

Appointment Confirmation  
**MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL  
ASSOCIATES**

23961 CALLE DE LA MAGDALENA SUITE 504  
LAGUNA HILLS, CA 92653-3665  
949-588-5800

Patient: \_\_\_\_\_

Appointment with: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

**If you are unable to keep this appointment, please give us at least 24 hours notice. Please call us at (949) 588-5800.**

**It is very important** you complete, date, and sign **all** of the enclosed forms and bring them in at the time of your appointment. Please do not wait until your arrival in the office to complete the information mailed to you. Failure to have all forms completed can result in rescheduling of your appointment. Do not mail them prior to your appointment. Please bring your insurance card(s), and any records, test results, and x-rays (with) reports which may be related to the problem for which you will be seen.

**Please take note of the following:**

**Work Related injuries:** Pre-authorization is required from the carrier who will be responsible for paying your bills. We will assist you with this procedure, but you must notify us in 48 hours prior to your appointment.

**Medicare:** This office accepts Medicare assignment and we will submit all of your charges directly to Medicare by electronic transmission. It is imperative that you give us your supplementary insurance information.

**Private Insurance/contracted coverage:** We will bill your insurance provided we have your ID#, your carrier's name, address, and a phone number for follow up. If coverage is denied for any reason, you will be responsible for all charges.

**YOUR INSURANCE CO-PAYMENT WILL BE COLLECTED FROM YOU AT THE SAME TIME WE COLLECT YOUR PAPERWORK, X-RAYS, ETC.**

We look forward to serving you. Please feel free to call us for any further explanations of our office policies and procedures.

MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL ASSOCIATES  
23961 CALLE DE LA MAGDALENA, SUITE 504  
LAGUNA HILLS, CA 92653

Tel: (949) 588-5800  
FAX: (949) 380-3344  
www.massouidimd.com

**PAYMENT POLICY**

It is the policy of Massoudi and Jackson Neurosurgical Medical Associates to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D./subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of employer.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Massoudi and Jackson Neurosurgical Medical Associates does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan **before** services are rendered. This also applies to any facility or provider your doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, noncovered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party. It is the policy of this medical group to receive payment in full 90 days from the date of service.

HMOs and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered. **Authorization does not guarantee payment by the insurance company.**

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 90 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, check, money order, and Mastercard, VISA, or Discover as your method of payment.

The fee for a returned check is \$15.00.

I have read the above policy and understand I am financially responsible for all medical services rendered.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**MASSOUDI & JACKSON NEUROSURGICAL MEDICAL ASSOCIATES**

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Massoudi & Jackson Neurosurgical Medical Associates may use and disclose protected healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Massoudi & Jackson Neurosurgical Medical Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Massoudi & Jackson reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Massoudi & Jackson Neurosurgical Medical Associates 23961 Calle de la Magdalena, Suite 504, Laguna Hills, CA 92653.

With my consent, Massoudi & Jackson Neurosurgical Medical Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

With my consent, Massoudi & Jackson Neurosurgical Medical Associates may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical treatment, including but not limited to: laboratory or radiological findings.

By signing this form, I am giving consent to Massoudi & Jackson Neurosurgical Medical Associates for the use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon this prior consent. Massoudi & Jackson Neurosurgical Medical Associates may decline treatment to me without this signed consent.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name



# ORANGE COUNTY NEUROSURGICAL ASSOCIATES

## Patient Information Form

Please print or write legibly. **CIRCLE ONE- Dr. Massoudi Jackson Kim**

<b>(LEGAL NAME)</b>							
Patient	_____	_____	_____	Male	Female	Marital Status	S M W D
	Last	First	MI				
Address	_____						
	Street		City	State	Zip	Apt #	
Home Phone ( )	_____		Cell #: ( )	_____			
Date of Birth	_____	Age	_____	Social Security #	_____		
Employer	_____			Work Phone # ( )	_____		Ext _____
Employer Address	_____						
	Street		City	State	Zip		

<b>FIRST NAME AND LAST NAME OF REFERRING MD.</b> _____						
Contact (not living with you)	_____	Relationship	_____	Phone # ( )	_____	
Employer	_____			Work Phone # ( )	_____	
Employer Address	_____					
	Street		City	State	Zip	
Spouse (or parent if patient is a minor)	_____					
Address	_____				Home Phone # ( )	_____
Employer	_____			Work Phone # ( )	_____	
Employer Address	_____					

<b>Primary Insurance</b>	_____	<b>Effective Date</b>	_____	<b>Co-pay Amt \$</b>	_____	<b>Deductible</b>	_____
<b>Name of Insured</b>	_____		<b>Date of Birth</b>	_____	<b>Employer</b>	_____	
<b>Subscriber #</b>	_____	<b>Group #</b>	_____	<b>Relationship to Patient</b>	_____		
PPO POS HMO EPO Medicare Medi-Cal W/C	INSURANCE CARD MUST HAVE PHONE # AND ADDRESS FOR BILLING PURPOSES.						
Insurance Co. Address	_____				Phone # ( )	_____	
<b>Secondary Insurance</b>	_____	<b>Effective Date</b>	_____	<b>Co-pay Amt</b>	_____	<b>Deductible</b>	_____
<b>Name of Insured</b>	_____		<b>Date of Birth</b>	_____	<b>Employer</b>	_____	
<b>Subscriber #</b>	_____	<b>Group #</b>	_____	<b>Relationship to Patient</b>	_____		
PPO POS HMO EPO Medicare Medi-Cal	Insurance Card must have phone # and address for billing purposes.						
Insurance Co. Address	_____				Phone # ( )	_____	
Financially Responsible Party (circle one):	Patient	Spouse	Parent/Guardian	Other:	_____		

I hereby assign the insurance benefits to which I am entitled to, directly to Robert J. Jackson, M.D., K. Anthony Kim M. D., Farzad Massoudi, M.D., Chiedozie Nwagwu, M.D. or Sylvain Palmer, M.D. I understand that I am financially responsible for all charges. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A Photostat of this authorization is accepted with the same authority as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_



<b>SYSTEMIC REVIEW: Do you have any of the following?</b>			
<u>General:</u>		<u>Genitourinary:</u>	
Recent weight change?	No Yes	Loss of urine	No Yes
Good general health most of your life?	No Yes	Frequent urination	No Yes
<u>Head-eye-ear-nose-throat:</u>		Night time urination	
Eye disease or injury	No Yes	Burning or painful urination	No Yes
Do you wear glasses?	No Yes	Blood in urine	No Yes
Double vision	No Yes	Kidney trouble	No Yes
Headaches	No Yes	Kidney stones	No Yes
Glaucoma	No Yes	Bright's disease	No Yes
Itching eyes or nose	No Yes	<u>Locomotor-Musculoskeletal:</u>	
Sneezing or runny nose	No Yes	Varicose veins	No Yes
Nosebleeds	No Yes	Weakness of muscles or joints	No Yes
Chronic sinus trouble	No Yes	Any difficulty in walking	No Yes
Ear disease	No Yes	Any pain in calves or buttocks when walking	No Yes
Impaired hearing	No Yes	...relieved by rest?	No Yes
Dizziness or transient unconscious episodes	No Yes	<u>Neuro-psychiatric:</u>	
<u>Neck</u>		Have you ever had psychiatric care?	
Stiffness	No Yes	Have you been advised to see a psychiatrist?	
Thyroid trouble	No Yes	Do you have, or ever had, fainting spells?	
Enlarged glands		Convulsions	
<u>Respiratory:</u>		Paralysis	
URI (cold) now	No Yes	<u>Hematological:</u>	
Spitting up blood	No Yes	Are you slow to heal after cuts?	
Chronic or frequent cough	No Yes	Blood disease	
Asthma or wheezing	No Yes	Anemia	
Difficulty breathing	No Yes	Phlebitis	
Any trouble with lungs	No Yes	Excessive bleeding after tooth extraction or surgery?	
Pleurisy or pneumonia	No Yes	Have you had abnormal bruising or bleeding?	
<u>Cardiovascular</u>		<u>Allergic:</u>	
Chest pain or angina pectoris	No Yes	Any allergies, including medication?	
Shortness of breath walking or lying down	No Yes	<u>Endocrine:</u>	
Difficulty walking two blocks	No Yes	Thyroid disease	
Heart trouble or heart attacks	No Yes	Hormonal therapy	
High blood pressure	No Yes	Change in hat or glove size	
Swelling of hands, feet or ankles	No Yes	Change in hair growth	
Awakening in the night smothering	No Yes	Has your skin been colder or dryer than before?	
Heart murmur	No Yes	<u>Skin</u>	
<u>Gastrointestinal</u>		Skin disease	
Peptic ulcer (stomach or duodenal)	No Yes	Jaundice	
Vomiting blood or food	No Yes	Hives, eczema or rash	

Gallbladder disease	No Yes		Frequent infection or boils	No Yes
Liver trouble	No Yes		Abnormal pigmentation	No Yes
Hepatitis	No Yes		<u>Gynecological:</u>	
Painful bowel movements	No Yes		Any pain with your periods?	No Yes
Bleeding with bowel movements	No Yes		Age periods started _____	
Black stools	No Yes		How long do periods last? _____	
Hemorrhoids or piles	No Yes		Number of pregnancies _____	
Recent change in bowel habits	No Yes		Number of miscarriages _____	
Frequent diarrhea	No Yes		Date and results of last cancer smear _____	
Heartburn or indigestion	No Yes		Frequency of periods; every _____ days	
Cramping or pain In the abdomen	No Yes		Number of children _____ Ages _____	
Does food stick in throat?	No Yes		Date of first day of last period _____	

ALLERGIES AND SENSITIVITIES				What other drugs or food? _____
	Circle one			
Penicillin or other antibiotics	Yes know	No	Don't	_____
Morphine, codeine, Demerol or other narcotics	Yes know	No	Don't	_____
Novocain or other anesthetics	Yes know	No	Don't	_____
Aspirin, Empirin or other pain remedies	Yes know	No	Don't	_____
Sulfa drugs	Yes know	No	Don't	_____
Tetanus antitoxin or other serums	Yes know	No	Don't	_____
Adhesive tape	Yes know	No	Don't	_____
Iodine or merthiolate	Yes know	No	Don't	_____
Any other drug or medication	Yes know	No	Don't	_____
Any foods, such as eggs, milk or chocolate	Yes know	No	Don't	_____
<u>Drugs Recently Taken During the past six months, has patient taken:</u>				
Cortisone	Yes know	No	Don't	
ACTH	Yes know	No	Don't	
Anticoagulants	Yes know	No	Don't	
Tranquilizers	Yes know	No	Don't	
Hypotensives (high blood pressure medication)	Yes know	No	Don't	
Aspirin	Yes know	No	Don't	
Has the patient ever received treatment for asthma, rheumatism or rheumatic fever?	Yes know	No	Don't	

Source of information, if other than patient: \_\_\_\_\_

Signature of person acquiring this information: \_\_\_\_\_

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient

# Orange County Neurosurgical Associates

## Spine Health Questionnaire

**Name:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

1. What is the main purpose of your visit?

2. Describe your problem

- a. Date of onset
- b. Aggravating factors
- c. Alleviating factors
- d. If you have pain, is it constant/intermittent, dull, sharp or burning?
- e. Rate your average pain level on a scale of 0 to 10
  - i. 0 no pain -----10 worst
  - ii. Aggravated by-Standing/walking/sitting/lying down
- f. Do you have weakness in the arms or legs?
- g. Do you have numbness/tingling in the arms or legs?
- h. Other MD's recommendations
  
- i. Have you had spinal surgery?
  
- j. Have you had Epidural steroid injections? How many?
  
- k. Have you had other treatments?

3. Is your problem related to an accident?

- a. Are you involved in any active litigation?

# OSWESTRY TEST

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Check (✓) 1 box from each section:**

<p><b>SECTION 1: PAIN INTENSITY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can tolerate the pain I have without having to use pain killers (0 points)</li> <li><input type="checkbox"/> The pain is bad, but I manage without taking pain killers (1 point)</li> <li><input type="checkbox"/> Pain killers give complete relief from pain (2 points)</li> <li><input type="checkbox"/> Pain killers give moderate relief from pain (3 points)</li> <li><input type="checkbox"/> Pain killers give very little relief from pain (4 points)</li> <li><input type="checkbox"/> Pain killers have no affect on the pain, and I do not use them (5 points)</li> </ul>	<p><b>SECTION 6: STANDING</b> (Remember, standing is NOT walking)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want without extra pain (0 points)</li> <li><input type="checkbox"/> I can stand as long as I want, but it gives me extra pain (1 point)</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 1 hour (2 points)</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes (3 points)</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes (4 points)</li> <li><input type="checkbox"/> Pain prevents me from standing at all (5 points)</li> </ul>
<p><b>SECTION 2: PERSONAL CARE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain (0 points)</li> <li><input type="checkbox"/> I can look after myself normally, but it causes extra pain (1 point)</li> <li><input type="checkbox"/> It is painful to look after myself, and I am slow and careful (2 points)</li> <li><input type="checkbox"/> I need some help, but manage most of my personal care (3 points)</li> <li><input type="checkbox"/> I need help every day in most aspects of self-care (4 points)</li> <li><input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed (5 points)</li> </ul>	<p><b>SECTION 7: SLEEPING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from sleeping well (0 points)</li> <li><input type="checkbox"/> I can sleep well only by using tablets (1 point)</li> <li><input type="checkbox"/> Even when I take tablets I have less than 6 hours sleep (2 points)</li> <li><input type="checkbox"/> Even when I take tablets I have less than 4 hours sleep (3 points)</li> <li><input type="checkbox"/> Even when I take tablets I have less than 2 hours sleep (4 points)</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all (5 points)</li> </ul>
<p><b>SECTION 3: LIFTING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain (0 points)</li> <li><input type="checkbox"/> I can lift heavy weights, but it gives extra pain (1 point)</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage, if they are conveniently positioned (for example: on a table) (2 points)</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned (3 points)</li> <li><input type="checkbox"/> I can lift only very light weights (4 points)</li> <li><input type="checkbox"/> I cannot lift or carry anything at all (5 points)</li> </ul>	<p><b>SECTION 8: SEX LIFE</b> (by pain = for fear of causing pain)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sex life is normal and causes no extra pain (0 points)</li> <li><input type="checkbox"/> My sex life is normal, but causes some extra pain (1 point)</li> <li><input type="checkbox"/> My sex life is nearly normal, but is very painful (2 points)</li> <li><input type="checkbox"/> My sex life is severely restricted by pain (3 points)</li> <li><input type="checkbox"/> My sex life is nearly absent because of pain (4 points)</li> <li><input type="checkbox"/> Pain prevents any sex life at all (5 points)</li> </ul>
<p><b>SECTION 4: WALKING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me walking any distance (0 points)</li> <li><input type="checkbox"/> Pain prevents me walking more than 1 mile (1 point)</li> <li><input type="checkbox"/> Pain prevents me walking more than .05 miles (2 points)</li> <li><input type="checkbox"/> Pain prevents me walking more than 0.25 miles (3 points)</li> <li><input type="checkbox"/> I can only walk using a stick or crutches (4 points)</li> <li><input type="checkbox"/> I am in bed most of the time, and have to crawl to the toilet (5 points)</li> </ul>	<p><b>SECTION 9: SOCIAL LIFE</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal, and gives me no extra pain (0 points)</li> <li><input type="checkbox"/> My social life is normal, but increases the degree of pain (1 point)</li> <li><input type="checkbox"/> Pain has no significant affect on my social life, apart from limiting energetic interests, such as dancing (2 points)</li> <li><input type="checkbox"/> Pain has restricted my social life, and I do not go out as often (3 points)</li> <li><input type="checkbox"/> Pain has restricted my social life to my home (4 points)</li> <li><input type="checkbox"/> I have no social life because of pain (5 points)</li> </ul>
<p><b>SECTION 5: SITTING</b> ("Favorite Chair" includes a recliner)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like (0 points)</li> <li><input type="checkbox"/> I can only sit in my favorite chair as long as I like (1 point)</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 1 hour (2 points)</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 0.5 hours (3 points)</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes (4 points)</li> <li><input type="checkbox"/> Pain prevents me from sitting at all (5 points)</li> </ul>	<p><b>SECTION 10: TRAVELING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere without extra pain (0 points)</li> <li><input type="checkbox"/> I can travel anywhere, but it gives me extra pain (1 point)</li> <li><input type="checkbox"/> Pain is bad, but I manage journeys over 2 hours (2 points)</li> <li><input type="checkbox"/> Pain restricts me to journeys of less than 1 hour (3 points)</li> <li><input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes (4 points)</li> <li><input type="checkbox"/> Pain prevents me from traveling, except to the doctor or hospital (5 points)</li> </ul>