Patient Information Sheet

Abay Neuroscience Center
3223 N. Webb Rd. Ste 1 Wichita KS 67226

Last Name	First Name	MI	DOB	SSN

Address	City	State	Zip Code

Primary Phone #	Secondary Phone #	Work Phone #

Email (for Portal invite)

Can we contact you by email? YES / NO

Sex: Male / Female **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Race: White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander☐ American Indian or Alaska Native☐ Other☐

Ethnicity: Hispanic ☐ Caucasian☐ African American ☐ Mexican American ☐ Arab American ☐ Native American ☐ Jewish American ☐ Asian American ☐ Unknown ☐

Preferred Language:_____

Referring Physician	**Phone:**
Primary Care Physician	**Phone:**
Emergency Contact	**Phone:**

Primary Insurance:

Insured Name:	**DOB:**
Identification #:	
Group/Policy #:	
Employer Name:	

Secondary Insurance:

Insured Name	**DOB:**
Identification #	
Group/Policy #:	
Employer Name:	

Please complete the back of this sheet (if applicable) and then sign the bottom.

Patient Information Sheet

Abay Neuroscience Center
3223 N. Webb Rd. Ste 1 Wichita KS 67226

Work Comp and MVA Claims

Insurance Name

Billing Address

Adjuster Name

Adjuster Phone **Adjuster Fax**

Claim # **Date of Injury:**

Nurse Case Manager **Phone**

Fax **Email**

DO YOU HAVE AN ATTORNEY REPRESENTING YOUR CASE? YES ☐ NO ☐

Attorney Name:

Address

Phone

Fax

Assignment and Release

I, the undersigned, certify that I (or my dependents) have insurance coverage as noted above and assign all insurance benefits, otherwise payable to me for services rendered, and payable directly to Abay Neuroscience Center (ANC). I understand that I am financially responsible for all charges whether or not they are paid by any insurance plan I participate in. Further, I understand if I fail to pay for my charges and ANC refers my account to an outside Attorney or collection agency, I am also responsible for all collection fees that an outside Attorney or collection agency may charge to collect the charges I owe. I hereby authorize ANC to release all information necessary to secure payment for services they provide me (or my dependents) medical records to my referring, primary and treating physician and diagnostic centers.

Responsible Party Signature Relationship, if not the patient Date

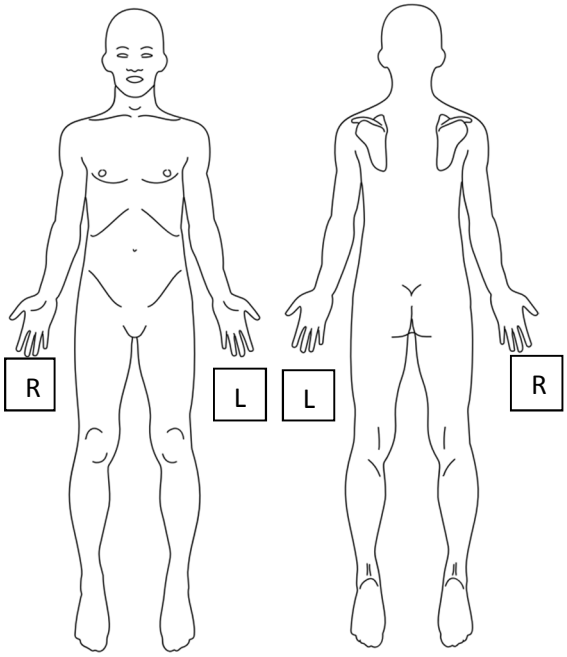
Today's Date: _____

ANC Abay Neuroscience Center

Patient Name: _____

Date of Birth:_____ Age: _____ Height: _____

Use symbols to draw in the location of your symptoms on diagrams:
Tingling/Numbness OOOO Pain XXXX Ache ////



My pain is:	Worse	Better
Walking	_____	_____
Standing	_____	_____
Sitting	_____	_____
Lying Down	_____	_____
Bending	_____	_____
Coughing/Sneezing	_____	_____

Neck Pain % in Neck _____ Arm _____=100%

Back Pain % in Back _____ Legs _____=100%

How long can you stand with no/minimal pain?_____
How long can you sit with no/minimal pain? _____
Circle how far you can walk with no/minimal pain:
0-50Feet 50-200Feet 200-500Feet 1/2 Mile Mile +

My pain affects my: (circle all that apply)

Appetite Activities of Daily Living School Sleep Work

Other:

Please Briefly Describe your main problem/complaint:

_____

_____

_____

How long have you had this problem? Has it gotten worse/better/stayed the same since onset?

_____

_____

_____

ABAY NEUROSCIENCE CENTER

Patient Name: _____ Date of Birth: _____

Review of Systems (please circle all that apply within the past year)

GENERAL	Bleeding Between Periods	**GI Symptoms**	Disorientation
Fatigue	Vaginal Discharge	Nausea	Forgetfulness
Chills	Pregnant	Abdominal Pain	Seizures
Weakness	Hot Flashes	Blood in Stool	Fainting
Fever	**Male Symptoms**	Bowel Incontinence	Lightheadedness
Night Sweats	Breast Lump	**GU Symptoms**	Difficulty Walking
Weight Loss	Nipple Discharge	Bladder Incontinence	Disturbances in Coordination
Weight Gain	Erectile Difficulties	Frequency in Urination	Numbness/Tingling
Headache	Testicular Pain	Painful Urination	Falls
Hoarseness	Penile Discharge	**Musculoskeletal**	Leg/Arm Weakness
Eye/Ear/Nose	Hot Flashes	Neck Pain	**Psychological Symptoms**
Blurry Vision	**Cardiovascular**	Thoracic Pain	Depressed
Double Vision	Chest Pain	Lumbar Pain	Nervousness
Loss of Vision	Irregular Heart Rate	Leg/Arm Pain	Loss of Sleep
Hearing Loss	Poor Circulation	Joint Pain	**Skin Symptoms**
Ringing in Ears	Other:	Joint Swelling	Itching
Sinus Problems	**Pulmonary Symptoms**	Muscle Cramps	Rash
Female Symptoms	Shortness of Breath	Leg Cramps	Hives
Breast Lump	Wheezing	**Neurological Symptoms**	Scars
Nipple Discharge	Chronic Cough	Dizziness	Sores that won't heal
Extreme Menstrual Pain	Bloody Sputum	Confusion	**Other:**

Have you been diagnosed with any of the following in the past year? Circle all that apply.

AIDS/HIV	GERD	Migraine Headache	Stroke or TIA
Anemia	Gout	Mitral Valve Prolapse	Suicide Attempts
Anorexia	Heart Disease	Multiple Sclerosis	Thyroid Problems
Appendicitis	Hepatitis	Pacemaker	Tuberculosis
Arthritis	Hernia	Multiple Sclerosis	Ulcers
Bulimia	High Blood Pressure	Pacemaker	Urinary Tract Infection
Chemical Dependency	High Cholesterol	Parkinson's Disease	Venereal Disease
COPD/Asthma	Kidney Stones	Psychiatric Care	Flu Vaccine
Diabetes	Kidney Disease	Seizure Disorder	Pneumonia Vaccine
Fibromyalgia	Liver Disease	Sleep Apnea	Other:
Cancer (Type)		Blood Disorder (Type)	

ABAY NEUROSCIENCE CENTER

Patient Name:_____ DOB:_____

Current Smoker? Yes / No Packs/Day_____ Former Smoker? Yes / No Date you Quit: _____

Smokeless Tobacco user: Yes / No When did you start?_____Date you Quit: _____

Alcohol Use? Yes / No Drinks per Week? _____

Recreational Drug Use? Yes / No Type of Drug: _____ Use(s) per week: _____

Medication	Dosage/Times per day	Medication	Dosage/Times per day

List all medication allergies with reaction: _____

Name of Pharmacy and Phone Number:

Surgery/Hospitalization	Treating Physician	Year

ABAY NEUROSCIENCE CENTER

Patient Name:_____ DOB:_____

Family History (please mark X for all that apply)

	Yes	Relationship		Yes	Relationship
Osteoarthritis			Heart Disease		
Rheumatoid Arthritis			High Blood Pressure		
Asthma			Kidney Disease		
Cancer			Strokes		
Chemical Dependency			Other		

Please list previous doctors that you have seen for your main condition: _____

_____

_____

Do you have a Cardiologist? Yes / No Name: _____

Do you have a Pain Management Physician? Yes / No Name:_____

Do you have an Oncologist? Yes / No Name:_____

Occupational:

Is your problem related to a (circle all that apply): Accident / Work Injury / Neither

Date of accident / injury: _____ Is there an attorney involved? Yes / No

Name and address of attorney:_____

Are you currently employed? Yes / No Job Title:_____

Who is your employer? _____

List restrictions (if you have any): _____

_____

>Who placed you on these restrictions? _____

Work exposes me to (circle all that apply):

Stress Heavy Lifting Hazardous Material

ANC Abay Neuroscience Center

Patient Name:_____ DOB:_____

Please mark which TREATMENTS you have had for your main problem/complaint and if it was helpful.

	+/-	When (Year)	Facility
Trigger Point Injections			
Epidural Steroid Injections			
Physical Therapy			
Electrical Stimulation			
Ultrasound			
Heat Packs			
Cold Packs			
Brace			
T.E.N.S. Unit			
Manipulations			
Traction			
Aqua Therapy			
Whirlpool			
Acupuncture			
Other:			

Have you tried any of these drugs previously for your current complaint and length taken?

Medication	Taken (+/-)	Helpful? Yes/No	Medication	Taken (+/-)	Helpful? Yes/No
Aleve			Mobic		
Arthrotec			Morphine		
Aspirin			MS Contin		
Baclofen			Norco		
Celebrex			Norflex		
Daypro			Prednisone		
Demerol			Relafen		
Excedrine			Robaxin		
Feledene			Roxicet		
Flexeril			Skelaxin		
Gabapentin			Soma		
Ibuprofen			Tylenol		
Ketoprofen			Tylenol #3		
Lidoderm Patch			Ultracet		
Medrol Dosepak			Ultram		
Methadone			Zanaflex		

_____

Patient Signature Date

ANC Abay Neuroscience Center

Last Name: First Name:

Date of Birth:

PLEASE READ EACH STATEMENT BELOW AND ON THE BACK OF THIS SHEET. INITIAL, SIGN AND DATE FOR AUTHORIZATION.

I, the undersigned, give my authorization to treat and assign directly ANC all medical benefits, if any, otherwise payable to me for services rendered. I understand I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions. I understand that all copays and/or self-pay payments are required at the time of service.

Please Initial:

I, authorize ANC to obtain any medical records required for care of insurance purposes. I understand the physician will need all physical therapy notes, epidural injection notes, referring physician notes, chiropractic notes, etc. I authorize use of this signature on obtaining any and all required medical records.

Physical Therapy Facility: Date/Year Attended:

Epidural Injection Location/Physician: Date/Year:

Referring Physician Name:

Primary Care Physician:

Chiropractor: Date/Year Attended:

Please Initial:

I acknowledge that a copy of the Practice's Notice of Privacy Practices was made available to me.

Please Initial:

Signature (Patient or Guardian) Today's Date

ANC Abay Neuroscience Center

Last Name: First Name:

Date of Birth:

CONTINUED: PLEASE READ EACH STATEMENT BELOW. INITIAL, SIGN AND DATE FOR AUTHORIZATION.

I authorize ANC to discuss my Health Information with my Family Member(s) and/or Friends listed:

Name	Phone	Relation
Name	Phone	Relation
Name	Phone	Relation
Name	Phone	Relation

I acknowledge my physician at this clinic is an owner of Kansas Spine and Specialty Hospital, LLC (KSSH). If I choose to receive treatment at KSSH, other physicians there may provide you treatment who may have ownership in KSSH. For your reference, following is a list of all physician owners or investors in KSSH.

Prince Chan, M.D.	John Dickerson, M.D.	Raymond Grundmeyer, III, M.D.
Matthew Henry, M.D.	Fadi Joudi, M.D.	Christian S. Lothes, M.D.
Timothy A. Richardson, M.D.	B. Theo Mellion, M.D.	James D. Weimar, M.D.
Chandra S. Tokala, M.D.		

I understand I have the right to choose the provider of my healthcare service. Therefore, I have the option to use a healthcare facility other than KSSH.

Print Name of Patient Signature (Patient or Guardian)

Date Print Guardian Name (if applicable)

ANC Abay Neuroscience Center

Fall Risk Assessment

1. Have you fallen one or more times in the past year?	YES	NO
2. Do you have difficulty rising from a chair? (i.e. rocking back for forward momentum, using assistive devices to rise)	YES	NO
3. Do you take ANY of the following prescription medications? a) Narcotics (i.e.Norco, Percocet, Dilaudid, Oxycodone, etc.) b) High Blood Pressure Medications (i.e.Lisinopril, Atenolol, Bystolic,etc.) c) Diuretics (water pills) d) Heart Medications (Beta-blockers, Ace inhibiters, etc.)	YES	NO
4. Do you feel dizzy when you get up from a bed or chair?	YES	NO
5. Do you have uncorrected vision issues? (i.e. glaucoma, cataract, macular degeneration, vision difficulties not corrected with glasses	YES	NO
6. Are you incontinent or have difficulty making it to the bathroom on time?	YES	NO
7. Do you have any of the following medical conditions? Low Blood Pressure, Seizures, Parkinson's, History of Stroke, Osteoporosis, Osteopenia	YES	NO
8. Do you have a history of a traumatic brain injury or concussion?	YES	NO
9. Are you over 65 years of age?	YES	NO

If you answered YES to 2 (two) or more of the above questions, you are at an elevated risk for falling.

What can you do to reduce your risk of falling?

- Wear non-skid shoes (tennis shoes, running shoes, walking shoes)
- Avoid using throw rugs at home or use non-skid carpet backing
- Install grab bars in your bathroom
- Use lighting at night
- Clear pathways of furniture and clutter
- Use non-skid rubber mats in showers and bathtubs
- Discuss medications with your primary care physician

Print Patient Name DOB

Patient Signature Today's Date

Medication Policy

Abay Neuroscience Center recognizes that appropriate pain management is an important part of your surgical and recovery process. Therefore, it is important that you are aware of our policies regarding dispensing prescriptive medications including opioids. Abay Neuroscience Center does not routinely prescribe pain medications in anticipation of surgery. Following surgery, you will be discharged with an appropriate prescription depending on the severity of your surgery or injury. The amount of opioid pain medication prescribed is related to your surgical procedure or injury and is only one part of your pain management program. Other important parts of pain control include nonsteroidal anti-inflammatory agents (NSAIDS: ibuprofen, naproxen, Celebrex, aspirin), muscle relaxant, ice, and rest.

Our surgeons will manage your postoperative pain following your surgery depending on the type of procedure done. If you have a history of chronic pain then consulting with a pain clinic or if you had been receiving opioid pain medication from another physician prior to your surgery or injury, you may need to return to that physician for further medical management.

Risks of Narcotic Medications

We are concerned about your overall health and the potentially negative effects of opioid medications. In addition to lack of effectiveness for some types of pain, the side effects of narcotic use include nausea, constipation, upset stomach, sexual dysfunction, depression and fatigue, increased sensitivity to pain, addiction, and drug tolerance.

Refill Policy for Prescriptions

We do not provide narcotic prescription refills between the hours of 5:00 p.m. and 8:00 a.m., weekends, or holidays. If you need your prescription refilled, please notify the surgeon during your clinic visit or call on your physician's clinic days. Clinic business hours are Monday – Friday, 8:00 a.m. – 5:00 p.m. Calls received late in the day may not be addressed until the following day. In order to receive a prescription your physician will have to be here in clinic to prescribe. Please note most of the physicians are only in clinic two days per week and in surgery the rest of the week. If you have questions on when your physician will be in please contact the office through the patient portal or you may call us at 316-609-2600.

I acknowledge that I have read and understand the medication policy. I understand each physician in this practice will ultimately decide on my medication protocol as they feel is appropriate. I understand that my physician is not required to provide me with pain medication and may refer me to another provider for such services if necessary. I acknowledge that if I am receiving opioid medication from a physician at Abay Neuroscience Center I will not receive any other opioid prescriptions from any other providers and if I do so I will be forfeiting any further prescriptions from this office. I acknowledge my physician may obtain prescription medication history from the pharmacy and/or other healthcare providers for treatment purposes. I acknowledge Abay Neuroscience Center does not provide any long-term medication management.

Patient Name _____ Date of Birth _____

Patient Signature _____ Today's Date _____

ANC Abay Neuroscience Center

Important Information

This first appointment will be a consultation and evaluation only. **It is very important for you to hand carry your MRI, CT Myelogram, and/or CT scan CD to this appointment. If you fail to bring the CD, then your appointment will likely be cancelled and rescheduled as the neurosurgeons do not recommend treatment off of the diagnostic report.** Please do not have these mailed as there is no guarantee we will receive it from the US Postal Service in time for your appointment.

If your neurosurgeon recommends surgery, it will have to be approved by your insurance company. *Most insurance companies require what is considered "conservative treatment" (i.e. physical therapy, epidural steroid injections, weight loss, etc.), in the last 3-6 months, before surgery is approved for a patient. They also are requiring patients to be nicotine free for 3 months prior to surgery.* Please take note, even if you have tried all the recommended treatment, it is ultimately the insurance company who makes the decision if surgery will be approved or not. This authorization process can be lengthy. It typically takes a minimum of 14 days to obtain authorization. This is if we have all the conservative treatment notes to send in. If we have to track down these notes, then the process could be even longer.

If your physician feels the best treatment for your condition is surgery, we will work closely with your insurance company and you to make the process as smooth as possible.

What can you do to help obtain authorization for your procedure?

- Contact your current treating providers for physical therapy, injections, pain management, or chiropractic notes. Please have the records faxed to our authorization department at 316-609-2895 or bring them to your scheduled consultation.
- Stop using any products with nicotine in them. Not only do most insurance companies require this prior to surgical intervention, it will also allow your body/bones to heal better.

ABAY NEUROSCIENCE CENTER

Patient Portal

Patient Portal Features

- You can request medication refills.
- You will be able to set up appointment reminders to be sent to your cell phone or email.
- You can send a private message through the patient portal to your provider's care team instead of playing phone tag.
- You will have access to our forms if you log into the portal.

Creating a Patient Portal Account is Easy

Step 1: Go to: https://patientportal.intelichart.com

Step 2: To self register your account: You are able to use an existing email or social media account. You will mark register with no PIN when registering and the clinic will review your information then send you a PIN once verified.

To register from the email invite: Write down your PIN number, then click on the link. You will follow the questions and enter your PIN number once prompted. Your portal should be ready for access once this step is completed.

You can also access our portal by going to: www.abayneurosciencecenter.com