Premier Spine Care
Patient Registration Information

PATIENT LEGAL NAME:_____

PLEASE INCLUDE YOUR MIDDLE INITIAL

ADDRESS:_____ CITY: _____ STATE/ZIP: _____
SS#:_____ BIRTHDATE:_____
HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____
EMPLOYER NAME:_____ ADDRESS:_____
EMAIL ADDRESS: _____

Marital Status (Circle One): Married/Single/Widowed/Divorced/Partner
Race (Circle One): American Indian/Asian/African American/Native Hawaiian/White/Other/Refuse to Report
Ethnicity (Circle One): Hispanic or Latino/Non Hispanic or Latino/Refuse to Report
Primary Language: _____

SPOUSE INFORMATION

NAME:_____ BIRTHDATE:_____ SS#:_____

EMERGENCY CONTACT INFORMATION

CONTACT NAME:_____ BIRTHDATE:_____
RELATIONSHIP TO PATIENT:_____WORK PHONE:_____ CELL PHONE:_____
DO YOU HAVE AN ADVANCE DIRECTIVE OR LIVING WILL? YES_____ NO_____

PHARMACY NAME: _____ ADDRESS: _____
CITY: _____ STATE/ZIP: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE (IF APPLICABLE):
INSURANCE PLAN:_____POLICY #:_____ GROUP #:_____
SUBSCRIBER:_____SUBSCRIBER BIRTHDATE:_____ RELATIONSHIP:_____
SUBSCRIBER SS#:_____ EMPLOYER: _____

SECONDARY INSURANCE (IF APPLICABLE):
INSURANCE PLAN:_____POLICY #:_____ GROUP #:_____
SUBSCRIBER:_____SUBSCRIBER BIRTHDATE:_____ RELATIONSHIP:_____
SUBSCRIBER SS#:_____ EMPLOYER: _____

REFERRING PHYSICIAN INFORMATION

NAME:_____ ADDRESS:_____ PHONE:_____

PRIMARY CARE PHYSICIAN INFORMATION

NAME:_____ ADDRESS:_____ PHONE:_____

PATIENT CONFIDENTIALITY

I hereby authorize the release of medical information to _____relationship_____

I hereby authorize Premier Spine Care to leave information on my voice mail at: (circle) HOME OFFICE CELL PHONE

I authorize the release of my medical records as needed to any physician, facility or other provider of service that Premier Spine Care asks to participate in my medical treatment. This authorization applies to all services until it is revoked by me or my representative.

PATIENT SIGNATURE:_____DATE:_____

INSURANCE/SELF-PAY PATIENTS ONLY:

I hereby give authorization of insurance benefits to be made directly to Premier Spine Care, I understand that I am financially responsible for all the charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits; and agree that a photocopy of this agreement shall be as valid as original. I hereby authorize payment of my Medigap benefits to Premier Spine Care for all claims filed on my behalf.

PATIENT SIGNATURE:_____ DATE:_____

Premier Spine Care

NAME_____
DATE_____

1. Describe the <u>DATE</u> and precisely <u>HOW</u> your current pain began. (Brief history of reason for visit)

_____
_____
_____
_____
_____
_____
_____
_____

2. What is your current <u>OCCUPATION</u>?

Employer:_____
Job Title:_____
Typical Duties:_____

Current Employment Status:

- ☐ Regular Duty
- ☐ Light Duty
- ☐ Terminated
- ☐ Disabled
- ☐ Retired
- ☐ New Occupation
- ☐ Out of work over past ____months

3. My pain is <u>INCREASED</u> by: (Check all that apply)

___bending/twisting your neck
___working overhead
___bending my back
___lifting
___twisting torso/lower back
___standing for a while
___sitting for a while
___coughing
___sneezing
___lying in bed

4. My pain is <u>DECREASED</u> by: (Check all that apply)

___rest
___heat
___lying down
___lying on my side
___brace
___medications
___stretching
___nothing

5. <u>PRIOR "SPINE" HISTORY</u>: If you have had any history of neck or low back pain in the past, please describe and when.

_____
_____
_____
_____

6. List the <u>PHYSICIANS</u> who have evaluated your current condition.

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

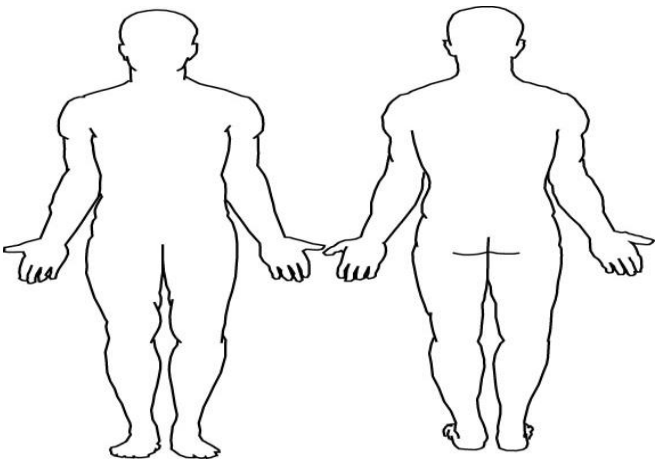
7. List any <u>TREATMENTS</u> that you have had for your *CURRENT* condition we are seeing you for.

___None
___Physical therapy
Where_____ When_____
Where_____ When_____
___Chiropractic
Where_____ When_____
Where_____ When_____
___Medications
What_____
___Epidural steroid injections
Where_____ When_____
Where_____ When_____
___Other(explain)_____
_____
_____
___PRIOR SPINE SURGERY? (When,What, Dr's Name)
1_____
2_____
3_____

7. What <u>TESTS</u> have been completed prior to your visit?

___none ___X-Rays
___CT Scan ___MRI Scan
___nerve studies("EMG") ___myelogram

9. Please complete the <u>PAIN DRAWING</u> below. (*Shade areas of pain and star areas of numbness)*



10. Your MEDICAL HISTORY: (i.e. high blood pressure, history of heart attack, stroke, cancer, etc)

1_____ 2_____
3_____ 4_____
5_____ 6_____

11. Your SURGICAL HISTORY: (list any prior surgeries you've had in any area)

1_____ 2_____
3_____ 4_____
5_____ 6_____

12. Your current MEDICATION LIST:

1_____2_____
3_____4_____
5_____6_____

13. Your DRUG OR MEDICATION ALLERGIES/REACTION:

1_____2_____
3_____ 4_____

14. Your SOCIAL HISTORY:

I am currently

___Single
___Married
___Divorced
___Widow/Widower

I am currently

___Unemployed
___Employed
___Retired
___Disabled

Do you use ALCOHOL?

__No __Infrequent __Weekly __Daily

Do you SMOKE?___Yes ___No Packs per Day_____
SMOKELESS TOBACCO?___Yes___No

If there is any history of DRUG OR ALCOHOL ABUSE, please describe.

_____
_____
_____

15. Is there any ATTORNEY involved in this case? If yes, please list name.

_____

16. REVIEW OF SYSTEMS/MYELOPATHIC/CONSTITUTIONAL?

(Please check all that apply)

__Chest Pain
__Consistently ill Feeling
__Shortness of breath
__Loss of Appetite
__Fatigue/Lethargy
__Abdominal pain
__Visual Changes
__Weight Loss
__Feel off balance walking
__Tripping/stumbling/falling
__Loss of hand coordination
__Complete loss of Bowel control
__Handwriting changes
__Complete loss of Bladder control

AGE_____ HT_____ WT_____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect answers can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform necessary services that I may require.

_____

(For office use only)

PHYSICAL EXAM:

Gait:
ROM:
Motor:
Sensory:
Reflexes:
SLR/Spurlings:
Hoffmans/Clonus:
Related joint:
Peripheral Nerve:

MRI's

Cervical( )	**Lumbar( )**
1-2	L1-2
2-3	2-3
3-4	3-4
4-5	4-5
5-6	5-1
6-7	S1-2
7-1	

XRAYS/RADIOGRAPHIC STUDIES

Cervical:
Thoracic:
Lumbar:
Other Studies:

IMPRESSION(S):

1)
2)
3)
4)
5)

PLAN:

Premier Spine Care

John M. Ciccarelli, MD
Adrian P. Jackson, MD

1. DOCTOR/PATIENT ACKNOWLEDGEMENT
2. ASSIGNMENT OF MEDICAL/SURGICAL BENEFITS
3. DISCLOSURE OF PHYSICIAN OWNERSHIP

1. I understand that I do not have to see Dr. Ciccarelli, Dr. Jackson and/or their associates as a patient if I do not wish to do so. Even if a third party, such as an insurance carrier, advises me that I must see them, I do not have to remain under their care unless I choose to do so. Dr. Ciccarelli/Dr. Jackson does not want me for a patient unless I want him/them and his/their office personnel to take care of me. This relationship will continue until I or Dr. Ciccarelli/Dr. Jackson, or their associates decide that I do not need to come back any more for evaluation of treatment. My records will remain confidential and the results of my studies (both records and x-rays) will not use my name specifically.

2. I hereby assign all medical and or surgical benefits, to include major Medical benefits to which I am entitled, private insurance, and any other health plan to Premier Spine Care.

3. During the course of your treatment at Premier Spine Care, you may be referred to obtain services or surgical procedures at Shawnee Mission Prairie Star Surgery Center, LLC. Shawnee Mission Prairie Star Surgery Center is a joint venture physician and hospital owned surgery center, of which Drs. Ciccarelli and Jackson have ownership or investment interest.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I understand Drs. Ciccarelli and Jackson have ownership or investment interest in Shawnee Mission Prairie Star Surgery Center, LLC.

Patient _____ Date _____

PREMIER SPINE CARE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Premier Spine Care, P.A. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Premier Spine Care, P.A."*

> *"It is our policy to provide a substitute health care provider, authorized by Premier Spine Care, P.A. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Premier Spine Care, P.A. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post*

card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Premier Spine Care, P.A. sponsored fund-raising events."

Change of Ownership

In the event that the Premier Spine Care, P.A. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Premier Spine Care, P.A. is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Premier Spine Care, P.A. amend your protected health information. Please be advised, however, that Premier Spine Care, P.A. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Premier Spine Care, P.A.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Premier Spine Care, P.A. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Premier Spine Care, P.A. is required by law to comply with this Notice.

Premier Spine Care, P.A. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: the Office Manager at 913-322-2700. If the Office Manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Premier Spine Care, P.A. has handled your health information should be directed to Office Manager by calling this office at 913-322-2700. If the Office Manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Premier Spine Care, P.A. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

PREMIER SPINE CARE, PA
FINANCIAL POLICY

The surgeons at our office are contracted with a variety of insurance plans. We also provide services for self pay patients. We will submit claims, on your behalf, to your primary insurance carrier and one secondary insurance carrier (if applicable). Our office does not contract or file claims with auto or liability insurances and payment is required at time of service. Submitting those claims will be the responsibility of the patient.

When you seek medical care there are two relevant contracts with your insurance company, YOUR contract, and OUR (the provider's) contract. Please remember your health insurance is an agreement between yourself and your insurer. It is your responsibility to know and understand the coverage, benefits and requirements of your health insurance plan. If you would like us to submit a claim for your services you must present a current insurance card at the time of service. If you do not have your card with you, payment in full at the time of service is required. You may provide the insurance information to our office within 7 days, and we will submit a claim for you. Upon receipt of payment from your insurance we will process a refund to you for any over-payment.

If your health plan requires a co-pay please be prepared to pay the co-pay at the time of service. A co-pay is part of the structure of YOUR contract with the insurance company and is designed to share some responsibility in your healthcare. The co-pay is not part of OUR contract with your insurer and it is not at our discretion whether or not your plan has a co-pay or what the amount may be. We are required to collect this at the time of service or face financial penalties. We accept cash, check, Visa, Mastercard, Discover or American Express. If you are not prepared to pay your co-pay or co-insurance balance at the time of service, it may be necessary to reschedule your appointment.

If you have a surgical procedure you will receive charges from the surgeon, facility, and anesthesiologist separately. Our office only has information related to the surgeon's charges.

Our office does not offer financing options for the healthcare services we provide. However, there are several companies in the marketplace that provide healthcare financing as a service. In the event your balance is not paid in a timely fashion and we must employ a collection agency or attorney, all interest and/or fees for collection will be your responsibility in addition to the original balance on the account being collected.

Credit Card/Debit Card Authorization Policy

Most insurance plans have a deductible and/or co-insurance requirement as part of YOUR contract with the insurance company. We are required to collect that directly. Our policy requires that a credit or debit card be placed on file prior to being seen by our providers. This card will only be charged if your account has a balance more than 30 days past due. We will verify that the card is valid and active at the time it is received. If you do not provide a credit or debit card prior to being seen by our providers, it may be necessary to reschedule your appointment.

Prior to surgical procedures, our office will verify insurance benefits. As bizarre as this may seem, you will see in YOUR contract with the insurance company, authorization for a procedure is still not a guarantee of payment. If you need more detailed policy information, you will need to contact your insurance company. We will not process payment on the credit/debit card until after we have filed a claim and received a negative response from your health insurance company. Ultimately, financial responsibility for medical care remains with the patient and we cannot police an insurance company on your behalf. As the policyholder paying premiums to the insurance company, you are the only one that has any true leverage to get the benefits you are due.

After each visit with us we will file a claim, on your behalf, with your health insurance company. After your insurance company processes your claim, Premier Spine Care will mail a statement to the address on file providing you with any balance due that is your responsibility. If we do not receive payment within 30 days of the statement date, we will process the balance due to the card on file. If you have questions about your bill, you must contact our office at 913-322-2700 prior to that time.

The security of your information is of the utmost importance. Your card information is stored by a credit card merchant vendor, that specializes in credit card storage/processing and maintains the highest level of security for that type of information. Our staff does not have access to your card information after it is entered into the merchant vendor's database. No personal medical information is stored with the credit card merchant company.

If you have any questions about the financial policy please contact our office at 913-322-2700.

I have read and understand the policies stated above and agree to them, as described. I understand that this agreement is final and irrevocable.

_____ _____

Patient Name (Printed) **Patient Date of Birth**

_____ _____

Patient Signature **Date**

Premier Spine Care
Cancellation/No Show Policy

- **Advance notice of 24 hours is requested if you are not able to keep an appointment.** If you miss a scheduled appointment, or do not call to cancel your appointment within 24 hours, you may be charged a **$50** fee. This $50 fee is the patient's responsibility and is not billed to the insurance company.

- Premier Spine Care understands that, on occasion, emergency situations may occur that prevent 24-hour notice. Inclement weather is one such situation. These cases will be handled on an individual basis at the discretion of the treating physician and/or front office staff.

- Please understand that we are reserving this time slot for ONLY YOU. Late notice or not showing to an appointment creates both a financial loss for our practice AND a missed opportunity to help another patient in need.

_____ _____

Patient Signature Date