Kenai Spine

PERSONAL INFORMATION

Place Label Here

1 PATIENT INFORMATION

☐Mr. ☐Mrs. ☐Ms. **Last Name:**_____ **First Name:**_____ **Middle Initial:** _____

Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary Phone: _____ Is it OK to leave a message about your care? ☐Yes ☐ No Please circle one Brief or Extended

Secondary Phone: _____ Is it OK to leave a message about your care? ☐Yes ☐ No Brief or Extended

Work Phone: _____ Is it OK to leave a message about your care? ☐Yes ☐ No Brief or Extended

Doctor that sent you here: _____ **Your regular/primary care Doctor:** _____

Other Doctors you are seeing:_____

Date of Birth (MM/DD/YYYY):_____ **Age:** _____ **Sex:** ☐M ☐F **Social Security:**_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated **Student:** Full-time_____ Part-time_____

Occupation: _____ **Employer:** _____

Employer's Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

Email:_____ **Language:** ☐English ☐Other: _____

Race: ☐Indian/AK Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐African American ☐Caucasian ☐Hispanic ☐Other ☐Decline

Ethnicity: ☐Hispanic/Latin American ☐Not Hispanic/Latin American ☐Decline

Preferred Pharmacy: _____**City:** _____ **State:** _____

2 PERSON RESPONSIBLE FOR THE BILL ☐ Same as above.

Full Name:_____ **Primary Phone:** _____**Secondary Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth (M/D/Y):_____ **Sex:** ☐Male ☐Female

3 INSURANCE INFORMATION

Primary Insurance:_____

Policy #: _____ **Group #:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Phone: _____

Name of Policy Holder: _____

Date of Birth (MM/DD/YYYY): _____

Secondary Insurance:_____

Policy #: _____ **Group #:** _____

Mailing Address:_____

City: _____ **State:** _____ **Zip:** _____

Insurance Phone: _____

Name of Policy Holder: _____

Date of Birth (MM/DD/YYYY): _____

Workers Comp/Motor Vehicle Accident: Date of Injury:_____ **Claim #:**_____

Kenai Spine

MEDICAL HISTORY PAGE 1

Place Label Here

Name:_____

1 YOUR SYMPTOMS

Are your symptoms mostly in the back, neck, or elsewhere?

_____

How long have you had these symptoms? _____

Does your pain radiate? ☐Yes ☐No

Do you have numbness? ☐Yes ☐No

Do you have weakness? ☐Yes ☐No

Have you lost bladder or bowel control? ☐Yes ☐No

The pain is: ☐Constant ☐Comes and goes

How many hours of sleep do you average per night? _____

Does your pain wake you up at night? ☐Yes ☐No

If so, how many times per night does pain wake you? _____

What things make the pain better?

☐Rest ☐Ice ☐Heat ☐Medication

What makes the pain worse?

☐Sitting ☐Standing ☐Lifting

Is your pain the result of: ☐Fall ☐Auto Accident

☐Other (List) _____

2 CURRENT WORK STATUS

Is there a law suit pending on your problem? ☐Yes ☐No

Which of the following describes your current status?

☐Employed ☐Full Time ☐Part Time ☐Unemployed

☐Homemaker ☐Retired

What is your occupation? _____

How long have you been at that job? _____

Does your job require:

☐Lifting ☐Prolonged Standing ☐Prolonged sitting

☐Not working because of: ☐Neck problem ☐Back Problem

Explain: _____

How long off work? ____

☐Not working because of another health problem

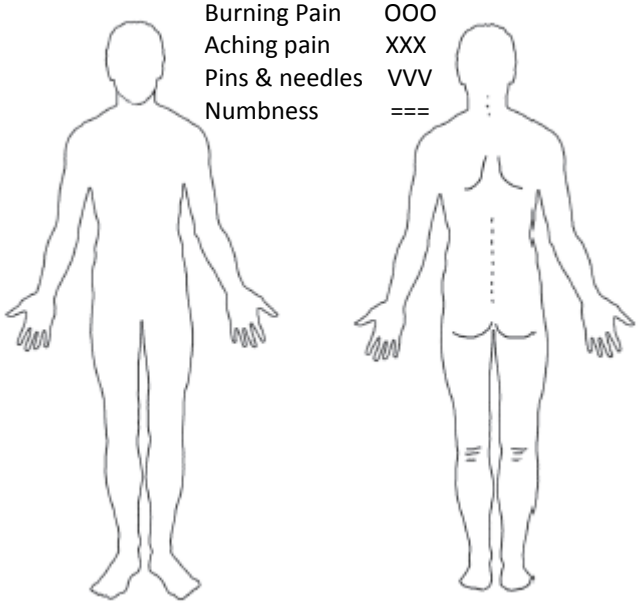
Explain: _____

How long off work? _____

3 YOUR PAIN

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Stabbing pain ///
Burning Pain OOO
Aching pain XXX
Pins & needles VVV
Numbness ===



Rate your pain: 0-10 (0= no pain, 10 = worst pain)

Pain level on your best days: _____

Pain level on your worst days: _____

4 Your Health

Are you a tobacco user? ☐Yes ☐No

☐Former tobacco user**:** When did you quit? _____

Do you smoke? ☐Yes ☐No

If yes, how many cigarettes do you smoke per day? _____

Are you ready to quit?

☐Ready to quit ☐Thinking about quitting ☐Not ready to quit

Do you drink alcohol? ☐Yes ☐No

If yes, how many drinks do you have per day? _____

Do you have a pacemaker ☐Yes ☐No

Do you have an implanted device or metal in your body? ☐Yes ☐No

Specify:_____

Kenai Spine

MEDICAL HISTORY PAGE 2

Place Label Here

5 YOUR HEALTH (con't)

Do you have any of the following medical problems?

- ☐ AIDS / HIV
- ☐ Anemia or Bleeding disorders
  Specify:_____
- ☐ Arthritis
- ☐ Cancer
  Specify:_____
- ☐ Coronary Artery Disease
- ☐ Connective Tissue Disease
  Specify:_____
- ☐ Diabetes: ☐Type I ☐Type II
- ☐ Epilepsy/Seizures
- ☐ Gastric Reflux/Heartburn
- ☐ Headaches
- ☐ Heart disease
- ☐ Hypertension (High blood pressure)
- ☐ Hypercholesterolemia
- ☐ Immune disorder
  Specify:_____
- ☐ Infection:
  ☐Spine Infection ☐Non-spine Infection
- ☐ Kidney Problems
  Specify:_____
- ☐ Liver Problems/Hepatitis
  Specify:_____
- ☐ Lung Problems
  ☐COPD ☐Other: _____
- ☐ Migraines
- ☐ Muscle disease
  Specify:_____
- ☐ Nerve disorder
  Specify: _____
- ☐ Peripheral Vascular Disease
- ☐ Psychiatric problems
  ☐Anxiety ☐Depression
  ☐ Other:_____
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid Problems? ☐Hyper ☐Hypo

Are you pregnant? ☐Yes ☐No ☐Possibly

6 PREVIOUS TREATMENT & TESTS

Have you had previous back or neck surgery: ☐Yes ☐No
Year:_____ Surgery:_____ Dr:_____
Year:_____ Surgery:_____ Dr:_____
Have you had any other previous surgeries: ☐Yes ☐No
Date:_____ Surgery:_____
Date:_____ Surgery:_____
Date:_____ Surgery:_____
Date:_____ Surgery:_____
Have you ever had an adverse reaction to anesthesia? ☐Yes ☐No If yes,
Describe:_____
Have you ever had a blood transfusion? ☐Yes ☐No If yes,
Describe:_____

Previous imaging studies or other studies:
☐CT Scan Date:_____ Location:_____
☐MRI Date:_____ Location:_____
☐X-Ray Date:_____ Location:_____
☐EMG Date:_____ Location:_____

Have you had any of the following treatments prescribed for your back or neck pain?
☐Chiropractic Care Duration:_____ Doctor:_____
Results:_____
☐Physical Therapy Duration:_____ Doctor:_____
Results:_____
☐Massage Therapy Duration:_____ Doctor:_____
Results:_____
☐Steroid Injection Date:_____ Doctor:_____
Results:_____
☐Anti-inflammatory medication Type:_____ Duration:_____
Results:_____
☐Other Describe:_____
Date/Duration:_____ Doctor:_____
Results:_____

HAVE YOU RECENTLY HAD

- ☐ Fever or chills
- ☐ Weight Loss
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Night sweats
- ☐ Dizziness/Lightheadedness
- ☐ Worse pain at night
- ☐ Nausea/Vomiting

7 FAMILY HISTORY [please indicate- Father(F), Mother(M), Daughter(D), Son(So)]

Diabetes: (Type) _____ ☐F ☐M ☐D ☐So
Hypertension (high blood pressure): ☐F ☐M ☐D ☐So
Heart Disease: ☐F ☐M ☐D ☐So
Stroke: ☐F ☐M ☐D ☐So
Cancer: ☐F ☐M ☐D ☐So (Type) _____
Back/Neck Problems: ☐F ☐M ☐D ☐So
Arthritis: ☐F ☐M ☐D ☐So
Please list any other pertinent family history: _____

Place Label Here

8 SAFETY/FALL ASSESSMENT

Do you have any difficulty following directions? ☐Yes ☐No
Have you fallen in the last year? ☐Yes ☐No
Do you have problems with loss of balance? ☐Yes ☐No
Do you require an assistive device (walker, cane, crutches) to walk? ☐Yes ☐Full Time ☐Part Time ☐No
Do you take any diuretic medications, anti-convulsants, sedatives, narcotics or other medication that has a warning from the pharmacy that it may cause any of the following symptoms? ☐Dizziness ☐Lightheadedness ☐Fainting ☐No
Do you have a history of any of the following? ☐Seizures ☐Low blood pressure ☐Stroke ☐No

9 FUNCTIONAL LEVEL

Please rate your functional level **prior to** developing this injury/illness/condition:
☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty
Please rate your **current** functional level:
☐No Difficulty ☐Mild Difficulty ☐Moderate Difficulty ☐Severe Difficulty
Please check the activities that are currently restricted due to this injury/illness/condition:
☐Walking ☐Driving ☐Working ☐Gripping ☐Overhead Activities ☐Sitting ☐Stairs ☐Lifting ☐Cooking
☐Sleeping ☐Leisure ☐Bending ☐Standing ☐Gripping ☐Eating ☐Bathing ☐Grooming ☐Social
☐Other: _____ ☐Other: _____
Please list any leisure activities that you are unable to participate in due to this injury/illness/condition:
_____

10 LIVING SITUATION

With whom do you live? _____
Do you have part-time assistance from a caregiver? ☐Yes ☐No If yes, how many hours per week?_____
Do you have any of the following obstacles in the home that limit or challenge mobility? ☐Stairs without rails ☐Stairs with rails
☐Split Level ☐Other (Please specify)_____
Do you have any adaptive equipment in the bathroom such as? ☐Raised toilet seat ☐Grab bars ☐Shower seat
☐Hand held shower head ☐Other (please specify)_____

Do you use any of the following assistive devices to help you walk or get around?

☐**Cane** ☐Part time ☐Full time

☐**Crutches** ☐Part time ☐Full time

☐**Front wheeled walker** ☐Part time ☐Full time

☐**Four wheeled walker** ☐Part time ☐Full time

☐**Manual Wheel Chair** ☐Part time ☐Full time

☐**Power wheel chair** ☐Part time ☐Full time

Place Label Here

11

ALLERGY INFORMATION

Please list any type of allergy and associated reaction (i.e. medication, food, latex, etc.)

Do you have a metal sensitivity? Yes or no (Please circle one)

Allergy:_________________________________ Reaction:_________________________________

Allergy:_________________________________ Reaction:_________________________________

Allergy:_________________________________ Reaction:_________________________________

Allergy:_________________________________ Reaction:_________________________________

Allergy:_________________________________ Reaction:_________________________________

Allergy:_________________________________ Reaction:_________________________________

12

MEDICATION INFORMATION [Please ask for an additional page if needed]

Please list all prescription and non-prescription medications you are currently taking as well as vitamins and supplements:

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

Medication:________________________ Prescribing Physician:________________________________

Dose:____________________ Frequency:____

NARCOTICS / CONTROLLED SUBSTANCES

The providers of Kenai Spine do not routinely prescribe narcotics on a long-term basis. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management provider. When indicated, long-acting opiates are prescribed in extremely limited quantities without automatic refills. Narcotic prescriptions will not be refilled after office hours or on weekends. By signing this policy, you agree to stay consistent with the use of the one pharmacy as listed below. If you have a current pain control contract in place please provide the name of the provider with whom you have the contract and bring this to our attention at the time of your first appointment. We will assist you in arranging for postoperative pain control through that provider.

NAME OF PAIN CONTRACT PROVIDER: _____ ☐N/A

PHARMACY: _____

We ask that you report either lost or stolen medications to the police immediately and that you provide a copy of the police report for our records. We will not replace lost or stolen pain medications without a copy of a valid police report. Having a copy of a valid police report does not guarantee that we will replace your prescription and each situation will be assessed on a case-by-case basis. It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore you agree that, unless otherwise authorized, the physicians at Kenai Spine will be the sole narcotic prescribing source for you at this time. Furthermore, by accepting controlled substances from Kenai Spine, you agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine multiple physicians are ordering prescriptions for pain medications, we will immediately cease all orders for such treatments from our office.

In the postoperative period, we may continue to aid you in pain control with the goal that you will taper and eventually discontinue your pain medications. If this cannot happen in a timely manner, you will be referred to a provider who can aid in this process.

REGARDING PRESCRIPTION REFILLS

Kenai Spine has a **48 hour** medication turn-around. Prescription requests submitted after 3 pm may not be called in until 2 business days later. Please allow ample time for this process. We do not refill prescriptions over the weekend. Be sure to submit your request before noon on Friday if you need your prescription filled on Monday. This is not guaranteed. For your own convenience, call your pharmacy before leaving home to make sure they have your prescription ready. Kenai Spine providers will not refill prescriptions for patients not seen in the past 90 days by a Kenai Spine provider.

ACKNOWLEDGEMENT OF PRESCRIPTION POLICY

I have read and understand Kenai Spine's policy regarding prescription medications. I agree to the terms involved in the Medication Policy.

_____	_____	_____
Patient Name (printed)	Signature of Patient/Patient Representative	Date

A copy of this policy will be provided if requested.

Place Label Here

Kenai Spine

PATIENT FINANCIAL POLICY

Thank you for choosing Kenai Spine. We understand that many patients find financial matters surrounding their medical care to be very complex and often times confusing. If you have any questions regarding our billing policies, we will be happy to assist you.

Private Health Insurance	Initial Here _____	We are ***NOT*** a contracted, "preferred", nor considered In-Network with most private health insurance plans. As the patient, you are responsible for requesting prior approval and/or Out-of-Network benefit level exceptions from your insurance company as required. Our office collects a standard 20% of amount due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicare	Initial Here _____	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient-notified non-covered services after Medicare processes your claim. No payment is required at the time of service.
Medicaid	Initial Here _____	We are a contracted provider with Medicaid. Please note, a referral is required if you are in the Lock-in Program; without a referral you will be considered a self-pay patient. Your co-pay is due at the time of service and failure to make payment may result in delayed future appointments.
Tricare / Triwest / VA	Initial Here _____	VA and Tricare visits must be preauthorized by your referring physician. We will bill Tricare on your behalf, however, you are responsible for your deductible/Co-pay and Co-insurance amounts as determined by Tricare.
Workers Compensation	Initial Here _____	We only accept Workers' Compensation claims that were filed with the Alaska or Washington Departments of Labor. Your claim must be open and accepted. You must complete a Physician Report as well as provide your carrier's information including claim number and date of injury. No payment is required at the time of service.
Self-Pay / Uninsured	Initial Here _____	Payment is due in full at the time of service unless other billing arrangements have been approved by the Kenai Spine Billing Department.
Auto Accident	Initial Here _____	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt unless other billing arrangements have been approved by the Kenai Spine Billing Department.
Payment Plan	Initial Here _____	Payment plans must be established through the Kenai Spine Billing Department. Please note our payment plans are determined on an individual bases. All payments will be applied to the oldest date of service first.
Other	Initial Here _____	

- I have read, understand, and agree to this financial policy.
- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Kenai Spine LLC to release medical information to my insurance carrier to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Kenai Spine LLC.
- I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- I will be held responsible for all fees associated with the collection of my account balance.

Name of Patient:_____ Signature of Patient:_____

Place Label Here

YOUR PERSONAL AND HEALTH INFORMATION

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment and as such would like to inform you of our privacy practices and procedures. This privacy notice describes how your personal and health information will be used and disclosed and how you can gain access to this information. Please read it carefully. Should you have any questions regarding these policies please do not hesitate to ask.

As part of our registration process, you and your family's personal and health information will be collected. This information is very important in the development of an effective treatment plan and we ask that you provide the most complete and accurate information as possible. Information such as; name, address, phone number, birth date, social security number, employer information, health history, insurance policy and coverage information will be collected from you and other health care entities you utilize. Throughout the course of your treatment we will also collect your health information regarding diagnosis, outside treatment plans, progress reports and any test lab results and or imaging studies you obtain from other health care facilities such as hospitals, laboratories, other physician offices, and imaging facilities.

HOW YOUR INFORMATION WILL BE USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of personal and health information will only be used upon receipt of your written authorization. We do not sell your personal and health information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed): _____ Signature: _____ Date: _____

Place Label Here

Kenai Spine

Protected Health Information Authorization

Personal Health Information:

I, _____, Date of Birth_____, Authorize Kenai Spine to speak to the person(s) listed regarding any and all of my medical and personal information:

- _____ Relationship to Patient _____
- _____ Relationship to Patient _____
- _____ Relationship to Patient _____

I, _____, Authorize Kenai Spine to release and dispense my medications to:

- _____ Relationship to Patient _____
- _____ Relationship to Patient _____
- _____ Relationship to Patient _____

I understand and assume responsibility of notifying Kenai Spine whenever the listed information changes. I understand this excludes insurance companies, attorneys and other health care providers.

Signed:_____

Date:_____

Witness/Staff Signature:_____

Date:_____

Place Label Here

240 Hospital Place Suite #103
Soldotna, Alaska 99669
Phone (907)260-5455
Fax (907) 714-3111

Kenai Spine

Physician ownership disclosure

Dear valued patient:

We are honored that you have selected Kenai Spine as your spine care provider. As a spine Center of Excellence, the physicians have published scientific papers and books on spine care and have invented medical implants that improve spine care. Our physicians may have obtained patents on medical inventions and developed spinal implants and have an involvement in companies that have medical products, surgery centers and diagnostic centers. Some of these efforts finance charitable mission programs that bring new spine technology to Africa to benefit the population there.

Consequently, during the course of your treatment with Kenai Spine, you may be referred to any of the following centers, or you may be prescribed treatment involving medical technology that we may have invented. With the above said, federal law requires physicians to notify a patient if a physician has an ownership or financial interest in any entity to which the physician is referring the patient. We are hereby disclosing to you that Kenai Spine or one of its physicians may have an investment interest in the following entities:

Muldoon Ambulatory Surgery Center
6911 Debarr Rd.
Anchorage, AK 99504

Kenai Surgery Center
100 Trading Bay Dr., Suite 9
Kenai, AK 99611

Revolution Sport and Spine Therapy
35249 Kenai Spur Highway, Suite C
Soldotna, AK 99611

Kenai Peninsula Imaging Center
100 Trading Bay Dr., Suite 7
Kenai, AK 99611

Meditech CURE Plate / Spinal implant

Zimmer Biomet Solitaire/Spinal implant

Balanced Back Artificial Disc/Joint Replacement

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider and the option of obtaining health care ordered by your physician at another location or with other medical technology. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers or alternative medical technology. If you have any questions concerning this notice, please feel free to contact our office manager. Your signature below documents your informed decision to decline the option to have your health care provided at another health care facility or with different medical technology.

Signature of Patient:_____Date: _____

Place Label Here