Dear Patient:

WELCOME TO INDIANA SPINE GROUP! We are pleased that you have chosen us for your care. Indiana Spine Group provides a complete continuum of spine care for patients with a variety of spine and neck disorders and abnormalities. This letter contains **important information regarding your appointment.** Completing these forms does not guarantee coverage for your visit(s)by your insurance company. To verify insurance coverage, please contact your insurance company prior to your visit. Please read through carefully and bring the completed forms with you to your appointment.

Enclosed is an information packet that you will need to complete before your appointment on _____ with:

- ☐ Kevin E. Macadaeg, MD
- ☐ John W. Arbuckle, MD
- ☐ John P. Gentile, MD
- ☐ Jennifer Turner, PA-C
- ☐ Rick Sasso, MD
- ☐ Kenneth L. Renkens, MD
- ☐ Paul E. Kraemer, MD
- ☐ Alixandria Pelych, PA-C
- ☐ Justin Miller, MD
- ☐ Joseph Smucker, MD
- ☐ Thomas Reilly, MD
- ☐ Jason Kuhnle, PA-C
- ☐ Jose Vitto, MD
- ☐ Robert Funk, MD

Please arrive at _____ ☐AM ☐PM for your appointment at _____ ☐AM ☐PM

- ☐ 13225 N. Meridian Street, Carmel, IN 46032
- ☐ 8040 Clearvista Pkwy Ste 450, Indianapolis, IN 46256
- ☐ 13914 Southeastern Pkwy, Ste 201 Fishers, IN 46037
- ☐ 821 North Dixon Road, Kokomo, IN 46901
- ☐ 112 Hospital Lane, Building #2, Suite 301, Danville, IN 46122
- ☐ 747 East County Line Road, Suite L, Greenwood, IN 46413

If you have had any tests or studies, your doctor will need you to bring any X-rays, MRI films, or any other test results you have received from another physicians, hospital, or testing facility. In order to obtain your films, you will need to contact the facility where the films were made or the test was performed **several days in advance of the day you will pick them up**. Each facility will have their own procedure to obtain your films or results. You will need to bring your films with you to your appointment. **Please do not have the facility mail the films to us.** It is important for you to understand that your doctor **will not see you without this medical information. If you are unable to obtain your films for your appointment, please call our office and we will reschedule your appointment.**

Indiana Spine Group participates in most health insurance plans. It is important that you bring your insurance card or cards with you for every appointment with your doctor. Our Business Office will need this information to bill your insurance company. **If you fail to bring your insurance card, your appointment will be rescheduled.** Most insurance plans require co-payment for office visits. If your insurance carrier requires a co-payment it will be collected **at the time of service.** If you do not have health insurance, payment is expected at time of service. In addition, any individual who requests completion of FMLA, disability, or insurance forms will be required to pay a $25 fee prior to completion of the form. For your convenience, we accept cash, checks, Visa, or Mastercard. If you have any questions, please contact our office at one of the numbers listed below. Again, thank you for choosing Indiana Spine Group.

Office Number: 317-228-7000

CONFIDENTIAL PATIENT INFORMATION FORM

Patient Information:

Name: (First) _____ (M I) _____ (Last) _____ Date of Birth: _____

Address: _____ City: _____ IN: _____ Zip Code: _____

Phone: _____ Home ☐Cell ☐Other Phone: _____ ☐Home ☐Cell ☐Other

Social Security Number: _____ Sex: ☐Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced

Are you currently living in a skilled nursing facility or using a Home Health Agency? ☐ yes ☐ no

If yes, Name of Facility/Agency: _____

Address: _____ Phone #: _____

Patient Employment:

Work Status: ☐ Employed ☐ Retired ☐ Other _____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Employer Phone #: _____

Is your visit due to an injury suffered on the job? ☐ Yes ☐ No

Is your visit due to an automobile accident? ☐ Yes ☐ No

Date of accident: _____ State of accident: _____

(Indiana Spine Group will not file any third party auto insurance claims. Any costs associated with an automobile accident not covered will be billed directly to the patient.)

How did you hear about us: ☐Physician ☐ Relative ☐Friend ☐ Internet Search ☐Facebook ☐ Twitter

☐ Advertisement ☐Other _____

Physician Information:

Name of Physician who referred you to our Group: _____ Phone #: _____

Referring Physician's address: _____ City: _____ State: _____ Zip Code: _____

Name of your Family Physician: _____ Phone #: _____

Family Physician's address: _____ City: _____ State: _____ Zip Code: _____

For your protection, information will not be released to any outside parties unless listed below.

☐ I decline to authorize release of information regarding my care to any further parties.

☐ I authorize Indiana Spine Group to leave messages on my answering machine, cell phone or employer number (if listed) pertaining to my care.

Indiana Spine Group may release information to/or contact in case of emergency the following parties:

Name _____ Relationship _____ Date of Birth _____ Phone _____

Name _____ Relationship _____ Date of Birth _____ Phone _____

This authorization will remain in effect until I change or revoke it. This authorization can be revoked by writing to the Indiana Spine Group or by completing a new form at any time.

Patient Signature: _____ Date: _____

Patient Past Medical History/Review of Systems

Date: _____ Patient Name: _____ DOB: _____

Patient/Family Medical History:

Have you or members of your immediate family had the following illness or problems? (*Explain further)

C= Patient current treatment P= Patient past history F=Family history

☐C ☐P ☐F Heart Attack	☐C ☐P ☐F Kidney Disease	☐C ☐P ☐F Depression
☐C ☐P ☐F Congestive Heart Failure	☐C ☐P ☐F Blood Clots/DVT's	☐C ☐P ☐F Claustrophobia
☐C ☐P ☐F High Cholesterol	☐C ☐P ☐F Pulmonary Embolism/PE	☐C ☐P ☐F Parkinson's
☐C ☐P ☐F Hyperlipidemia	☐C ☐P ☐F Asthma	☐C ☐P ☐F Alzheimer's
☐C ☐P ☐F Heart Surgery/ Stents	☐C ☐P ☐F COPD/Emphysema	☐C ☐P ☐F Bleeding Disorder*
☐C ☐P ☐F Pacemaker/AICD	☐C ☐P ☐F Sleep Apnea	☐C ☐P ☐F Anemia
☐C ☐P ☐F High Blood Pressure	☐C ☐P ☐F Gastric Reflux	☐C ☐P ☐F Seizure Disorder
☐C ☐P ☐F Stroke/CVA	☐C ☐P ☐F Ulcer	☐C ☐P ☐F Cancer*
☐C ☐P ☐F TIA/Mini stroke	☐C ☐P ☐F Osteopenia/Osteoporosis	☐C ☐P ☐F Thyroid Disease
☐C ☐P ☐F Liver Disease*	☐C ☐P ☐F Arthritis	☐C ☐P ☐F Tuberculosis
☐C ☐P ☐F Hepatitis	☐C ☐P ☐F Fibromyalgia	☐C ☐P ☐F MRSA/VRE*
☐C ☐P ☐F HIV/AIDS	☐C ☐P ☐F Psychiatric Illness*	☐C ☐P ☐F Other: _____
☐C ☐P ☐F Diabetes* (I or II)	☐C ☐P ☐F Anxiety	☐C ☐P ☐F Other: _____

Please explain any answers below:

Review of Systems:

Please mark an "X" in the box beside any symptoms you may be experiencing.

Skin:
- ☐ Itching
- ☐ Rash
- ☐ Bruises easily
- ☐ Skin tears/fragile skin
- ☐ Other: _____

Eyes/Ears/Nose/Throat:
- ☐ Difficulty swallowing
- ☐ Vocal cord damage
- ☐ Blurred vision
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Sinus problems
- ☐ Other: _____

Respiratory:
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Other: _____

Cardiovascular:
- ☐ Chest pain
- ☐ Diaphoresis
- ☐ Poor circulation
- ☐ Irregular heart beat
- ☐ Other: _____

Gastrointestinal/Genitourinary:
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Urinary frequency
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Loss of bowel control
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other: _____

Respiratory:
- ☐ Excessive thirst
- ☐ Excessive heat
- ☐ Excessive cold
- ☐ Other: _____

Muscle/Joint/Bone:
- ☐ Back pain
- ☐ Leg pain
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/swelling
- ☐ Weakness of arm/legs
- ☐ Difficulty walking
- ☐ Other: _____

Neurologic:
- ☐ Dizziness
- ☐ Slurred speech
- ☐ Confusion
- ☐ Headache
- ☐ Memory loss
- ☐ Other: _____

Hematologic/Lymphatic:
- ☐ Bruise easily
- ☐ Bleeds easily
- ☐ Clots easily
- ☐ Abnormal blood cells
- ☐ Swollen lymph nodes
- ☐ Other: _____

Indiana Spine Group

Date: _____ Patient Name: _____ DOB: _____

Previous Surgeries:

Vaccinations:

Most current date:

Flu Vaccine _____ Pneumonia Vaccine _____ Tetanus Vaccine _____

Tobacco Use: ☐ No ☐ Yes If yes, how many packs per day/week? _____

Have you ever smoked? ☐ No ☐ Yes How long has it been since you quit? _____

Alcohol Use: ☐ No ☐ Yes ☐ Rare (less than 1 drink/month)
☐ Occasionally (1-4 drinks/month)
☐ Socially (1-2 drinks/week)
☐ Occasionally (3-5 drinks/week)
☐ Frequently (5 or more drinks/week)

Recreational Drug Use: ☐ No ☐ Yes

If yes, please specify: Types: _____ Frequency: _____

Educational Level: ☐ Grade School
☐ High School/GED
☐ College
☐ Graduate Level

Exercise Level: ☐ Never ☐ Rarely ☐ Weekly € Daily

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children and Ages: _____

Living Situation: ☐ Lives Alone ☐ With Someone ☐ Assisted Living ☐ Nursing Home ☐ Home Health

Nationality: _____ Primary Language: _____

Allergies/Medications

Date: Patient Name: DOB:

Allergies: Reaction:

1.
2.
3.
4.
5.

Are you allergic to latex? ☐ YES ☐ NO Are you allergic to tape? ☐ YES ☐ NO

Pharmacy Name: Pharmacy Number:

Pharmacy Address:

Medications:

	Name	Dosage (mg)	Frequency	for what
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				

INDIANA SPINE GROUP

MOTOR VEHICLE ACCIDENT
INFORMATION FOR OUR PATIENTS

Motor Vehicle Accidents involve considerable administrative work and frequently result in a delay in claims being processed. Therefore, Indiana Spine Group would like to explain the process that we follow.

At the first visit for a motor vehicle accident we require the following information from your auto insurance carrier: a case number, name of your claims manager, telephone number, address and date of injury. You will be responsible for obtaining this information from your Automobile Insurance Carrier, and it is best when presented in a letter format. This authorizes us to provide treatment and allows us to file a claim on your behalf. Please call with authorization information prior to your appointment. This will assist with expediting the check-in process when you arrive for your appointment.

You will also need to bring your health insurance information.

If you cannot obtain claim authorization, you will be required to pay a $250.00 down payment prior to your visit. If you do not have authorization from your auto insurance carrier and you do not have health insurance, you will be treated as a self-pay patient. Please call for further information.

The process for filing claims for payment:

Your claim must first be filed with your auto insurance carrier prior to filing with your health insurance. Your health insurance company will not pay or will ask for money back once they realize the reason for your visit to the physician is due to an auto accident.

Once your claim is filed with the auto insurance carrier, they will either pay for your services or provide us with a denial for payment. Once we receive a written notice from your auto insurance with their denial or that your benefits are exhausted, we can then file your claims with your health insurance company if applicable.

We are glad to assist you in any way that we can, however, we are dependent upon your complying with requirements for assisting us with proper documentation. If you have any questions, please feel free to call our office at (317) 228-7000 or 1-(866) 947-7463 and ask for the billing department.

Thank you for your understanding,

Indiana Spine Group

NEW PATIENT PACKET

DID YOU REMEMBER TO …

- [ ] Fill out your paperwork and medication sheet with your pill bottles in front of you.
- [ ] Verify insurance coverage with your insurance company prior to your visit.
- [ ] Please bring your films to your appointment.
- [ ] Bring the reports from your test results to your appointment.
- [ ] Make plans to arrive at Indiana Spine Group 30 minutes before your appointment time.
- [ ] Bring picture ID, insurance card, and co-pay to your appointment. We accept cash, check, master card, and visa.
- [ ] Bring a referral from your primary care physician, if required by your insurance.

Thank You

Indiana Spine Group