The Spine Center of Central Kentucky

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Male ❑ Female	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:

Address:	Social Security no.:	Home phone : ( )

City	State	Zip Code	Cell phone: ( )

Occupation:	Employer:	Employer phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )

Occupation:	Employer:	Employer address:	Employer phone: ( )

Primary insurance: **Effective Date:**

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

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

Secondary insurance (if applicable): **Effective Date:**

Subscriber's name:	**Subscriber's S.S.#**	**Birth date:** / /	**Group no.:**	**Policy no.:**

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Do you have a Power of Attorney? ***If so, name:***

What Medications are you currently taking?		
MEDICATION	***DOSAGE***	***HOW MANY TIMES PER DAY***

Medication List

Central Kentucky Spine Surgery, PLLC
Robert P. Knetsche, M.D.
Ellen J. Flinchum, M.D.
Justin B. Cecil, PA-C

Bluegrass Brace Shop, LLC

236 W. Main Street, Suite 200-203 Danville, Ky 40422
Ph:859-238-7746 Fax: 859-236-0261

CONSENT TO TREAT

I authorize the physician(s) at The Spine Center of Central Kentucky, and/or their delegates to examine and treat me according to the accepted medical practices and within the scope of their abilities. Treatments done in the office may include, but are not limited to, trigger point injection, subacromial injection, intra-articular joint injection, epidural steroid injection, facet joint injection, kyphoplasty, stimulator trial, and EMG. I understand that it is my right to refuse any examination and/or treatment that I do not wish to receive. If I choose to refuse recommended treatment, I will not hold the physician(s), their delegates, or The Spine Center of Central Kentucky liable for any deleterious health effects or complications that may arise as a result of my refusal.

CONSENT TO BILL

I authorize the physician(s) at The Spine Center of Central Kentucky, and/or their delegates to bill medical claims to my insurance carrier(s) (including worker's compensation and motor vehicle insurances, when applicable). I authorize any release of information necessary to expedite payment of insurance claims. I understand that I am responsible for all charges regardless of insurance coverage and I agree to remit payment for any charges not covered by my insurance company.

CONSENT TO RELEASE/OBTAIN INFORMATION

I authorize the physician(s) at The Spine Center of Central Kentucky, and/or their delegates to release information to and obtain information from other medical practices, physicians, hospitals, laboratory and radiology providers, and any other medical entity in order to optimize or facilitate medical care provided to me. I understand that any release of information will be made under the provisions of the Health Information Portability and Accountability Act (HIPPA) and my privacy will be maintained to the greatest extent possible.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

I acknowledge The Spine Center of Central Kentucky has provided me a copy of its Notice of Privacy Practices, which provides a more detailed description of the uses and disclosures allowed by this consent.

In order for us to protect your privacy, we ask that you let us know if you have a person that resides in your household whom you do **NOT** want us to discuss your health information. In addition, if you have someone who does not reside in your household with whom you **DO** want us to share your health information, please complete the Disclosure Consent Form available at our front desk.

_____
Print Patient Name

_____ _____
Signature of Patient or Personal Representative Date

INFORMED CONSENT – CONTROLLED SUBSTANCES

In accordance with Kentucky House Bill 1, you, the patient have the right to be informed that in the course of treatment, the physician(s) at The Spine Center of Central Kentucky may prescribe a medication that is considered a controlled drug. It is your right to make an informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is made in an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by your physician, including your physician's authorized associates, technical associates, nurses, staff, and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREAT AND/OR DRUG THERAPY: I voluntarily request my physician treat my condition. I hereby authorize and give my voluntary consent to administering or prescribing the prescription(s) for controlled drugs (medications) as an element in the treatment of my condition.

The Spine Center of Central Kentucky may prescribe medication(s) which include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I understand that the medication(s) may lead to physical dependence and/or addiction and may produce adverse side effects or results. Alternative methods of treatment and the possible risks involved have been explained to me. I understand that the side effects and risks described below are the most common, but all possible side effects and risks exist, and death is also a possible result from taking the medication(s).

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUG(S) IN MY TREATMENT INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

I HAVE BEEN INFORMED and understand that I will undergo medical tests and examinations before and during my treatment. These tests include random unannounced checks for drugs, and may include psychological evaluations if and when deemed necessary. I hereby give permission to perform the tests and understand that my refusal may lead to termination of treatment.

For Female Patients:
To the best of my knowledge I AM NOT pregnant. I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant.

I understand that, at present, there have not been enough studies conducted on the long-term use of may medication(s) i.e. opioids/narcotics to assure complete safety to unborn child(ren). With full knowledge of this, I consent to the use of any recommended drug(s) and hold my physician harmless for injuries to the fetus/embryo/baby.

I understand that during my appointment I will be given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s).

_____
Patient Name – Print

_____ _____
Patient Signature Date

THE SPINE CENTER OF CENTRAL KENTUCKY

FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at time of service unless arrangements have been made in advance by your carrier. We accept checks, Mastercard, Visa and Discover. There is a service charge on all returned checks.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. For your convenience, we have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will file claims on your behalf with these companies. We will bill primary and secondary insurance, when applicable. However, you are required to pay a copayment at the time of service.

4. A copayment is the specified amount your insurance company requires that you pay for certain services. The copayment is separate from and in addition to any applicable co-insurance and/or deductible. The copayment is usually listed on your insurance card. Any applicable copayment is due at the time of service.

5. If you are insured by a plan that we do not have a prior arrangement with, this means that we **cannot** file a claim for you. In this case, you must work directly with you insurance company to file the claim. Therefore, our charges for your care are due at the time of service.

6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from this office. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

7. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

8. Missed appointments represent a cost to us, to you and to other patients who could have been seen at the time set aside for you. We request 24 hours notice for cancellation of an appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

9. The Spine Center attempts to schedule all services we order for you in your insurance company's network. We will attempt to schedule ancillary services (images, labs, etc.) in the facility closest to you. While we have no control over the charges at any facility, we may be aware of alternatives and are happy to discuss other options with you. It is your choice to use any facility you may wish to have these services performed. Please let a staff member know your preferences.

10. I understand that my eligibility for coverage by personal insurance may not or cannot be confirmed at this time. I wish to receive medical services from The Spine Center of Central Kentucky. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____

Initials

Forms: There is a $15.00 fee, payable in advance, for filling out a disability form, employer/work related forms or any other form relating to your medical condition. These are done in the order they are received and will be sent to the patient or insurance when completed

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time

_____ _____

Signature of Responsible Party Please print the name of the patient

IF YOU ARE VISITING US DUE TO A WORKERS COMP OR MOTOR VEHICLE ACCIDENT AND THEY ARE PAYING FOR YOUR VISIT, PLEASE SIGN THE APPROPRIATE SECTION BELOW.

Worker's Compensation: In order for us to accept assignment of worker's compensation insurance the patient must bring a written acceptance of financial responsibility from the employer or the employer's worker's compensation carrier. However, **the patient is still responsible for the bill if the insurance carrier does not pay within 60 days**. The case manager, insurance company or your employer must make all appointments that are not scheduled immediately following each visit. This includes any changes in scheduled appointments.

_____

Motor Vehicle Accidents: Patients must provide our billing department with all motor vehicle insurance information, as well as health insurance information, in advance of their appointment to allow our office to verify coverage. If you do not have individual health insurance, a $300 deposit will be required at your first visit. If an attorney is representing your interests, it is our policy to extend the courtesy of credit upon receipt of a protection letter from your attorney. Your attorney must provide a letter of protection to secure any uncovered service before you begin care and regardless of your health insurance or med-pay coverage benefits.

_____

THE SPINE CENTER OF CENTRAL KENTUCKY

MEDICATION AGREEMENT

I, _____ have agreed to the following conditions:

As part of my treatment for spinal and nerve related pain, I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each month.

I understand the following guidelines for continuing pain treatment under the care of any provider of The Spine Center:

1. I understand that I have the following responsibilities:
   a. I will take medications at the dose and frequency prescribed.
   b. I will not increase or change how I take my medications without the approval of my Spine Center health care provider.
   c. I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or on weekends.
   d. I will obtain all refills for these medications at _____ pharmacy.
   e. I will not request any pain medications or controlled substances from other providers and I will inform my Spine Center provider of all other medications I am taking.
   f. I will inform my other health care providers that I am taking these pain medications and of the existence of this agreement. In the event of an emergency, I will provide this same information to emergency department providers.
   g. I will protect my prescriptions and medications. I understand that lost or misplaced or soiled/damaged prescriptions/medications may not be replaced.
   h. I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
   i. I agree to participate in any medical, physical therapy, psychological or psychiatric assessments recommended by my provider.
   j. I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.

2. I will not use illegal or street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:
   - 12-step program and securing a sponsor
   - Individual counseling
   - Inpatient or outpatient treatment
   - Other: _____

   If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to my Spine Center provider and I will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. A blood nicotine level is considered a drug test.

_____
Initials

4. I will consent to random pill counts to assure that I am taking my medication as prescribed. I understand I will be expected to come to The Spine Center within 24 hours and bring the bottle of my prescription medication.

5. I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.

6. I understand that this provider may stop prescribing medications if:
   - I do not show any improvement in pain or my activity has not improved.
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.
   - My behavior is inconsistent with the responsibilities outlined above, ***which may also result in being prevented from receiving further care from this clinic.***

7. The Spine Center's prescription pain medication drug policy is as follows:
   A. All refill requests require at least 72 hours notice before being approved or denied.
   B. If you are on a reasonable pain medication regime by another provider, the Spine Center providers may elect to have that provider continue to provide your pain medications so that only one provider is giving you medications.
   C. If you come into the office and request your pain medication at the front window, the 72 hour notice policy still applies.
   D. We do not fill prescriptions for patients who have not been seen by one of the Spine Center providers.
   E. Narcotic pain medications may be discontinued at 6 weeks post surgery or per physician discretion.
   F. Patients who need narcotic pain medications after 6 weeks post surgery may be referred to a physician-directed narcotic withdrawal program.
   G. I understand that The Spine Center may use several devices or medications in an "off-label" fashion because they have been found to be safe and effective and supported by the spine surgery/neurosurgery scientific medical literature.
   H. Patients who fail to attend or are not compliant with a scheduled physician-directed narcotic withdrawal program may not be prescribed any more narcotic pain medications by The Spine Center providers and may be dismissed from any other care from The Spine Center.
   I. Abusive behavior directed towards the Spine Center staff over medication prescriptions or any other issue will be cause for immediate dismissal action from The Spine Center.

Patient Signature: _____ Date: _____

Refusal to sign this agreement will result in The Spine Center not being responsible for management of any narcotic pain medications.