

Welcome To Our Practice!
Raymond I. Haroun, M.D.

The following information is very important to your health. Please take time to fully and completely fill out this information.

Name: _____ Social Security Number: _____ Sex: M F

Address: _____ Date of Birth: _____ Age: _____

City, State ZIP _____ Marital Status: S M W D Spouse's name: _____

Telephone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact phone numbers: _____

Who referred you to our office? _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Please list all other physicians you would like us to send a report to:

1. Name _____

3. Name: _____

Phone number: _____

Phone number: _____

2. Name: _____

4. Name: _____

Phone number: _____

Phone number: _____

Reason for seeing the doctor today: _____

Date Problem Began: _____ Is this work-related? **Y N** Is this related to an automobile accident? **Y N**

Please be as detailed as possible with your answers to the following:

What, if anything, triggered the problem? _____

What part of your body is affected? Right, Left, Both, _____

Describe your symptoms (numbness, sharp pain, tingling, stabbing)? _____

Have you experienced any weakness, clumsiness, or difficulty walking? _____

On a 0 to 10 scale, with 10 being the worst, how severe is the pain? _____

How do the symptoms interfere with your daily activities, (Preparing meals, dressing, walking, hobbies, etc.)? _____

Where do your symptoms radiate (neck, arm, hand, shoulder, thigh, calf, ankle, foot, etc.) _____

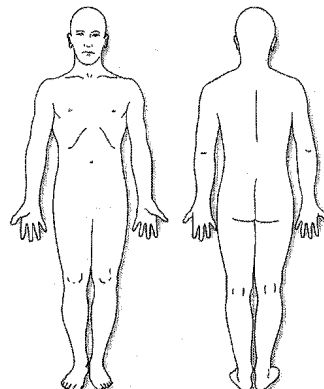
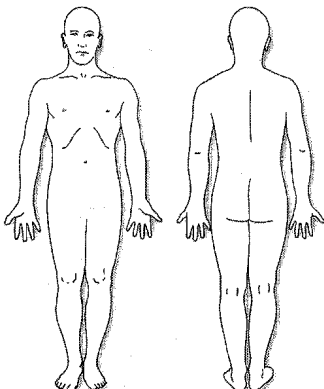
What makes your symptoms better? _____

What makes your symptoms worse? _____

Do you have a history of chronic neck pain? **Y N** For how long? _____ A history of chronic back pain? **Y N** For how long? _____

In the diagram, below darken the areas where you initially began having symptoms.

In the diagram below, darken the areas where you are currently experiencing symptoms.



Please list or circle all treatments you have undergone for this condition (ex: Physical therapy, Chiropractor, Steroids, Injections, pain medications.): _____

Have you been treated by any other physicians, therapists, etc., regarding this condition? Yes / No

1. Doctor's name _____ Specialty _____

What treatments / Recommendations _____ Date of last visit _____

2. Doctor's name _____ Specialty _____

What treatments / Recommendations _____ Date of last visit _____

Have you had any diagnostic studies (Please circle)? MRI CT EMG Myelogram Other: _____

Medical History

Do you have any of the following health conditions? (Circle Y or N for all)

High Blood Pressure	Y/N								
High Cholesterol	Y/N	Diabetes	Y/N	Heart attack/Heart Disease	Y/N	Lung Disease	Y/N	Cancer	Y/N
Bleeding Disorder	Y/N	Sleep Apnea	Y/N	Ulcers/Acid Reflux	Y/N	Thyroid Disease	Y/N	Stroke	Y/N
Blood Clots	Y/N	Seizures	Y/N	Rheumatoid Arthritis	Y/N	Depression	Y/N	HIV	Y/N
Hepatitis	Y/N	Glaucoma	Y/N	Kidney Disease	Y/N	Anemia	Y/N		

Do you have any other medical problems? Y/N (Please List) _____

Have you ever had a blood transfusion? Y/N When? _____

Current Medications/Herbal Supplements/Alternative Medications

Name of medication:	Reason for taking:	Name of medication:	Reason for taking:
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Do you have any medication allergies: Y/N If yes, please list: _____

Reaction: _____

Are you allergic to: Iodine Y/N Latex Y/N Shellfish/Seafood Y/N

Please list any surgeries you have had, with dates: 1. _____ 2. _____
3. _____ 4. _____ 5. _____

Social History: Do you: Drink Alcohol? Y/N How much? _____ Smoke? Y/N How much? _____ Use Drugs? Y/N Type? _____

What is your highest level of education: Grade School High School College/Vocational Graduate

Where do you work? _____ What is your position? _____ Are you right handed or left handed?

What is your height? _____ Weight? _____

For Women: When was your last menstrual period? _____ Are you post-menopausal? _____

Family History: Please list any health problems in your immediate family: Mother: _____

Father: _____ Other: _____ Do you have children? Y/N How many? _____

In the past few weeks have you had any of the following: (Circle Y or N for all and explain each Y below)

Fevers, Chills, Weight Loss Y/N Chest Pain Y/N Difficulty Breathing Y/N Seizures Y/N

Bowel/Bladder changes Y/N Skin Sores Y/N Bruising/Bleeding Y/N Vision Changes Y/N

Urinary Infection Y/N Joint Pain Y/N Nausea, Vomiting Y/N Hearing loss Y/N

Other problems: _____

Please explain: _____

Your Signature: _____ Date: _____ Doctor Haroun's Signature: _____

The above is true and correct to the best of my belief.

Maryland Spine and Brain Specialists, LLC

3449 Wilkens Avenue, Ste 100
Baltimore, MD 21229

Raymond I. Haroun, M.D.
Diplomate
American Board of Neurological Surgery

Phone 410-646-4800
Fax 410-646-9700

Authorization for Release of Medical Records

I, _____, hereby authorize you to release to Dr. Raymond Haroun, and/or Maryland Spine and Brain Specialists, LLC., a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

(Signature)

(Date)

******This authorization will expire exactly one year from the date which it was signed******

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Notice of Patient Privacy Practices

We are committed to preserving the privacy of your health care information. So that we may provide you with appropriate medical care, personal information you provide to us is used for administrative and medical purposes. Typically, this includes treatment, billing to insurance carriers, and clerical uses. Transfer of this information may include but is not limited to personal communication, the use of electronic or manual equipment such as telephone, fax machines, internet, US mail, modem transfer, etc. The following is a non-inclusive list, of the most common types of entities that we would most typically provide personal health or related information:

- Physicians & non-physician providers (ex: physical therapists) who work outside of this practice.
- Medical facilities (ex: hospitals, diagnostic imaging centers).
- Laboratories for the purpose of running medical tests.
- Other health care providers, such as pharmacies, durable medical equipment suppliers, etc.
- Insurance Companies for obtaining payments, reviewing medical necessity, authorizations, or case management.
- State or Federal agencies that require the submission of specific health related information.

In the event that we may need to contact you via telephone, we will first try your home phone number, however if you are not available and you have provided us with other phone numbers (work, cell phone, emergency contact, etc.) we will try to contact you there. If you are not available at those numbers we will leave you a message asking you to call back for a specific reason (ex: test results, account balance, etc.) or we will leave a reminder of an upcoming appointment. Periodically, depending on the situation, we may mail recall notices, test results, billing statements, etc. to your home address.

We may contact your insurance company to verify coverage, eligibility, unmet deductible, co-insurance, and/or co pay requirement, etc. You may request copies of your medical record be sent to another physician for coordination of your care, a disability carrier, attorney, etc. We will forward this information after receiving a signed and valid authorization from you.

You may review and/or obtain a copy of your medical record for which a charge may apply. You may request, in writing, changes be made to your medical record. We will review your reason for such a request and, if we agree, will make the change. If we do not agree with your request, you are entitled to have your statement added to the record. Also, you may request information regarding who we have disclosed your medical information to for purposes other than treatment, payment, and health care operations. Also, you may request in writing a restriction of your protected health information. Your physician is not required to agree to a restriction that you may request. However, if your physician does agree to the restriction, we may not disclose your protected health information unless it is needed to provide emergency treatment.

We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. By law, we are required to notify various health departments as well as other governmental agencies when certain disease diagnoses are made without patient authorization. The disclosure will be made for the purpose of controlling disease, injury or disability.

We are committed with providing you with the best health care possible. Should you have any concerns or complaints, please forward them to our office administrator at the above address. You may also file a complaint with the Secretary of Health and Human Services if you feel your privacy rights have been violated. There will be no retaliation for filing a complaint. From time to time, our patient privacy policies may be modified to ensure compliance with practice operations, State, and/or Federal privacy regulations.

I _____ acknowledge the receipt of these policies and consent to their use relevant to the information in my medical record.

Signature: _____

Date: _____

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Welcome to our office:

Following is a list of our updated office policies and procedures.

- Office hours are Monday thru Friday 9am-4pm and until 12pm on Wednesday. For routine matters such as prescription refills and appointments please call during regular business hours.
- Office visits are by appointment only. Additionally, if you arrive more than 20 minutes late for a scheduled appointment, your appointment may need to be rescheduled.
- In order for you to receive the best possible care, it is essential that you follow the physician's treatment plan. If the doctor sends you for any studies, testing, or consultations with other physicians, please have these completed before your next appointment or it may need to be rescheduled. **It is essential for you to call to schedule an appointment for these results.**
- Referrals and Co pays are **required** at the time of your appointment. If your medical insurance requires you to have a referral to see a specialist, it will need to be presented BEFORE you see the doctor. If your primary doctor is faxing a referral, we recommend that you contact our office prior to arriving for your scheduled appointment to make sure we have received the referral. We will not call your primary doctor for a referral at the time of your visit. If you arrive without a co pay and/or referral your appointment may need to be rescheduled.
- For co payments and/or payments on a previous balance we accept cash, personal check and/or credit cards. Our fee for cancelled or returned checks is \$25.
- All forms such as disability paperwork and attorney requests will be handled within 5-7 business days from the date in which they are received. We will automatically generate a generic disability form free of charge. If your insurance company requires that its own form be filled out, there is a \$25 fee associated with this. This fee is payable in advance, before the forms are completed by our office.
- It is essential that we are made aware of any changes in address, phone number, insurance, etc. Without advising us of insurance changes, you may be responsible for bills sent to an insurance carrier with whom you are no longer covered.
- In order for our office to review and process prescriptions, requests for medications must be made at least three (3) business days in advance. Please note that we generally cannot fulfill same day prescription requests.
- Dr. Haroun can generally prescribe pain medications within your three month post operative period. If you still require routine pain medication after that time, you may need a referral to a pain management specialist. Referrals will be handled on an individual basis.
- If, during a period of 12 months, you miss more than three scheduled appointments, you will be discharged from our practice.
- Any imaging studies left in our office for more than 30 days will become the property of our office and are subject to immediate destruction. Please note that all films will be destroyed in compliance with HIPPA regulations.

****I understand that my signature below certifies that I have read, understand, agree to and have received a copy of, the above policies and procedures.***

Signature

Date