ANDRE PANAGOS MD

NEW PATIENT WELCOME PACKET

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WELCOME

Thank you for choosing us to help you achieve your healthcare goals. We are grateful to have refined the skill and knowledge necessary to rescue many individuals from chronic and debilitating conditions, working closely with colleagues to usher in the future of medicine.

To help us most effectively partner with you, please read and complete the following forms and gather any medical records you feel are important. Examples of important medical records include physician clinic notes, imaging results (x-ray, MRI, CT), and blood lab results.

At your first consultation, we will begin to build a narrative of your condition, understand your successes and failures to date and chart a preliminary course. As you know, not all journeys are smooth and direct. With a solid partnership, we can help you avoid pitfalls and chart the most direct passage for success.

DEMOGRAPHICS

Name _____

Date of Birth _____ Age _____ Gender ☐ Male ☐ Female

Social Security # _____

Primary Address

Number and Street _____ Apt _____

City _____ State _____

Zip code/Postal code _____ Country _____

Alternative Address

Number and Street _____ Apt _____

City _____ State _____

Zip code/Postal code _____ Country _____

Phone/Email Contacts

Home phone _____ Other _____

Mobile phone _____ Other _____

Email _____ Fax number _____

Emergency Contact

Emergency Contact Name _____ Phone # _____

Relationship to patient _____

Number and Street _____ Apt _____

City _____ State _____

Zip code/Postal code _____ Country _____

Primary Care Physician

Name _____

Phone number _____ Fax number _____

Pharmacy

Name _____

Number and Street _____ City _____

Phone number _____ Fax number _____

ASSIGNMENT OF BENEFITS

initials

I request that payment of authorized insurance benefits be made either to me or on my behalf to the provider for services rendered to me. I authorize any holder of my medical information to release the information to the health care finance administration and its agents, or any other health insurance any information that is needed to determine these benefits or the amount payable for related services.

initials

I agree to pay any charges not covered by my insurance carrier(s) in full at the time of service or on receiving a billing statement. These charges include, but are not limited to, co-insurances, deductibles, and co-payments on my insurance policy as well as non-covered services. I understand that the aforementioned payments are non-refundable. If I have any questions related to this matter, I will contact my insurance company or medical plan administrator. I agree to keep a credit card on file for payment of charges related to my insurance coverage and non-covered services and I understand that I will be notified in advance before any charges over $100 are charged. Failure to address the aforementioned payments will affect my ability to schedule future appointments.

APPOINTMENTS

We focus on providing excellent customer service. To accomplish this we have a 12 hour cancellation policy. If the appointment is not canceled at least 12 hours prior to my scheduled appointment I understand that I will be charged an administrative fee of ***$100***. The fee also applies to appointments that are rescheduled less than 12 hours prior to the scheduled appointment.

initials

I may only cancel my appointment by calling the office and speaking to one of the scheduling professionals directly during regular business hours of 9 AM to 5 PM or by leaving a detailed message via voice mail. I understand that appointments cannot be cancelled or rescheduled via any other method. This agreement shall be valid and enforceable for all dates of service. If multiple no-show or same day cancellations occur, I understand that this will affect my ability to schedule future appointments.

CONTINUOUS QUALITY IMPROVEMENT/RESEARCH

initials

You are asked to provide consent for Spine & Sports Medicine of New York to use information from your medical records for continuous clinical quality improvement and research. This will help us improve our treatment protocols. No personal identifying information will be used in any study. Your decision as to whether or not to consent to the use of your medical records is entirely voluntary and will not affect the quality of care you receive. Even if you decide to consent to the use of your medical records in connection with the studies, you may withdraw your consent at anytime without affecting the care you receive.

TELEPHONE CALLS

initials

We are available for non-urgent questions. These questions should be succinct and easily answered. If your question is complex or requires further investigation you may be asked to schedule a consultation. Messages that take over 10 minutes will be billed at the same rate as a non-covered in-person appointment. Please call the office and do not electronically message us about matters that require same-day attention or that are best discussed during an appointment.

PRESCRIPTIONS

New Prescriptions: We will not prescribe new medications over the phone. A prescription for a new condition or one written by another physician requires an office visit.

initials

Routine Prescriptions: When Dr. Panagos writes prescriptions he will provide you with enough medications to last until your follow-up visit. If you run out of medication and/or refills, you are probably due for a return visit. In situations when you have been to the office recently for other issues, we may be able to refill your prescription without another visit. If you have not been to the office in at least six months, you will need a follow up visit before receiving further refills in order for us to monitor your dose.

Controlled Substances: All controlled substance refills require an office visit. If you run out of medication and cannot make it into the office, we can only call in a three-day emergency supply to your pharmacy. You must follow-up before your next refill.

TEST RESULTS

initials

We look forward to reviewing the results for every study and test we order. We find that this is most effective in person, so we set up an appointment to review your results. Test results can take from 7 to 30 days to be received by our office. If you do not hear from us within 15 business days, please give us a call to make sure we have received them.

By initialing and signing below, I acknowledge that I have had an opportunity to review this agreement and understand the policies.

Signature: _____ Date: _____

Printed name: _____

INTERNET COMMUNICATION CONSENT AGREEMENT

Spine & Sports Medicine of New York provides patients the opportunity to communicate with us by email. However transmitting confidential health information by email has a number of risks that should be considered before using email.
The following should not be regarded as a complete list of possible risks. Email can be immediately broadcast worldwide and received by many intended and unintended recipients. Recipients can forward email messages to other recipients without the original sender(s) permission or knowledge. Users can easily misaddress an email. Email is easier to falsify than handwritten or signed documents. Backup copies of email may exist even after the sender recipient has deleted their copies. Patients who send and receive email from their place of employment risk having their employer read their emails.

It is our policy at Spine & Sports Medicine of New York that all email containing information pertaining to diagnosis and treatment of a patient will be included in their protected personal health information and we will treat these email messages or internet communication with the same degree of confidentiality as their protected personal health information. All individuals who have access to the protected personal health information will have access to the email messages as well. We will use reasonable means to protect the security and confidentiality of email or internet communication, but we cannot guarantee the security and confidentially of email or internet communication. Patients must consent to the use of email for confidential medical information after having been informed of the above risks.

Consent to use email includes agreement with the following conditions:

- All emails to and from patients concerning diagnosis and/or treatment will be made part of their protected personal health information. As part of their protected personal health information, other individuals or entities such as Spine & Sports Medicine of New York staff, associated healthcare providers, insurance coordinators will have access to email messages. Upon written request, other healthcare providers and insurers will also have access to email messages containing protected personal health information.
- Spine & Sports Medicine of New York may forward email messages within the practice as necessary for diagnosis and treatment. We will not however forward email outside of the practice without the consent of the patient as required by law.
- Spine & Sports Medicine of New York will endeavor to read email promptly but cannot provide assurance that the recipient of the particular email will read the email message promptly therefore email must not be used in a medical emergency.
- It is the responsibility of the sender to determine whether the intended recipient received the email as well as when the recipient will respond.
- Some medical information can be very damaging if disclosed to an authorized individual. Therefore email should not be used for communications concerning the diagnosis or treatment of sexually transmitted diseases such as AIDS/HIV, mental health or developmental disability, or alcohol and drug abuse.
- Spine & Sports Medicine of New York cannot guarantee that electronic communication will be private. We will, however, take reasonable steps to protect the confidentially of all email or internet communication. Spine & Sports Medicine of New York is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
- If consent is given for the use of email, it is the responsibility of the patient to inform Spine & Sports Medicine of New York of any types of information that they do not want to be sent by email.
- It is a responsibility of the patient to protect their password and other means of access to email sent or received from Spine & Sports Medicine of New York to protect confidentiality. Spine & Sports Medicine of New York is not liable for breaches of confidentiality caused by the patient.

Any further use of email initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing. I understand that my consent to use email may be withdrawn anytime by email or written communication with Spine & Sports Medicine of New York. I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with the use of email.

Signature: _____ Date: _____

Printed name: _____

INFORMED CONSENT AGREEMENT

I seek the medical and healthcare services of Andre Panagos, M.D., his employees, and staff. I understand that this medical practice uses conventional evaluation and treatment options in addition to other diagnostic and treatment methods that are variously known as complementary, alternative, integrative, regenerative, environmental and holistic. Some of these methods have not been accepted by conventional medical practitioners conforming to the common standards of practice in the United States. Many of these methods, however, are considered mainstream in other parts of the world. Some of the methods that are used in this practice include the following:

1. ***Patient Participation*** - Dr. Panagos believes each patient should be involved in their own healthcare and strongly encourages questions and participation in diagnosis and treatment. Although he encourages consultations with other healthcare practitioners, their diagnosis and treatment approaches may not align with Dr. Panagos. It is important that you understand our treatment approach may not always follow the standard conventional medical practices but are instead based on many years of research and clinical experience.
2. ***Lifestyle*** - A person's lifestyle which includes diet, exercise, sleep, stress, and relationships contributes to the development and progression of illness. Dr. Panagos acknowledges and evaluates these lifestyle choices and guides patient's to establish more positive approaches in their lives.
3. ***Exercise*** - Exercise is a critical component for health and wellbeing and helps patients recover faster from illness. Exercises that include strengthening, stretching and aerobic activities are strongly encouraged for most patients.

initials

4. ***Diagnostic Tests*** - Dr. Panagos looks for imbalances in the body and for trends that may result in illness using tests that may be considered by standard conventional medical practices to be unnecessary. These tests may include evaluations for nutritional status, hormone levels, and allergy tests.
5. ***Detoxification*** - Dr. Panagos believes that environmental factors play a role in health and disease. Individuals vary greatly in their susceptibility to illness from exposure to various substances. Dr. Panagos attempts to identify these problematic substances to help patients detoxify and return their body to their natural state of equilibrium.
6. ***Mind-Body*** - The mind-body connection is an important part of wellness and disease prevention. A part of your program may include a referral for meditation, counseling, or psychotherapy.
7. ***Nutritional supplements*** - Nutritional supplements are important to promote healing. Dr. Panagos may recommend nutritional supplements that may include vitamins, minerals, enzymes, amino acids, essential fatty acids, and herbs.
8. ***Regenerative Medicine*** - Regenerative medicine is a new and innovative approach which focuses on healing tissues that may have been damaged recently, many decades ago, or from prior surgical interventions that are not amenable or resistant to other forms of treatment.
9. ***IV Therapy*** – In addition to recommending that a patient take nutritional supple-

ments by mouth, Dr. Panagos may recommend a series of injections either intravenously or intramuscularly. This allows the body to absorb certain nutrients that may be difficult to absorb orally or due to a specific absorption problem.

WE MAKE NO REPRESENTATIONS, CLAIMS OR GUARANTEES THAT YOUR MEDICAL PROBLEMS OR CONDITIONS WILL IMPROVE BY SEEKING CARE AT THIS MEDICAL PRACTICE. Yet, Dr. Panagos will do his best to help you accomplish your healthcare and wellness goals.

Sale of Supplements - Nutritional supplements and other products are sold in this office, yet you are in no way obligated to purchase these products from us. You are free to purchase these products from any source that you choose.

Health Insurance - Health insurance plans have clauses that limit coverage to "usual and customary services". Since many treatments used in this medical practice are not recognized by conventional medical practitioners, we cannot guarantee the amount or availability of coverage for our services and treatments under your health insurance policy. You are responsible for payment of our invoice at the time of service, without regard to insurance coverage. You are entitled to know the cost of all services and procedures in advance.

I have read, understand and agree to the foregoing. I agree that if I have any claim with respect to the services and treatment given to me by Andre Panagos M.D., his employees and/or staff that they shall be judged by the standards and principles of complementary, alternative, integrative, regenerative, environmental and holistic medicine. I have executed this consent freely and willingly and understand its provisions. I recognize that Andre Panagos M.D. will rely upon execution of this document in accepting me as a patient. I acknowledge receipt of a copy of this consent.

By initialing and signing below, I acknowledge that I have had an opportunity to review this agreement and understand the policy.

Signature: _____ Date: _____

Printed name: _____

MEDICAL QUESTIONNAIRE

Please take a moment to answer the following questions. Your responses will help us understand your problem and lead to a more effective treatment plan.

Name_____Age:_____

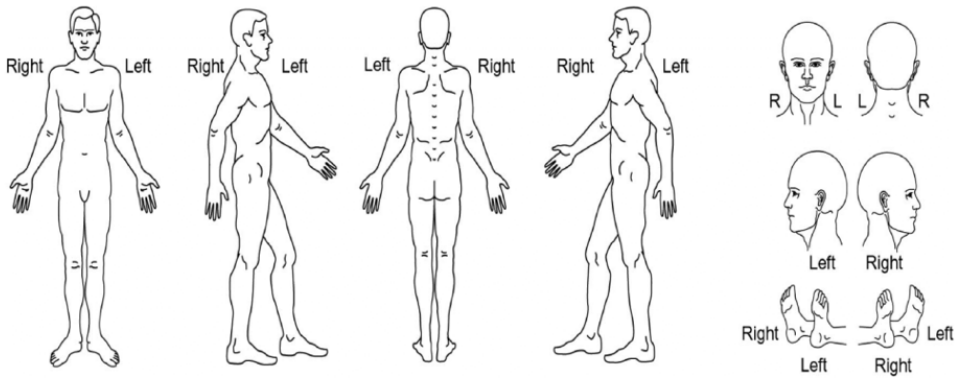
Today's Date: _____/_____/____ Date of Birth: _____/_____/____

Referred by: ☐ self, ☐ physician _____, ☐ other (please specify) _____

What do you hope to achieve with today's visit? _____

A. CURRENT STATUS

Please indicate on the figure below where your condition is located.



1. When did the current condition begin? _____

2. How did it occur? _____

3. What activities improve your condition? _____

4. What activities worsen your condition? _____

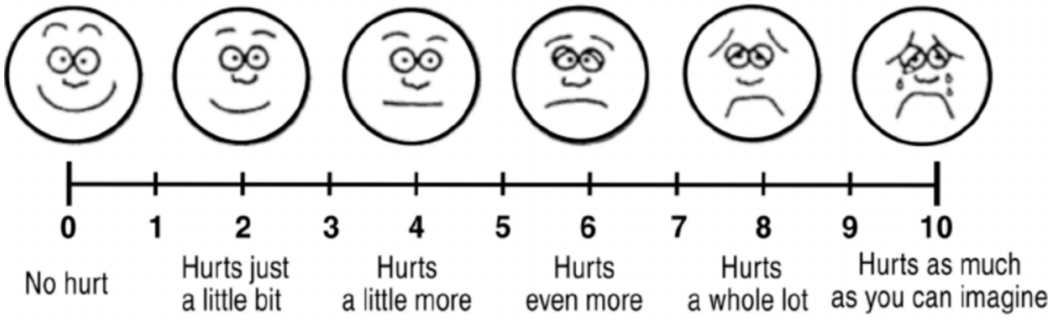
5. How have you most effectively relieved your condition thus far? _____

6. Do you have ☐ numbness/tingling or ☐ weakness? If so, please describe its location: _____

B. PAIN SEVERITY

1. If you have pain, please describe its character: ☐ sharp, ☐ dull/aching, ☐ throbbing, ☐ radiating, ☐ burning

2. If you have pain, please rate your current level or range of pain:



C. TESTING

1. Have you had previous testing for this condition? ☐ Yes, please explain below, ☐ No

Workup	Date	Results
X-rays	___/___/___	_____
MRI	___/___/___	_____
Other	___/___/___	_____

D. PAST TREATMENTS

1. Please list the medical professionals you have seen for your condition:

Type of Doctor **Doctor's Name** **Location** **Dates and Types of Treatment**

_____

_____

E. GENERAL HEALTH HISTORY

1. Do you have any past or present **medical problems** or **surgeries**? ☐ Yes ☐ No

_____

_____

2. Do you take **prescription medications**, vitamins, herbs and/or supplements? ☐ Yes ☐ No

Name of Medication **Dosage** **How long have you been taking these?**

_____

_____

3. Do you have **allergies** to medications and/or foods and if so what kind of reactions occur? ☐ Yes ☐ No

Medication/Item **Reaction**

_____

_____

4. What is your height: _____ (feet), usual weight: _____ (lbs.)

F. SOCIAL HISTORY

1. Usual Occupation:_____

2. Marital status: ☐ Single ☐ Married/Partner ☐ Divorced ☐Widowed ☐ Significant Other

3. If you have children, what are their ages?_____

4. What is your highest level of education or training?
☐ H.S. diploma/equivalent ☐ College degree ☐ Masters/Doctorate degree ☐ Professional degree

5. What is your native language?_____

6. Circle the number to indicate the extent of problems you have with each of the following:

	None									Severe
Anxiety	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Irritability	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10

7. What is your approximate weekly use of alcoholic beverages?
☐ I don't drink alcohol ☐ 3-6 drinks a week
☐ less than 1-2 drinks a week ☐ daily

8. Have you ever smoked? ☐ Yes ☐ No
If yes, how many packs per day? ☐ One pack per day ☐ 1-2 packs per day. ☐ 2+ packs per day
If you have quit, at what age did you quit? _____

G. FAMILY HISTORY

1. Has anyone in your family ever been diagnosed with neck pain, back pain, arthritis, cancer, heart disease, etc.?
If yes, please explain_____

_____

H. REVIEW OF SYSTEMS

Please check the boxes below that apply for symptoms that have occurred over the past TWO weeks.

	Yes	No
Constitutional Systems		
Fever/chills	☐	☐
Weight loss/gain	☐	☐
Fatigue	☐	☐
Night sweats	☐	☐
Skin		
Rashes or color changes	☐	☐
Itching or dryness	☐	☐
Eyes		
Visual changes	☐	☐
Ears, Nose, Mouth, Throat		
Hearing Changes	☐	☐
Dentures	☐	☐
Cardiovascular		
Chest pains or palpitations	☐	☐
Leg pain with walking	☐	☐
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐

	Yes	No
Gastrointestinal		
Swallowing difficulty	☐	☐
Heartburn	☐	☐
Constipation/diarrhea	☐	☐
Stool incontinence	☐	☐
Genitourinary		
Urinary frequency	☐	☐
Urinary pain/blood	☐	☐
Urinary incontinence	☐	☐
Urinary retention	☐	☐
Gynecologic		
Currently pregnant	☐	☐
Pain with intercourse	☐	☐
Musculoskeletal (see above)		
Neurological		
Headaches/Dizziness	☐	☐
Tremor	☐	☐
Loss of balance/falls	☐	☐
Psychiatric (see above)		

Signature:_____ Date _____/_____/_____

Reviewed by Andre Panagos M.D. _____ Date _____/_____/_____

Thank You