INSTITUTE FOR NERVE MEDICINE

CENTER FOR ADVANCED SPINAL NEUROSURGERY

2716 OCEAN PARK BLVD., SUITE 3082
SANTA MONICA, CA 90405
310-314-6410
nervemed.com espinehealth.com

PATIENT APPOINTMENT CHECKLIST **complete everything & fax to us/bring with you**

Welcome to the Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery. Our staff looks forward to providing you with exceptional medical care and excellent customer service. In order to serve you best, we have assembled all your preliminary forms into this convenient package. Please complete them either by printing them out and filling them in by hand, or by filling in the PDF's fields in Adobe Reader and then printing out the results, which you can then fax to us at 310-314-2414 or bring to your appointment. Either way, please have your forms complete by the time of your appointment. If you have any questions regarding these forms, please contact us at 310-314-6410 between 9AM-5PM weekdays.

Please arrive on time for your scheduled appointment. If you are more than 20 minutes late, your appointment will be cancelled and rescheduled for a later date.

Our office requires a credit card or debit card to be on file in order to confirm your appointment. Unless you have provided this guarantee, please do not consider your appointment time to be reserved. If you need to cancel your appointment, please contact our office within 48 hours of your scheduled appointment time or you will be charged a $100 cancellation fee.

Please note you will be in the office at least TWO HOURS. Incomplete paperwork will delay your appointment.

1. **IDENTIFICATION:** Bring ALL insurance cards, referral forms, and authorizations. In addition, bring the name of the physician currently treating you and their contact information.

2. DIAGNOSTIC IMAGES: **BRING ALL DIAGNOSTIC IMAGES AND REPORTS**
   While reviewing all imaging is sometimes beneficial, ONLY, reports and images conducted within the current year are necessary. Requests for extensive review for testing over one year old will incur additional charges. Please utilize the subsequent list to ensure that you have all of the images needed for a comprehensive examination. **IF YOU DO NOT HAVE ALL OF YOUR IMAGES AND REPORTS, YOU WILL DELAY THE START OF YOUR TREATMENT PLAN,** as an additional appointment will be necessary to complete your initial procedure plans**.**
   - MRN
   - MRI
   - C.T.
   - X-ray
   - Ultrasound
   - Nuclear Medicine
   - Dexa
   - DOS ___________________________ (month / day / year)

3. **PROCEDURE, INTERVENTION OR SURGERY REPORTS:** Bring ALL treatment reports and referring physician tests pertaining to body regions involved in your reason for consultation. Please refer to the following list to ensure that you have all reports needed for a complete evaluation.
   - Outpatient surgery report
   - Inpatient surgery report
   - Spinal Nerve Blocks
   - Epidural Blocks
   - RF and Fluro guided injections
   - DOS ___________________________ (month / day / year)

LOCATION AND PARKING: The Institute for Nerve Medicine and The Center for Advanced Spinal Neurosurgery is located at 2716 Ocean Park Blvd., Suite 3082, Santa Monica, California, on the south side of Ocean Park Boulevard, just west of 28th Street. Parking is in the back of the building entering off 28th Street. We do not offer parking validation, so please be prepared to pay for your parking fees. As there is a long waiting list for appointments, if you are unable to keep your appointment, please call our office (310-314-6410) to reschedule as soon as possible. Thank you for choosing our medical office to provide your care. We look forward to seeing you in our office soon.

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Aaron Filler, MD, PhD

PATIENT INFORMATION

Date: ______________________ Home Phone: ______________________
Patient: ______________________ Soc.Sec.: ______________________
Address: ______________________ Email: ______________________
City: ______________________ State: ____________ Zip: ____________
Sex: M F Age: ________ Birthdate: ____________ Single Married Widowed Divorced
Patient Employer: ______________________ Occupation: ____________
Business Address: ______________________ Bus. Phone: ______________________
Referring Physician: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________
Primary Care Physician: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________
Pain Management Doctor: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________
Reason for visit: ______________________

OTHER INFORMATION

Person Responsible for Account: ______________________ Phone: ______________________
Relationship to Patient: ____________ Soc.Sec.: ____________ Date of Birth: ______________________
Address (if different from patient): ______________________
Person Responsible Employed By: ______________________ Phone: ______________________
Is this a work-related injury? Yes No If Yes, please fill out Workers Compensation Information below
Is this case under litigation? Yes No Attorney’s Name: ______________________
Attorney Address: ______________________ Phone: ______________________
In case of emergency who should we notify?: ______________________ Phone: ______________________

INSURANCE INFORMATION

Insurance Company: ______________________ Phone: ______________________
Claims Address: ______________________
Insured Name: ______________________ Date of Birth: ______________________
Contract #: ____________ Group #: ____________ Subscriber #: ____________

WORKERS COMPENSATION INSURANCE

Employer’s Name: ______________________ Phone: ______________________
Date of Injury: ______________________ Claim #: ______________________
Worker Compensation Carrier: ______________________
Carrier Address: ______________________
Adjuster’s Name: ______________________ Carrier Phone: ______________________
Coverage Verified By: (Office Use Only) ______________________ Carrier Fax: ______________________

Please continue to the second page of this form

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ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________________ and assigned directly to The Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

In the event that my health insurance sends me a check in my name that has been issued to reimburse the costs of these health care services, I agree to endorse over the check to INM/CASN by writing on the back of the check "Pay to Institute for Nerve Medicine" and signing immediately below this statement. I will then send the check with this endorsement to INM at 2716 Ocean Park Blvd., Suite 3082, Santa Monica, CA 90405.

I further understand that Dr. Aaron Filler is not a provider of services with my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ____ Date: ______________________

OPT-OUT PROVIDER MEDICARE ADVISORY

I, the undersigned, gives up all Medicare payment for services furnished by the “opt out” physician; agrees not to bill Medicare or ask the physician to bill Medicare; is liable for all of the physician’s charges, without any Medicare balance billing limits; acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

Signature: ____ Date: ______________________

SPECIAL NOTICE TO GOVERNMENT EMPLOYEES, MILITARY & ARMED FORCES PERSONNEL (ACTIVE & RETIRED)

Insurances like TriWes Care may require contracting for your reimbursement. Please be advised that this provider does not contract with any insurance carrier. This medical practice has opted out of Medicare; the provider has a deactivated UPIN number. Your signature acknowledges that we will not sign a contract for your insurance payment.

Signature: ____ Date: ______________________

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PATIENT FINANCIAL RESPONSIBILITY

The Institute for Nerve Medicine is pleased to provide medical care for you today. It is our goal to make available to each patient the quality medical care they deserve. As our patient please be advised that Dr. Aaron Filler is not a contracted or participating provider with your insurance network and, it is ultimately your responsibility that The Institute for Nerve Medicine is fully reimbursed for the services provided.

If you are using insurance for your medical treatment, it is your responsibility to know the terms and conditions of your coverage and to provide us with a copy of your most current insurance card. Keep in mind, you do have the right to decline services recommended by a provider. If our service(s) is not covered by your insurance or if your insurance coverage has lapsed, you will be personally responsible to pay for that service in full. Payment will be processed from the credit card authorization on file and any installment payment arrangements must be made in advance of services provided, and for established patients please note that partial payments can not be made once insurance has been finalized. Please note that you will receive a statement from us even though we have billed your insurance carrier.

ASSIGNMENT OF BENEFITS FORM

We will be happy to bill your insurance for your medical charges, but in order to do so we must have your signature below authorizing the Assignment of Benefits. If we do not have your signature below, we cannot bill your Insurance and the total charge will be due from you. We thank you for your prompt cooperation.

I hereby assign to Aaron Filler, MD, PhD, APC DBA The Institute for Nerve Medicine, 2716 Ocean Park Blvd, #3082, Santa Monica, CA 90405, all my rights, title and interest to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, rendered by the assignee effective as of the below stated date and as described in the any subsequent medical claim forms for services provided.

I authorize and direct my insurance carrier to make all payments directly to the provider, I surrender and assign all right, title and interest I may have in any benefits or payments and in any interest on late payments that are paid by check written out to me or to the primary insurance member who is responsible for my coverage as custodian of the funds due to the provider. When my insurer includes the provider's Tax ID to the IRS on a 1099 basis in relation to any payment for medical services under my health insurance, I agree to immediately turn over any such funds to the provider associated with that Tax ID. If I do not immediately turn over the funds, I agree to reporting to the IRS and State tax authorities as well as to law enforcement within two weeks of the receipt of any such funds intended for the provider.

By affixing your signature below you are affirming your acceptance of services, you acknowledge that you are financially responsible for all services provided by The Institute for Nerve Medicine.

Patient Signature: ______________________________ Date: ________________
(Or responsible party)**

Print Name: ____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize THE INSTITUTE FOR NERVE MEDICINE to furnish medical information concerning my care to my referring physician and 3rd Party Payers including bank and credit card companies. Any and all information may be released, including but not limited to mental health records protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if any except as specifically provided below: ____.
This information may be used only for the following purposes:* Diagnosis and Treatment, Payment by 3rd Party Payer. This authorization is effective now and will remain in effect indefinitely until I decide to change it by providing written authorization to comply with HIPAA rules and regulations. I understand that I have the right to receive a copy of this authorization.

Patient Signature: ______________________________ Date: ________________
(Or responsible party)**

Print Name: ____

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PAYMENTS AND FINANCING

Payment is due at the time medical service is rendered. Our office is pleased to accept VISA, MasterCard, and American Express in addition to your personal check.

We are pleased to provide medical care for you. It is our goal to make available to each patient the quality medical care they deserve. As our patient, please be advised that this practice is not a contracted or participating provider with your insurance network and, it is ultimately your responsibility that we are fully reimbursed for the services provided.

Our billing service is offered as a courtesy and convenience for processing your insurance. If you are utilizing insurance for your medical treatment, it is your responsibility to know the terms and conditions of your coverage and to provide us with a copy of your most current insurance card. Please keep in mind that if our service(s) is not covered by your insurance or if your insurance coverage does not fully cover the total billed charges, you will be personally responsible to pay for that service in full. Other persons providing payment on your behalf are asked to also sign the payment policy form otherwise we will not be able to accept their payment on your behalf. Optional payment plans such as monthly payments can be made until insurance is finalized but for no longer than one year beyond the date of service. Payment arrangements must be made in advance of services provided.

Patient Signature: ____ Date: ____________________
(Or responsible party)**

Print Name: ____

OTHER PARTY PROVIDING PAYMENT ON YOUR BEHALF:

Payer Signature: ____ Date: ____________________

Print Name: ____

FOR BLUE CROSS PATIENTS ONLY

In some cases, health insurance coverage for a non-contracted provider such as INM results in the insurer sending the reimbursement check to the patient/subscriber rather than sending it to the physician. In that case, I agree to sign the check over to INM and send the check to INM and agree not to deposit or cash it on my own behalf.

Patient Signature: ____ Date: ____________________
(Or responsible party)**

Print Name: ____

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HOW MUCH WILL THIS COST?

Each week we get several hundred inquiries asking us how much these services cost. If we have not already seen you as a patient, then it is very difficult to tell you exactly what your care will cost. In fact most providers will not be able to tell you because there is no way of knowing what the confirmed diagnosis or resulting service action may be. Instead we can obtain a courtesy general benefit disclosure and tell you what your insurance will cover according to the type of plan you have chosen. As part of our response we also tell patients that Dr. Aaron G. Filler is not a contracted insurance provider so medical services received through the neurological practice of Institute for Nerve Medicine would be covered at the out of network benefit rate for your insurance plan.

Many patients concerned with out of pocket amounts are frustrated by the out of network status and incorrectly assume that this is a way for the doctor to charge more for the medical service. At the Institute for Nerve Medicine, being out of network is not a way to get more money rather it is a quality of care issue. Many insurance plans will only provide basic services from alternate methods or means that have failed to work. Since we have pioneered many of the medical treatments in this subspecialty field, we stand by our need to be able to provide the best in quality care and to exceed the medical standard of care. Having set the standard of care high, many patients are surprised to learn the value of our medical services. A comprehensive consult in our clinic is only $500 and this is the price that has not changed in over 6 years despite many medical specialties routinely charging between $800 and $1200.

We value our exceptional clinical standards and stand by our successful and objective formal patient outcomes as recorded in numerous peer reviewed papers touting. Our methods are often mimicked but never successfully achieved within network. A good question to ask yourself is how successful the in-network treatments have been at resolving the pain conditions? So if you are concerned about going out of network and are debating the merits of how to best use your resources, please know that ‘worth’ is not necessarily about money rather it is also the value of the medical service being provided. We are proud to consistently exceed the standard of care and look forward to working with all prospective patients to ensure that the value of our services are available to everyone.

Treatment of complex medical conditions: The diagnosis and treatment of medical conditions is an effort by a physician to determine what is causing your symptoms and to provide treatments that are expected to help resolve the problem. This practice specializes in treating patients with complex and difficult problems by obtaining technologically advanced diagnostics and using technologically advanced treatment methods guided by a physician who is a very knowledgeable expert and leader in the field of complex nerve and spine disorders. By signing below, you acknowledge that you understand that there is no 100% guarantee of cure. The services provided are the best efforts available to try to find and confirm the cause of your disorder and to carry out the indicated treatments with the utmost of care.

Patient Signature: ______________________________ Date: ______________

Print Name: ____

OTHER PARTY PROVIDING PAYMENT ON YOUR BEHALF:

Payer Signature: ______________________________ Date: ______________

Print Name: ____

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FEES & FINANCING

As patients consider care from Aaron G. Filler, MD, they frequently ask for information about the various payment options. We hope the following information and fee estimates are helpful and informative.

As a Non-Contracted Provider, please be advised that we do not share an insurance contract with your insurance carrier. Some insurance plans do not allow you to go out of network and those that do may have a lower reimbursement rate, meaning a greater out-of-pocket expense to you. Moreover, the usual and customary percentage rate that is set by your carrier does not apply to a non-contracted provider.

After your calendar-year deductible is met, your carrier will reimburse you according to their fee schedule which we are not bound to. We cannot provide insurance appeals or participate in any insurance grievance that you may initiate with your insurance carrier. It is imerative that you contact the 800 numbers on the back of your insurance card(s) for the correct percentage reimbursement for all procedures, interventions or surgeries. We provide live internet connectivity for online insurance inquiries to your insurance carrier from within our offices.

Since you have made the decision to go out of network, you have the responsibility for being informed about your insurance policy and its payment benefits. Our office is not responsible for any payment denials or reduction in fee payments that your plan may apply. Any insurance appeals or grievances that you may have with your carrier does not preclude prompt payment to our office.

ESTIMATED FEE SCHEDULE

Super bill Estimates with CPT codes and charges for your procedure are provided at the time of procedure order. Please be advised that these are estimates ONLY and that medical service charges can only be confirmed upon conclusion of the procedure. Any hospital, surgi-center facility and radiological or anesthesia services are separate from these professional fee estimates.

The following represents a summary of some of our most frequently ordered procedures, and their estimates costs:

Open MR-guided procedure Piriformis / Pudendal: $2900 to $3900
Open MR-guided procedure TOS or Scalene: $3500 to $5000
Open MR-guided procedure Spine: $1900 to $3250
Piriformis Surgery: $8000 to $12,000
Brachial Plexus Surgery: $15,750 to $20,000
Re-Operative Spine Surgery: $20,000 to $35,000

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PAYMENT & FINANCING

Payment for injections and surgery are due in full at the time of scheduling for your procedure. In order to confirm your appointment for procedures, interventions or surgeries, payment must be received by our billing office. We provide a number of payment options which may be used individually or combined, according to your wishes.

Our financial coordinators are readily available to meet with you personally to provide the specific information you desire.

Cash or Check: Personal check, cashier's check or cash
Financing Applications: Detailed information and applications for these companies are available from our patient coordinators. They can assist you in the process of obtaining your preferred financing option by calling us at 866-41-NERVE.

The Institute for Nerve Medicine and the
Center for Advanced Spinal Neurosurgery
accept these as methods of payment

PLEASE READ THE FOLLOWING NOTICE AND SIGN BELOW

The Institute for Nerve Medicine is a neurosurgical practice. By signing below, I indicate my understanding that the Institute for Nerve Medicine (INM) is a professional neurosurgical practice. The physician you see may order specialized diagnostic tests to be done at other facilities including MR Neurography studies offered by a separate radiological practice, which is the Neurography Institute (NIMA).

If specialized interventional diagnostics or treatments are carried out, you may require services at a separate medical facility such as Cedars Sinai Medical Center (for open surgery) or at the Image Based Surgicenter (for MRI Guided interventional diagnostics and/or surgery).

You may expect to receive separate billing from 1) your physician for professional services 2) any diagnostic facility for diagnostic MRIs, MRN's, X-rays and CT scans and 3) any interventional facility for operating room, inpatient hospital or outpatient surgicenter charges.

Patient Signature: ______________________________ Date: ____________________

Print Name: ____

OTHER PARTY PROVIDING PAYMENT ON YOUR BEHALF:

Payer Signature: ______________________________ Date: ____________________

Print Name: ____

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CREDIT CARD AUTHORIZATION FORM

CREDIT CARDHOLDER INFORMATION					
NAME ON CREDIT CARD					
TYPE OF CREDIT CARD	VISA	MC	AMEX	DISCOVER	OTHER
TYPE OF ACCOUNT	PERSONAL		BUSINESS/ COMPANY NAME		
ACCOUNT NUMBER					
EXPIRATION DATE/ CVS code					
BILLING ADDRESS					

CITY		STATE		ZIP CODE	
PHONE		EMAIL		FAX NUMBER	

AUTHORIZED USER OF CREDIT CARD	
NAME/ RELATION TO OWNER	
PHONE NUMBER/ EMAIL ADDRESS	
AUTHORIZED AMOUNT	

AUTHORIZATION OF CARD USE

Auto Charge Authorization: to sign up for this monthly service please sign below.

I hereby authorize the Institute for Nerve Medicine to charge my credit/debit card to pay charges as they become due. This authorization shall remain in effect unless revoked by me in writing and until Institute for Nerve Medicine confirms receipt of such notice. Institute for Nerve Medicine assumes no responsibility for penalties, interest, late fees and bank service charges associated with use of this credit/debit card payment. This authorization shall be effective only upon receipt by Institute for Nerve Medicine. Please note your auto credit card payment will include any and all past due charges , including any charges that may be past due at the time of you sign up for this service. “past due’ is defined as 31 days or more from the date of service.

CARD HOLDER NAME

SIGNATURE DATE

I certify that I am the authorized holder and signer of the credit card referenced above.

I certify that all information above is complete and accurate.

I hereby authorize collection of payment for all charges as indicated above.

CARDHOLDER NAME			
SIGNATURE		DATE	

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MEDICAL QUESTIONNAIRE FOR PATIENTS OF AARON FILLER, MD, PhD

Patient's Name: ______________________________ Date: ______________

Date of Birth: ______________ Age: ________ Sex: M F Weight: ______________

Occupation: ____________________ Are You?: Working Disabled Retired

Are You?: Married Single Separated Widowed Are You?: Right-Handed Left-Handed

CURRENT PROBLEM

Symptoms: Duration:

PAST MEDICAL HISTORY

Previous Operations: Dates:

Implants?: Yes No Type: ____________________ Location: ____________________

Other Past and Current Medical Problems (examples: hypertension, diabetes, stroke, cancer, etc.)

Family History - Parents, Grandparents, Siblings (alive; if deceased, list cause)

MEDICATIONS

List all Current Medications (including aspirin and herbal supplements):

Allergies to Medications: Other Allergies:

____

Smoke ________ packs per day Alcohol Usage: ______________________________

Recent X-rays, CTs, MRIs, etc. (include dates):

Are you claustrophobic? Yes No Do you need sedation? Yes No

Other:

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GENERAL REVIEW OF SYSTEMS

Patient's Name: ______________________ Date: ______________

Last Dental Visit: ____________ Last Eye Exam: ____________ Last Physical: ____________

Please check the items that pertain to you during your lifetime

ALLERGIES

Asthma
Hay Fever
Skin Eruption

CARDIOVASCULAR

Chest Pain
Irregular Heart Beat
High / Low Blood Pressure
Poor Circulation
Rapid Heartbeat
Swelling of Ankles
Varicose Veins
Cold Hands or Feet
Heart Murmur

CONSTITUTIONAL

Chills / Sweats / Fever
Fainting
Forgetfulness
Headaches
Loss of Sleep
Weight Loss
Nervousness

EENT

Bleeding Gums
Difficulty Swallowing
Earache
Ear Discharge
Hearing Loss
Sinus Problems
Nosebleeds
Persistent Cough
Ringing in Ears

ENDOCRINE

Rapid Weight Loss / Gain
Intolerance to Warm Room
Multiple Broken Bones
Cessation of Menstrual Periods
Excessive Hunter / Thirst
Loss of Libido
Spontaneous Nipple Discharge

EYES

Blurred Vision
Crossed Eyes
Double Vision
Vision Flashes or Halos

GENITOURINARY

Blood in Urine
Lack of Bladder Control
Painful Urination
Urinary Retention

GASTROINTESTINAL

Bloating
Bowel Changes
Constipation
Diarrhea
Gas
Hemmorhoids
Indigestion
Nausea
Poor Appetite
Rectal Bleeding
Stomach Pain
Vomiting Blood

HEMATALOGIC / LYMPH

Swollen Lymph Nodes
Easy Skin Bruising
Prolonged Bleeding from Tooth Extraction

INTEGUMENTARY

Skin Rashes or Eruptions
Chronic Skin Itching
Unusual Moles
Poor Scaring

MEN

Breast Lump
Lump in Testicle
Penile Discharge
Sore on Penis/Genitals

MUSCULOSKELETAL

Pain, Weakness, Numbness or swelling in:
Hands, Wrists, Hips, Knees or Joints
Pain in Arms or Legs

NEUROLOGICAL

Fainting
Headache
Numbness of Arms or Legs
Seizures
Tingling of Hands, Feet, Arms or Legs
Problems with Memory

PSYCHIATRIC

Anxiety
Depression
Panic Attack
Restlessness

PULMONARY

Coughing up blood
TB
Chronic Cough
Dizziness
Shortness of Breath
Smoker - How much / how long

WOMEN

Abnormal PAP
Bleeding Between Periods
Breast Lump
Extreme Menstrual Pain
Hot Flashes
Menopause
Painful Intercourse
Date of Last Period:
Date of Last PAP:
Last Mammogram:
Are you Pregnant? Y N
If Yes, how long?
# of Pregnancies:
# of Miscarriages:
# of Children:
Ages:

COMMENTS

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PAIN-FUNCTIONAL QUESTIONNAIRE

Patient's Name: ______________________________ Date: ______________

Date of Birth: ______________ How long have you been in pain? Years _____ Months _____ Weeks _______

Note: you may be asked to complete this form on subsequent visits during your treatment.

Please read prior to filling out questionnaire: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which mostly closely describes your problem.

Section 1 - Pain Intensity

- ❏ I can tolerate the pain I have without having to use pain killers
- ❏ The pain is bad but I manage wthout taking pain killers
- ❏ Pain killers give complete relief from pain
- ❏ Pain killers give moderate relief from pain
- ❏ Pain killers give very little relief from pain
- ❏ Pain killers have no effect on the pain and I don't use them

Section 2 - Personal Care (washing, dressing, etc.)

- ❏ I can look after myself normally without causing extra pain
- ❏ I can look after myself normally but it causes extra pain
- ❏ It is painful to look after myself and I am slow and careful
- ❏ I need some help but manage most of my personal care
- ❏ I need help every day in most aspects of self care
- ❏ I do not get dressed, wash with difficulty and stay in bed

Section 3 - Lifting

- ❏ I can lift heavy weights without extra pain
- ❏ I can lift heavy weights but it gives extra pain
- ❏ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on the table
- ❏ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ❏ I can lift only very light weights
- ❏ I cannot lift or carry anything at all

Section 4 - Walking

- ❏ Pain does not prevent me from walking any distance
- ❏ Pain prevents me from walking more than 1 mile
- ❏ Pain prevents me from walking more than one-half mile
- ❏ Pain prevents me from walking more than one-quarter mile

Section 5 - Sitting

- ❏ I can sit in any chair as long as I like
- ❏ I can only sit in my favorite chair as long as I like
- ❏ Pain prevents me from sitting for more than one hour
- ❏ Pain prevents me from sitting for more than 30 minutes
- ❏ Pain prevents me from sitting for more than 10 minutes
- ❏ Pain prevents me from sitting at all

Section 6 - Standing

- ❏ I can stand as long as I want without extra pain
- ❏ I can stand as long as I want with a little pain
- ❏ Pain prevents me from standing for more than one hour
- ❏ Pain prevents me from standing for more than 30 minutes
- ❏ Pain prevents me from standing for more than 10 minutes
- ❏ Pain prevents me from standing at all

Section 7 - Sleeping

- ❏ Pain does not prevent me from sleeping well
- ❏ I can sleep well only by using tablets
- ❏ Even when I take tablets, I have less than six hours of sleep
- ❏ Even when I take tablets, I have less than four hours of sleep
- ❏ Even when I take tablets, I have less than two hours of sleep
- ❏ Pain prevents me from sleeping at all

Section 8 - Sex Life

- ❏ My sex life is normal and causes no pain
- ❏ My sex life is normal but increased on the degree of pain
- ❏ My sex life is nearly normal but it is very painful
- ❏ My sex life is nearly absent because of pain
- ❏ Pain prevents me from any sex life at all

Section 9 - Social Life

- ❏ My social life is normal and give me no extra pain
- ❏ My social life is normal but increases the degree of pain
- ❏ Pain has no significant effect on ny social life apart from limiting my more energetic interests, e.g. dancing, sports, etc.
- ❏ Pain has restricted my social life and I do not go out as often
- ❏ Pain has restricted my social life to my home
- ❏ I have no social life becasue of pain

Section 10 - Traveling

- ❏ I can travel anywhere without extra pain
- ❏ I can travel anywhere but it give me extra pain
- ❏ Pain is bad but I manage journeys over two hours
- ❏ Pain restricts me to journeys of less than one hour
- ❏ Pain restricts me to short, necessary journeys under 30 minutes
- ❏ Pain prevents me from traveling except to the doctor or hospital

Adapted and modified Owestry Pain Scale for Outcome Analysis, Physiotherapy, August 1980, vol 66:8

INM
CASN
INSTITUTE FOR NERVE MEDICINE
CENTER FOR ADVANCED SPINAL NEUROSURGERY

2716 OCEAN PARK BLVD., SUITE 3082
SANTA MONICA, CA 90405
310-314-6410
nervemed.com espinehealth.com

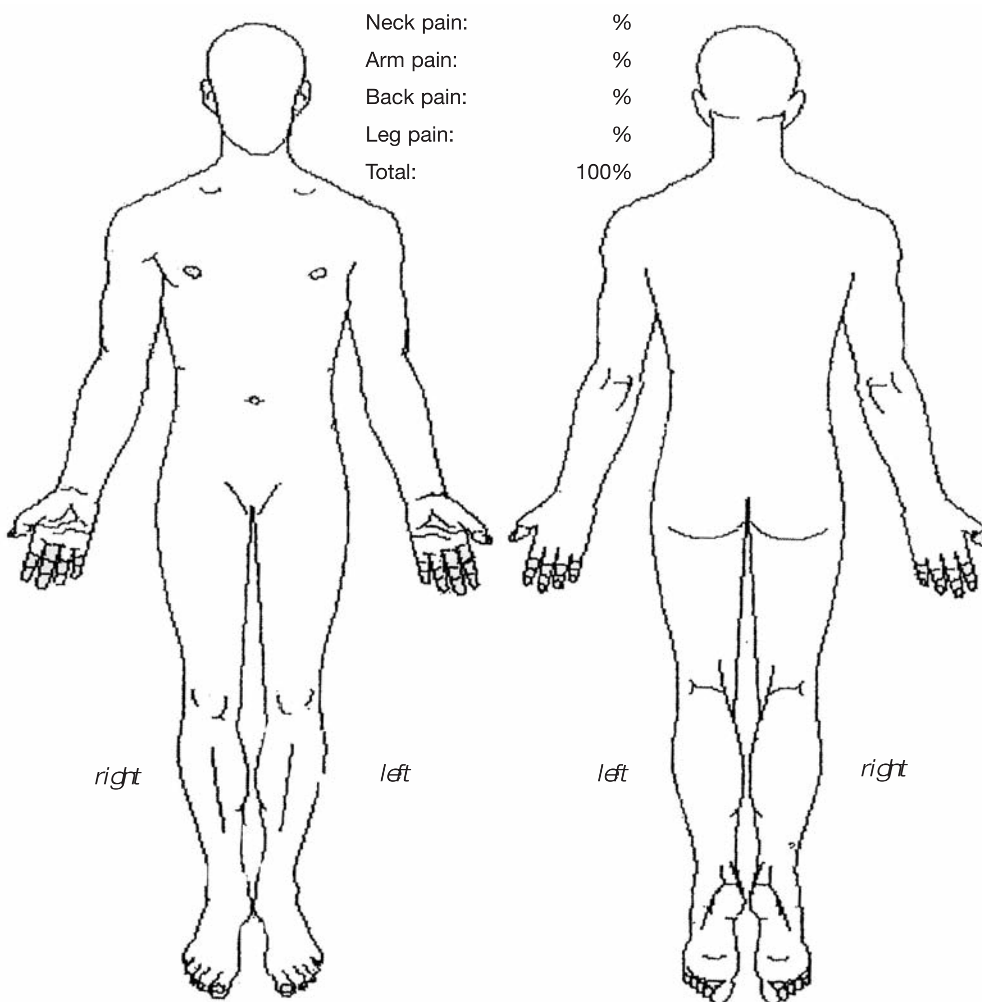
PAIN LOCATIONS

Patient's Name: ______________________________ Date: ______________

Age: ______________

Where is your pain now? Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation using the symbols indicated below. Include all affected areas. Just to complete the picture, please draw in your face.

active pain	^^^^^ ^^^^^	numb	ooooo ooooo	pins & needles	◆◆◆◆◆ ◆◆◆◆◆	burning	✖✖✖✖✖ ✖✖✖✖✖	radiating pain	///////// /////////



How bad is your pain right now? (1=no pain 10=worst pain)									
1	2	3	4	5	6	7	8	9	10

How bad is your pain at its worst?										**How bad is your pain at its best?**									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10

How consistent is your pain now?			
Continuous	Positional	Intermittent (on/off)	Unable to rate

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TREATMENT INTENSITY SCORE

Patient's Name: ______________________________ Date: ______________

Date of Birth: ______________

Please answer the questions below, choosing the answer that most closely describes your situation at the present time. We understand there may be one or more alternatives that may apply to you. Please choose the one you feel is most descriptive of your problem.

1. What medications are you taking for your pain?
   a. None
   b. Tylenol, Aspirin, Motrin, Aleve or other non-prescription pain medication
   c. Vicodin, Codeine, Darvocet, Ultram
   d. Medrol Dose Pack Morphine Analogs (Oxycontin, MS Contin, Percocet, etc.)

2. How long is the pain relieved before you need medication again?
   a. 24 hours or more (rarely take medication)
   b. 12 hours
   c. 8 hours
   d. 6 hours
   e. 4 hours
   f. Less than 4 hours

3. How long have you taken these medications?
   a. Use them occasionally only (i.e. do not need them every day)
   b. 6 weeks
   c. 3 months
   d. 6 months
   e. 1 year
   f. 2 years or more

4. Have you needed to seek other treatment options, specifically because of the pain in your neck, shoulder, arms, buttocks, legs or back?
   a. None
   b. Massage therapy, Shiatsu, Acupressure, etc.
   c. Supervised Physiotherapy and/or Chiropractor
   d. Acupuncture, Acupressure, Alternativei Medicine Therapies
   e. Injections such as Nerve Root Blocks or Epidural Steroids
   f. Spinal Cord Stimulator, Morphine Pump

5. How often have you had to see a Doctor, Therapist, or gone to the Emergency Room, specifically because of unbearable pain (please don't include/disregard any routine follow-up visit)?
   a. Never
   b. Once in 6 months or less
   c. Once in 3 months
   d. Every 6 weeks
   e. Every week or 2-3 times a week
   f. Needed admission to the hospital for severe pain

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PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and anychildren, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Healthcare Association (CHA) and the California Medical Association (CMA), as they may be amended from time to time, which are hereby incorporated into this agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the California Medical Association, P.O. Box 7690, San Francisco, Ca, 94120-7690, Attention: Arbitration Rules, I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), I have indicated the earlier date I intend this agreement to be effective from and initialed below.

Earlier effective date: ____________________ Patient's Initials: ____________________

ARTICLE 7: 1 have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signed: ____________________ Dated: ____________________
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: ____________________

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 4 above.

Signed: ____________________ Dated: ____________________

(Physician or Duly-Authorized Representative)

Title: ____________________ Print Name: ____________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY ISSUES

Aaron Filler, MD, PhD
Privacy Official
310-314-6410

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. 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: _______________________________ Dated: ____________________

Print Name: ____________________________ Phone: ____________________

If not signed by the 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: ____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS TRACKING INFORMATION

Patient Name: ____

Address: ______________________________ Phone: ________________

City / State / Zip: ____

FOR OFFICE USE ONLY

Date received:	Processed by:
Practice Follow-up: Yes No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgement:

Efforts to Obtain:

____

____

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NOTICE OF PRIVACY PRACTICES

Effective Date: April 12, 2006

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. I f you have any questions about this Notice, please contact our Privacy Officer listed at the end of this document.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

20. Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Reauest Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed below.

Institute for Nerve Medicine, Inc.
Privacy Official
310-314-6410
310-314-2414 FAX

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

INSTITUTE FOR NERVE MEDICINE

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nervemed.com espinehealth.com

CORPORATE DISCLOSURE STATEMENT

Aaron G. Filler, MD PhD, FRCS, is a board-certified neurosurgeon with both US and UK credentials (Licensure in California, GMC Licensure in the UK).

Dr. Filler is also the lead inventor for MR Neurography and for Diffusion Tensor Imaging (advanced types of MRI).

You may receive three separate types of bills/charges from each of three separate entitles:

1. INM - Institute for Nerve Medicine: a neurosurgical professional practice
2. NIMA - The Neurography Institute: a radiological practice offering both scanning and scan interpretation
3. IBSC - Image Based Surgery Center: a surgicenter offering open MRI guidance equipment and operating room facilities

Each of these entities is an entirely separate California Corporation in full compliance with all State and Federal Health regulatory law as to billing compliance, HIPAA law, and referral practice law.

In Santa Monica, California, Dr. Filler will see you for evaluation and treatment at 2716 Ocean Park Blvd. The UK office is at 10 Harley Street in London.

INM - The Institute for Nerve Medicine

The Institute for Nerve Medicine is Dr. Filler's neurosurgical private practice (Aaron G. Filler, MD, PhD, APC). All professional services (exam, evaluation, surgery, muscle and nerve treatments carried out by Dr. Filler) will result in billing from the Institute for Nerve Medicine (INM).

NIMA - The Neurography Institute Medical Associates

The Neurography Institute is a separate radiological practice. Through NIMA leased time, facilities for Neurography scanning at various locations around the US and in the UK are provided. In addition, NIMA arranges for the professional interpretation (reading) of your Neurography scans. These services will result in billing from NIMA for the scanning, multi-planar image reconstructions, and professional interpretation - usually assmbled into a single "global" bill.

IBSC - The Image Based Surgicenter Corporation

The IBSC provides a surgicenter accredited to the exacting standards of the AAAHC, the Accreditation Association for Ambulatory Health Care. Like a hospital bill, the IBSC bill covers the costs associated with building, maintaining and operating a world-class, technologically advanced surgical procedure setting for MRI-guided procedures - done inside the body under real-time MRI guidance. This is among the most technologically advanced diagnostic and treatment facilities in the world. Your IBSC services will result in a bill that covers operating room time, recovery room time, MRI guidance, medication and equipment.

Acknowledgement of understanding of Corporate Disclosure

Signed: ______________________________ Dated: ____________________

Print Name: ______________________________ Phone: ____________________

If not signed by the 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: ____