

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (**HIPPA**). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and training purposes

I have been given the right to review and receive a copy of my surgeon's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

I understand that I may request in writing that you restrict how my private information is used or disclosed. I understand that my surgeon is not required to agree to my requested restrictions, but if he does agree then he is bound to abide by such restrictions.

Patient Name: _____ **Date:** _____

Signature: _____

Relationship to patient (if not patient): _____

Please list any family members, friends, or personal representative with whom you allow access to your health information (other than the basic knowledge needed to help with your care or payment of a bill):

For office use only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation

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SeanKeemmd.com

PATIENT INFORMATION		
Name:	Date of Birth:	Age:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	
Cell Phone:	email:	
Social Security #:	Sex: M or F	Marital Status:
Spouse's Name:	Daytime Phone:	
Patient's Employer:	Occupation:	
Employer's Address:		
Emergency Contact:	Relationship:	
Daytime Phone:	Address:	
INSURANCE INFORMATION		
Primary Insurance:	Name of Insured:	
ID#:	Group #:	
S.S.# of insured: (if different from patient)	D.O.B. of insured:	
Secondary Insurance:	ID#:	Group#:
RESPONSIBLE PARTY (If different than patient)		
Name:	S.S.#:	Relationship to patient:
Address:		
Home phone:	Work phone:	
REFERRAL INFORMATION		
Referring Physician's Name:	Phone :	
Address:		

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to my insurance company, the Social Security Administration, the Health Care Finance Administration or its intermediaries any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payments of medical insurance benefits to my physician.

I authorize Keem Spine Institute, PC to release information to any medical facility or physicians to which I may be referred to by this office. I also authorize Keem Spine Institute, PC to obtain copies of medical information from any medical facility or physician which may be related to my care and/or treatment.

Signed _____

Date _____

Name: _____ Date: _____
 Age: _____ Height: _____ Weight: _____

CHIEF COMPLAINT

Who referred you to Dr. Keem? _____

For what condition are you seeing Dr. Keem? _____

When did this problem begin? _____

How did this problem begin? _____

Is this an on-the-job injury? ___ Yes ___ No Date of the injury: _____

What makes your condition worse? _____

What makes your condition better? _____

Have you had physical therapy? How long? _____

Have you had an epidural injection? How many times? _____

MEDICAL HISTORY

Please mark as many medical conditions you may have or have been diagnosed with:

- ___ Open sores, draining wounds or infections (location: _____)
 ___ AIDS _____ Arthritis (type: _____) _____ Asthma
 ___ Blood clot in leg (Thrombophlebitis) _____ Blood clot in lung (Pulmonary embolus)
 ___ Bleeding disorder (type: _____) _____ Cancer (type: _____)
 ___ Diabetes (type: _____) _____ Epilepsy/Seizures _____ Fibromyalgia
 ___ Heart disease (type: _____) _____ High Blood Pressure
 ___ Irritable Bowel Syndrome _____ Lung Disease (type: _____)
 ___ Psychological Disorder (type: _____) _____ Polio
 ___ Thyroid Disease (type: _____) _____ Tuberculosis _____ Liver Disease
 ___ Frequent bladder infections _____ Kidney infections _____ Gastric/duodenal Ulcers

Please list or describe any other medical problems, injuries, or reasons for **hospitalization other than for operations:**

Please list all operations you have had, especially spinal surgeries. When (month/year) and where (body location) were operations performed?

Please list any health care professionals involved in your care. Include Physicians, Chiropractors, Physical Therapists, etc:

MEDICATIONS: List all medications taken regularly

DRUG	DOSE	HOW OFTEN	HOW LONG	PRESCRIBED BY
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ALLERGIES:

FAMILY HISTORY

Please list the health status or cause of death of your blood related family:

Father: _____

Mother: _____

Sisters: _____

Brothers: _____

If there are any hereditary diseases in your family, please list:

SOCIAL HISTORY

Are you: Single Married Divorced Widowed

Do you have children? If so, how many? _____ Do you live alone? _____

Are you at risk for AIDS? _____ Hepatitis? _____

Would you be willing to have an HIV test before surgery? _____

Occupation: _____

Have you been hospitalized for a psychiatric problem? _____

If so, when? _____

Do you have a history of substance abuse? If so, what? _____

Do you smoke? _____ If so, how much & how long? _____ packs a day for _____ years

Have you ever smoked? _____ If so, when did you quit? _____

If you currently smoke and find you need surgery, would you be willing to quit prior to surgery and for 12 months after, to decrease the chances of complication? _____

Do you consume alcohol? If so, how much at a time, how often and how long have you been drinking?

WOMEN: Could you be pregnant? Yes No

REVIEW OF SYSTEMS

Please note any problems you are having in any of these areas:

Head _____ Heart _____

Ears _____ Lungs _____

Eyes _____ Stomach/Intestines _____

Nose _____ Genitals/Urinary Tract _____

Throat/Voice _____ Muscles/Bones _____

Others

NAME: _____

DATE: _____

PATIENT PAIN DRAWING

Using the colors given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

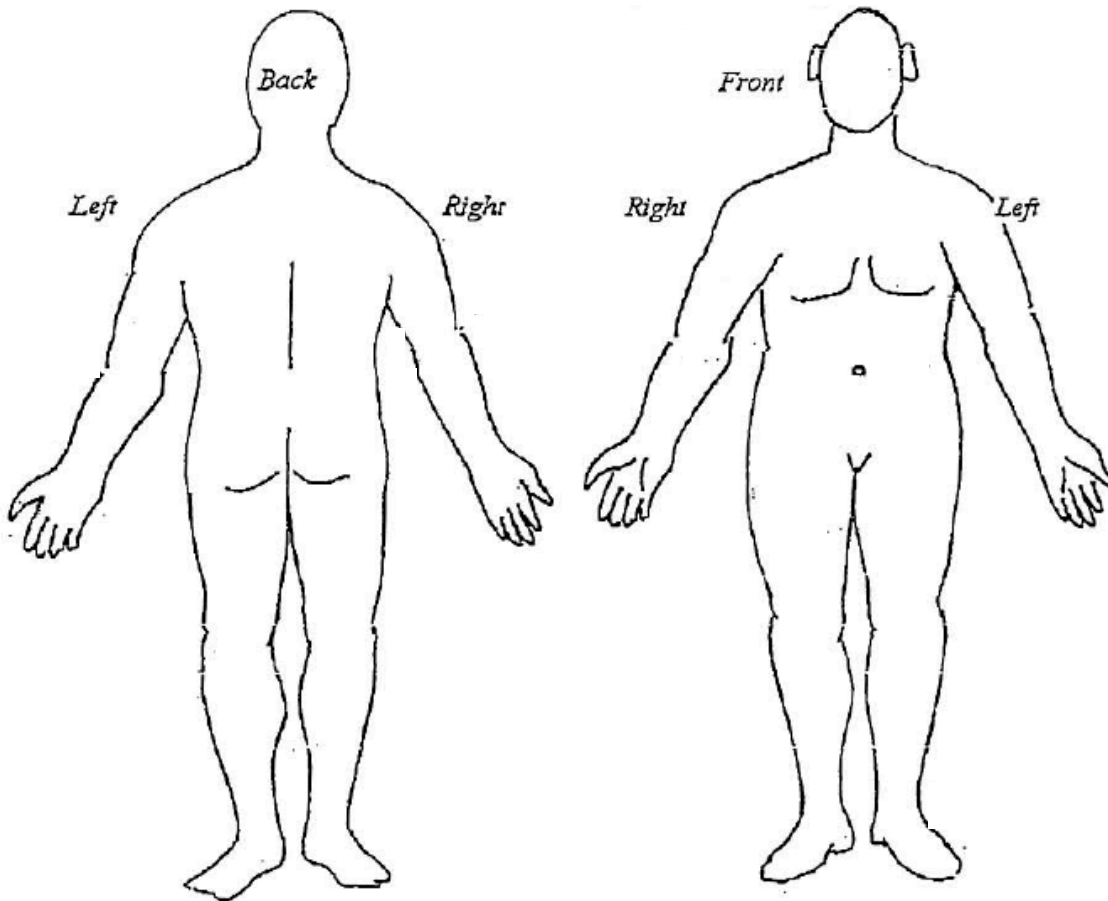
Aching
Red

Numbness
blue

Pins-and-Needles
yellow

Burning
green

Stabbing
purple



How bad is your neck pain? None 1 2 3 4 5 6 7 8 9 10 Worst pain possible

How bad is your arm pain?

Right None 1 2 3 4 5 6 7 8 9 10 Worst pain possible

Left None 1 2 3 4 5 6 7 8 9 10 Worst pain possible

How bad is your back pain? None 1 2 3 4 5 6 7 8 9 10 Worst pain possible

How bad is your leg pain?

Right None 1 2 3 4 5 6 7 8 9 10 Worst pain possible

Left None 1 2 3 4 5 6 7 8 9 10 Worst pain possible

Keem Spine Institute Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to treatment.

Insurance:

We may accept assignment of insurance of benefits, provided we are in the network for your plan. We cannot bill your insurance company unless you provide us with complete and coverage information, both primary and secondary.

Your insurance company may require a deductible or co-payment. **Please be prepared to pay your portion at the time of service.** We accept cash, checks, MasterCard and Visa. Our office fee for returned checks is \$50, and separate from any fee your bank may apply. Balances older than 30 days may be subject to additional collection fees and interest charges of 5% per month. It is our policy to forward delinquent accounts 90 days past due to a collection agency.

Your insurance policy is a contract between you and your insurance company. Should your insurance company require a specialist referral, it is your responsibility to obtain that referral prior to your appointment. In the event that services are provided and your insurance denies reimbursement, **please remember that you, the patient, are ultimately responsible for payment on your account.**

In the instance of a motor vehicle accident, be aware that we DO NOT file third party liability claims. You are responsible for payment in full regardless of insurance coverage and any pending litigation. We do not treat patients on a contingent basis, nor do we accept an attorney's lien in lieu of payment.

Appointments:

It is our goal to see you at your scheduled appointment time. However, with the nature of our practice, appointments do not always run on schedule, as some patients need more time with the doctor than others. Also, emergencies arise where the doctor is called away. Therefore, please be patient with your wait and know that when you are seen you will have as much time as you need.

We ask that if you need to cancel or reschedule an appointment it be done at least a day in advance of the appointment. If you do not show up for your appointment or cancel with less than 24 hours notice, a fee of \$50 will be charged to you. You will be personally responsible for this charge. This charge will not be billed to or paid for by your insurance company. Future appointments will not be scheduled until this fee is paid.

I have read, understand, and agree to abide by the terms and conditions stated in the financial policy.

Signature of patient or responsible party

Date