropathy ☐ Numbness ☐ Memory or concentration difficulties ☐ Loss of Balance ☐ Falls ☐ Head Injuries
MUSCULOSKELETAL	☐ Neck Pain ☐ Shoulder Pain ☐ Elbow Pain ☐ Wrist/Hand Pain ☐ Carpal Tunnel Syndrome ☐ Low Back Pain ☐ Hip Pain ☐ Knee Pain ☐ Foot/Ankle Pain ☐ Gout
ENDOCRINE	☐ Thyrod Problem ☐ Diabetes ☐ Excessive Thirst
PSYCHIATRIC	☐ Depression ☐ Anxiety ☐ Anger ☐ Guilt
HEME-LYMPH	☐ Easy Bruising ☐ HIV Exposure ☐ Bleeding Problems
ALLERGIC-IMMUNOLOGIC	☐ Seasonal Allergy Allergies ☐ Anaphylactic (Severe) Medication Allergies ☐ Anaphylactic (severe) Reaction to Bee Stings

MEDICAL HISTORY Please Circle: P - PAST HISTORY or C - CURRENT PROBLEM.

	DATE	STATUS		DATE	STATUS
Alzheimer's Disease/Dementia		P C	HIV/Aids Disease		P C
Anxiety		P C	Hypertension (High Blood Pressure)		P C
Asthma/COPD		P C	Irritable Bowel Syndrome (IBS)		P C
Atrial Fibrillation		P C	Kidney Disease		P C
Blood Disorder:_____		P C	Lupus		P C
Cancer: Type_____		P C	Lyme Disease		P C
Cardiac Pacemaker		P C	Marfan Syndrome		P C
Chronic Regional Pain Syndrome		P C	Migraines		P C
Depression		P C	Osteopenia/Osteoporosis		P C
Ehlers Danlos Syndrome		P C	Parkinson's Disease		P C
Gastric Ulcer		P C	Peripheral Neuropathy		P C
Glaucoma		P C	Peripheral Vascular Disease		P C
Head Injury or Concussion		P C	Rheumatoid Arthritis		P C
Heart Disease (Coronary Artery Disease)		P C	Seizure Disorder		P C
Heart Failure		P C	Shingles		P C
Hernia		P C	Sleep Apnea		P C
High Cholesterol		P C	Stroke (CVA)		P C

Additional Medical History:

SURGICAL HISTORY

☐ **No Pertinent Past Surgical History**

Please list all surgeries: _____

CURRENT MEDICATIONS:

NAME:	DOSE	How often are you taking it?	Reason for Taking it?	HELPFUL?	
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No
				☐ Yes	☐ No

PAST MEDICATIONS:

NAME:	REASON FOR STOPPING IT?	NAME:	REASON FOR STOPPING IT?

ALLERGIES:

Please list any medication allergies you have.

_____

_____

Are you allergic to latex? ____ Yes ____ No

IN THE LAST THREE MONTHS, HOW MANY DAYS DID YOU:	**DAYS**
Have a headache (if a headache lasted more than a day, count each day	
See a health care provider for headaches	
Go to a minor emergency center for headaches	
Call a physician's office to receive emergency pain medication for headaches	
Miss work or school because of your headaches	
Have your productivity at work or school reduced by half or more because of headaches	
Not do household work because of headaches	
Have your productivity in household reduced by half or more because of headaches	
Miss family, social, or leisure activities because of your headaches	
On a scale of 0 to 10, on average how painful were these headaches?	

DIAGNOSTIC TESTTING

☐ Plain X-Ray If yes, where_____	☐ MRI If yes, where_____	☐ Myelogram If yes, where_____
☐ CAT Scan If yes, where_____	☐ EMG/Nerve Conduction If yes, where_____	☐ Diagnostic Blocks If yes, where_____

HABITS:	**How often?**	**Have you ever had a problem with this?**	
Smoking	_____per day	☐ Yes ☐ No	
Alcohol Consumption	Beer _____per week Wine _____per week Liquor _____per week	☐ Yes ☐ No	
Recreational Drugs	_____per day	☐ Yes ☐ No	
Coffee	_____per day	☐ Yes ☐ No	☐ Caffeinated ☐ Decaf
Soda	_____per day	☐ Yes ☐ No	☐ Caffeinated ☐ Decaf
Tea	_____per day	☐ Yes ☐ No	☐ Caffeinated ☐ Decaf
Exercise	_____per week	☐ Yes ☐ No	
Relaxation/Stress Management	_____per week	☐ Yes ☐ No	

SOCIAL HISTORY:

Current Marital Status: ☐ Single, never married ☐ Married/live-in _____ years
☐ Divorced _____years ☐ Widowed _____ years

Number of children by present marriage/relationship: _____

Number of previous marriages: _____ Number of step-children living with you: _____

Number of children by previous marriages/relationships: _____

	EXCELLENT	**GOOD**	**FAIR**	**POOR**
Describe the quality of your childhood:				
Describe the quality of your life:				
Describe the quality of your social support system				

Military History: ☐ Not applicable ☐ Active Duty ☐ Honorable Discharge
☐ Medical Discharge ☐ Dishonorable Discharge

Legal History: ☐ No legal problems ☐ Prior history of legal problems ☐ Current legal problems

Work History: ☐ Currently Working ☐ Not Working

Please indicate any additional information that you feel might be helpful to us in treating you: _____

_____

_____

_____

_____

EFFECTIVE: 1/2/2019
REVISED: 1/9/2024