AXIS SPINE CENTER

FULL LEGAL NAME			PREVIOUS LAST NAME
FIRST	LAST	M.I	

DATE OF BIRTH	MARITAL STATUS	GENDER	SSN
	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	◯ M ◯ F	
MM-DD-YYYY			XXX-XX-XXXX

ADDRESS			
STREET OR PO BOX	CITY	STATE	ZIP

CONTACT INFORMATION: (PLEASE CHECK YOUR PREFERRED CONTACT NUMBERS)			
☐ **CELL PHONE**	☐ **HOME PHONE**	☐ **WORK PHONE**	☐ **E-MAIL**

EMERGENCY CONTACT		
NAME	RELATIONSHIP	PHONE

EMPLOYER		
NAME	STATUS (FULL-TIME/PART-TIME)	PHONE

REFERRING PROVIDER	PRIMARY CARE PROVIDER
NAME	NAME

PREFERRED PHARMACY					
NAME	STREET	CITY	STATE	ZIP	PHONE

WHO ARE YOU HERE TO SEE?				
	☐ DR JAMESON	☐ DR ROLAND KENT	☐ DR JOE KENT III	☐ DR BLIZZARD
	☐ ASHLEY LAMMERS	☐ MOLLY LITER	☐ JENNIFER TOROK	☐ GARY HURST
	☐ ADAM MILLS	☐ PATRICIA VIETH		

INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY NAME	ID#	GROUP #	INSURANCE PHONE #
SUBSCRIBER – EMPLOYEE NAME	DOB (MM-DD-YYYY)	SSN	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME	ID#	GROUP #	INSURANCE PHONE #
SUBSCRIBER – EMPLOYEE NAME	DOB (MM-DD-YYYY)	SSN	RELATIONSHIP TO PATIENT

DOB: DATE

Acknowledgement of Receipt of, and Agreement with, Notice of Privacy Practices for AXIS SPINE PLLC

I understand that under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices of Axis Spine PLLC (the "Practice"). These practices are acceptable to me. I also understand that the Practice has the right to change its Notice of Privacy Practices and that this updated information is on the company website (www.axisspinecenter.com) and that I may contact the Practice at any time to obtain a current copy of its Notice of Privacy Practices.

_____

Signature (Patient, Legal Guardian, or Personal Representative) Date

_____

Print Name and Relationship (if not Patient)

Authorization for Use and Disclosure of Personal Health Information ("PHI") by Axis Spine PLLC

I hereby authorize Axis Spine ("the practice") and its employees to use and disclose my medical and financial information (PHI) to the person(s) or organizations(s) identified below. It is at my request, that the specific information that may be used and disclosed includes any and all of my personal health and financial information in the records of the practice that pertain to me. ***In addition, I understand that by signing this document, I agree that as part of my physical and emotional health care, my PHI may be disclosed to other clinical providers upon request, as well as to any Health Insurance or other insurance or benefit company or employer (including their agents) from whom I or my family may seek benefits or leave of absence; further, my employer may receive Work Status reports which may contain PHI. I agree to notify Axis Spine PLLC in writing if I wish to exclude any such company or employer from receiving PHI.***

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

This Authorization shall expire upon the earlier of 1) a written revocation of this Authorization; 2) upon my termination of all services with the Practice; or 3) until the date of _____.

I understand that:

*It is my responsibility to inform the Practice of any desired change in this Authorization.

*I have the right to revoke this Authorization at any time by alerting the Privacy Officer, in writing, at 7600 N Mineral Drive Ste #700 Coeur d'Alene, ID 83815, 208-457-4208, except to the extent the Practice has taken action in reliance of th this authorization prior to receipt of my revocation.

*I have the right to refuse to sign this Authorization. The Practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my authorization.

*The person(s) I authorize may not be governed by privacy laws, therefore, information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.

_____

Signature (Patient, Legal Guardian, or Personal Representative) Date

_____

Print Name and Relationship (if not Patient)

DOB: DATE

Financial Policy

Thank you for choosing Axis Spine PLLC as your health care provider. We are committed to the successful treatment of your condition. Your clear understanding of our Financial Policy is important to our relationship. Please call our billing department if you have any questions.

- All patients must complete our Patient Registration Forms
- For cases which we bill insurance directly, we must have a copy of your Insurance ID card(s).
- For cases where we bill a third party (WC/Auto), we require a copy of your private Insurance ID card(s) for our records.
- Insurance Co-Payment is due at time of service.
- We accept cash, check, or credit card (Visa or MasterCard)

INSURANCE (PPO/POS/Commercial/Medicare Advantage Plans)

All co-payments are due at the time of service. We are members of most, but not all, plans. You are responsible for verifying that we are providers for your plan. If we are not contracted providers for your plan, you agree to pay patient responsibility charges for claims processed as "Out of Network". You are responsible for co-payments, deductibles and co-insurances on your plan. We maintain the right to collect payment towards patient responsibility prior to any high cost treatment (Surgery, MRI, other). If applicable, you will be directed to speak to a patient representative. You are responsible for any service denied by your insurance as a non-covered service.

HMO INSURANCE

All co-payments are due at time of service. You are responsible for providing the referral for your visit. We will assist with referrals for surgery and other services as directed by your plan. If you are an HMO member, you will not be billed additionally as long as we have the necessary referrals.

MEDICARE

We do accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved amount and the amount that Medicare pays, and of course, your deductible. If you have supplemental insurance, please provide a copy of the card and we will bill it for you. You will receive a bill after your insurance has paid if there is any remaining balance.

SELF PAY

Payment is due in full at the time of service. If you are unable to pay your balance in full, you must see a patient representative to make other arrangements.

WORKERS' COMPENSATION

If you are being seen here as a result of work related injury, you must notify our staff **prior** to your appointment. We will require information regarding both your Workers' Compensation insurance and your private health insurance. We must obtain treatment authorization prior to your visit. If authorization for treatment under Workers' Compensation is denied, as a courtesy we will bill your health insurance carrier. If payment is not received from these parties, we have a right to bill you directly. If you have obtained an attorney, we will need the name, address and phone number for our records.

AUTO ACCIDENT CLAIMS

If you are being seen as a result of an auto accident, you must notify our staff **prior** to your appointment. We require both your Auto Insurance information and your private health insurance. If payment is not received from these parties, we have a right to bill you directly. If you have obtained an attorney, we will need the name, address and phone number for our records.

TREATMENT FOR A MINOR CHILD

A parent or legal guardian must accompany patients who are minors (under 18 years of age). This accompanying adult is responsible for payment of the account, according to policy outlined above.

RETURNED CHECK

A $35.00 charge will be added to your account for any check returned by your bank for any reason.

DISABILITY or INSURANCE FORMS

There will be a charge of $30.00-$50.00, depending on the complexity, for the completion of medical/disability/FMLA forms. Payment is due before paperwork is processed. Please allow 7-10 days for completion of these forms.

NO SHOW POLICY

You will be charged $50.00, if you were scheduled for an appointment in our office, but you did not attend the appointment and did not provide advanced notice of cancellation to our clinic

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

_____

Name of Patient (please print)

_____

Signature of Patient or Responsible Party Date

DOB: DATE

Reason for visit	☐ Neck pain ☐ Back pain ☐ Surgical consult ☐ Other:

PLEASE LIST ALL KNOWN ALLERGIES AND YOUR REACTION	
	Reaction type:
	Reaction type:
	Reaction type:
PLEASE INDICATE IF YOU ARE ALLERGIC TO THE FOLLOWING: ☐ IODINE ☐ SHELLFISH ☐ LATEX	
☐ NO KNOWN MEDICATION ALLERGIES	

CURRENT MEDICATIONS Please list all medications with dosage and the frequency that you take them. Please include herbal and over-the-counter drugs. Use an additional sheet if necessary	

PAST FAMILY HISTORY PLEASE INDICATE YOUR RELATION		
☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ DIABETES
☐ NEUROLOGICAL DISEASE	☐ DEPRESSION	☐ SLEEP APNEA/COPD
☐ CANCER(TYPE):	☐ BIPOLAR DISORDER	☐ OTHER:

SOCIAL HISTORY			
DO YOU HAVE AN ADVANCE CARE PLAN OR DIRECTIVE? ◯ YES ◯ NO			
DO YOU USE NICOTINE PRODUCTS? ☐ YES ☐ NO		PACKS/DAY	YEARS
ALCOHOL USE? ☐ YES ☐ NO		DRINKS/DAY	
OTHER SUBSTANCES? ☐ YES ☐ NO		LIST:	LAST USED:
WHAT ARE YOUR HOBBIES?			

DOB:

DATE

SURGICAL HISTORY: PLEASE LIST			
SURGERY		DATE:	
SURGERY		DATE:	
SURGERY		DATE:	
DO YOU HAVE ANY IMPLANTED DEVICES?			
☐ SCREWS, PINS, PLATES	☐ PACEMAKER	☐ IUD	☐ VENOUS ACCESS
☐ ANEURYSM CLIP(S)	☐ AICD	☐ BREAST IMPLANT	☐ SPINAL CORD STIMULATOR
☐ INTRATHECAL PUMP			

PAST MEDICAL HISTORY		
☐ GASTRIC REFLUX	☐ COPD	☐ HYPERTENSION
☐ ANXIETY	☐ SLEEP APNEA	☐ NEUROLOGICAL DISEASE
☐ DEPRESSION	☐ DIABETES	☐ OTHER:
☐ CANCER (TYPE)	☐ HEART DISEASE	
HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE MRSA? ◯ YES ◯ NO		

REVIEW OF SYSTEMS

Please check below if you have, or recently experienced, any of these medical conditions:

Fever	Y◯N⊙	Palpitations	Y◯N◯	Seizures	Y◯N◯
Weight gain	Y⊙N◯	Shortness of breath	Y◯N◯	Psychological problems	Y◯N◯
Weight loss	Y⊙N◯	Abdominal pain	Y◯N◯	Depression	Y◯N◯
Chills/Night sweats	Y⊙N◯	Black/tarry stools	Y◯N◯	Anxiety	Y◯N◯
Changes to vision	Y⊙N◯	Urinary Incontinence	Y◯N◯	Fatigue	Y◯N◯
Dental problems	Y⊙N◯	Leg or arm swelling	Y◯N◯	Swollen glands	Y◯N◯
Chest pain	Y⊙N◯	Skin wounds	Y◯N◯	Easy bruising	Y◯N◯
Irregular heart beat	Y⊙N◯	Rash	Y◯N◯	Easy bleeding	Y◯N◯

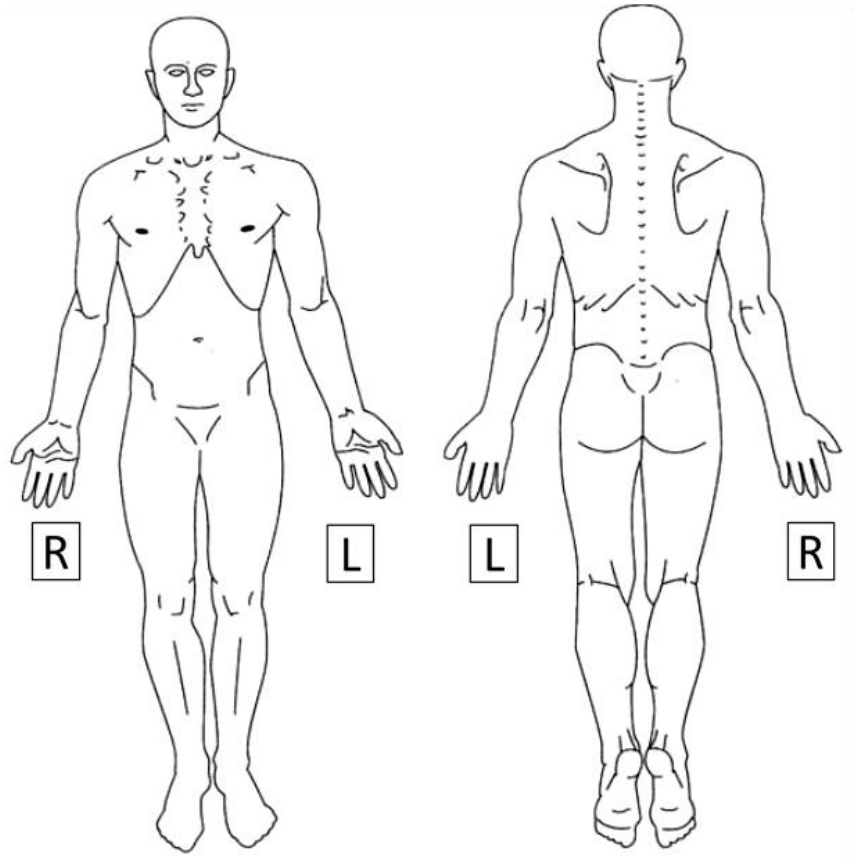
DOB:

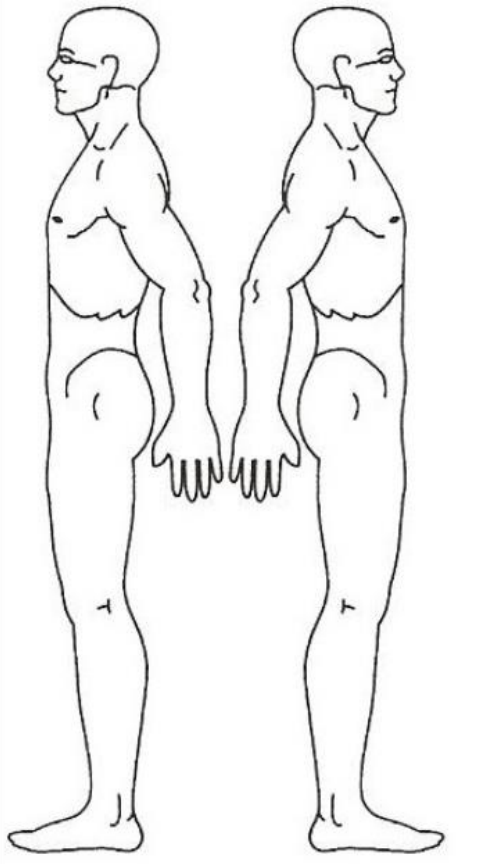
DATE

HOW DID THIS PAIN BEGIN?			
☐ AUTOACCIDENT	☐ AT WORK	☐ AT HOME	☐ FOLLOWING SURGERY
☐ AFTER AN ILLNESS - TYPE?	☐ GRADUALLY		
☐ OTHER /UNKOWN:			
IF AN ACCIDENT OR INJURY CAUSED YOUR PAIN, PLEASE BRIEFLY DESCRIBE			

WHEN DID THE PAIN BEGIN OR WHAT WAS THE DATE OF YOUR INJURY?

PLEASE MARK WHERE YOUR PAIN IS. PLEASE USE THE SYMBOLS TO INDICATE WHAT TYPE OF PAIN YOU EXPERIENCE IN EACH AREA.				
ACHING	BURNING	NUMBNESS	PINS AND NEEDLES	STABBING
ΔΔΔΔΔΔΔ	XXXXXXXX	==========	oooooooo	/////////





LEFT SIDE

RIGHT SIDE

DOB:

DATE

PLEASE RATE THE SEVERITY OF YOUR PAIN ON A SCALE OF 1 TO 10

TODAY	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○ 9 ○10
BEST DAY	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○ 9 ○10
WORST DAY	○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○ 9 ○10

SCALE

0 = NO PAIN
1 = VERY MILD PAIN: YOU ARE AWARE OF THE PAIN BUT IT DOESN'T BOTHER YOU
2 = MILD PAIN THAT YOU CAN TOLERATE WITHOUT TAKING MEDICATION
3 = MILD TO MODERATE PAIN THAT REQUIRES MEDICATION TO TOLERATE
4-5 = MODERATE PAIN THAT SOMETIMES IS NOT CONTROLLED AND CAUSES YOU TO FEEL ANTISOCIAL
6 = FAIRLY SEVERE PAIN THAT INTERFERES WITH DAILY LIFE.
7-9 = INTENSELY SEVERE PAIN
10 = WORST PAIN IMAGINABLE

HOW OFTEN DO YOU HAVE PAIN?	
☐ CONSTANTLY (100% OF THE TIME)	☐ INTERMITTENTLY (50% OF THE TIME)
☐ FREQUENTLY (75% OF THE TIME)	☐ OCCASIONALLY (25% OF THE TIME)

WHAT MAKES THE PAIN FEEL BETTER?			
☐ WALKING	☐ LEANING FORWARD	☐ RELAXATION	☐ HEAT
☐ LYING FLAT	☐ LYING WITH HIPS / KNEES BENT	☐ REST	☐ ICE
☐ INTRATHECAL PUMP	☐ OTHER:		

WHAT MAKES THE PAIN WORSE?		
☐ STANDING	☐ LAYING DOWN	☐ BOWEL MOVEMENTS
☐ SITTING	☐ LIFTING	☐ COUGHING / SNEEZING
☐ GETTING UP OUT OF BED	☐ BENDING FORWARD	☐ DAMP WEATHER
☐ WALKING	☐ BENDING BACKWARD	☐ RAISING OUT OF A CHAIR
☐ TWISTING	☐ LOOKING UP	☐ EXERCISE
☐ COLD	☐ LOOKING DOWN	☐ URINATION
☐ OTHER:		

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?		
☐ NUMBNESS	☐ BLADDER INCONTINENCE	☐ WEAKNESS IN ARM
☐ TINGLING	☐ BOWEL INCONTINENCE	☐ WEAKNESS LEG

DOB: DATE

HAVE YOU EVER HAD SURGERY ON YOUR BACK OR NECK?
◯ YES ◯ NO
AT WHAT LEVEL? WHEN? Who performed the surgery?

WHAT CONSERVATIVE CARE TREATMENTS HAVE YOU TRIED BEFORE?		
☐ REST/ACTIVITY MODIFICATION	☐ ACUPUNCTURE	☐ CHIROPRACTOR VISITS
☐ STEROID / CORTISONE INJECTIONS	☐ HEAT THERAPY	☐ PHYSICAL THERAPY
☐ ELECTRICAL STIMULATION (TENS)	☐ NERVE BLOCK	☐ MASSAGE THERAPY
☐ BIOFEEDBACK	☐ PSYCHOTHERAPY	☐ OTHER:

REGARDING THE ABOVE TREATMENTS: TYPE
DATES OF CARE:
DURATION OF TREATMENT:
TREATING PROVIDER:

REGARDING THE ABOVE TREATMENTS: TYPE
DATES OF CARE:
DURATION OF TREATMENT:
TREATING PROVIDER:

REGARDING THE ABOVE TREATMENTS: TYPE
DATES OF CARE:
DURATION OF TREATMENT:
TREATING PROVIDER:

HAVE YOU TRIED ANY OF THESE MEDICATIONS FOR YOUR PAIN?	
☐ ACETAMINOPHEN (TYLENOL)	☐ ANTIDEPRESSANT
☐ GABAPENTIN (NEURONTIN)	☐ ORAL STEROID (MEDROL DOSE PAK)
☐ IBUPROFEN (ADVIL)	☐ PREGABALIN (Lyrica)
☐ NAPROXEN (ALEVE)	☐ OPIOID (NARCOTIC)
☐ OTHER	

DOB:

DATE

DO YOU HAVE A PERSONAL HISTORY OF?		
☐ ALCOHOL ABUSE	☐ ILLEGAL DRUG USE	☐ PRESCRIPTION DRUG ABUSE
DID YOU SEEK PROFESSIONAL TREATMENT FOR DETOXIFICATION		
◯ YES ◯ NO		

DO YOU HAVE A FAMILY HISTORY OF?			
☐ ALCOHOL ABUSE	☐ ILLEGAL DRUG USE	☐ PRESCRIPTION DRUG ABUSE	
WHO:	☐ FATHER	☐ MOTHER	☐ CHILD ☐ SIBLING

DO YOU HAVE A DIAGNOSIS OF?		
☐ ADD/ADHD	☐ OCD	☐ BI-POLAR
☐ SCHIZOPHRENIA	☐ DEPRESSION	☐ OTHER
ARE YOU ON A MEDICATION FOR ANY OF THE ABOVE?		
NAME:		

DO YOU HAVE A HISTORY OF PRE-ADOLESCENT SEXUAL ABUSE?
◯ YES ◯ NO

HAVE YOU HAD ANY OF THE FOLLOWING STUDIES?		
☐ MRI	☐ X-RAY	☐ CT SCAN
☐ MYELOGRAM	☐ DISCOGRAM	☐ EMG/NCV
☐ BONE SCAN	☐ OTHER:	

HAVE YOU SEEN ANY OTHER PHYSICIAN FOR THIS PAIN?	
◯ YES ◯ NO	
PHYSICIAN NAME	
SPECIALTY	
HAVE ANY LEGAL CLAIMS BEEN FILED RELATED TO YOUR PAIN?	
◯ YES ◯ NO	

DOB:

DATE

PLEASE INDICATE YOUR EMPLOYMENT STATUS:		
☐ UNEMPLOYED BECAUSE OF PAIN	☐ ON DISABILITY	☐ EMPLOYED, PART-TIME
☐ UNEMPLOYED BUT LOOKING FOR WORK	☐ RETIRED	☐ EMPLOYED, FULL-TIME
☐ HOMEMAKER	☐ OTHER:	
JOB DESCRIPTION		

ARE YOU TAKING ANY OF THE FOLLOWING?
☐ COUMADIN (WARFARIN)
☐ PRADAXA (DABIGATRAN)
☐ XARELTO (RIVAROXABAN)
☐ PLAVIX (CLOPIDOGREL)
☐ LOVENOX (ENOXAPARIN)
☐ ASPIRIN
☐ AGGRENOX
☐ BRILINTA
☐ TICLID
☐ OTHER BLOOD THINNER?

WHY:	
PRESCRIBING PHYSICIAN:	

DOB:

DATE