

*****IMPORTANT*****

Notice of Medical Visit

St Charles Spine Institute
550 St. Charles Drive, Ste 208
Thousand Oaks, CA 91360
Telephone: (805) 379-2322 Fax: (805) 435-0259

www.stcharlesspine.com

Appointment Date: _____ Time: _____

All attached forms need to be completed by your appointment date.

Please arrive 20 minutes prior to your appointment with your paperwork completed.

****You will be rescheduled if forms are not completed.****

Please bring the following:

- Picture ID such as Driver's License and Insurance Cards
- X-Rays , MRI, CT Scans with CD/Films and Reports (within 2 years)
- Past EMG and Operative Reports
- Current Medication List
- Health Advance Directive

Should you need to cancel this appointment for any reason, please call our office at 805-379-2322 OPTION 2 at least 48 hours in advance.

Thank you for your cooperation in this matter.

ST CHARLES SPINE INSTITUTE
550 St Charles Drive Suite # 208
Thousand Oaks, CA 91360
(805) 379-2322 option 2

PATIENT INFORMATION

Name: _____ Date of birth: _____
Age: _____ Sex: _____ Marital Status: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
E-Mail Address: _____ Social Security #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

HOW DID YOU HEAR ABOUT US? _____

PHYSICIAN INFORMATION

Primary Care Physician (**FIRST NAME LAST NAME**) _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
Referring Physician: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Address: _____
Subscriber/Policy #: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____ Subscriber SS# _____
Secondary Insurance Name: _____
Address: _____
Subscriber/Policy #: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____ Subscriber SS# _____

AUTHORIZATION OF BENEFITS AND INFORMATION RELEASE

I hereby authorize that medical and/or surgical benefits otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize St Charles Spine Institute and my physician to release any information required by my insurance company to process claims.

Patient/Guarantor Signature

Date

St. Charles Spine Institute

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION

Patient Name:		Date:
Date of Birth:	Height:	Weight:
Referring Physician:		Primary Care Physician:

I. What are you being seen for today? Neck Back Other _____

II. Which side is affected? Right Left Bilateral
 Are you? Left handed Right handed

III. Date of Injury or start of pain: _____
 How did the pain occur? Injury Chronic Spontaneous
 Is this work related? Yes No
 Is this the result of a motor vehicle accident? Yes No

IV. Pain Description
 Quality of your pain? Mild Moderate Severe
 Type of pain? Sharp Dull Other: _____

V. Pain Calculation: Questions A and B should total 100%
 A. What percentage of your problem is due to back/neck pain?
 0% 25% 50% 75% 100%
 B. What percentage of your problem is due to leg/arm pain?
 0% 25% 50% 75% 100%

VI. General Questions
 How would you rate your pain? Place a circle on the pain level below:
 No pain 0| _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 very severe pain
 Have you had any change in bowel or bladder function? Yes No
 Does your pain disrupt your sleep? Yes No
 Does pain or weakness keep you from doing your regular activities? Yes No
Did you attend physical therapy for greater than 6 weeks? Yes No
Did you experience relief from physical therapy for greater than 3 weeks? Yes No
 Does your pain radiate? Yes No If so, where _____

VII. Pain medications?
 Anti-inflammatory agent Yes No Drug Name: _____
 Pain Medication Yes No Drug Name: _____
 Tylenol Yes No
Have you had any injections/epidurals? Yes No
How many in the last 12 months? _____ **Date of most recent injection:** _____
Did you get any relief? Yes No
If Yes, how much? > 50% > 80%

VIII. Have you had any testing?

MRI

EMG/NCS

X-ray

CT Scan

Medical History

Do you have or have you had:	Yes	No		Yes	No
Asthma/COPD	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Acid Reflux Disease	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>
Kidney Problems	<input type="radio"/>	<input type="radio"/>	Blood Clots	<input type="radio"/>	<input type="radio"/>

Social History

Marital status:	<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Widowed	<input type="radio"/> Divorced
Do you smoke?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Have Previously	
<i>If yes,</i>				
How many packs/ day?	<input type="radio"/> <1	<input type="radio"/> 1-2	<input type="radio"/> >2	
How many years have you smoked?	<input type="radio"/> 1-4	<input type="radio"/> 5-10	<input type="radio"/> >11	
Do you consume alcohol?	<input type="radio"/> Yes	<input type="radio"/> No		
How often do you consume alcohol?	<input type="radio"/> Daily	<input type="radio"/> Social	<input type="radio"/> Never	
Do you exercise regularly?	<input type="radio"/> Yes	<input type="radio"/> No		
In the past did you consume alcohol?	<input type="radio"/> Yes	<input type="radio"/> No		
Working status:	<input type="radio"/> Full time	<input type="radio"/> Part Time	<input type="radio"/> Student	<input type="radio"/> Unemployed

Family History

Father	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease
Mother	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease
Siblings	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease
Grandparents	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease

Review of Systems

Constitutional

Fatigue

Yes

No

Weight change Yes No

Fever Yes No

Neurological

Migraine Headaches Yes No

Numbness/ Tingling Yes No

Seizures Yes No

Dizziness Yes No

Coordination Problems Yes No

Neck Pain Yes No

Respiratory

Shortness of Breath Yes No

Chest Pain Yes No

Trouble Breathing Yes No

Wheezing/ Asthma Yes No

Chronic Coughing Yes No

Coughing up Blood Yes No

Cardiovascular

Chest Pain Yes No

Irregular Heartbeat Yes No

High Blood Pressure Yes No

Leg/Ankle swelling Yes No

Severe Back Pain Yes No

Spine Curvature Yes No

Back Problems Yes No

Musculoskeletal

Joint pain Yes No

Joint stiffness Yes No

Joint swelling Yes No

Gastrointestinal

Nausea/ Vomiting Yes No

Stomach Ulcer Yes No

Diarrhea Yes No

Blood in stool Yes No

Skin

Rashes/sores Yes No

Skin Cancer Yes No

Itching/ Burning Yes No

Hematologic

Anemia Yes No

Easy Bruising Yes No

Bleeding problem Yes No

Women ONLY:

Are you pregnant or could possibly be pregnant?

Yes No

Spine

Allergies

Are you allergic to any medications? Yes No

If yes, please list: _____

Are you allergic to food or environmental substances? Yes No

If yes, please list: _____

Medications (Please list name of medication and dosage)

Hospitalization (Please list) Surgeries (Please list surgery type and year)

Patient Signature _____ Date _____

St. Charles Spine Institute

550 St. Charles Drive, Suite 208
Thousand Oaks, CA 91360

Current Medication List

Patient Name: _____ DOB: _____

Today's Date: _____

Medication Name	Strength	How many tablets per day?
-----------------	----------	---------------------------

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

If the space provided is not sufficient, please continue list on the back.

St. Charles Spine Institute

Patient/Provider Assessment

Name: _____ Date: _____
First Last

Gender: _____ Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Primary Insurance: _____

Please answer the following questions to the best of your ability. Mark yes with a "X" in the box.

Section A:

Have you ever been diagnosed with or do you experience:

- | | |
|--|---|
| <input type="checkbox"/> Numbness or a feeling of pins and needles in hands or feet? | <input type="checkbox"/> High cholesterol? |
| <input type="checkbox"/> Diabetes Type I with tingling in your feet or toes? | <input type="checkbox"/> Diabetes Type II with tingling in your feet or toes? |
| <input type="checkbox"/> High blood pressure? | <input type="checkbox"/> Low blood pressure? |
| <input type="checkbox"/> Peripheral neuropathy (normally a result of damage to your nerves often causing weakness, numbness and pain in hands and feet)? | <input type="checkbox"/> Circulation issues or Peripheral Vascular Disease? |
| <input type="checkbox"/> Gangrene? | <input type="checkbox"/> An irregular heart beat or arrhythmia? |
| <input type="checkbox"/> Raynaud's Syndrome or your fingers and toes feel numb and cold often? | <input type="checkbox"/> Buerger's Disease? |
| <input type="checkbox"/> Abdominal pain? | <input type="checkbox"/> Dizziness when standing? |
| <input type="checkbox"/> Often feel fatigued? | <input type="checkbox"/> Excessive sweating ? |
| <input type="checkbox"/> Have pain in your neck? | <input type="checkbox"/> Pain in your upper back? |
| <input type="checkbox"/> Rapid heart rate? | <input type="checkbox"/> Get dizzy or light headed when you stand up or ever faint? |

Section B:

Do you have or do you ever experience:

- | | |
|--|---|
| <input type="checkbox"/> Ataxia (lack of coordination)? | <input type="checkbox"/> Hyperlipidemia? |
| <input type="checkbox"/> High triglycerides? | <input type="checkbox"/> Carpal tunnel? |
| <input type="checkbox"/> Pain in your lower back? | <input type="checkbox"/> Family history of heart disease? |
| <input type="checkbox"/> Swelling in your hands or feet? | <input type="checkbox"/> Pain in your arms and/or legs? |
| <input type="checkbox"/> Numbness or tingling in your hands or feet? | <input type="checkbox"/> Excess weight? |

Section C:

- | | |
|--|--|
| <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Do you have a pain or insulin pump? |
| <input type="checkbox"/> Do you have a pacemaker or defibrillator? | <input type="checkbox"/> Do you have any electrical or metal implants or sensors of any kind? If yes, what kind? _____ |

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimize your quality of care through access to your healthcare data. as part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines.

Patient Signature

Provider Signature

St Charles Spine Institute
Bumin Kong, M.D
550 St Charles Drive, Suite # 208
Thousand Oaks, CA 91360
Tel 805-379-2322 Fax 805-435-0259

Pain Management Treatment Agreement

This document is an agreement between _____, the patient, and Dr. Bumin Kong Patient agrees to the policies as listed below to manage chronic pain. Patient acknowledges the fact of habituation on the opioid medication as a direct consequence of its use. Because of the controlled nature of these medications, strict accountability is required. The following policies are necessary for continued treatment:

- Regularly monthly visits for patient with scheduled II medication must be made to assess response and observe complications
- ALL pain medications will be prescribed by ONE physician, which in case, Dr. Bumin Kong.
- ALL pain medication prescriptions will be filled at one pharmacy, patient chooses:

Pharmacy Name: _____

Address: _____

Phone: _____

- Physician has complete liberty to discuss treatment details with the pharmacist at the dispensing pharmacy, and may ask the pharmacy for information about other medications, which have been prescribed for the patient.
- Random urine drug screens will be requested at any time. Urine must be given before given medication prescription
- Prescribed medication will be closely guarded. Please note these medications could be hazardous or lethal to another person, who is not tolerant to their effect. Patient will take as much care with medications, and written prescription, as they would their driver license or credit cards.
- Medications WILL NOT be replaced (if they are lost, fall in the toilet, eaten by pets, etc. If your medications are lost or stolen an INCIDENT REPORT must be filed at the local police station or by a police officer. Once a hard copy of the police report is obtained, ONE exception may be made. Be sure to ask officer for turnaround time.
- Early refills will not be given. If a patient uses a month supply of medications within three weeks, the last week will be without medications.
- All confidentiality of prescription and medication records is waived if there is any request from legal authorities for the information concerning inappropriate or unlawful use of controlled substances. Failure to adhere to these policies will result in permanent cessation of pain medication prescribed by Dr. Bumin Kong. Patient understands that he/she will not take medications or substances (prescription or recreational), which have been disclosed to the physician.

St Charles Spine Institute
Bumin Kong, M.D
550 St Charles Drive, Suite # 208
Thousand Oaks, CA 91360
Tel 805-379-2322 Fax 805-435-0259

▪ Pursuant to Health and Safety Code section 11165.4(a), the mandatory consultation requirement requires health care practitioners to consult the CURES database to review a patient's controlled substance history under both of the following circumstances:

- 1 . Before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time; and
- 2 . At least once every four months thereafter if the substance remains part of the treatment of the patient.

▪ "First time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

Signature:	Date:
Print Name:	Witness:
Physician:	Date:

ST. CHARLES SPINE INSTITUTE

550 St. Charles Drive, Suite 208
Thousand Oaks, CA 91360

OFFICE POLICY & INFORMATION

Financial Policy:

Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. You bear full financial responsibility for the services rendered and products provided by St. Charles Spine Institute and agree to pay at the time of service. Additionally, you authorize and request that insurance payments be made directly St Charles Spine Institute should we elect to receive such payments.

Payments that you are responsible for include, but are not limited to, any and all copayments, coinsurance, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like orthopaedists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though St Charles Spine Institute will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company St Charles Spine Institute. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due, you will receive a statement. If a refund is a due, we will be happy to mail it to you.

Authorization for Treatment/Referrals (POS PLANS):

You are responsible for obtaining an authorization for examinations & treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Otherwise, the insurance company will not pay for your visit. Without a referral, you have the option to receive services on a fee for service basis.

Keeping Your Account Up-To-Date:

It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies give us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

Delinquent Accounts:

Accounts turned over to a collection agency will be assessed a \$25.00 fee. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

Lab/Diagnostic Testing Results:

It is the patient's responsibility to contact this office for the results of any lab work or diagnostic testing.

Please note:

The surgeons at St. Charles Spine Institute may hold the patents or have worked on the development of some implants purposed for your spinal surgery. They do NOT receive any financial compensation for implanting these devices. If you have questions, please discuss this with your Surgeon during your appointment.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

Returned Checks: There will be a \$25.00 charge for all returned or cancelled checks.

Release of Medical Records

There will be a \$15 clerical fees, plus up to \$.25 cents per page for medical records. If you need any insurance forms completed by our office, there will be a \$20.00 charge on each form. You authorize us to release all medical records to the referring and family physicians and to your insurance company, if applicable. You allow fax transmittal, telephone and by mail of your medical records, if necessary.

All copayments, coinsurances, deductible fees, and outstanding balances must be settled before seeing the physician. We reserve the right to immediately cancel your care for conduct, non-cooperation, or non-payment. You will be responsible for your Medicare Co-Insurance if you don't have secondary insurance.

YOUR SIGNATURE represents your consent to treatment necessary for the patient named, your acknowledgement of full financial responsibility, and your understanding and acceptance of our policies detailed above.

Name Of Patient: _____ **DOB:** _____

Signature: _____ **Date:** _____



NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998

("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I acknowledge that I have received 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 at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

Advanced Directive Status

St. Charles Spine Institute

I have been informed of my right to formulate an Advanced Directive, and I have been provided with information regarding the execution of an Advanced Directive.

Please Select One:

- I have previously completed an Advanced Directive and have provided a copy of inclusion in my medical record
- I will provide a copy of my previously executed Advanced Directive to St. Charles Spine Institute for Inclusion in my medical record
- A copy of my Advanced Directive is on file with: _____
Name of Provider or Health Care Facility
- I have not executed an Advanced Directive and I am not interested in any further information
- I am interested in formulating an Advanced Directive and will discuss my options with my primary care physician

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Comments: Include steps taken to obtain a copy of Advanced Directive

- A copy of the Advanced Directive has been requested

Signature of Group Representative: _____ Date: _____

St. Charles Spine Institute
Bumin Kong, M.D.
550 St. Charles Drive, Suite #208
TAX ID: 47-4299199 NPI: 1497382220

ASSIGNMENT OF BENEFITS AGREEMENT
Direct Payment to Doctor

I hereby authorize _____ Insurance Company to pay by check made payable to and mailed directly to St. Charles Spine Institute for Medical expense benefits allowable, and otherwise payable to, under my current insurance policy, as payment towards charges for professional services rendered.

Financial Responsibility

I understand that I am financially responsible to reimburse St. Charles Spine Institute for any charges not covered by health care benefits. It is my responsibility to notify St. Charles Spine Institute of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

Assignment of Benefits

I hereby assign all medical benefits, to include any surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance or any other health/medical plan, to issue payment directly to St. Charles Spine Institute. I have requested medical services from St Charles Spine Institute on behalf of myself and/or my dependents and understand by making this request that I become fully financially responsible for any and all charges incurred during the course of treatment authorized.

Name of Person Financially Responsible (Print): _____

Relationship to Insured: _____

Signature of Insured: _____

Today's Date: _____