

South Atlanta Neurosurgery

Shahram Rezaiani, MD, FACS

Scott Linacre, PA-C, MMSc

Phone: 770-997-0600

Fax: 770-991-5576

We have four convenient locations:

Riverdale (Campus of Southern Regional Medical Ct) **Stockbridge** (ONYX building)
33 S.W. Riverdale Rd., #25 1365 Rock Quarry Road, #304
Riverdale, GA 30274 Stockbridge, GA 30281

Fayetteville (Campus of Piedmont Fayette hospital) **Rockdale**
1267 High way 54 west, #5200 1301 Sigmon Road NE, #100
Fayetteville, GA 30214 Conyers, GA 30012

To our valued patients and their families:

Welcome to our neurosurgery practice. Here we strive to provide the highest quality medical and surgical care and to reach our goal we need your cooperation. Please read the following information to get familiar with our practice and if you have any questions please do not hesitate to ask.

Dr. Rezaiani opened South Atlanta Neurosurgery on May, 2001. He moved to the United States in 1982 and in 1984 attended the University of Washington to complete his degree in electrical engineering, after which he worked professionally for two years. He completed his medical school training in 1994 at the University of Washington also. He completed his neurosurgery residency and complex spine fellowship in 2001 at the University of Rochester in New York and Eastern Virginia Medical School of Medicine in Virginia. Dr. Rezaiani is the first and only neurosurgeon in the South Atlanta area that performs a new minimally disruptive procedure, called XLIF. He also uses Image Guided Surgery for brain tumors and spinal diseases. He will also be leading the introduction of minimally invasive surgery to this region.

So that we can better service you please note the following:

- ❖ No Cell phones, pagers or small children (under 12 years of age) are allowed in the exam room. NO EXCEPTIONS.
- ❖ Prescriptions will be refilled during the office hours ONLY. No prescriptions will be phoned in after the office has closed. NO EXCEPTIONS.
- ❖ We do not manage pain medication for non-surgical patients. We do refer our patients to the pain medicine specialists.
- ❖ Pain medication is to be taken as prescribed. Improper use of medications can lead to the termination of the physician-patient relationship.
- ❖ We require a 24-hour advance notice for prescription refills, so that we may carefully review all patient records.
- ❖ If you do not show up for the appointment and have not notified our office at least 24 hours in advance, you have to discuss the case with our office manager to be considered for another appointment.
- ❖ To all patients: we are VERY RESTRICTIVE in prescribing narcotics / pain killers.
- ❖ We do not complete disability forms (except for a short period for those pending surgery).
- ❖ Post-operative patients: Disability forms will be completed very accurately and honestly; regardless of how long you have been on disability,. This is our strict policy.

If you have any questions or concern, please raise the issue and it will be dealt with promptly.

Sincerely yours,
Practice Management.

I have read and understand the above information:

Patient Signature

South Atlanta Neurosurgery

Shahram Rezaiani, MD, FACS

Scott Linacre, PA-C, MMSc

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I _____ understand that I am entering into a contractual relationship with South Atlanta Neurosurgery, the office of Dr. Shahram Rezaiani for professional care. I further understand that merit less and frivolous claims for medical practice have an adverse affect upon the cost and availability of medical care and may result in irreparable harm to the medical provider. As additional consideration for professional care provided to me by medical practice/physician, I or my representative agree not to advance, directly or indirectly, any false, merit less, and / or frivolous claims of medical malpractice against South Atlanta Neurosurgery (Dr. Rezaiani).

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I or my representative agree to use ABMS board-certified expert medical witness in the same or similar specialty as Dr. Rezaiani.

Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by specialty societies for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, Dr. Rezaiani agree to the same stipulations.

Shahram Rezaiani, MD, FACS

Patient

Patient Information

Name _____ Date of Birth _____ Age _____

First middle last

Address _____

Street Apt City State Zip

Social Security Number ____ - ____ - ____ Home Phone (____) _____ Marital Status _____

Male__ Female__

Name of Spouse or Parent (if a minor): _____

Contact's Phone #: _____

Employed By: _____

Business Address: _____

Occupation: _____ Phone #: _____

Insurance Information

Primary: _____ ID #: _____

Group #: _____

Secondary: _____ ID#: _____

Group #: _____

Referrals

Referred By: _____ Family Physician: _____

Phone #: _____ Address: _____

Phone #: _____

Pharmacy information: _____

Phone: _____

Fax: _____

Is this a WORK RELATED injury? Y / N Date of Injury: _____

Is this an AUTO ACCIDENT RELATED injury? Y / N

Date of accident: _____ Adjuster's name: _____

Phone #: _____ Auto Ins. Co.: _____ Claim #: _____

Phone #: _____

Auto Insurance Address: _____

Privacy Policy

By signing this form, I acknowledge that I have reviewed a copy of South Atlanta Neurosurgery's notice of privacy policies. I understand that a copy of the policy is available on our website (www.atlantaspineandbrain.com) or by print at our waiting room.

METHOD OF PAYMENT FOR TODAY'S SERVICES:

_____ Cash _____ Check

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. WE DO NOT FILE INSURANCE FOR OFFICE VISITS UNLESS YOU HAVE A CONTRACTED INSURANCE COMPANY WITH THIS OFFICE. CO-PAY FEES ARE DUE AT THE TIME OF EACH OFFICE VISIT. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT REGARDLESS OF INSURANCE COVERAGE. THERE IS A \$40.00 CHARGE FOR EACH FORM COMPLETED IN THIS OFFICE. ALLOW 3 – 5 BUSINESS DAYS FOR COMPLETION. THERE IS A \$35.00 CHARGE FOR ALL RETURNED CHECKS.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY AUTHORIZE SOUTH ATLANTA NEUROSURGERY, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR DEPENDENTS. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I DO HEREBY GIVE AUTHORIZATION TO SOUTH ATLANTA NEUROSURGERY, P.C. TO TREAT AND EXAMINE THE ABOVE NAMED PATIENT.

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

Patient Name: _____

Name _____ Date of Birth _____

1. Please state the main reason you are here today? What is the main complaint?
2. How long have you had these symptoms?
3. Are these symptoms getting worse lately? Are they progressively getting worse?

4. Please list your medical problems:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

5. Please list any surgeries you have had:

1. _____
2. _____
3. _____
4. _____
5. _____

6. Please list any medications you are taking now:

1. _____
2. _____
3. _____
4. _____
5. _____

7. Do you Smoke? Y / N If so how much? _____ If you quit smoking when was that?

8. Do you presently use or have you ever used illicit drugs such as cocaine?

9. Do you drink Alcohol? Y / N If so how much?

10. Please circle any of the following symptoms you have now:

- | | | |
|-----------------------|------------------|-----------------------|
| - Palpitations | - Lightheadness | - Joint stiffness |
| - Poor appetite | - Muscle cramps | - Feeling hot or cold |
| - Constipation | - Neck pain | - Hearing problems |
| - Chest pain | - Cough | - Urinary symptoms |
| - Weight loss | - Joint swelling | |
| - Diarrhea | - Back pain | |
| - Shortness of breath | - Syncope | |
| - Weight gain | - Feet swelling | |
| - Vision problems | - Headaches | |
| - Dizziness | - Anxiety | |

Name _____ Date of Birth _____

If you have neck or arm pain answer the following questions:

Circle all that apply

- How long do you experience neck pain? : _____
- I have neck pain more than I do arm pain.
- I have arm pain more than I do neck pain.
- How long have you had the arm pain? : _____
- I have pain in the left arm.
- I have pain in the right arm.
- I have more pain in the left arm than I do the right arm.
- I have more pain in the right arm than I do in the left arm.
- What makes your neck pain worse? _____
- What eases your neck pain?: _____
- What makes your arm pain worse? : _____
- What eases your arm pain? : _____

Circle the test that you have had already

MRI

CAT scan

Myelogram

Plain X-rays

Circle all that apply

- I have weakness in my arms.
- Left / Right / BOTH
- My handwriting is getting worse lately
- My balance is getting worse lately
- I have difficulty with buttoning my shirts
- I have been dropping objects lately
- I have numbness in my: arms / hands / BOTH

Name _____ Date of Birth _____

If you have back or leg pain answers the following questions:

Circle all that apply

- ❖ How long do you experience back pain:

-
- ❖ I have back pain more than I do leg pain.
 - ❖ I have leg pain more than I do back pain.
 - ❖ How long have you had leg pain? :

-
- ❖ I have pain in the left leg
 - ❖ I have pain in the right leg
 - ❖ I have more pain in the left leg than I do in the right leg.
 - ❖ I have more pain in the right leg than I do in the left leg.
 - ❖ What makes your back pain worse?
- Laying down - Sitting - Standing up - Walking
 - ❖ What eases your back pain?
- Laying down - Sitting - Standing up - Walking
 - ❖ What makes your leg pain worse?
- Laying down - Sitting - Standing up - Walking

Circle the tests you have had already:

- MRI
- Cat Scan
- Myelogram
- Plain X-rays

Circle all that apply

- ❖ I have weakness in my leg: Left / Right / Both
- ❖ How many blocks can you walk (How long can you walk) :

- ❖ My balance is getting worse lately.
- ❖ I have been falling lately.
- ❖ I have numbness in my legs.

Please write down what kind of sexual problems you are experiencing:

Name _____ Date of Birth _____

Please List any treatments you have had?

1. Physical Therapy: What For? _____ Dates: _____ How long? _____
2. Chiropractor: What For? _____ Dates: _____ How long? _____
3. Pain Management: What For? _____ Dates: _____ How long? _____
4. Injections: What For? _____ Dates: _____ How long? _____
5. Traction: What For? _____ Dates: _____ How long? _____
6. Other: _____ What For? _____ Dates: _____ How long? _____

Has this affected your sex life? No / Yes If yes: Mildly Moderately Severely please describe: _____

Name _____ Date of Birth _____

Please indicate from zero to ten, how bad your sexual life has been affected by the pain that you have been experiencing:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Not affected = 0.....10 severely affected

Please indicate from zero to ten, how much back pain you are experiencing:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Not affected = 0.....10 severely affected

Please indicate from zero to ten, how much leg pain you are experiencing:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Not affected = 0.....10 severely affected

Please indicate from zero to ten, how much neck pain you are experiencing:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Not affected = 0.....10 severely affected

Please indicate from zero to ten, how much arm pain you are experiencing:

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Not affected = 0.....10 severely affected

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Name _____ Date of Birth _____

Please mark on the figure the area that you have pain on your body.



