KANSAS JOINT & SPINE SPECIALISTS
EXCEPTIONAL ORTHOPAEDIC CARE BEGINS HERE

10100 East Shannon Woods Circle, Suite 100 | Wichita, KS 67226
Patterson Health Center | 485 North Kansas Highway 2 | Anthony, KS 67003
Tel: (316) 219-8299 | (888) 397-7362
Fax: 1 (855) 587-4501

Bradley Bruner, M.D.
Kellis Bulleigh, M.D.
Justin Strickland, M.D.
Damion Walker, D.O.
Camden Whitaker, M.D.

PATIENT INFORMATION

Patient ID#_____

Name: _____ Date of Birth: _____ Age: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
SSN: _____ Email: _____
Primary Phone Number: _____ Cell Phone Home Work (circle one)
Alternate Phone Number: _____ Cell Phone Home Work (circle one)

Sex:
❑ Male ❑ Female

Marital Status:
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Ethnicity
❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported

Who Is Filling Out This Form?
❑ Self ❑ Husband ❑ Wife
❑ Partner ❑ Child ❑ Parent
❑ Grandparent ❑ Other Relative ❑ Friend

Race
❑ Unreported or refused to report ❑ White
❑ American Indian or Alaskan Native ❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander

Preferred Communication Method:
❑ US Mail ❑ Work Phone ❑ Secure Email
❑ Cell Phone ❑ Home Phone

Preferred Language
❑ English ❑ Spanish ❑ Other
❑ Declined to Answer

EMERGENCY CONTACT INFORMATION

First Name: _____ **Last Name:** _____
Relation To You: ❑ Husband ❑ Wife ❑ Partner ❑ Child ❑ Parent ❑ Grandparent ❑ Other Relative ❑ Friend
Primary Phone Number: _____ Cell Phone Home Work (circle one)
Alternate Phone Number: _____ Cell Phone Home Work (circle one)

HEALTH INSURANCE INFORMATION

I do not have health insurance, I will be self paying. ❑
Name of Primary Insurance Co: _____
(Examples: Aetna, Blue Cross Blue Shield, Cigna, United Healthcare, etc.)
Policy Holder Name: _____
Date of Birth: _____

Guarantor Information (for minors only)

First Name: _____ Last Name: _____
Date of Birth: _____

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE PAYMENTS OF MEDICAL INSURANCE BENEFITS TO KANSAS JOINT & SPINE SPECIALISTS. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature of Patient/Insured: _____ Date: _____

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PATIENT NAME (LAST) (FIRST) (MIDDLE)	PATIENT ID	DATE

HISTORY OF PRESENT ILLNESS

What body part are you here for?: _____ Date of First Symptoms: _____

Which side are you here for?: ❑ Lt ❑ Rt ❑ Both (Which is worse?: ❑ Lt ❑ Rt)

Is this an injury or an accident? ❑ Yes ❑ No

When were you injured? _____ Where were you injured? _____

How were you injured? _____

Is there an attorney involved? ❑ Yes ❑ No If Yes, Attorney's Name and Phone #: _____

Auto related? ❑ Yes ❑ No Work Comp related? ❑ Yes ❑ No Name of Work Comp Adjuster: _____

WORK STATUS

Employer: _____ Occupation: _____

Please Indicate Your Current Work Status:

❑ Working Full time ❑ Working Part time ❑ Seeking Employment

❑ Not Working by Choice (Retired, Homemaker, Student, Etc.)

❑ Physically Unable to Work Due to Musculoskeletal Problem

❑ Physically Unable to Work Not Due to Musculoskeletal Problem

❑ How long have you been out of work? _____

OTHER DOCTORS YOU'VE SEEN

I have not seen any doctors in the past year. ❑

Primary Care Doctor's Name: _____

(First) (Last)

Information on Other Doctors, Specialists, or Other Care Providers You've Seen:

Name of Doctor and Specialty:

First Name: _____ Last Name: _____ Specialty: _____

OUTSIDE TESTS

Have you had any imaging studies done? ❑ Yes ❑ No

X-Rays? ❑ Yes ❑ No If so, Where? _____

MRI? ❑ Yes ❑ No If so, Where? _____

CT Scan? ❑ Yes ❑ No If so, Where? _____

EMG/NCT? ❑ Yes ❑ No If so, Where? _____

Bone Scan? ❑ Yes ❑ No If so, Where? _____

CT/Myelogram? ❑ Yes ❑ No If so, Where? _____

Discogram? ❑ Yes ❑ No If so, Where? _____

Dexa Scan? ❑ Yes ❑ No If so, Where? _____

KANSAS JOINT & SPINE SPECIALISTS

Patient ID # _____

FINANCIAL POLICY

Thank you for choosing us as your healthcare 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 to read and sign this policy before any treatment can be rendered.

MISSED APPOINTMENT: We reserve the right to charge a fee of $50 for all missed appointments that are not cancelled with a 24-hour advance notice. This fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple missed appointments or cancellations in any 12-month period may result in discharge from the practice.

SURGERIES: We reserve the right to charge a fee of $200 for a surgery that is cancelled by the patient within 1 week of the scheduled surgery. A fee of $50 will be charged to the patient each time the surgery is rescheduled upon the patient's request. If the patient misses surgery without notice, we reserve the right to charge a fee of $1,500. These fees are not billable to insurance or reimbursable and must be paid before we can schedule any further appointments or surgeries. If you are requesting a refund of your surgery deposit, you will receive your refund less any applicable fees.

REGARDING HMOs, PPOs, and MANAGED CARE PROGRAMS: We do not participate in some of these programs. Please check with your insurance company to see if we are providers of your plan. It is your responsibility to obtain initial referral forms, etc., required by your particular insurance company. This also includes follow-up visits and visits to other physicians in our group. Please be aware that if you are seen out of network, you are liable for the difference in coverage benefits. Also, some HMO/PPO/ managed care primary care physicians require all X-rays be taken at their office only. Check with your physician before your appointment.

COPAYS: You will be expected to pay your copay prior to seeing your physician. If you are unable to pay, you will be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE: Payment is due at the time of service.

REGARDING MEDICARE: All of our providers are participating physicians with Medicare. We will file all charges (including X-rays, braces, etc.) with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance, you will only be billed for the 20% not paid by Medicare or any deductible that has not been met.

COMPLETION OF FORMS (Disability, FMLA, Physician Statements, Etc.) A charge will be assessed per form. Prepayment is required before the form(s) will be completed.

REGARDING WORKMEN'S COMPENSATION/AUTO/LIABILITY: Our office requires authorization prior to initial visit. If authorization is not received, our office will call on the initial visit and try to obtain it. If we cannot obtain authorization, we will ask for your health insurance information. Also, you will be responsible for all fees until the case has been settled. WE DO NOT BILL ATTORNEYS IN WORK COMP, AUTO, AND/OR LIABILITY CASES.

MINOR PATIENTS: If you are a minor, your parents and/or guardian need to accompany you to our office before treatment can be rendered. You need to make arrangements prior to being seen with your parent and/or guardian for payment to be made at the time of treatment.

X-RAY: For your convenience, we do have X-ray facilities in the building. If X-rays are indicated in your treatment, charges are handled in the same manner as the physician charges. If you have had X-rays taken somewhere else, please bring them with you to your appointment.

LAB: In the event we need to have a lab drawn, our office uses an outside laboratory service. You will receive a separate bill for the lab services.

PAYMENT FOR SERVICE: All patients must complete a patient information form and provide insurance information, if appropriate, or make payment arrangements prior to leaving the clinic.

·Payment in full: Payment in full is expected and can be made by cash, check, or credit card.

·Payment plan: If you are unable to pay the account in full, financial arrangements will be established based on the following guidelines. When establishing a payment plan, the patient (or their guarantor) will sign a contract agreement with the 1st payment due upon signing the contract. This approach requires a minimum payment of $25. The contract will specify the dollar amount of subsequent payments and the day of the month the payments will be made. When you set up a payment plan, you will continue to receive a monthly statement. If you miss one (1) payment and fail to bring the account current by the due date of the following payment, the account will be referred to the clinic's collection agency.

- ·Patient Due Balances of $500 or less will be set up on a 90-day payment plan.
- ·Patient Due Balances of $501 – $1,000 will be set up on a 180-day payment plan.
- ·Patient Due Balances of $1,000+ will be set up on a 1-year payment plan.

UNIFORM APPLICATION OF POLICY: This policy will apply to all patients, employees, or others who present themselves for services [at anytime, including any future visits].

It is always your responsibility to see that your account is paid, regardless of insurance or any other circumstances (such as litigation). The patient is responsible for costs associated with collecting said owed balances, including but not limited to collection agency fees, attorney fees, and court costs. I have read, understand, and agree to adhere to the above Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

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Kansas Joint & Spine Specialists Controlled Substance Treatment Agreement

Your physician may prescribe a controlled substance medication for pain management. This treatment agreement is a platform for communication allowing us to work together in good faith and for you to understand the importance of this medication in allowing you to function better. We expect to be partners in creating the best treatment plan for your pain management. If you cannot agree with the following points, it will result in discontinuing the controlled substance.

1. You will take the medication exactly as prescribed and will not change the medication dosage and/or frequency without the approval of your physician, physician assistant, and/or nurse practitioner.
2. You will keep regularly scheduled appointments with your physician, physician assistant, and/or nurse practitioner. There may be times when your medication will need a refill between visits. In this instance, please call our staff at least 1 to 2 days before your medication runs out. Refill requests will only be taken Monday – Thursday from 8 AM to 5 PM. Your physician, physician assistant, and/or nurse practitioner on call will not refill any pain meds after hours or over the weekend. This is not considered an emergency and will not be treated as such.
3. The controlled substance pain medication prescribed is being given in order to control pain and allow you to function better. If there are any changes to your activity level or your physical condition, the treatment may be changed or discontinued.
4. You will be ready to taper or discontinue the controlled substance pain medication as your condition improves.
5. You agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.
6. We expect you not to accept or seek controlled substance medications from other physicians or healthcare providers outside of our practice.
7. If you have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing physician, including any pain medication for your orthopedic condition.
8. You agree that Kansas Joint & Spine Specialists may request and use your prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.
9. You understand that it is important to use one pharmacy for all prescriptions in order to provide consistency.
10. You understand that lost, stolen, or misplaced prescriptions will not be replaced. All patients are expected to act responsibly with their medication. This medication is prescribed for you and only your needs for pain control. To allow others to use your pain medication is illegal and will not be tolerated by your physician or our practice.
11. You understand that if you are taking controlled substances (pain medication) on a schedule that is more frequent or in greater dose than can be prescribed per hospital/surgery center protocols, that you may not receive as much pain medicine. You understand that this may make your recovery/rehabilitation much more difficult.

Using illegal and recreational drugs is dangerous with prescription medications.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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PERMISSION TO GIVE OUT INFORMATION

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak with regarding your medical and/or financial information.

I, _____ hereby grant the physicians and staff of Kansas Joint & Spine Specialists my permission to speak with the following people about my health and well-being.

Effective Date: _____

Name: _____ Relationship: _____ Telephone #: _____

Name: _____ Relationship: _____ Telephone #: _____

The following information may be given to the above individual:

- ☑ 1. Appointment Time
- ☐ 2. Financial Information
- ☑ 3. Test/Lab Results
- ☑ 4. Medications
- ☑ 5. Procedures
- ☐ 6. Other information regarding my Health

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA BROCHURE)

I acknowledge that I have received the attached Privacy Notice.

I understand I may revoke this consent at any time by giving written notice to Kansas Joint & Spine Specialists.

Signed: _____ Dated: _____

Printed Name: _____

In the event the patient is unable to sign, a signature by the designated personal representative is acceptable.

Personal Representative: _____

Relationship to Patient: _____

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PATIENT NAME (LAST) (FIRST) (MIDDLE)	DATE OF BIRTH

REVIEW OF SYSTEMS

Please check the boxes below that describe your current symptoms:

GENERAL HEALTH

- ❑ Denies General Health Symptoms
- ❑ Recent Weight Gain of More Than 10 Pounds
- ❑ Fevers
- ❑ Night Sweats
- ❑ Recent Weight Loss of More Than 10 Pounds
- ❑ Seen Primary Care Physician in the Last Year
- ❑ Chills

RESPIRATORY

- ❑ Denies Respiratory Symptoms
- ❑ Wheezing
- ❑ Pneumonia
- ❑ Chronic Cough
- ❑ Sleep Apnea

BLOOD/ONCOLOGY

- ❑ Denies Hematologic/ Oncologic Symptoms
- ❑ Blood Thinning Medications
- ❑ Blood Transfusion
- ❑ Easy Bruising
- ❑ Organ Transplant

CARDIAC

- ❑ Denies Cardiac Symptoms
- ❑ Chest Pain
- ❑ Shortness of Breath

GASTROINTESTINAL

- ❑ Denies Gastrointestinal Symptoms
- ❑ Nausea
- ❑ Diarrhea
- ❑ Abdominal Pain
- ❑ Vomiting
- ❑ Liver Problems

KIDNEY AND BLADDER

- ❑ Denies Genitourinary Symptoms
- ❑ Abnormal Kidney Function
- ❑ Pain With Urination
- ❑ Frequent Urinary Infections

MUSCLES, BONES & JOINTS

- ❑ Denies Musculoskeletal Symptoms
- ❑ Hip Pain
- ❑ Joint Swelling
- ❑ Muscle Weakness
- ❑ Shoulder Pain
- ❑ Knee Pain
- ❑ Muscle Cramps
- ❑ Fibromyalgia
- ❑ Spine Pain
- ❑ Wrist or Hand Pain
- ❑ Joint Pain
- ❑ Lupus

NERVOUS SYSTEM

- ❑ Denies Neurological Symptoms
- ❑ Headaches
- ❑ Tremors
- ❑ Poor Speech
- ❑ Changes in Vision

SKIN

- ❑ Denies Skin Symptoms
- ❑ Rash
- ❑ Dryness
- ❑ Itching
- ❑ Lesions

MENTAL HEALTH

- ❑ Denies Mental Health Symptoms
- ❑ Sleep Disturbance
- ❑ Feeling Hopelessness

ENDOCRINE SYSTEM

- ❑ Denies Endocrine Symptoms
- ❑ Thyroid Problems
- ❑ Increased Thirst

OTHER

Any other symptoms our providers need to be aware of?

PATIENT MEDICAL HISTORY

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PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	❑ MALE ❑ FEMALE	AGE	HEIGHT	WEIGHT

Please check the boxes that describe your previous medical history:

RHEUMATOLOGIC

❑ Arthritis ❑ Gout
❑ Osteoporosis ❑ Lupus

NEUROLOGIC

❑ Alzheimer's Disease
❑ Migraines
❑ Multiple Sclerosis
❑ Parkinson's Disease
❑ Stroke ❑ Epilepsy
❑ Seizures ❑ Fainting Spells

MENTAL HEALTH

❑ Anxiety ❑ Depression

ENDOCRINE

❑ Diabetes Type 1
❑ Diabetes Type 2
❑ Hypoglycemic
❑ Thyroid Problems

CANCER

❑ Cancer
What type of cancer?

Where is the cancer located?

RESPIRATORY

❑ Asthma ❑ Emphysema
❑ COPD ❑ Sinusitis
❑ Bronchitis ❑ Sleep Apnea
❑ CPAP Machine ❑ Pneumonia
❑ Oxygen Dependent

HEMATOLOGIC

❑ Anemia
❑ Blood Clotting Disorder
❑ Sickle Cell Anemia

GASTROINTESTINAL

❑ Bowel/Stomach Disorder
❑ History of Ulcers

HEPATIC

❑ Hepatitis ❑ HIV/AIDS
❑ Jaundice

URINARY

❑ Bladder Disorder ❑ Dialysis
❑ Kidney Problems
❑ Creatinine Higher Than 2

FEMALE SPECIFIC

❑ Currently Pregnant
❑ Not Pregnant

OTHER

❑ Glaucoma
❑ Hearing Problems
❑ Vision Problems
❑ Latex Sensitivity
❑ Problems With Anesthesia
❑ Malignant Hyperthermia

CARDIAC

❑ High Blood Pressure
❑ CVA/Stroke
❑ Palpitations
❑ Fast Heartbeat
❑ Irregular Heartbeat
❑ Heart Murmur
❑ Deep Vein Thrombosis
❑ Heart Disease
❑ Chest Pain
❑ Metal Heart Valve
❑ Non-Metal Heart Valve
❑ Pacemaker/Defibrillator
❑ Cardiac Stent
What year was stent placed?

What kind of stent?

Are you on medication for the stent?

❑ Congestive Heart Failure
❑ Treated in the Last 3 Months?
❑ Heart Attack
❑ Treated in the Last 6 Months?
❑ Short of Breath When You Lie Down?
❑ Climb a Flight of Stairs Without Panting?

VACCINATIONS

Influenza (flu) shot?
❑ Within the Last 6 Months
❑ 6 to 12 Months
❑ 12 to 24 Months
❑ More Than 2 Years Ago
❑ Never or Can't Remember

Pneumonia shot?
❑ Within the Last 2 Years
❑ 2 to 5 Years Ago
❑ 5 to 10 Years Ago
❑ More Than 10 Years Ago
❑ Never or Can't Remember

PATIENT MEDICAL HISTORY - (PG. 2)

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH

Check boxes below that apply:

PATIENT'S FAMILY HISTORY

Patient's Mother ❑ Alive ❑ Deceased ❑ Unknown Patient's Father ❑ Alive ❑ Deceased ❑ Unknown

	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	No History
Aneurysm									
Arthritis									
Bleeding/Clotting									
Breast Cancer									
Cancer (Other Types)									
Colon Cancer									
Depression									
Diabetes Type 1									
Diabetes Type 2									
Heart Disease									
High Blood Pressure									
Mental Illness									
Stroke									

SOCIAL HISTORY

What is your smoking status?

❑ Current Everyday Smoker
❑ Current Some-Day Smoker
❑ Former Smoker
❑ Never Smoker
❑ Status Unknown

❑ **Use recreational drugs?**

Cigars/Day ____ Packs/Day ____ Pipes/Day ____ Chewing Tobacco ____

❑ **Use alcohol?**

How many drinks per occasion?
❑ 1 ❑ 2 ❑ 3 ❑ 4 or More ❑ N/A

Comments ____

❑ Have you recently traveled outside of the United States?

Years of tobacco use?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5
❑ 10+ ❑ 15+ ❑ 20+ ❑ 25+

❑ Have you been counseled to quit/cut down on your tobacco use within the last 6 months?

PATIENT'S SURGICAL HISTORY

❑ Orthopaedic Surgery? — What type of orthopaedic surgery? ____

❑ Gynecologic Surgery? — What type of gynecologic surgery? ____

❑ Ear, Nose, or Throat Surgery? — What type of ear, nose, or throat surgery? ____

❑ Cardiac Surgery? — What type of cardiac surgery? ____

❑ Urological Surgery? — What type of urological surgery? ____

❑ Abdominal Surgery? — What type of abdominal surgery? ____

Surgeries Not Listed Elsewhere: ____

PATIENT MEDICAL HISTORY - (PG. 3)

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH

CURRENT MEDICATIONS

Please list all current medications (including any herbal medications and/or supplements):

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

Please list any medications that you are allergic to and your reaction to them:

_____

_____

_____

Pharmacy Name: _____ Phone Number: _____

PATIENT SIGNATURE	DATE	BLOOD PRESSURE	PULSE

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PREVIOUS TREATMENTS

	How Often?	How Long?	Date of Last Treatment?
❑ Previous Treatments	_____	_____	_____
❑ Chiropractic Care	_____	_____	_____
❑ Heat	_____	_____	_____
❑ Ice	_____	_____	_____
❑ Massage	_____	_____	_____

PREVIOUS INJECTIONS

Date of Last Injection?

❑ Facet Joint _____
❑ Cervical Epidural _____
❑ Transforaminal Lumbar Epidural _____
❑ Lumbar Epidural _____
❑ Sacroilliac Joint (SI Joint) _____
❑ Nerve Block _____
❑ Trigger Point _____

❑ Psychological Consultation for Pain Relief
❑ Other Remedies Tried
_____
❑ Where did you have your last injection?
_____

HOW DO ANY OF THE FOLLOWING AFFECT YOUR PAIN?

Sitting	O Better O Worse O No Change	Heat	O Better O Worse O No Change
Standing	O Better O Worse O No Change	Cold	O Better O Worse O No Change
Walking	O Better O Worse O No Change	Massage.....	O Better O Worse O No Change
Lying Down	O Better O Worse O No Change	Physical Activity....	O Better O Worse O No Change
Rising from a chair	O Better O Worse O No Change		

ASSOCIATED SYMPTOMS

Weakness ..... O Arms/Hands O Legs/Feet O None
Numbness (loss of feeling) ..... O Arms/Hands O Legs/Feet O None
Tingling (falling asleep) ..... O Arms/Hands O Legs/Feet O None
Is your pain worse at night? ..... O Yes O No
Does your pain wake you up at night? ..... O Yes O No
Does coughing affect your pain? ..... O Yes O No
Do your legs feel tired or hurt if you walk too far? ..... O Yes O No
If yes, answer the following:
How far can you walk? ..... O Less Than 1 Block O 1 to 3 Blocks O More Than 3 Blocks
Is this relieved by resting your legs? ..... O Yes O No
Is this relieved by bending forward? ..... O Yes O No

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PAIN DIAGRAM

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH

Please mark the areas where you experience the following sensations:

Ache ^^^ ^^^ ^^^

Numbness ooo ooo ooo

Pins & Needles === === ===

Burning xxx xxx xxx

Stabbing /// /// ///