CAPITAL CITY NEUROSURGERY

MINIMALLY INVASIVE SPINE SURGERY

Welcome to Capital City Neurosurgery!

You have been scheduled for a consultation with ***Kelly J. Kiehm, M.D.*** Our office number is (614) 442-0700. You have been scheduled at the following location:

Main Office	**Mansfield Clinic**
3600 Olentangy River Rd., Bldg 480	**408 Glessner Ave**
Columbus, OH 43214	**Mansfield, OH 44903**

Your appointment is on _____, ____/____/____ @ _____am/pm. You must arrive with the following information:

- ✓ **The enclosed patient information forms *completed* in their entirety**
- ✓ **Driver license, or photo identification, along with your insurance card(s)**
- ✓ ***ACTUAL films or CD(s)* and written reports of any radiology testing**

IF YOU DO NOT HAVE YOUR FILMS OR CD, PHOTO ID, COPAY, OR INSURANCE CARD(S) AT THE TIME OF YOUR APPOINTMENT, YOU MAY BE ASKED TO RESCHEDULE

Insurance:

► **Medical Insurance:** Please bring your insurance card(s). It is important that you check with your insurance company to see if a referral from your primary care physician is needed for your appointment. Most insurance companies will NOT back date a referral. YOUR COPAY IS DUE AT THE TIME OF CHECK IN. We accept cash, check or VISA/MC.

► **Worker's Compensation (BWC)**: Please have your BWC card and the name and phone number of your Managed Care Organization (MCO). **It is important that you obtain prior authorization from your physician-of-record before your appointment.** Dr. Kiehm DOES NOT assume physician-of-record responsibilities.

► **Motor Vehicle Accidents:** We do not bill commercial or government insurance for personal injury or motor vehicle accident claims. You need to make arrangements with your attorney.

► **Self-Pay**: We expect full payment at the time services are rendered.

Failure to arrive at your appointment time may result in the re-scheduling of your appointment. It is our intention to be as timely as possible; however, due to the nature of our specialty, there may be a delay at the time of your appointment and/or circumstances in which your appointment needs to be re-scheduled. We appreciate your understanding in advance.

Capital City Neurosurgery, LLC

REGISTRATION FORM
(Please Print)

Today's date:	**FAMILY PHYSICIAN**:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Nickname:	Social Security no.:	Email address:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	P.O. Box:	Home phone no.: ( )

City:	State:	ZIP Code:	Cell phone no: ( )

Occupation:	Employer:	Employer phone no.: ( )

Employer address:	Spouse's name:	Spouse's SSN:

Whom may we thank for referring you?	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medical Mutual	❑ Aetna	❑ Cigna	❑ United Health Care

❑ Blue Cross/Blue Shield	❑ Self Pay	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Birth date of subscriber:	Subscriber's S.S. no.:
					/ /	

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Dr. Kiehm** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature *Relationship* *Date*

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Kiehm** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier aggress to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature *Date*

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Release of Medical Information

I hereby authorize the release of any and all medical records pertaining to my care to:

Kelly J. Kiehm, MD
Capital City Neurosurgery
3600 Olentangy River Road
Building 480
Columbus, OH 43214

Fax: 614-678-8851
Phone: 614-442-0700

Patient Name:_____

Date of Birth:_____ Social Security No:_____

Signature:_____

Capital City Neurosurgery, LLC

3600 Olentangy River Road Building 480
Columbus, OH 43214
614-442-0700

PATIENT ACKNOWLEDGMENT FORM
NOTICE OF PRIVACY PRACTICES AND CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Capital City Neurosurgery, LLC. Privacy Practices.

CONSENT OF HEALTH INFORMATION: This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to you health care information.

I hereby give my consent to ***Capital City Neurosurgery, LLC.*** **to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care with this practice.**

CONSENT FOR TREATMENT: I, with my signature, authorize this practice and any employee working under the direction of the physician, to provide medical care for me, or to this patient which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

CONSENT TO RELEASE OF INFORMATION FOR PAYMENT AND OPERATIONS: I also authorize this practice to furnish information to the identified insurance carrier (s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the privacy practice notice.

CONSENT RELATED TO THE PRIVACY NOTICE: I have had a chance to review the Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Practice Notice may change and I may obtain these revisions by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on the use, it is bound by that agreement.

If we are unable to reach you personally, do we have your permission to leave a message on your voicemail or answering machine? **(Initial here for YES) _____ Phone#_____**

I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING:

1. _____RELATIONSHIP_____PHONE #_____
2. _____RELATIONSHIP_____PHONE #_____
3. _____RELATIONSHIP_____PHONE #_____

PATIENT PRINTED NAME _____

PATIENT SIGNATURE _____Date_____

PATIENT'S PERSONAL REPRESENTATIVE _____Date_____

OFFICE REPRESENTATIVE_____

REPRESENTATIVE SIGNATURE _____Date_____

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OFFICE USE ONLY	**Height**	**Weight**	**Blood Pressure**	**Pulse**

Name	Date of Birth Age
Primary care physician name and address	Referring physician name and address

Major Complaint:

When did it start and what happened?

Were you injured at work? If so, when? BWC Claim #:	Is this a result of a motor vehicle accident? If so, when? Attorney name and phone:

Have you had an MRI and/or CT? Where?

	Low Back	Leg		Neck	Arm
Where (circle)	Left/Right/Center	Left/Right/Both		Left/Right/Center	Left/Right/Both
% of pain (should add up 100%)					
Do you always have pain there (Y/N)					
What makes it worse? (i.e. walking,standing, lifting…)					
What makes it better? (i.e. laying down, sitting, resting…)					

Please circle your pain level on the scale.

No pain 1 2 3 4 5 6 7 8 9 10 Intense pain

Medications	
Name/Dose/Frequency	Reason for taking medication

Medication Allergies

Medical Problems

Past Surgeries

Family History

Social History
☐ Single ☐Married ☐Life Partner ☐Divorced ☐Widowed Number of Children: Education: Occupation: Are you working now? How much do you drink? How much do you smoke? Illicit drug use? Have you ever had a drug overdose?

What have you tried to control your pain? (check boxes below)

☐Epidural Injections	☐Spinal Cord Stimulator	☐Radiofrequency Ablation	☐Herbal Medications
☐Physical Therapy	☐Chiropractic Care	☐Massage Therapy	☐Aquatic Therapy
☐Acupuncture	☐Joint Injections	☐Nerve Blocks	☐TENS Unit
☐Biofeedback	☐Counseling	☐Celebrex	☐Naprosyn
☐Relafen	☐Arthrotec	☐Daypro	☐Motrin
☐Soma	☐Norflex	☐Robaxin	☐Skelaxin
☐Baclofen	☐Zanaflex	☐Valium	☐Ativan
☐Xanax	☐Elavil	☐Nortriptyline	☐Trazadone
☐Paxil	☐Zoloft	☐Prozac	☐Vicoprofen
☐Percocet	☐MsContin	☐Kadian	☐Oxycontin
☐Duragesic	☐Methadone	☐Neurontin	☐Topamax
☐Depakote	☐Tegretol	☐Dilantin	☐Zonegran
☐Lidoderm	☐Flector	☐Cymbalta	☐Avinza
☐Lyrica	☐Tylenol	☐Advil	☐Surgery

Other:_____

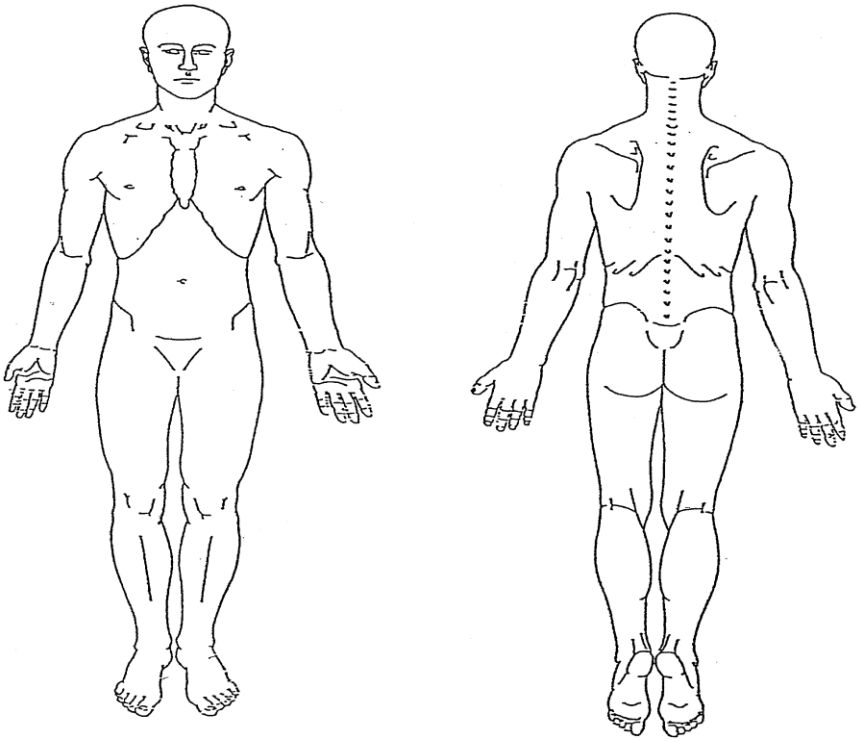
_____

Which of those treatments helped? (Please circle)

Have you ever been evaluated in a pain clinic? _____
If so, where and by who?_____

_____

Please shade in where your pain is located.



Review of Systems

Are you currently or have you in the past 3 years had the following:

	Yes	No
Constitutional		
Fever		
Weight Loss		
Excessive Fatigue		
Night Sweats		
HEENT		
Double or Blurred Vision		
Hearing Loss		
Dizziness/Vertigo		
Cardiovascular		
High Blood Pressure		
Palpitations		
Chest Pain		
Respiratory		
Shortness of Breath		
Coughing		
Wheezing		
Gastrointestinal		
Loss of appetite		
Nausea/vomiting		
Abdominal Pain		
Heart Burn		
Diarrhea		
Constipation		
Genitourinary		
Loss of bladder control		
Difficulty urinating		
Frequent urination		

	Yes	No
Neurological		
Numbness		
Lack of coordination		
Confusion		
Memory problems		
Tremors		
Fainting		
Headaches		
Dizziness/Vertigo		
Hematologic		
Blood Clots		
Anemia		
Bleeding tendency		
Swollen glands		
Psychiatric		
Anxiety		
Depression		
Insomnia		
Skin		
Rashes		
Easy Bruising		
Redness		
Musculoskeletal		
Spasms		
Cramps		
Arm weakness		
Leg weakness		
Joint pain or swelling		

Other:

The information provided above is accurate to the best of my knowledge.

Patient's Signature:_____ Date:_____

I have reviewed the information above with the patient.

Physician's Signature:_____ Date:_____