



PATIENT INFORMATION SHEET

Patient Information

Name: _____
 _____ Last _____ First _____ MI _____ Preferred/Nickname _____ Maiden _____
 Prefix(circle) Dr. Mr. Ms. Mrs. Miss Sex(circle) Female Male DOB: ___/___/___ Age _____
 Street Address: _____ City: _____ State: ___ Zip: _____
 2nd/Seasonal Address: _____ City: _____ State: ___ Zip: _____
 Home phone: () _____ - _____ Work phone: () _____ - _____ Cell phone: () _____ - _____
 Marital Status(circle) Single Married Divorced Widowed Social Security Number: _____ - _____ - _____
 Primary Language(circle) English Spanish Other: _____
 Pharmacy Name: _____
 Pharmacy Phone: () _____
 Emergency Contact Name: _____
 Emergency Contact Phone: () _____ - _____ When did your pain first start? _____
 Primary Care Physician: _____ Phone: () _____ - _____

How did you hear about us? (circle)		
Newspaper	Magazine	Online
Flier/Brochure	Lecture	Friend
Yellow Pages	Physician	
Other: _____		

Responsible Party/Insurance Information

Primary Ins Name: _____	Secondary Ins Name: _____
Ins Address _____	Ins Address _____
Ins Phone: () _____ - _____	Ins Phone: () _____ - _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Cardholder's Name: _____	Cardholder's Name: _____
DOB: ___/___/___ SS#: _____ - _____ - _____	DOB: ___/___/___ SS#: _____ - _____ - _____
Relation to Patient: _____	Relation to Patient: _____

Employer: _____ Occupation: _____
 Employer Address: _____ Phone: () _____ - _____

If this is a job related injury, is this the employer you were working for at the time? _____
 If due to an injury, date of loss: ___/___/___ First symptoms: _____

Will an attorney or Liability Carrier be involved in payment of charges? (circle) YES NO

If YES, please explain: _____

Is injury related to: (circle) Accident Auto Accident Job Related Other

If Job related: claim # _____ Case Manager _____ Phone() _____ - _____

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that while The CORE Institute® contracts with many insurance companies, it is my responsibility to verify with my plan that The CORE Institute® is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that The CORE Institute will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize The CORE Institute® to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines.

Patient/Representative Name(print) _____

Signature _____

Date ___/___/___



MEDICAL QUESTIONNAIRE CERVICAL SPINE

Height: _____
Weight: _____

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Check All That Apply:

Currently Working Unemployed Retired
 Leave of Absence Disabled Other

Primary Care Physician: _____

Present Illness:

What is the primary problem for which you are seeking care today?

How long have you had this problem? _____

Are you right-handed or left-handed? Right Left

Do you presently have:

Neck Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shoulder Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arm Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What percentage of your pain is:

In the Back?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the Leg?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Did you have an Injury? Yes No

If Yes:

What were you doing when the injury occurred?

Have you had any of the following additional symptoms:

- Numbness (or tingling) in the legs/feet? Yes No
- Weakness in the legs? Yes No
- A recent change in bladder or bowel habits? Yes No

Did your symptoms develop: Gradually? Yes No

Suddenly? Yes No

How would you describe your pain: Sharp Dull Burning

Is your pain? Constant Intermittent Infrequent

Indicate how the following activities affect your back problem:

Increase, Decrease or No Change

Bed Rest: _____
Sitting: _____
Standing: _____
Walking: _____
Bending: _____
Physical Activity: _____
Coughing or Sneezing: _____

Do your hands feel clumsy? Yes No

Are you having difficulty walking? Yes No

Do you lose your balance when walking? Yes No

Have you had prior Treatment? Yes No

If yes, mark the type(s) of non-operative treatment:

Medication Chiropractic Care Exercise/PT

Physical Therapy Brace Other: _____

Have you had similar neck/arm pain in the past? Yes No

Were you injured at work? Yes No

Were you injured in a car accident? Yes No

Do you have an attorney working with you? Yes No

If yes, Name and Address:

Past SURGICAL History

List all Prior Operations (and the year of surgery)

Past MEDICAL History

List Your Current Medical Problems

Medications

List All Medications You Are Currently Taking (and their doses)

Allergies

Are you allergic to contrast dye? Yes No

Are you allergic to any other medications? Yes No

If so, please list:

Review of Symptoms

Have you experienced any of the following symptoms or health problems?

Arthritis Yes No

Fever or Chills Yes No

Recent weight loss Yes No

Pain during the night Yes No

Anxiety Yes No

Depression Yes No

Serious personal problems Yes No

Chest Pain Yes No

Wheezing or shortness of breath Yes No

Stomach Ulcers Yes No

Social History

Tobacco

Do you smoke cigarettes? ___ Yes ___ No

If yes, how many packs/day? _____

For how many years? _____

Have you quit smoking? ___ Yes ___ No

If yes, how long ago? _____

Alcohol

Do you drink on a regular basis? ___ Yes ___ No

If yes, how many drinks/day? _____

Exercise

Do you exercise on a regular basis? ___ Yes ___ No

If yes, how often? _____

What type of exercise? _____

Work Situation

Check all that apply:

- | | |
|-------------------------|-----------------------|
| ___ Retired | ___ Currently working |
| ___ Unemployed | ___ Disabled |
| ___ On Leave of Absence | ___ Other: _____ |

Thank you for taking the time to complete this questionnaire.
Additional pages will be completed by the physician during your visit today.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of The CORE Institute®, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

Signature of Patient/Patient's Representative

Date

Printed Name of Patient/Patient's Representative

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of The CORE Institute®. I was unable to obtain written acknowledgement because:

- Individual refused to sign this acknowledgement
- A communication barrier prohibited obtaining signed acknowledgement
- An emergency situation prevented obtaining signed acknowledgement
- Other(please specify): _____

Employee Signature

Date



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION

I hereby authorize Center for Orthopedic Research and Education, Inc., an Arizona corporation doing business as The CORE Institute (“CORE”), to disclose to

_____ (“Recipient”),
any and all of my protected health information, of any kind and description (the “Records”). Disclosure under this Authorization is for the following purpose:

This Authorization will remain effective until one-year following the date set forth below or, if no date is set forth below, the date the Company receives this executed Authorization, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to The CORE Institute’s Privacy Officer attention at The CORE Institute’s facility located in Winslow, Arizona. I understand that my revocation will not be effective to the extent The CORE Institute has taken action in reliance on this Authorization.

I understand that neither The CORE Institute nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Patient or Patient’s Representative

Date

Printed Name of Patient or Patient’s Representative



FINANCIAL POLICY

Effective September 1, 2007

Thank you for choosing The CORE Institute® as your orthopedic specialist. Please carefully read and initial by each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. ____ I understand that if I do not have my insurance card, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. ____ I understand that The CORE Institute® will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and The CORE Institute®. Our office will provide written notification to you detailing anticipated charges. If full deductible is not applied to your claim by your insurance company, we will refund any overpayment to you when we receive overpayment.
3. ____ I understand if my account is not paid in full within 90 days, a \$35 collection-processing fee will be added to the outstanding balance and will be turned over to JR Brothers for further processing. No additional appointments will be made for delinquent accounts until they are brought current.
4. ____ I understand that a \$35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).
5. ____ I understand that if I am unable to make a scheduled appointment I need to contact The CORE Institute® at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A \$25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.
6. ____ The CORE Institute® will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process claim for services. It is also my responsibility to notify The CORE Institute® if there is a change in my insurance coverage, residence, or phone number.

ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

7. ____ *I have read and I understand the above Financial Policy and I agree to abide by its terms.*

Printed name of patient

Signature of Patient/Responsible Person

Date

Relationship of Responsible Person to Patient



AUTHORIZATION FOR RESEARCH DATA BASE

The purpose of this Authorization is to authorize The CORE Institute® to maintain a copy of your health information in its research database, which is called The CORE Research Registry (the “Registry”). The Registry stores patient information for both clinical care and research purposes. By using the information in the Registry, The CORE Institute® believes it can improve musculoskeletal health care.

All of the patient information in the Registry is confidential and protected by the Federal Privacy Rule which limits how healthcare providers, including The CORE Institute®, may use and disclose a patient’s health information. Except as required by law, neither The CORE Institute® nor any third party may access or use your information in the Registry without first obtaining your written authorization or the approval of a research institutional review board. For example, if The CORE Institute® uses your information for educational purposes, any information that could identify you (e.g., your name, date of birth, clinical number, etc.) would be deleted.

By signing this authorization, you authorize The CORE Institute® to include in the Registry all of your health information, of any kind and description, in the possession of The CORE Institute®, including x-rays, medical history, intraoperative photos, test results, pathologic specimens, and HIV/HIV related diseases and communicable disease related information (“Information”). The Privacy Rule Requires The CORE Institute® to inform you that individuals who access the Registry may re-disclose the Information and that the Information may no longer be protected by the Privacy Rule. However, it is our policy never to disclose any identifiable patient Information in the Registry to a third party. Your treatment, payment, enrollment or eligibility for benefits at The CORE Institute® is not dependent upon whether you sign this Authorization.

Although this Authorization will not expire, you have the right to revoke this Authorization at any time by sending a written notice of revocation to The CORE Institute® in Arizona, attention to the Privacy Officer. However, your revocation will not be effective to the extent The CORE Institute® has already taken action in reliance on this Authorization or with the respect to Information used in the Registry before receipt of the revocation to the extent necessary to preserve the integrity of the Registry.

Upon request, you will receive a photocopy of this Authorization, which will be considered effective and valid as the original. The CORE Institute® thanks you for your consideration of participation in our Registry and is proud to continue to help advance orthopedics through our research and education.

Signature of Patient/Patient’s Representative

Date

Printed Name of Patient/Patient’s Representative

Description of the authority of Patient’s Representative



NOTICE TO PATIENTS

Re: Relationships with Medical Device Companies

Dear Patient:

Recently, you may have heard that the Federal Government completed inquiries into the practices of several large orthopedic device manufacturing companies. Although The CORE Institute was not involved in any of those investigations, we would like to make sure you have accurate information regarding our relationships with some of these companies.

As our name suggests, our physicians, engineers, scientists and graduate students are actively involved in clinical care, education and research. Because of our mission, we focus our recruitment efforts on physicians who have superior academic and clinical training, and who also are actively involved in research and education directed at advancing orthopedic surgery and improving patient outcomes. Information about our physicians' education, training and experience can be accessed on our website at www.thecoreinstitute.com.

Our Division of Research and Development and our partnership with The Sun Health Research Institute allow us to be actively involved in laboratory research aimed at improving the quality of medical care. We are currently working on projects studying total knee replacement devices; ways to improve hip fracture implants; improved methods of fracture treatment; and release of antibiotics from implants in an attempt to reduce the risk of post-operative infections. We are very proud of our success in this field and believe that we have contributed to the improvement in the care of orthopedic conditions.

Because of the qualifications of our physicians and other professionals, we often are approached by companies involved in the development of medical devices, instruments and related equipment. The companies know that our physicians have invaluable hands-on experience in the treatment of orthopedic problems, and that orthopedic surgeons frequently make important contributions to the development and improvement of devices and other equipment used in the treatment of orthopedic conditions. Surgeons and researchers at The CORE Institute are currently working with at least half a dozen companies, both large and very small, to help them create and improve products for patient care. We also have developed and patented products of our own that we have and/or will license or sell to industry.

Although CORE physicians donate a great deal of their time to the advancement of orthopedic research and education, they also enter into contracts that provide payment for some of their efforts. Payment for the services provided by orthopedic surgeons may come in the form of hourly consulting fees for services provided by the physicians; royalties based on sales of products to which CORE physicians made important contributions (excluding sales of products used on our patients); and/or outright purchase of technologies. All of these transactions are compliant with all federal and state laws

The following is a current list of the CORE physicians who have contractual relationships with device manufacturers, and the companies with whom they have those relationships:

Physician	Company Name	Website
Matthew Hansen, MD	Exactech	www.exac.com
David Jacofsky, MD	Stryker Orthopaedics	www.stryker.com
Mark Campbell, MD	Stryker Navigation	www.stryker.com
Jeffrey Lyman, MD	Stryker Navigation	www.stryker.com
Steven Myerthall, MD	Stryker Navigation	www.stryker.com
M. Wade Shrader, MD	Stryker Navigation	www.stryker.com

If your care might involve the placement of a medical device, please feel free to ask your surgeon about his or her recommendation as to what type of device best suits your needs.

We hope this clarifies the nature of our involvement in research and development leading to advances in orthopedic care. We are proud to remain leaders in innovation and are honored to have such a talented research staff at The CORE Institute. As always, we remain committed to complete transparency and disclosure with our patients, and we welcome your questions on this or any subject relating to your care.