IMPORTANT

Notice of Medical Visit

St Charles Spine Institute
Erik Spayde, M.D.
558 St Charles Drive # 200
Thousand Oaks, CA 91360
Telephone No: (805) 379-2322 Fax No: (805) 379-2373
www.stcharlesspine.com

Please do not miss this medical examination. This appointment is to evaluate your medical condition.

Please bring the following:

- Picture ID such as Driver's License
- X-Rays, MRI Films, CT Scans and reports (within 2 years)
- Past EMG and Op. Reports, Medication List

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

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

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

Thank you for your cooperation in this matter.

ERIK C. SPAYDE, M.D.
558 St. Charles Drive, Suite # 200
Thousand Oaks, CA 91360
(805) 379-2322

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
E-Mail Address: _____
Street / Mailing Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Sex: ☐ Male ☐ Female Age: _____
Driver's License #: _____ SS#: _____ Occupation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

GUARANTOR INFORMATION (if other than self)

Last Name: _____ First Name: _____ Middle Initial: _____
E-Mail Address: _____
Street / Mailing Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Sex: ☐ Male ☐ Female Age: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMPLOYER INFORMATION

Employer Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

INSURANCE INFORMATION

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

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

PHYSICIAN & INJURY INFORMATION

Primary Care Physician: _____ Phone: _____
Address: _____ Fax: _____
Referring Physician: _____ Phone: _____
Address: _____ Fax: _____

When did your injury occur or symptoms begin? _____
Is your injury work related? ☐ Yes ☐ No In relation to an auto accident? ☐ Yes ☐ No

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

Erik C. Spayde, M.D.

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? O Neck O Back O Other _____

II. Which side is affected? O Right O Left O Bilateral

Are you? O Left handed O Right handed

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV. Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other:_____

V. Pain Calculation: Questions A and B should total 100%

A. What percentage of your problem is due to back/neck pain?

O 0% O 25% O 50% O 75% O 100%

B. What percentage of your problem is due to leg/arm pain?

O 0% O 25% O 50% O 75% O 100%

VI. General Questions

How would you rate your pain? Place a vertical mark on the line 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? O Yes O No

Does your pain disrupt your sleep? O Yes O No

Does pain or weakness keep you from doing your regular activities? O Yes O No

Have you had physical therapy? O Yes O No

Does your pain radiate? O Yes O No If so, where _____

VII. Pain medications?

Anti-inflammatory agent O Yes O No Drug Name:_____

Pain Medication O Yes O No Drug Name:_____

Tylenol O Yes O No

Have you had any injections/epidurals? O Yes O No

How many in the last 12 months? _____ Date of most recent injection: _____

Did you get any relief? O Yes O No

If yes, for how long? _____

VIII. Have you had any testing? O MRI O EMG/NCS O X-ray O CT Scan

Medical History

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

Social History

Marital status: O Single O Married O Widowed O Divorced

Do you smoke? O Yes O No O Have Previously

If yes,

How many packs/ day? O <1 O 1-2 O >2

How many years have you smoked? O 1-4 O 5-10 O >11

Do you consume alcohol? O Yes O No

In the past did you consume alcohol? O Yes O No

How often do you consume alcohol? O Daily O Social O Never

Do you exercise regularly? O Yes O No

Working status: O Full time O Part Time O Student O Unemployed

Family History

Father	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Mother	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Siblings	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Grandparents	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease

Review of Systems

Constitutional

Fatigue	O	Yes	O	No
Weight change	O	Yes	O	No
Fever	O	Yes	O	No

Neurological

Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No
Coordination Problems	O	Yes	O	No
Neck Pain	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No
Chest Pain	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No
Coughing up Blood	O	Yes	O	No

Cardiovascular

Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No

Spine

Severe Back Pain	O	Yes	O	No
Spine Curvature	O	Yes	O	No
Back Problems	O	Yes	O	No

Musculoskeletal

Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No

Gastrointestinal

Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No

Skin

Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No

Hematologic

Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No

Women ONLY:

Are you pregnant or could possibly by pregnant?

O Yes O No

Allergies

Are you allergic to any medications? O Yes O No

If yes, please list: _____

Are you allergic to food or environmental substances? O Yes O 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 _____

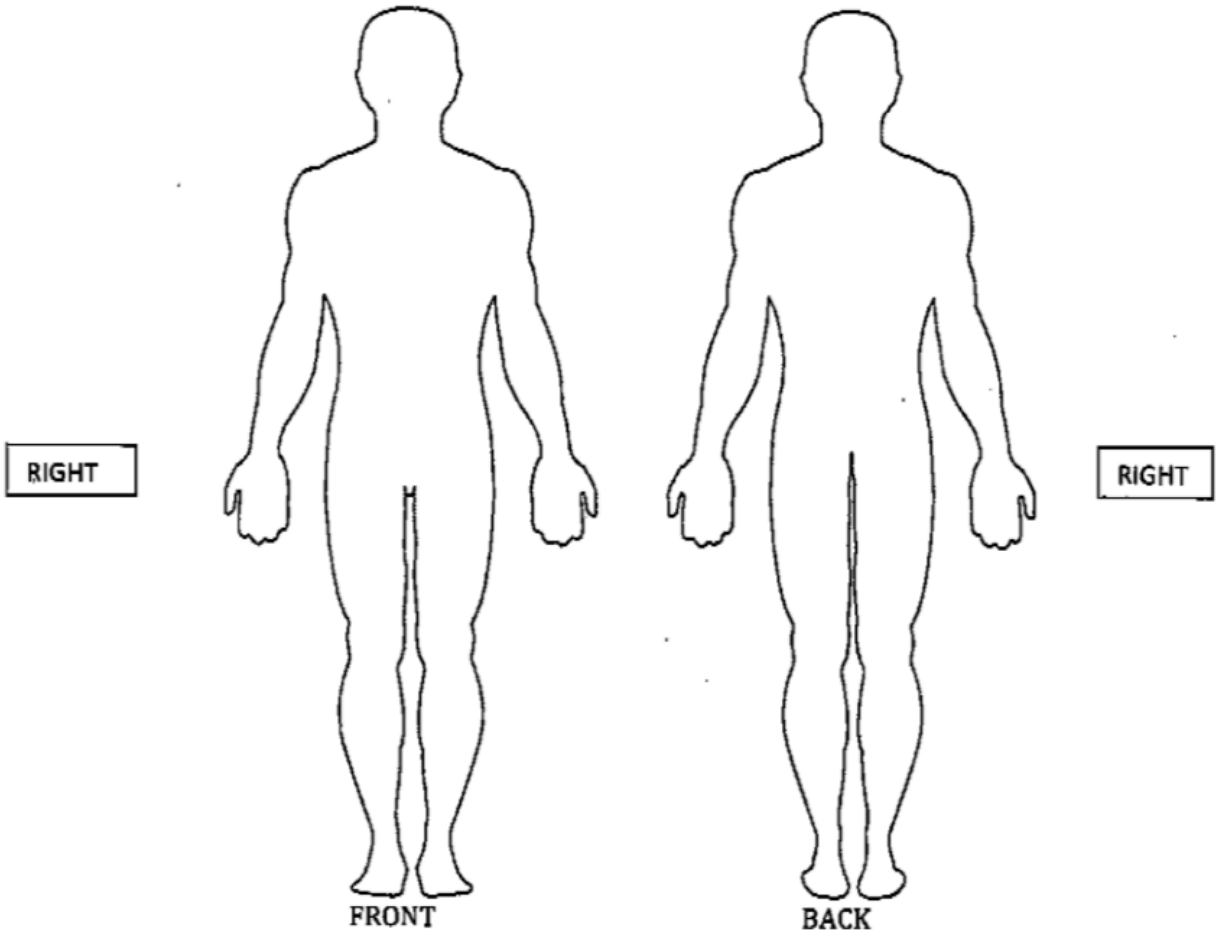
Pain Diagram

Patient's Name: _____ DOB: _____

Physician: Dr. Erik C Spayde, MD

Please indicate the body area(s) where you are experiencing pain or discomfort

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
^^^^^	=====	*****	XXXXX	/////



How would you rate your pain? Place a mark on the line below:

NO PAIN___1____2____3____4____5____6____7____8____9____10___VERY SEVERE PAIN

Does the pain disrupt your sleep? Please circle one: **YES / NO**

Patient's Signature: _____ Date: _____

ST. CHARLES SPINE INSTITUTE
Dr. Erik C Spayde, MD
558 St. Charles Drive, Suite 200
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 Erik C. Spayde, M.D., Inc and agree to pay at the time of service. Additionally, you authorize and request that insurance payments be made directly to Erik C. Spayde, M.D., Inc should he 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 Erik C. Spayde, M.D., Inc 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 Erik C. Spayde, M.D., Inc. 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.

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 physicians 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: _____

558 St. Charles Drive, Suite # 200 Thousand Oaks, CA 91360

Advanced Directive Status
Erik C. Spayde M.D.
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
Erik C. Spayde, MD
Jonathan T. Rice, PA-C
558 St. Charles Drive, Suite # 200
Thousand Oaks, CA 91360
Tel 805-379-2322 Fax 805-379-2373

Pain Management Treatment Agreement

This document is an agreement between _____, the patient, and Dr. Erik C. Spayde. 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 schedule II medication must be made to assess response and observe complications

• ALL pain medications will be prescribed by ONE physician, which in case, Dr. Erik C. Spayde.

• ALL pain medications 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 by 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. Erik Spayde. 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
Erik C. Spayde, MD
Jonathan T. Rice, PA-C
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• 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 month 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

558 St. Charles Drive, Suite 200
Thousand Oaks, CA 91360

Current Medication List

Patient Name: _____ DOB: _____

Physician: Dr. Erik Spayde, M.D. Today's Date: _____

	Medication Name	Strength	How many tablets a Day?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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

Eric C Spayde M.D., Inc.
558 St. Charles Drive, Suite #200
Thousand Oaks, CA 91360
20-4657944

OUT OF NETWORK FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____

RE: Date of Service: _____

It has come to our attention that your insurance company may not assign benefits of your policy to Dr. Erik C Spayde, meaning payment may go directly to you. Please note that your policy with your insurance company is an agreement between you and your insurance carrier. Dr. Erik C Spayde rendered excellent medical care to you and it is your responsibility to ensure that he and his practice are paid. To avoid being responsible for the entire claim amount, please follow our guidelines.

When the insurance company sends you a check for services provided by Dr. Erik C Spayde for the above referenced date of service, or other dates of service not listed above, please follow the process below:

1. Open the communication and explanation of benefits you receive from your insurance in a timely manner.
2. When the check is received, please NOTE it is not necessary to case the check. We would ask you to endorse the check in the following manner:
    a. Sign your name on the upper portion of the check
    b. Directly under your signature, write the following: “For further endorsement to Erik C. Spayde MD, Inc”
    c. Place the endorsed check in the enclosed envelope and mail to the address preprinted on envelope
3. Upon receipt of the endorsed check, we will deposit and post the funds to your account with Dr. Erik C Spayde. If there are any additional monies owed to Dr. Erik C Spayde, you will receive a traditional statement that will explain in detail the balance due after insurance – if there is a balance. Please note that they payment you are receiving is the insurance payment, which does not include any co-insurance amounts, deductible, co-payments, or out-of-pocket expenses owed by you, the patient.

Your satisfaction is important to us and we hope that you understand our collection policies for payments not sent directly to our office, but instead to the patient. Our goal is to minimize any inconvenience, and we appreciate your assistance with helping us keep your account balance in order.

Signature: _____ Date: _____

Eric C Spayde MD
St Charles Spine Institute
558 St. Charles Drive, Suite #200
TAX ID: 20-4657944 NPI: 1790717965

ASSIGNMENT OF BENEFITS AGREEMENT
Direct Payment to Doctor

I hereby authorize _____ Insurance Company to pay by check made payable to and mailed directly to Erik C Spayde, M.D. Inc 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 Erik C Spayde, M.D. for any charges not covered by health care benefits. It is my responsibility to notify Erik C Spayde, M.D. Inc 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 Erik Spayde, M.D. Inc.
I have requested medical services from Erik C Spayde, M.D. Inc 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: _____