PREMIER SPINE CARE

Patient Registration Information

PATIENT INFORMATION

Patient Legal Name (include middle initial): _____

Address: _____ City: _____ State/ZIP: _____

SS#: _____ Birthdate: _____

Sex: ☐ Male ☐ Female ☐ Other ☐ Decline to answer

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Employer Address: _____

Email Address: _____

Preferred contact method: ☐ Phone ☐ Text ☐ Email

DEMOGRAPHICS

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Primary Language: _____ How did you hear about us? _____

SPOUSE INFORMATION

Name: _____ Birthdate: _____ SS#: _____

EMERGENCY CONTACT

Contact Name: _____ Birthdate: _____

Relationship to Patient: _____ Work Phone: _____ Cell Phone: _____

Do you have an Advance Directive or Living Will? YES _____ NO _____

PHARMACY

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: _____

PHYSICIAN INFORMATION

Referring Physician

Name: _____ Address: _____ Phone: _____

Primary Care Physician

Name: _____ Address: _____ Phone: _____

AUTHORIZATION & CONSENT

I hereby authorize the release of medical information to: _____ Relationship: _____

I hereby authorize Premier Spine Care to leave information on my voice mail at: ☐ Home ☐ Office ☐ Cell

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.

SIGN Patient Signature: Date:

INSURANCE / SELF-PAY ASSIGNMENT

I hereby give authorization of insurance benefits to be made directly to Premier Spine Care. I understand that I am financially responsible for all 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 the original. I hereby authorize payment of my Medigap benefits to Premier Spine Care for all claims filed on my behalf.

SIGN Patient Signature: Date:

PREMIER SPINE CARE

Patient History

Name: _____ Date: _____

HISTORY OF CURRENT CONDITION

Describe when and how your current pain began:

_____

_____

_____

_____

Prior neck or back pain (describe and when):

_____

_____

_____

Prior spine surgery (when, what, surgeon):

_____

_____

OTHER PHYSICIANS EVALUATING THIS CONDITION

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

OCCUPATION

Employer: _____

Job Title: _____

Typical Duties: _____

Current employment status (check one):

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

PAIN CHARACTERISTICS

Pain INCREASED by (check all that apply):

- ☐ bending/twisting neck
- ☐ bending my back
- ☐ twisting torso/lower back
- ☐ sitting for a while
- ☐ sneezing
- ☐ working overhead
- ☐ lifting
- ☐ standing for a while
- ☐ coughing
- ☐ lying in bed

Pain DECREASED by (check all that apply):

- ☐ rest
- ☐ lying down
- ☐ brace
- ☐ stretching
- ☐ heat
- ☐ lying on my side
- ☐ medications
- ☐ nothing

PRIOR TREATMENTS FOR THIS CONDITION

- ☐ None
- ☐ Physical therapy
  - Where/When: _____
  - Where/When: _____
- ☐ Chiropractic
  - Where/When: _____
  - Where/When: _____
- ☐ Medications
  - What: _____
- ☐ Epidural steroid injections
  - Where/When: _____
  - Where/When: _____
- ☐ Other (explain):

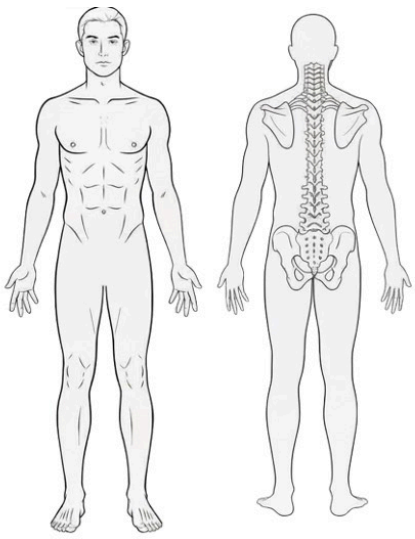
_____

TESTS COMPLETED PRIOR TO VISIT

- ☐ None
- ☐ CT scan
- ☐ Nerve studies (EMG)
- ☐ X-rays
- ☐ MRI scan
- ☐ Myelogram

PAIN DRAWING

Please shade the area of pain or numbness using the markup tool in your PDF viewer with your mouse, or shade in with a pen after printing.



PREMIER SPINE CARE

Medical History

Age: _____ Height: _____ ft. _____ in. Weight: _____

MEDICAL HISTORY

List any current or past medical conditions (high blood pressure, heart attack, stroke, cancer, etc.):

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

SURGICAL HISTORY

List any prior surgeries (any area of body):

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

CURRENT MEDICATIONS

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

DRUG / MEDICATION ALLERGIES & REACTIONS

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

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Employment status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker

Alcohol use: ☐ No ☐ Infrequent ☐ Weekly ☐ Daily

Smoking: ☐ Current ☐ Former ☐ Never Packs/day: _____ Years: _____

Smokeless tobacco: ☐ Yes ☐ No

If you have a history of drug or alcohol abuse, please describe:

_____

_____

LEGAL

Is there an attorney involved in this case? If yes, list name: _____

REVIEW OF SYSTEMS

Please check all symptoms that apply:

☐ Chest pain
☐ Shortness of breath
☐ Abdominal pain
☐ Loss of appetite
☐ Visual changes
☐ Numbness / tingling in arms or legs
☐ Feel off balance walking
☐ Loss of hand coordination
☐ Complete loss of bowel control
☐ Weight loss
☐ Fever / night sweats
☐ Fatigue / lethargy
☐ Consistently ill feeling
☐ Pain at night
☐ Muscle weakness
☐ Tripping / stumbling / falling
☐ Handwriting changes
☐ Complete loss of bladder control

PATIENT ATTESTATION

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.

SIGN Patient Signature: Date:

PREMIER SPINE CARE

Acknowledgements & Consents

1. DOCTOR / PATIENT ACKNOWLEDGEMENT

I understand that I do not have to see Dr. Jackson, Dr. Ciccarelli, 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. This relationship will continue until either I or one of the doctors terminates this relationship. My records will remain confidential with the exception of what must be legally disclosed.

2. ASSIGNMENT OF MEDICAL / SURGICAL BENEFITS

I hereby assign to Premier Spine Care all medical and/or surgical benefits to which I am entitled, including major medical benefits, private insurance, and any other health plan. This assignment will remain in effect until revoked by me in writing, and a photocopy of this assignment shall be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance, and I hereby authorize the assignee to release all information necessary to secure payment of benefits.

3. DISCLOSURE OF PHYSICIAN OWNERSHIP

During the course of my treatment at Premier Spine Care, I may be referred to obtain services or surgical procedures at Shawnee Mission Prairie Star Surgery Center, LLC, in which Drs. Jackson and Ciccarelli have an ownership or investment interest.

4. YOUR HEALTH INFORMATION RIGHTS

Under HIPAA, you have the right to:

- Request restrictions on certain uses and disclosures of your health information. (Premier Spine Care, P.A. is not required to agree.)
- Have your health information communicated by alternative methods or to alternative locations upon request.
- Inspect and copy your health information.
- Request amendments to your protected health information. (Premier Spine Care, P.A. is not required to agree. If denied, you will receive a written explanation and information about how to disagree.)
- Receive an accounting of disclosures of your protected health information.
- Receive a paper copy of the Notice of Privacy Practices at any time upon request.

5. COMPLAINTS, CHANGES & CONTACT

Premier Spine Care, P.A. reserves the right to amend its Notice of Privacy Practices at any time; until then, it is required by law to comply with the current Notice. Complaints about your privacy rights should be directed to the Office Manager at 913-322-2700. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at 1-800-368-1019 or www.hhs.gov/ocr/complaints.

6. ACKNOWLEDGEMENT & CONSENT

I have read the Notice of Privacy Practices and understand my rights as described. By my signature below, I provide Premier Spine Care, P.A. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations, and I confirm my agreement to the acknowledgements and disclosures above.

Patient Name (print): _____ Date: _____

SIGN Patient Signature: 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 you with notice of our legal duties and privacy practices.

HOW WE USE & DISCLOSE YOUR HEALTH 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. On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Premier Spine Care, P.A. In the event your primary provider is absent due to vacation, illness, or another emergency, an authorized substitute provider may assess or treat you without advance notice.

Payment. We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. As a courtesy, we submit an itemized billing statement to your insurance carrier on your behalf. This statement contains medical information, including diagnosis, date of injury or condition, and codes describing the healthcare services rendered.

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 your death.

OTHER PERMITTED DISCLOSURES

Public Health. We may disclose your health information to public health authorities for purposes such as preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting problems with products or medication reactions to the FDA; and reporting disease or infection exposure.

Judicial & 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 approved by an Institutional Review Board.

Public Safety. It may be necessary to disclose your health information to appropriate persons 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.

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

PREMIER SPINE CARE

Financial Policy

INSURANCE & CLAIMS

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 insurance; 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 that your health insurance is an agreement between you 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 overpayment.

CO-PAYS

If your health plan requires a co-pay, please be prepared to pay it at the time of service. A co-pay is part of YOUR contract with the insurance company and is designed to share the cost of your healthcare. The co-pay is not part of OUR contract with your insurer, and it is not at our discretion whether your plan has one 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.

SURGICAL CHARGES

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.

FINANCING & COLLECTIONS

Our office does not offer financing options for the healthcare services we provide; however, several companies in the marketplace provide healthcare financing as a service. If your balance is not paid in a timely manner and we must engage a collection agency or attorney, you will be responsible for all collection fees and interest in addition to the outstanding balance.

CANCELLATION & NO-SHOW POLICY

- We request 24 hours' advance notice if you are not able to keep an appointment. If you miss a scheduled appointment, or do not call to cancel 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 emergency situations may occasionally 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 reserve this time slot exclusively for you. Late notice or failing to attend an appointment creates both a financial loss for our practice AND a missed opportunity to help another patient in need.

Patient Name (print): _____ Patient Date of Birth: _____

SIGN Patient Signature: Date: