MARK F. HAMBLY, M.D.
D. MICHAEL HEMBD, M.D.
CHRISTOPHER O. NEUBUERGER, M.D.
PRUDENCIO S. BALAGTAS, D.O.
CONOR W. O'NEILL, M.D.
SAMEER K. SHARMA, M.D.
RUWAN P. RATNAYAKE, M.D.

NORTHERN CALIFORNIA SPINE & REHABILITATION Associates

NCSRA MEDICAL CORPORATION
2801 K Street, Suite 410
Sacramento, CA 95816
(916) 389-7100 Phone line
WWW.NCSRAMEDICAL.COM

Dear Patient,

You have been referred to NCSRA Medical Corporation for an evaluation. We would like to take this time to welcome you to our practice and look forward to assisting you with your health care needs.

Please call the office right away if this date and/or time does not work for you or if you are experiencing flu like symptoms 1-2 days prior to your appointment.

PROVIDER:	**SAMEER K. SHARMA, M.D.**
APPOINTMENT:	**Please contact the office to create your patient portal.**
ARRIVAL TIME:	**Arrive 30 min. early**
LOCATION:	**2801 K STREET, SUITE 410, SACRAMENTO, CA 95816**

BEFORE YOUR APPOINTMENT:

1. Contact the office: (916) 389-7100 to register for your NCSRA Patient Portal.
2. In addition, complete the enclosed paperwork and bring it with you to your appointment.

BRING THE FOLLOWING ITEMS:

1. Actual current insurance card(s) are required.
2. Hand carry any diagnostic studies (MRI, CT, x-rays), failure to do so may result in rescheduling.

PARKING GARAGE: $1.00 every 20 minutes.

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ABOUT OUR OFFICE

Website: WWW.NCSRAMEDICAL.COM

Mission Statement

Our mission is to provide our patients the highest level of comprehensive care available in the Northern California region. Our surgeons, physicians and diagnosticians endeavor to be advocates for our patients while providing a complete spectrum of treatments that include education, conservative rehabilitation, and minimally invasive procedures to the most complex of surgeries.

NCSRA is HIPAA compliant.
You may review a copy of the Privacy Policy to read upon check in, if you choose a copy will be provided to you. If you have any questions we would be happy to answer them when you arrive.

Payment for services rendered: It is your responsibility to know your benefits prior to your appointment.
Co-pays, PPO deductibles and HSA deductibles are due at the time of service. We will bill your insurance plan whenever possible, however, please remember that the primary responsibility for payment is yours, not your insurance companies. Not all physicians at NCSRA Medical Corporation are contracted with all plans or the same plans. Please check with your carrier to see if our physician is a member of your insurance plan, if not you may be required to pay in full for services.

Appointment cancellation policy:
24 hour notice is required. Failure to do so may result in a fee. Payment is due prior to rescheduling.
Fee: Follow up: $25.00 Consultation/Evaluation: $50.00 EMG/injection procedures: $50.00

Payment: We accept cash, check, Visa, MasterCard or Discover.

Credit Card Fee: There is a service fee when payment is made using a credit card.

Returned check: A $35.00 fee is due and payable by cash, money order or credit card for returned checks.

Prescription refills: Must be done during your scheduled visit. We do not refill on Fridays, weekends, or by telephone.

Disability/Insurance Forms: There is a pre-paid fee due for most forms. You may contact the office to discuss.

Directions: For directions please call 916-389-7100 ext. 6.

Parking Garage: $1.00 every 20 minutes. Entrance is located on K street.

NCSRA1: REGISTRATION

REVIEW CAREFULLY

PATIENT:		[ ]Correct
		[ ]Correct
		[ ]Correct
Marital Status:	[ ]Single [ ]Married [ ]Widow [ ]Divorced [ ]Domestic Partner	
Primary Language:	[ ]English [ ]Spanish [ ]Other, please list: [ ]Interpreter needed? Y N	
Race:	Ethnicity:	
Home Phone:	Okay to leave a message? [ ]Yes [ ]No	[ ]Correct
Cell Phone:		[ ]Correct
Email Address:		[ ]Correct
Appointment Reminder:	[ ]Phone call [ ]Text message [ ]Email message	
Emergency Contact:	Phone #:	
Primary Care MD:	P: F:	
Referring MD:	P: F:	

HIPAA: Health Insurance Portability and Accountability Act		
List any person by name whom may act on your behalf to discuss and/or request medical information, you may also choose "none".		
**Full name only:		[ ]None
Smoking Status:	[ ]Never [ ]Ex-smoker [ ]Light smoker [ ]Occasional smoker [ ]Daily smoker [ ]Heavy smoker	
Flu Shot:	Did you get your flu shot this season?	[ ]Yes [ ]Not yet [ ]Declined shot
Fall Risk Assessment (64+ years only):	Did you fall more than once in the past year? Were you injured?	[ ]Yes [ ]No [ ]Yes [ ]No

INSURANCE COVERAGE YOU MUST PRESENT YOUR INSURANCE CARD AT EACH VISIT			
	COMPANY	ID#	SUBSCRIBER/DOB & RELATIONSHIP
Primary:			[ ]Self [ ]Spouse:
Secondary:			[ ]Self [ ]Spouse:
Other:			[ ]Self [ ]Spouse:

WORKER'S COMPENSATION COVERAGE	
Insurance Carrier:	Adjuster:
Employer:	Claim Number:
Body Part(s):	Date of Injury:
Length of employment:	Social Security Number:

Notiсy of Privacy Practices: I hereby acknowledge that I received a copy or have access to a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Shenna Kaufusi, Administrator (916) 389-7100- Privacy Officer

Assignment of Benefits, Release of information: I hereby assign all necessary medical and/or surgical benefits to which I am entitled, including private insurance and any other plan to NCSRA Medical Corporation for all services rendered by its medical providers and representatives. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid for by said insurance according to contract or regulations. I hereby authorize NCSRA or its representatives to release or obtain necessary medical records for treatment purposes and/or to secure payment.

Patient or Parent/Guardian Signature:_____	DATE:
Printed Name:_____	_____

NCSRA2: PHQ-9

Name:

Over the last 2 weeks, how often have you been bothered by any of the following problem?

(Please circle to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + _____ + _____ + _____

Total score: = _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
[ ]	[ ]	[ ]	[ ]

Patient Signature_____ **Date**_____

NCSRA3: OSWESTRY

Patient Name: Date:_____

This questionnaire has been designed to give us information regarding how your back and/or neck pain has affected your ability to manage everyday life. We realize you may consider that two or more statements in any one section relate to you. Please select only the one that most clearly describes your condition.

- ***Mark ONLY ONE answer for each section***
- ***Answer every section.***

Section 1: Pain Intensity

[ ] I have no pain at the moment.
[ ] The pain is very mild at the moment
[ ]The pain is moderate at the moment
[ ]The pain is fairly severe at the moment
[ ]The pain is very severe at the moment
[ ]The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. Washing, dressing)

[ ]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 can 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 me extra pain
[ ]Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. On table
[ ]Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
[ ]I can lift very light weights
[ ]I cannot lift or carry anything

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 1/4 mile
[ ]Pain prevents me from walking more than 100 yards
[ ]I can only walk using a stick or crutches
[ ]I am in bed most of the time

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 more than 1 hour
[ ]Pain prevents me from sitting more than 30 minutes
[ ]Pain prevents me from sitting 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 but it gives me extra pain
[ ]Pain prevents me from standing more than 1 hour
[ ]Pain prevents me from standing more than 30 minutes
[ ]Pain prevents me from standing more than 10 minutes
[ ]Pain prevents me from standing at all

Section 7: Sleeping

[ ]My sleep is never disturbed by pain.
[ ]My sleep is occasionally disturbed by pain.
[ ]Because of pain I have less than 6 hours of sleep
[ ]Because of pain I have less than 4 hours of sleep
[ ]Because of pain I have less than 2 hours of sleep
[ ]Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

[ ]My sex life is normal and causes no extra pain
[ ]My sex life is normal but causes some extra pain
[ ]My sex life is nearly normal but is very painful
[ ]My sex life is severely restricted by pain
[ ]My sex life is nearly absent because of pain
[ ]Pain prevents any sex life at all

Section 9: Social Life

[ ]My social life is normal and gives me no extra pain
[ ]My social life is normal but increases the degree of pain
[ ]Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sports
[ ]Pain has restricted my social life and I do not go out as often
[ ]Pain has restricted my social life to home
[ ]I have no social life because of pain

Section 10: Travelling

[ ]I can travel anywhere without pain
[ ]I can travel anywhere but it gives me extra pain
[ ]Pain is bad but I manage journeys over two hours
[ ]Pain is bad but I manage journeys over one hour
[ ]Pain restricts me to short necessary journeys under 30 minutes
[ ]Pain prevents me from travelling except to receive treatment

NCSRA4: PAIN DISABILITY INDEX

Patient Name: Date: _____

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each category of life activity listed, please circle the number on the scale that describes the level of disability you typically experience with and without medication. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

With medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability
Without medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

With medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability
Without medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

With medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability
Without medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

With medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability
Without medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, eating, sleeping etc.)

With medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability
Without medication: No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

NCSRA5: SOAPP VERSION 1.0-14Q

Patient: Date:_____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opiods for their pain.

Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents or grandparents, had a problem with alcohol or drugs.	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4
11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

NCSRA6: WORK COMP QUESTIONNAIRE
(For work comp patients only)

Name: **Date:**_____

Date of Injury: ___/___/___ **Time of Injury**_____:_____ am/pm

Current work status (Circle one): Regular duty Modified duty (since)_____ Off work (since)_____

Name of Employer at the time of injury: _____

Employer Address:_____

City:_____ State_____ Zip_____ Phone ( ) _____

Occupation_____ Length of employment_____ years/months/weeks

Job Description: _____

1. In terms of an 8 hour workday: (Circle number of hours for each activity)
Sit: 1 2 3 4 5 6 7 8 hrs. **Stand:** 1 2 3 4 5 6 7 8 hrs. **Walk:** 1 2 3 4 5 6 7 8 hrs.

2. On the job, I perform the following activities: (Circle as many as apply)

a) Bend/Stoop **b)** Squat **c)** Crawl **d)** Climb **e)** Reach above shoulders

f) Crouch **g)** Kneel **h)** Push/Pull **i)** Maintain awkward positions

3. Do you use your hands for repetitive movements such as: (Circle as many as apply)

a. Simple grasping: Left hand / Right hand
b. Firm Grasping: Left hand / Right hand
c. Fine Manipulating: Left hand / Right hand

4. On the job, I regularly lift between:
1-10 lbs. 11-24 lbs. 25-34 lbs. 35-50 lbs. 51-74 lbs. 74-100 lbs.

5. Are you required to bend over while lifting? Yes No

6. Prior to this accident were you experiencing any similar physical complaints? (Yes No)
If yes, please explain:_____
_____

7. In your own words, please describe how you were injured:
_____
_____

8. Do you have any prior Workers' Compensation injuries or claims?(circle one) Yes No
If yes, please explain:_____
_____

Important: This form may be used in the determination of your Workers Compensation eligibility and the amount of compensation you are entitled. To protect your rights please fill out this form correctly and completely.