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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)

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Retired naturally   | <input type="checkbox"/> Homemaker   |
| <input type="checkbox"/> Retired due to back | <input type="checkbox"/> Student     |
| <input type="checkbox"/> Heavy Labor         | <input type="checkbox"/> Unemployed  |
| <input type="checkbox"/> Moderate Labor      | <input type="checkbox"/> Other _____ |

### REASON FOR TIME OFF WORK

- |  |
|--|
| <input type="checkbox"/> MD prescribed time off work         |
| <input type="checkbox"/> MD prescribed light duty            |
| <input type="checkbox"/> Patient decided they could not work |
| <input type="checkbox"/> 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:

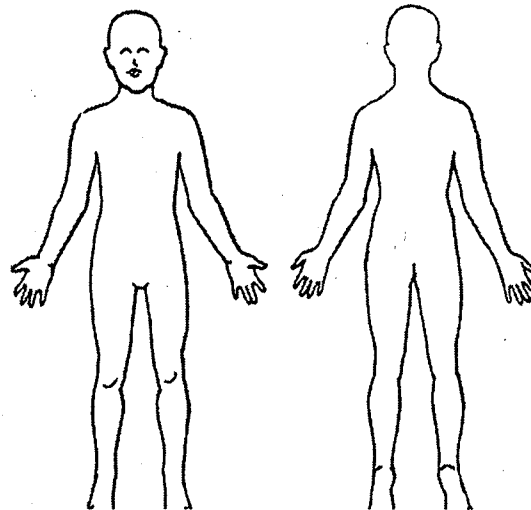
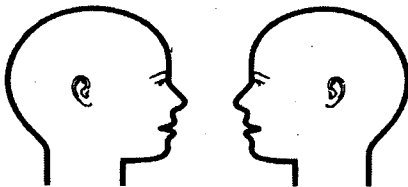
**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst**

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, Sterioids)			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 \_\_\_  
INFECTON? 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):
<b>Family History of Substance Abuse?</b> 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

**Brian J. Ipsen, M.D.**  
**Terry Vogt, PA-C**  
**Christopher Jones, PA-C**

**Joseph Mark Graham, Jr., D.O.**  
**Joshua Sweet, PA-C**

\_\_\_\_\_  
Date

**Michael L. Hearndon, D.O.**  
**Jickie Parker, APRN**  
**Stephanie Hallacy, APRN**





# 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:



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# \_\_\_\_\_



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: \_\_\_\_\_