KEIPERSPINE PC

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1410 Oak Street, Suite 200, Eugene, OR 97401
Phone: 541-485-2357 **Fax:** 541-485-2358

Date: _____

First, MI, Last Name: _____ **DOB:** _____

Mailing Address: _____

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

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

SSN: _____ **Email:** _____

Referring Provider: _____

Primary Care Provider: _____

Emergency Contact: _____ **Phone:** _____

How did you hear about KeiperSpine? _____

Please mark the correct boxes below: (Answers are optional but KS is asked to report # of each to State of Oregon)

Ethnicity:

Hispanic ☐ Non-Hispanic ☐ Prefer not to list ☐

Race:

Caucasian ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other ☐

African American/Black ☐ American Indian ☐ Prefer Not To List ☐

Current Symptoms:

Please mark the boxes below that correlate with your symptoms

Back Pain: ☐ Neck Pain: ☐

Lower Extremities: Left Side: ☐ Right Side: ☐ Both: ☐ Numbness/Tingling: ☐ Weakness: ☐ Pain: ☐

Upper Extremities: Left Side: ☐ Right Side: ☐ Both: ☐ Numbness/Tingling: ☐ Weakness: ☐ Pain: ☐

Other: _____

Diagnostic Studies And Conservative Treatments:

This information is used to help obtain insurance authorization for procedures.

MRI

Where: _____ When: _____

X-Ray

Where: _____ When: _____

CT/CT Myelogram

Where: _____ When: _____

EMG/NCV

Where: _____ When: _____

Discogram

Where: _____ When: _____

Physical Therapy

Where: _____ When: _____

Epidural Steroid Injections

Where: _____ When: _____

Chiropratic Treatment

Where: _____ When: _____

Acupuncture

Where: _____ When: _____

Medications Tried

What: _____ When: _____

Other(home exercises, etc)

What/Where: _____ When: _____

Past_Medical History:

Diagnosis	Managing Physician	Active/Inactive/Resolved?

Past Surgical History:

Type	Year

Social History:

Tobacco Use:

Never: ☐ Every Day: ☐ Some Day: ☐ Former: ☐

Alcohol Use:

Never: ☐ Every Day: ☐ Some Day: ☐ Former: ☐

Marijuana Use:

Never: ☐ Every Day: ☐ Some Day: ☐ Former: ☐

Marital Status:

Married: ☐ Single: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐ Domestic Partner: ☐

Occupation:

Employed: ☐ Unemployed: ☐ Retired: ☐ Disabled: ☐

Job Title:_____Employer:_____

Family History:

Problem	Relation
Spine Surgery	
Brain Tumors	
Cancer	
Diabetes	
Heart Disease	
Migraines	
Strokes	
Tuberculosis	

Allergies And Sensitivities:

(Please list all including drugs, foods, environmental, inhalants, insects, and plants)

☐ None

Allergy or Sensitivity	Reaction

Medication List:

☐ None ☐ List attached

Medication	Dosage	SIG (how you take it)	Why You Are Taking

Review Of Systems:

Please check all that apply

- ☐ Night Sweats
  Notes:_____
- ☐ Fever
  Notes:_____
- ☐ Recent Weight Loss
  Notes:_____
- ☐ Eye Pain
  Notes:_____
- ☐ Swallowing Difficulty
  Notes:_____
- ☐ Sleep Apnea with C-PAP
  Notes:_____
- ☐ Irregular Heart Beat
  Notes:_____
- ☐ Chest Pain
  Notes:_____
- ☐ Shortness of Breath
  Notes:_____
- ☐ Constipation
  Notes:_____
- ☐ Abdominal Pain
  Notes:_____
- ☐ Bowel Incontinence
  Notes:_____
- ☐ Dysuria (painful urination)
  Notes:_____
- ☐ Urinary Incontinence
  Notes:_____
- ☐ Impotence
  Notes:_____
- ☐ Joint Pain
  Notes:_____
- ☐ Skin Cancer
  Notes:_____
- ☐ Depression
  Notes:_____
- ☐ Anxiety
  Notes:_____
- ☐ Thyroid
  Notes:_____

Review of Systems (Continued):

- ☐ Diabetes
  Notes:_____
- ☐ Use of Blood Thinners
  Notes:_____
- ☐ Easy Bruising
  Notes:_____
- ☐ Free Bleeding
  Notes:_____
- ☐ History of Bleeding Disorder
  Notes:_____
- ☐ Easy Infection
  Notes:_____
- ☐ Headaches
  Notes:_____
- ☐ Dizziness
  Notes:_____
- ☐ Blackouts
  Notes:_____
- ☐ Convulsions
  Notes:_____
- ☐ Confusions
  Notes:_____
- ☐ Memory Problems
  Notes:_____
- ☐ Blurred Vision
  Notes:_____
- ☐ Clumsiness
  Notes:_____
- ☐ Loss of Balance
  Notes:_____
- ☐ Numbness
  Notes:_____
- ☐ Weakness
  Notes:_____

I attest that information provided here is true and correct to the best of my knowledge:

Signature:_____ Date:_____

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

(A NOTICE OF PRIVACY PRACTICE WILL BE OFFERED TO YOU DURING YOUR VISIT: OR YOU MAY REQUEST A COPY AT ANY TIME)

I have received a copy of this office's notice of privacy practices:

Please Print Name:_____

Patient Signature/Guardian:_____Date: _____

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I/We authorize medical service providers to release to KeiperSpine, PC, any medical, clinical or financial records required for my care. I/We also authorize KeiperSpine, PC release medical or financial records that may be required to ensure continuity of care to the other health providers, insurers, or contracted service providers. This includes but is not limited to my insurance company, rehabilitations services, Social Security Administration, and Workers Compensation.

Patient Signature/Guardian:_____Date:_____

If you would like us to be able to discuss your care with a friend or family member, please complete the below.

I authorize KeiperSpine, PC to discuss my care in person and over the phone with:

_____ (NAME), who is my _____ (RELATIONSHIP)

☐ They may also obtain my records or request that KeiperSpine, PC release clinical and/or financial records to a designated third party.

Patient Signature/Guardian:_____Date:_____

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Financial Agreement

It is your responsibility to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current photo ID and insurance cards should be presented at each office visit. As a courtesy, we will file your insurance claim(s) for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance.

Financial Agreement:

I understand that I am responsible for the payment of services rendered if the services are not covered by my insurance for any reason. KeiperSpine is a participating provider with most health plans, however, participation is subject to change. I understand it will be my responsibility to verify with my insurance carrier the plan participation status of KeiperSpine prior to services being rendered. Insurance will be according to the billing/payment guidelines of my primary insurance contract. If a referral is required by my plan, I understand it is my responsibility to obtain, or my insurance may not pay my claims.

Payment Agreement:

Co-payment, deductibles, co-insurance, non-covered services (including pre-existing conditions) and services denied due to lack of referral are my responsibility.

Assignment of Insurance Benefits:

I assign medical benefits paid by my insurance carrier(s) to be sent to KeiperSpine, PC. I acknowledge that I will be billed for charges not covered under my insurance policy as well as those portions indicated as my responsibility.

Additional Charges:

There may be additional medical services ordered by us, such as laboratory or radiology, for which you will be referred out of this clinic. If this occurs, you will receive a separate billing from that provider, for which you will be responsible. If surgery occurs, anesthesia and facility charges will bill separately from KeiperSpine as well.

Release of Information:

I authorize KeiperSpine, PC to furnish my insurance company(s), employer, other payer(s) or their representative's any and all information required to process my claim. Special permission is necessary to release the following information: drug/alcohol abuse, mental health or HIV related conditions.

Patient Balance:

I agree to pay any balance remaining on my account upon receipt of a statement. I understand that if I fail to pay the balance on my account this may result in KeiperSpine, PC pursuing any collection means possible. If my account becomes delinquent, it will most likely be forwarded to an outside collection agency (Quick Collect, Inc., phone: 800 252-6322). If this happens, I will be responsible for all costs of collection, including but not limited to, interest, rebilling fees, court costs, attorney fees and collection agency costs. At minimum, a $20.00 fee is added when an account is more than 2 months delinquent and if referred to collections, interest will begin accruing. If it becomes necessary, court costs and attorney fees typically start at $210.00.

I have read and I understand KeiperSpine's financial policies, and I accept responsibility for the payment of any fees associated with my care.

Patient Name:_____DOB:_____

Signature of Patient/Guardian:_____Date:_____