SPINAL DIAGNOSTICS

Robert D. Heros, M.D. * Jason G. Anderson, D.O. * Tyler G. Huntington, PA-C* Ayumi Mizuno, AGNP-C

Date: _____ Patient: _____

You have been scheduled for an office consultation with:

- ☐ Robert D. Heros, M.D.
- ☐ Jason G. Anderson,D.O.
- ☐ Tyler G. Huntington, PA-C
- ☐ Ayumi Mizuno, AGNP-C

Appointment Date: _____

Check In at: _____

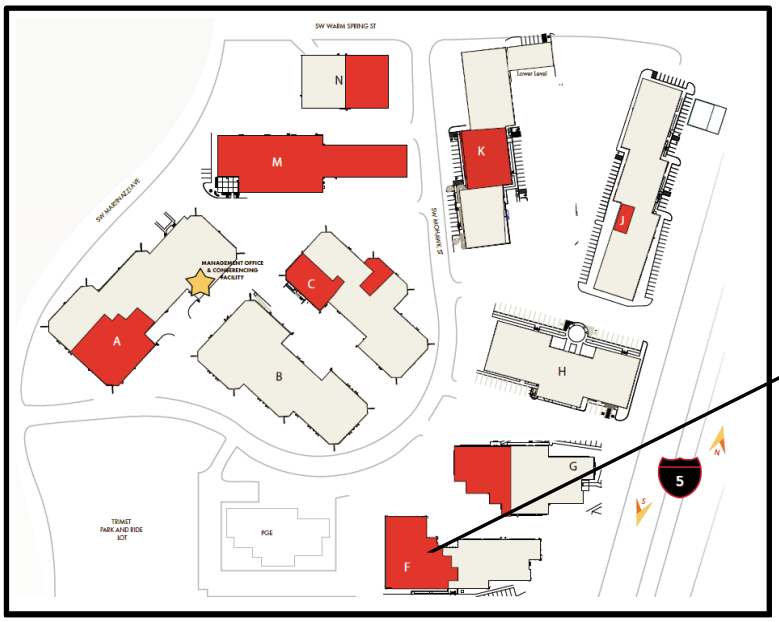
Appointment Time: _____

This appointment is for the **consultation only**. Procedure appointments will be scheduled at a different time and location. **If you have any films, please remember to bring them with you.**

The appointment has been scheduled at his office located at т790{ ² a2Ƙl·ǿʅ{ǘ.* ¢dzl·ƒl·ǘλyΣ hwφ фтлсн We request a 24 hour notice if you need to cancel or reschedule your appointment or there will be a late cancellation charge of $50.00.

Our office has enclosed new patient forms for you to complete and bring with you to your visit. Your initial consult/evaluation can last up to 1 hour. We ask that you keep this in mind when making arrangements for your appointment.

Should you have any questions or concerns regarding your appointment, please contact our office at (503) 885-1515.



Mohawk Business Park

Building F

7790 SW Mohawk St., Tualatin, OR. 97062
P: 503-885-1515 **F:** 503-885-1520 **E:** moreinfo@spinaldx.com **W:** www.spinaldx.com

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PATIENT INFORMATION

Please use an ink pen

Today's Date: _____

Name: _____ [ ] Male [ ] Female Date of Birth:_____
Address: _____ Telephone: (_____) _____
City: _____ State: _____ Zip: _____ SSN#_____-_____-_____
Employer: _____ Telephone: (_____) _____-_____
Mobile Ph # (_____) _____ Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ] Partnered
Spouse/Partner's Name:_____ Spouse/Partner's Phone#: (_____) _____

Preferred Language: _____ Ethnicity: _____ Hispanic/Latino: [ ]Yes [ ] No
E-MAIL: _____

EMERGENCY CONTACT, NEAREST RELATIVE OTHER THAN SPOUSE:

Name: _____ Relationship: _____Telephone:(_____) _____
Address: _____ City: _____ State: _____ Zip:_____

REFERRING PHYSICIAN OR SOURCE OF REFERRAL

Physician's Name: _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Family Physician's Name: _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Other Consulting Physicians: _____

INSURANCE INFORMATION

Are you being treated for a work related injury, motor vehicle injury or personal injury? [ ] Yes [ ] No
Primary Insurance Company _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Insured's Name: _____ [ ] Male [ ] Female Date of Birth: _____
Policy /ID #: _____ Group Name/#: _____ Employer: _____
Secondary Insurance Company: _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Insured's Name: _____ [ ] Male [ ] Female Date of Birth: _____
Policy/ID #: _____ Group Name/#: _____ Employer: _____

Present your insurance cards to submit a claim to your insurance company. We will need complete and detailed information in order to process your claim.

IF YOUR APPOINTMENT IS DUE TO WORK RELATED INJURY OR CONDITION:

Claim # or ID #: _____ Date of injury: _____
Name of Employer through which claim was filed: _____ Employer's Phone: (___) _____
Name of Employer's Insurance carrier: _____ Carrier's Phone: (_____) _____
Claims Examiner/Contact: _____ Phone No. (_____) _____
Insurance Carrier's Address: _____ City: _____ State: _____Zip: _____
What injury(s) did you sustain: _____

IF YOUR APPOINTMENT IS DUE TO AN AUTO ACCIDENT/PERSONAL INJURY:

Date Of Injury: _____ State in which accident occurred: _____ Insurance Co. _____
Phone #: (_____) _____ Insurance Carrier's Address: _____
City: _____ State: _____ Zip: _____ Insured's Name: _____
Policy # _____ Attorney's Name: _____
Address: _____ City: _____ State: _____ Zip: _____

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RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All other insurance companies and/or third party payers: I HEREBY AUTHORIZE Spinal Diagnostics Robert D. Heros, M.D., Jason G Anderson, D.O., Tyler G. Huntington, PA-C, Ayumi Mizuno, AGNP-C and/or any of their representatives to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician(s) rendering the service. I authorize the release of any and all medical information to my insurance carrier or it intermediaries for services rendered.

Medicare: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers any and all information needed for this or a related Medicare claim. I authorize and request that payment be made directly to Spinal Diagnostics, or their representative.

Guarantee of Payment: I UNDERSTAND that filing a claim with my insurance company or other third party payor, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Spinal Diagnostics (Dr. Heros, Dr. Anderson, Tyler Huntington, PA-C, Ayumi Mizuno, AGNP-C)to me. I understand that it is ultimately my responsibility to verify my insurance benefits, eligibility and authorization requirements prior to any scheduled appointments. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Worker's Compensation, automobile accidents and/or personal injuries. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit. Payment must be made in full within 30 days of being billed unless prior arrangements have been made.

I AGREE that this authorization shall be valid until rescinded in writing or replaced on a later date.

_____ _____

*Patient's signature (parent or Guardian if patient is a minor) Date of Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice

_____ _____

*Patient's signature (parent or Guardian if patient is a minor) Date of Signature

_____

*Please Print Name

If Personal Representative's signature(s) appears above, please describe the relationship to the patient:

_____

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FINANCIAL POLICY

Welcome to Spinal Diagnostics. Please take a moment to review our Payment Policies. You may receive more than one charge for an appointment with our office. We require patients to provide a copy of their insurance card, proof of Identification and co-payment at check-in for every visit. If you do not have your insurance card, photo ID or co-payment with you at the time of your visit your appointment may be rescheduled.

PATIENT RESPONSIBILITY

Patients are responsible for all charges resulting from treatment provided by Spinal Diagnostics. Payment is due in full within 30 days of receiving your first statement unless other financial arrangements have been made with the Billing Coordinator. Please remember your insurance policy is an agreement between you and your insurance company, and it is ultimately your responsibility to pay for any balance not paid or covered by your insurance company. This includes your Motor Vehicle Coverage and Worker's Compensation Coverage.

REQUIRED PATIENT DEPOSITS-PATIENTS WITHOUT INSURANCE

We do offer a 40% discount for patients who do not have insurance. Patients will be required to pay in full at the time of their appointment. Fees will be based on provider billing and provided after the office visit.

CO-PAYMENTS DEDUCTIBLES AND CO- INSURNACE

Co-payments are the amounts your insurance policy require us to collect with each visit and are due at the time of service. Patients who arrive without their co-pay, may be rescheduled. We accept cash, check and most major credit cards. You are welcome to pay through our online payment system at onpatient.com.

PAYMENT ARRANGEMENTS

All patients will be required to pay of their balances within 30 day of receiving their first statement unless payment arrangements have been made with Spinal Diagnostics. Please contact our Billing Coordinator at 503-885-1515 ext. 1107 as soon as possible after receiving your statement if payment arrangements are needed.

INSURANCE BILLING

As a courtesy we will bill your primary insurance, secondary insurance, Motor Vehicle Accident, and Worker's Comp. claim for you. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the patient if your insurance changes, please present your new card at your visit. All of our providers are participating with Medicare. If you have Motor Vehicle Accident or Workers Comp claims please provide the adjusters name, contact number, claim number and the date of incident. If you do not have your insurance card with you at the time of your visit to provide us with valid insurance information, you will be billed for the services, or your appointment rescheduled.

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CANCELLATION AND RESCHEDULE FEE

If you need to cancel or reschedule your office visit, you must notify us at least 1 business day prior to your office visit time. You may be charged a $50 cancellation/reschedule fee from insufficient notice for your office visit. If you arrive 10 minutes or more after your scheduled appointment time, you maybe charged a cancellation fee and rescheduled.

RETURNED CHECK OR PAYMENT FEE

Any payments returned to Spinal Diagnostics will incur a $15 return payment charge in addition to the balance owed.

NO SHOW FEE

You may be charged a $50 fee for not showing to your scheduled office visit. If you have a pattern of no shows, frequent reschedules and/or late cancellations, you may be dismissed from Spinal Diagnostics.

PAST DUE AND COLLECTIONS ACCOUNTS

We reserve the right to send accounts with balances that have been outstanding over 90 days from the date of service or the date of payments received from your insurance company, whichever is more, to a collection agency. If you have a balance on your account that is more than 60 days old, and over $300, you will be referred to the Spinal Diagnostics Billing Coordinator to make payment arrangements. If any portion of your past due amount has been assigned to a collection agency you will need to pay 100% of the balance before your appointment can be scheduled.

The patients signature (or signature of the patients parent or legal guardian) acknowledges that you understand and accept the above information. **I have read the above Financial Policy and agree with the terms of this agreement.**

Print Name_____Date_____

Signature_____

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AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

MAY WE LEAVE DETAILED VOICEMAIL MESSAGES?

_____ Yes, at this phone number: (_____) _____
Initial

_____ No, please only leave a message asking me to call back.
Initial

PLEASE DISCLOSE MY PERSONAL HEALTH INFORMATION TO:

Name: _____

Phone number: _____

_____ Spinal Diagnostics may disclose ANY information to this person(s).
Initial

_____ Spinal Diagnostics may disclose LIMITED information to this person (s).
Initial

_____ Appointment information
Initial

_____ Other Specific Information: _____.
Initial

Name: _____

Phone number: _____

_____ Spinal Diagnostics may disclose ANY information to this person(s).
Initial

_____ Spinal Diagnostics may disclose LIMITED information to this person (s).
Initial

_____ Appointment information
Initial

_____ Other Specific Information: _____.
Initial

I authorize Spinal Diagnostics to disclose my personal health information to the person(s) names on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by law.

I have the right to take back ("revoke") my authorization at any time, in writing, except to the extent that Spinal Diagnostics has already acted based on my permission.

Signature: _____ Date: _____

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AUTHORIZATION TO OBTAIN & DISCLOSE HEALTH INFORMATION

I authorize the use or disclosure of the individual's health information named below to be used or disclosed as follows:

Patient Name: _____

Alias or Other Names: _____

Date of Birth: _____

Please **OBTAIN** information **FROM** the following:

_____
Name & Title of Provider/Organization Name

_____
Street Address (or specific fax number)

_____
City/State/Zip (This information must be provided)

Please **SEND** my health information **TO**:

_____
Name & Title of Provider/Organization Name

_____
Street Address (or specific fax number)

_____
City/State/Zip (This information must be provided)

For the purpose of: [ ] Patient Care[ ] Self/Personal Records [ ] Other: _____

DESCRIPTION OF NATURE OF INFORMATION TO BE USED AND/OR DISCLOSED:

[ ] Most recent 2yrs of records [ ] Clinician office notes [ ] History & Physical Exams

[ ] X-ray & imaging reports [ ] Consultations [ ] Lab reports [ ] All Clinic records [ ] Billing statements

Records for the following dates of treatment: _____

[ ] Other (specify):_____

List specific dates of records to be released: _____

THE FOLLOWING (*) MUST BE *INITIALED* BY THE PATIENT TO BE INCLUDED IN THE USE AND/OR DISCLOSURE OF OTHER HEALTH INFORMATION:

_____*HIV/AIDS related information and/or records _____*Mental Health information _____*Psychotherapy notes

_____*Genetic Testing information _____**Drug/Alcohol information

**Federal regulation requires a description of how much and what kind of information will be disclosed.

DURATION: This authorization shall begin immediately and remain in effect until notified otherwise.

RESTRICTIONS: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by privacy laws or regulations.
RIGHTS: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy and Spinal Diagnostics has up to 30 days to comply with my written request. I understand that I have the right to revoke this authorization by sending a written statement to the clinic manager of the disclosing location listed above. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Signed:_____ Date: _____
(*Patient or Legal Representative)*

If signed by legal Representative, name & relationship to patient: _____

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HEALTH HISTORY

Patient Name: _____ Date of Birth:_____

Who referred you to us?_____

Occupation:_____Primary Care Provider: _____

Is this a: [ ] Workman's Comp Claim *or* [ ] Motor Vehicle Accident Do you have a lawyer for this injury? [ ] Yes [ ] No

Is English your primary language? [ ] Yes [ ] No If no, which language? _____

IN THE PAST 2 WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? *(Check all that apply)*

☐	Fever	☐	Chills	☐	Night Sweats	☐	Insomnia
☐	Involuntary Weight Loss	☐	Headache	☐	Sore Throat	☐	Visual Difficulty
☐	Ringing In Ear	☐	Seizures/Tremors	☐	Sinus Congestion	☐	Chest Pain
☐	Palpitations	☐	Wheeze/Cough	☐	Nausea/Vomiting	☐	Stomach Pain
☐	Diarrhea	☐	Rash	☐	Blood In Urine/Stool	☐	Easy Bruising
☐	Joint Pain/Swelling	☐	Swelling	☐	Excessive Thirst/Appetite	☐	Fainting
☐	Recent Bleeding	☐	Shortness of Breath	☐	Loss of Bowel/Bladder Control	☐	Hearing Loss

PAIN HISTORY

Date of onset of present pain (date of injury or accident): _____

CAUSE OF PAIN:

☐	Motor Vehicle Accident	☐	Accident at Work	☐	Accident Away from Work	☐	Sports
☐	Unknown Cause	☐	Other:				

PAIN LOCATION:

☐	Left Side	☐	Right Side	☐	Both Sides				
☐	Headache	☐	Neck	☐	Shoulder	☐	Leg/Foot	☐	Arm/Hand
☐	Chest	☐	Upper Back	☐	Mid Back	☐	Abdomen	☐	Low Back
☐	Buttock	☐	Other:						

PAIN QUALITY:

☐	Burning	☐	Throbbing	☐	Aching	☐	Stabbing	☐	Numbness
☐	Tingling	☐	Weakness	☐	Shooting	☐	Dull	☐	Sharp
☐	Other:								

PAIN DURATION:

☐	Occasional	☐	Off and On	☐	Quick/Shooting	☐	Frequent	☐	Daily	☐	Constant

ACTIVITIES THAT MAKE PAIN WORSE:

☐	Sitting	☐	Standing	☐	Walking	☐	Bending Forward
☐	Arching Backwards	☐	Rotational Movement	☐	Driving	☐	Rest/Sleep

TIMES OF PAIN:

☐	In The Morning	☐	In The Evening	☐	With Certain Movements	☐	During Rest	☐	During of After Activity

ACTIVITIES THAT MAKE PAIN BETTER:

☐	Sitting	☐	Standing	☐	Walking	☐	Movement
☐	Lying Down	☐	Leaning Forward	☐	Leaning Back	☐	Heat
☐	Ice	☐	Rest	☐	Other:		

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Patient Name: _____ Date of Birth: _____

Height: _____ Weight : _____

DO YOU HAVE A SIGNIFICANT HISTORY OR CURRENTLY HAVE:

Y	N	NEURO		
		Seizures	Last:	
		Stroke/TIA	Date:	
		Glaucoma		
		Numbness/Weakness/Paralysis		
		Bell's Palsy/Parkinson's	Dementia **YES**	**NO**

Neurologist:

Opthamologist:

Y	N	CARDIOVASCULAR	
		Heart Attack (MI)	Date:
		Chest Pain (Angina)	
		Irregular Heart Rate/Rhythm/Pacemaker	
		High Blood Pressure	
		Bleeding Disorder: (specify)	
		Anticoagulant Treatment	

Cardiologist:

Anticoagulant Management:

Y	N	RESPIRATORY
		Shortness of Breath
		Asthma or Wheezing/Inhaler
		Snoring/Sleep Apnea/Difficult Airway
		Emphysema/COPD
		Chronic/Frequent Bronchitis or Pneumonia
		Tuberculosis (TB)

Pulmonologist:

Y	N	LIFESTYLE		
		Do you smoke?	# years smoked:	# packs per day:
		Former Smoker, year you quit?		
		Do you drink alcohol?	Drinks/week:	
		Treated for drug/alcohol dependency?		
		Currently pregnant?		
		Date of your last period:		
		[ ] Menopause [ ] Hysterectomy		

Y	N	SKIN
		Open Wounds/Breaks in Skin
		Rashes
		History of Cold Sores/Shingles/Herpes

Dermatologist:

Y	N	GASTROINTESTINAL/GENITOURINARY
		Heartburn/GERD/Reflux/Hiatal Hernia
		Kidney Disease: (specify)
		Hepatitis/Liver Function
		Colitis/Other Abdominal Problems

Gastroenterologist:

Nephrologist:

Y	N	ENDOCRINE/IMMUNE SYSTEM	
		Diabetic: [ ] Type 1 [ ] Type 2	Avg AM level:
		Thyroid Problems	
		HIV/AIDS	

Endocrinologist:

Y	N	MUSCLE/SKELETAL
		Osteoporosis
		Use of a Cane/ Wheelchair/Walker

Y	N	OTHER	
		MRSA Infection	Date:
		Cancer/Chemo: (specify)	

Oncologist:

		Serious problems with any prior anesthetics
		Family history with serious anesthesia problems
		Infection/Illness in past 6 months:
		Current, or Date Resolved:

Other medical problems or comments:

When was your last vaccination/flu shot?

OFFICE USE ONLY

Patient Initials: ____ Date: _____ Patient Initials: ____ Date: _____

Patient Initials: ____ Date: _____ Patient Initials: ____ Date: _____

Patient Initials: ____ Date: _____ Patient Initials: ____ Date: _____

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Patient Name: _____ Date of Birth: _____

PREVIOUS TREATMENTS FOR THIS PAIN

PHYSICAL THERAPY

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

Where?_____ How long/Last Treatment: _____

CHIROPRACTIC CARE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

MASSAGE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

ACUPUNCTURE

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

SPINE INJECTIONS

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

SPINE SURGERY

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

MEDICATIONS/OTC PAIN MEDS

☐ Never Tried ☐ Not Helpful ☐ Minimally Helpful ☐ Somewhat Helpful ☐ Helpful

DIAGNOSTIC IMAGING

MRI Where:_____ Approx Date: _____

CT Where:_____ Approx Date: _____

XRAY Where:_____ Approx Date: _____

MEDICATIONS

PREVIOUS SURGERIES

MEDICATION NAME Please list all current prescription and over-the counter medications.	SURGERY	YEAR

Preferred Pharmacy: _____ City: _____ Phone: _____

ALLERGIES:

Please list ALL medication allergies

☐ No known drug allergies ☐ Tape/Adhesives ☐ Latex ☐ Iodine/Contrast Dye ☐ Shellfish

Substance	**Reaction**(Itching, rash, breathing difficulties, etc.)

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