Orthopaedic Specialists of the Four States, LLC
444 Four States Drive, Suite 1
Galena, Kansas 66739 (620) 783-4441

Patient Name: _____ Social Sec #: _____-_____-_____
Date of
Birth: ____/____/____ Age: _____ Sex: M / F (Circle one) Married Single Divorced Widow
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____-_____ Cell Phone: (____) _____-_____
Employer Name: _____Employer Ph #: (_____) _____
Employer Address: _____City: _____State: ____Zip: _____
Primary Care Physician: _____ Referred By: _____
Are you currently in a Nursing Facility? Yes ___ No___ ***If YES please fill in the information below:***
Facility Name: _____Address: _____Telephone:_____

Who to call for an emergency:
Name: _____Address:_____
Home #: (_____) _____ - _____ Work #: (_____) _____-_____Relationship:_____

PERSONS PRESENTING AS GUARDIANS TO AN ADULT OR MINOR (UNDER 18):
Recognized guardian would be a biological parent, legal guardian, foster parent or POA (with legal documentation). If no documentation is available at the time of service it is at the provider's discretion if services will be rendered.

Name: _____Relationship_____
Address is different from patient: _____
Phone #:_____
For minors (person under 18) only. This is for our information only.
Mother's name: _____PH #_____
Father's name: _____PH#_____
Stepmother's name: _____PH#_____
Stepfather's name: _____PH#_____

PRIMARY INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____Group #: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder Employer: _____ Employer Address: _____
Policy Holder's Social Sec Number: _____ - _____ - _____ Policy Holder's Dob: ____/____/____

SECONDARY INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____Group #: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder Employer: _____ Employer Address: _____
Policy Holder's Social Sec Number: _____ - _____ - _____ Policy Holder's Dob: ____/____/____

TERTIARY INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____Group #: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder Employer: _____ Employer Address: _____
Policy Holder's Social Sec Number: _____ - _____ - _____ Policy Holder's Dob: ____/____/____

Brian J. Ipsen, M.D.
Joseph Mark Graham, Jr., D.O.
Toby G. Moore, D.O.
Spine & Orthopaedic Surgery

Michael L. Hearndon, D.O.
Physical Medicine & Rehabilitation
Fellowship Trained-Interventional Pain Management

Orthopaedic Specialists of the Four States, LLC

Spine Pain Questionnaire

Date:_____

Name:_____ Date of Birth:_____

Address:_____ Phone:_____

Occupation:_____ Dominant Hand right____ left____

TYPE OF WORK(mark all that apply)

___ Retired naturally
___ Retired due to back
___ Heavy Labor
___ Moderate Labor
___ Homemaker
___ Student
___ Unemployed
___ Other_____

REASON FOR TIME OFF WORK

___ MD prescribed time off work
___ MD prescribed light duty
___ Patient decided they could not work
___ Patient not employed outside home

Where is your pain? _____

_____

_____

_____

_____

_____

_____

_____

How long have you had this pain? _____ years _____ months

What were you doing when it started? _____

_____

How did the pain start? Gradually Rapidly Injury **(please circle)**

Is your pain? Constant Intermittent Both **(please circle)**

Was this a work related injury?_____

Who has treated you for this injury?_____

Is an Attorney working on this injury?_____

Please circle the number that corresponds to your average **NECK** or **BACK** pain over the last several days:

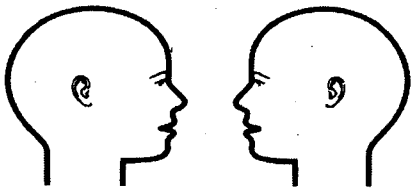
No Pain 0___1___2___3___4___5___6___7___8___9___10___ **Worst**

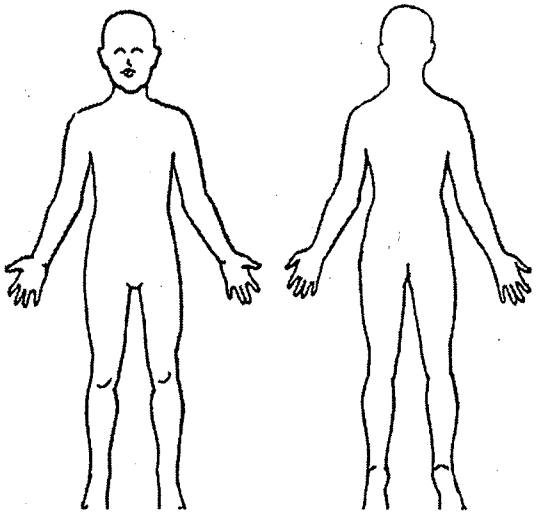
Please circle the number that corresponds to your average **ARM** or **LEG** pain over the last several days:

No Pain 0___1___2___3___4___5___6___7___8___9___10___ **Worst Possible Pain**

Indicate on the diagram below where you pain is located and what type of pain you feel **at the present time**. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>>	Sharp
///	Stabbing
Xxx	Burning
Ooo	Pins & Needles
====	Numbness/Tingling





Does it feel BETTER when you are:

	YES	NO		YES	NO
Standing			Walking		
Sitting			Exercising		
Lying down			Other:		

Does it feel WORSE when you are:

	YES	NO		YES	NO
Coughing/sneezing			Bending		
Sleeping			Lifting		
Sitting			Walking		
Standing			Other:		

What Kind of TREATMENT have you had for THIS CURRENT EPISODE of pain?

	YES	NO	
Bed Rest			How many days?
Medications			What Kind?
Physical Therapy			How Many Weeks/When/Where?
Chiropractor			
Acupuncture			
Braces			
Injections: (cortisone,Steriods)			What kind/Hospital? (epidural, etc.)?
Massage Therapy			Where/How Long?
Other:			

Have you had X-rays?_____ Where?_____ When?_____

Have you had an MRI?_____ Where?_____ When?_____

Have you had a CT scan?_____ Where?_____ When?_____

Medical problems:_____

_____

_____

Do you have DIABETES? Yes___ No___ HEART DISEASE? Yes___ No___

INFECTION? Yes___ No___ Have you ever had Cancer? Yes___ No___

Surgeries: Year Complications

_____

_____

_____

_____

_____

_____

_____

Allergies:_____

Height:_____ft _____in Weight:_____

Marital Status: S M W D **Spouses age:**_____ **Number of Children:**_____

Education: Last grade attended: Grade school___ High School___ Voc. School___

College___ Graduate Education___

Do you **Smoke**? Yes___ No___ Quit?___ months/years ago

If yes, how many packs per day? _____packs per day for _____years.

Do you **drink alcohol**? No___ never (rarely.) No___but I used to. Yes___ Daily___

Or how many times a week? _____.

Have you ever abused drugs? Yes___ No___ If yes what type_____

Have you ever abused prescription drugs? Yes___ No___ If yes what type_____

FAMILY MEMBERS with medical problems? (cancer, diabetes, etc.)

Relationship:	Disease(s):
Family History of Substance Abuse? Yes or No	If so, what kind? _____

For Women:

Pelvic/breast exams?	YES	NO	Last exam date:
Abnormal results?	YES	NO	When?
Last menstrual period	Date:		Irregularities:

Please **check Yes or No to EACH item** to indicate which of the following symptoms you are **CURRENTLY** experiencing:

MUSCULOSKELATAL	YES	NO
Joint Stiffness		
Joint Pain		
Osteoporosis		
Joint Swelling		
Back Pain		
Gout		
Rheumatoid Arthritis		
Limb Swelling		
Ankle Swelling		
Extremity Pain		
Neck Pain		

GASTROINTESTINAL	YES	NO
Heartburn		
Gastric Ulcer		
Nausea		
Vomiting		
Blood in stool		
Liver, stomach or bowel disorder (circle one)		
Hepatitis		

ENDOCRINE	YES	NO
Excessive Thirst		
Excessive urination		
Temperature Intolerance		
Thyroid Disorder		
Diabetes Mellitus		

CONSTITUTIONAL	YES	NO
Weight loss _____lbs		
Fever		
Decreased appetite		

EARS, NOSE, THROAT	YES	NO
Loss of hearing		
Hoarseness		

EYES	YES	NO
Blurry vision		
Double vision		
Visual impairment		

CARDIOVASCULAR	YES	NO
Chest pain		
Palpitations		
Heart disease		
High blood pressure		

RESPIRATORY	YES	NO
Chronic cough		
Shortness of breath		
Wheezing		

GENITOURINARY	YES	NO
Painful urination		
Blood in urine		
Renal disorder		

INTEGUMENTARY	YES	NO
Skin rash		
Skin lesions		
Skin lump		
Psoriasis		
Skin wound		

NEUROLOGICAL	YES	NO
Headaches		
Dizziness		
Seizures		
Dementia		
Numbness/Tingling		

PSYCHOSOCIAL	YES	NO
Depression		
Alcohol use		
Drug use		
Sleep disturbances		

HEMATOLOGIC/LYMPHATIC	YES	NO
Easy bleeding		
Easy Bruising		
Anemia		
HIV/AIDS		

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

_____ _____

Patient Signature Date

Brian J. Ipsen, M.D. **Joseph Mark Graham, Jr., D.O.** **Michael L. Hearndon, D.O.**
Terry Vogt, PA-C **Joshua Sweet, PA-C** **Jickie Parker, APRN**
Christopher Jones, PA-C **Stephanie Hallacy, APRN**

Name: _____ Date of Birth: _____ ACCT #: _____

Continuation of List of Current Medications

Page_____of _____

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	**Dosage** *Example: 10.5 mg*	**How often do you take the Medication?** *Once daily, every 4 hours, every 12 hours, etc*	**How do you take:** *By mouth, apply to skin, inhale, under tongue, injection, etc*	**Type:** *Tablet, Capsule, Patch, Drops, Ointment, Spray, liquid, etc*	

DATE: _____ Patient initials: _____

Name: _____ Date of Birth: _____ ACCT #: _____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	**Dosage** *Example: 10.5 mg*	**How Often do you take the Medication?** *Once daily, every 4 hours, every 12 hours, etc.*	**How do you take?** *By mouth, apply to skin, inhale, under tongue, injection, etc*	**Type:** *Tablet, Capsule, patch, drops, ointment, spray, liquid, etc.*	

DATE: _____ Patient initials: _____

ORTHO FOUR STATES PAIN
PATIENT TREATMENT AGREEMENT

Patient Name (print): _____ DOB: _____

As a patient being treated by **Ortho Four States Pain**, I freely and voluntarily agree to accept this treatment agreement as follows:

1. I agree to keep and be on time to all my scheduled appointments and procedures.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner while in the doctor's office and the procedure suite.
4. I agree **NOT** to sell, share, or give any of my medications to another person including family. I understand that such mishandling of my medications is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected this will result in my treatment being terminated without any recourse for appeal.
6. I agree that my medications/prescriptions can only be given to me at my regular office visits. A missed visit will result in inability to get my medications/prescriptions until the next scheduled visit.
7. I agree that the medication(s) I receive is my responsibility and I agree to keep it in a safe, secure place. I agree lost/stolen medication(s) will not be replaced.
8. I agree not to obtain medication(s) from any doctors, pharmacies or other sources without telling my treating physician.
9. I agree to take my medication(s) as my doctor has instructed and not to alter the way I take my medication(s) without first consulting my doctor.
10. I agree to provide random urine/blood samples when requested to do so. I will also comply with requests of random "call-ins" for audits of my medication(s) and drug screening.
11. I understand Ortho Four States pain has the right to terminate services at any time.
12. **I understand that violations of one or more of the above will be grounds for termination of treatment.**

_____ _____
Patient Signature Date

_____ _____
Witness Signature (Office Staff) Date

Statistics and Portal Access Confirmation form

Patient name: Date of Birth: Chart#:

Population Statistics
(Please circle one)

Gender: Male Female

Race: White American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander Unknown Patient Declines

Ethnicity: Hispanic or Latino Non Hispanic or Latino Unknown Patient Declines

Language: English Spanish French Russian Italian Dutch Unknown

Smoking Status (13 years and older): Current/ everyday Current/ some days Former Never Former/ Current Unknown

(These questions are required by our Electronic Medical Record for accurate documentation purposes and the physicians appreciate your cooperation.)

Name of Pharmacy:_____

Do you want to access your medical records electronically? Yes No

If yes, please provide your email address: _____

Date:

Kiosk drg 10252016

Orthopaedic Specialists of the Four States, LLC

Patient's Name: _____ Date of Birth: _____

By answering the following questions it will help us and your insurance to determine if another party may be financially liable for payment of your claims. We ask that you answer these questions truthfully, as this form could be provided to your insurance company and could impact your financial responsibility.

Is the condition for which you are seeking medical treatment from the result of an accident or injury?

YES _____ NO _____ (if you have marked NO, you may stop here and sign below.)

If "YES", what was the date of injury? _____

In what state did the accident/injury occur? _____

Give a brief description of what happened:

_____

_____

_____

Is this condition, accident, or injury:

_____Work related? _____Motor Vehicle related?

_____On another person's/company's property? _____ N/A

If another party is responsible for your injuries, please advise of the following:

Name _____ Phone # _____

Address_____ City/State/Zip _____

If your injuries were a direct result of your employment or other work for wage or profit, did you file a report of injury? YES _____ NO_____

Employer's Name _____ Phone# _____

Do you have an attorney representing you? YES _____ NO _____

Attorney Name _____ Phone# _____

Sign Here

Patient or Legal Guardian Signature _____ Date_____

Relationship to the patient _____

ORTHOPAEDIC SPECIALISTS OF THE FOUR STATES, LLC- FINANCIAL POLICY

J. Timothy Ogden, MD
J. Christopher Banwart, MD
Jonathan L. Grantham, MD
Brian J. Ipsen, MD
Robert F. Stringer, DO
Toby Moore, DO
Paul W. Toma, DO
Mark E. McNemar, DO
Michael L. Hearndon, DO
Joseph Mark Graham, DO
David L. Blancho, DPM

_____
Patient name (print)

_____
Acct number

Ortho 4 States MRI and Four States Physical Therapy and Aquatic Rehabilitation are a department of Orthopaedic Specialists of the Four States, LLC.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy we require you read and sign prior to any treatment.

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Please remember that Insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. We will file to your health insurance as a courtesy. You are responsible for providing us with up-to-date copies of your health insurance cards. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred; your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. We require all patients to pay their deductible, copay and/or coinsurance payment at each visit. Payment methods we accept include: CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT. There is a $25 fee assessed for all returned checks.

Assignment of Benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to J. Timothy Ogden, MD; J. Christopher Banwart, MD; Jonathan L. Grantham, MD; Brian Ipsen, MD; Robert Stringer, DO; Paul W. Toma, DO; Mark E. McNemar, DO; Michael L. Hearndon, DO; Joseph Mark Graham, DO; and/or David Blancho, DPM.

Consent for Health Care: Patient voluntarily consents to such medical care including but not limited to laboratory, diagnostic or medical treatment which may be ordered by patient's physician or assistants, or designees for medical treatment which they may deem necessary and advisable.

The agreements and assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I, the undersigned, authorize Orthopaedic Specialists of the Four States, LLC to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician or agents or employees of Orthopaedic Specialists of the Four States, LLC for the purposes of business operations, payment for health care services rendered, and continual treatment or coordination of care.

I understand that Orthopaedic Specialists of the Four States L.L.C. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Orthopaedic Specialists of the Four States L.L.C, I agree to forward Orthopaedic Specialists of the Four States L.L.C. all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Minor Patients: THE ADULT ACCOMPANYING A MINOR TO HIS/HER APPOINTMENT IS RESPONSIBLE FOR PAYMENT. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/American Express, or payment by cash or check at time of service has been verified.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient/Guardian Signature_____ Date: _____

Printed Name _____ Relationship to Patient _____

PRIVACY CONSENT
Orthopaedic Specialists of the Four States, LLC
Confidential Channel Communication Request and Notice of Privacy Practice Acknowledgement

This form is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You have a right to request that communications concerning your personal health information be made through confidential channels. We will make necessary efforts to accommodate all reasonable requests. Some method of contact must be provided.

I, _____, hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

May we use telephone number (s) and your email address to contact you? Yes No
If not, what telephone number (s) and email address(es) may we use?
_____ _____

May we discuss pertinent information with anyone else? Yes No

If yes, please state name and relationship to the patient.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

I hereby acknowledge that I have had the opportunity to read and/or receive a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.*

Name of Patient: _____ Signature: _____
(please print) (patient or legal guardian's signature)

Date: _____ Witness: _____

******* IF PATIENT IS A MINOR (UNDER 18), PLEASE FILL OUT THE AUTHORIZATION FOR MEDICAL CARE OF A MINOR ON THE BACK OF THIS FORM *******

Orthopaedic Specialists of the Four States, LLC
444 Four States Drive, Suite 1
Galena, Kansas 66739 (620) 783-4441

Authorization for Medical Care of a Minor

If you are not immediately available when your child becomes ill or has an accident, this form allows a guardian to give permission to a physician to provide necessary emergency care. This form is designed in accordance with legal requirements. All blanks should be filled in. This consent is not valid if the care of a child is entrusted to a person under 18 years of age. By law it is necessary for your physician to have a written release to treat your child when accompanied by anyone other than the legal guardian. Please be sure to complete this form when sending your child to his/her doctor with any other person.

I, _____ (Parent's Name) the undersigned parent/person having legal custody or the Legal guardian of (Patients Name) _____
DOB _____ do hereby authorize:

Authorized Person	Relationship to Child
_____	_____
_____	_____
_____	_____
_____	_____

To consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician or surgeon licensed under the state of Kansas.
In giving this consent I recognize and understand that in situations where the above named minor requires medical or hospital care it may not be possible to contact me and that in such situations I will not be able to knowledgeably evaluate and choose the available alternative treatments or procedures, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment. In such situations, I authorize a physician or surgeon to exercise his professional judgement and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as they in their professional judgement determine to be necessary for the health and safety of the above named minor.

**** IF PARENTS ARE DIVORCED OR SEPARATED PLEASE FILL OUT THIS SECTION****

Who has custody /physical guardianship? _____

Do parents have joint custody over the child? _____

Any legal restrictions regarding the non-custodial parent from consenting/obtaining medical treatment? Y/N
If yes, please explain and provide a copy of the legal restriction.
_____

Signature: _____ Relationship _____

Printed name: _____ Date: _____