John K. Hong, M.D. and Andrew Kalin, M.D.
Interventional Pain Specialists
Board Certified, ABA

Main: 630.226.1130
Fax: 630-226-1134
Web: gatewaypain.com

In order to better serve you, please bring the following items with you on the day of your appointment and arrive at least 30 minutes early:

- Your completed "**New Patient Forms**".
- Your **Valid Photo ID and Insurance Card**
  - If you have a secondary insurance, please bring that as well.
  - If you have a copayment for your insurance, you will be expected to pay that at the time of service.
  - Please bring the actual insurance cards and not copies. If you only have copies, you will not be seen by the doctor the day of your appointment.
- Any MRI, CT or X-ray **Reports** that you may have.
- All related medical records from other doctors.
- If you are a **HMO patient**, you must have a **written referral** at the time of your visit. If you do not have a referral, you will not be seen on the day of your visit and will have to reschedule the appointment.
- If you are a **cash pay patient**, we except Visa, MasterCard, Discover and America Express or cash at the first visit; **no personal checks will be accepted**.

****

IF YOU NEED TO RE-SCHEDULE OR CANCEL YOUR APPOINTMENT, WE REQUIRE A 24 HOUR NOTICE OR THERE WILL BE A CHARGE OF $150.00 FOR A NEW PATIENT NO SHOW FEE. THIS FEE WOULD NEED TO BE PAID BEFORE THE NEXT APPOINTMENT IS SCHEDULED.

If you have any questions, please feel free to ask out staff. We look forward to working with you.

Thank you

Gateway Spine & Pain Physicians
Intake Form

E-MAIL ADDRESS: ______________________

PATIENT INFORMATION

Name: ______________________

Address: ______________________

____

Home Phone: ______________________

Mobile Phone: ______________________

Date of Birth: ______________________

Social Security #: ______________________

Marital Status: [ ] Married [ ] Single [ ] Divorced

Sex: [ ] Male [ ] Female

REFERRING PHYSICIAN

Name: ______________________

Specialty: ______________________

Address: ______________________

____

Phone: ______________________

Fax: ______________________

PRIMARY CARE PHYSICIAN

Name: ______________________

Address: ______________________

____

Phone: ______________________

Fax: ______________________

PATIENT EMPLOYMENT

Employer Name: ______________________

Address: ______________________

____

Work Phone: ______________________

GUARANTOR

[ ] Same as Patient

Name: ______________________

Address: ______________________

____

Date of Birth: ______________________

Social Security #: ______________________

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: ______________________

Insured Phone: ______________________

Company: ______________________

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: ______________________

Insured Phone: ______________________

Company: ______________________

EMERGENCY CONTACT

Name: ______________________

Phone Number: ______________________

Relationship: ______________________

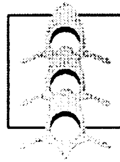
PHARMACY (must use only one pharmacy)

Name: ______________________

City: ______________________

Phone: ______________________

Fax: ______________________



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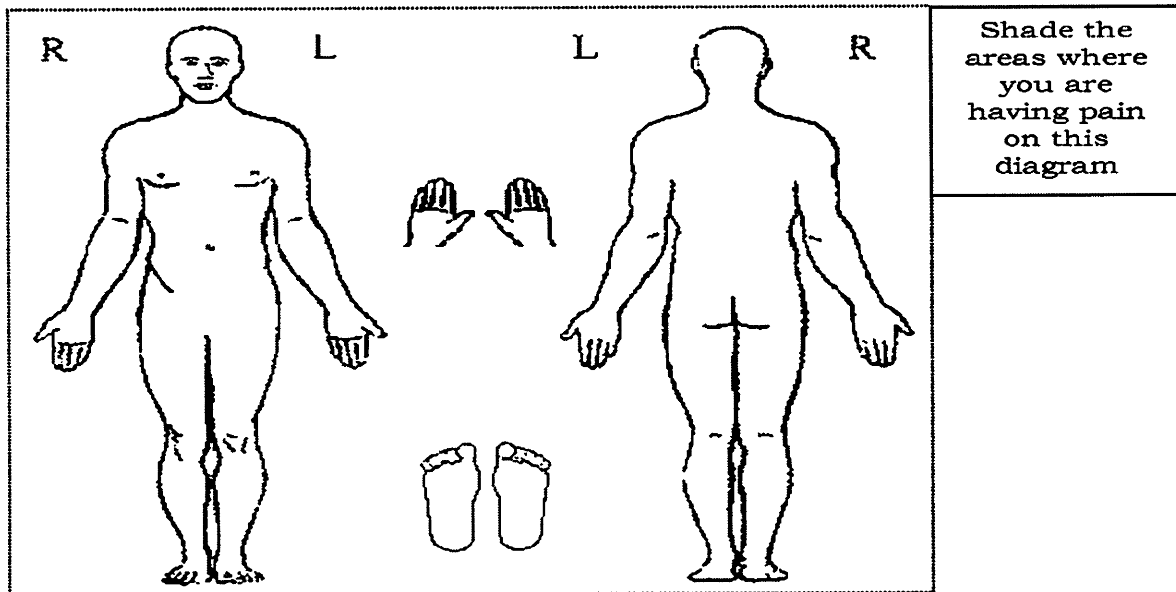
Pain Clinic Initial Evaluation Patient Form

Name________________________ Age________ Appointment Date_______________

Referring Physician __________________________ Primary Care Physician_________________

Please fill out the following papers to help us learn more about your conditions so we can better assist your needs.

1) **Where is your worst pain located?** ________________________________



2) **When did your pain begin?** ___________________________________

3) **What was the injury or cause of pain?** _____________________________

3a) **Does your pain travel (radiate) anywhere? Yes _____ No_____**

If so, where? ____

3b) ***Check one.*** **Is your pain: Constant____________ Intermittent___________**

3c) What is the intensity of your pain on a scale of 0-10 (0 meaning no pain, 10 being worst pain)

At best __________ At worst__________ On Average __________

4) Circle any of these that describe your pain: Dull Sharp Burning Shooting Aching

Pinpoint Other__________________________

5) Is your pain associated with any of the following?

Weakness ☐ Yes ☐ No

Numbness ☐ Yes ☐ No

Tingling ☐ Yes ☐ No

Skin color or temperature changes ☐ Yes ☐ No

Bladder or bowel problems ☐ Yes ☐ No

Skin sensitive to light touch ☐ Yes ☐ No

Skin sensitive to heat or cold ☐ Yes ☐ No

6) When is your pain the best? AM Afternoon Night

When is your pain the worst? AM Afternoon Night

7) Circle which factors make your pain better

Sitting Standing Walking Bending Forward Lying Down

Driving Coughing/Sneezing Leaning Back

8) Circle which factors make your pain worse

Sitting Standing Walking Bending Forward Lying Down

Driving Coughing/Sneezing Leaning Back Twisting

9) List other Doctors who have treated you for this problem

10) List tests that have been performed (i.e. MRI, CAT scan, Myelogram, etc.):

11) Circle any treatments you have tried before to treat your pain

Physical Therapy   Chiropractor   Massage Therapy   Ice   Heat   TENS Unit   Other

12) Have you previously had any injections/epidurals for your pain?

13) Have you been treated by other pain specialists/clinics in the past?

14) List all pain medications you have tried in the past that did not relieve your pain or caused bad side effects:

15) Please answer the following questions if your problem is the result of an injury:

Mark only one:

☐ I have never had back/neck problems before this injury.

☐ I had back/neck problems before, and this injury made the problem worse.

Mark all that apply:

☐ This injury occurred at work.

☐ My injury did not occur at work.

☐ I have filed a claim through worker's compensation

☐ I have pursued or will pursue legal action as a result of this injury

Past Medical History

Do you have any of the following conditions?

Condition	Response	Condition	Response
Any contagious disease	☐ Yes ☐ No	Hyperthyroidism	☐ Yes ☐ No
High blood pressure (Hypertension)	☐ Yes ☐ No	Hypothyroidism	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Suppressed immune system	☐ Yes ☐ No
Heart disease (Coronary Artery Disease)	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Lung Disease (Asthma/COPD)	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Kidney Disease (Chronic Kidney Disease)	☐ Yes ☐ No	Seizure Disorder	☐ Yes ☐ No
High cholesterol (Hyperlipidemia)	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Stomach ulcers (GERD, Peptic Ulcer Disease)	☐ Yes ☐ No	Bleeding Problems	☐ Yes ☐ No
Stroke (TIA/Cerebral Vascular Accident)	☐ Yes ☐ No	Allergies	☐ Yes ☐ No

Previous Surgeries & Years Performed

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Family History

(Blood Relatives)

1. Cancer
2. Chronic Pain
3. Other

Please list all Drug Allergies

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Current Medications

List all your medications, dosages and reason for their usage

	Medication and Dosage	Reason for Taking Medication
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Are you taking any blood thinners? ☐ Yes ☐ No

If yes, check one: ☐Plavix (Clopidogrel) ☐Aspirin ☐Warfarin (Coumadin) ☐Heparin (Lovenox)

☐Aggrenox (Pletal) ☐Arixtra (Fondaparinux) ☐Eliquis ☐Others:____________________

Social History

- Marital Status: Single Married Divorced Legally Separated Widowed
- Children Living at Home? ☐ Yes ☐ No
- Occupation: _________________________ Currently: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired
- Tobacco Do you smoke? ☐ Yes ☐ No

  If yes, for how many years? _______ How many packs per day? _________

- Alcohol Do you drink alcohol? ☐ Yes ☐ No If so, how often? ________________

  Do you have any history of alcohol or drug addiction ☐ Yes ☐ No

Review of Systems

In the past few months have you experienced any of the following symptoms or complaints?

Symptom	Yes	No	Symptom	Yes	No
1. Fever	☐ Yes	☐ No	14. Difficulty Controlling Bowels	☐ Yes	☐ No
2. Chills	☐ Yes	☐ No	15. Difficulty Controlling Urine	☐ Yes	☐ No
3. Sudden weight gain	☐ Yes	☐ No	16. Low back pain	☐ Yes	☐ No
4. Sudden weight loss	☐ Yes	☐ No	17. Joint pain	☐ Yes	☐ No
5. Hearing problems	☐ Yes	☐ No	18. Red swollen joints	☐ Yes	☐ No
6. Chest pain	☐ Yes	☐ No	19. Numbness	☐ Yes	☐ No
7. Heart palpitations	☐ Yes	☐ No	20. Weakness	☐ Yes	☐ No
8. Difficulty breathing (Dyspnea)	☐ Yes	☐ No	21. Bleeding Problems	☐ Yes	☐ No
9. Persistent Cough)	☐ Yes	☐ No	22. Easy Bruising	☐ Yes	☐ No
10. Constipation	☐ Yes	☐ No	23. Depression	☐ Yes	☐ No
11. Diarrhea	☐ Yes	☐ No	24. Anxiety	☐ Yes	☐ No
12. Nausea	☐ Yes	☐ No	25.Sleep Loss	☐ Yes	☐ No
13. Acid Reflux (Heart Burn)	☐ Yes	☐ No			

Gateway Spine & Pain Physicians
Missed Appointment & Late Arrival Policy

Our goal is to provide you with courteous and timely service. This requires all patients to make an effort to arrive on time and to let us know when appointments cannot be kept. Your efforts regarding this is very appreciated.

Missed Appointment Policy:

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our service. To better serve all our patients, we require 24 hour notification should you need to cancel or reschedule any appointment.

Should you miss, or reschedule your appointment for a visit with less than 24 hour notice, you will be charged $50.00 for a Clinic Visit, $150.00 for a New Patient Visit and $150.00 for a Procedure Visit. Payment will be required prior to your next appointment. Your insurance company will not cover fees for missed appointment.

Late Arrival Policy:

The appointment time you are given is when you are expected to be in the exam room or operating room. We require that new patients come in 30 minutes early, and established patients 15 minutes early to complete paperwork. Patients coming for a procedure must arrive 30 minutes early if they require sedation, and 15 minutes if they do not.

It is the policy of Gateway Spine & Pain Physicians that Patients are to arrive on time. Patients who arrive late for visits or procedures cannot expect or demand to be seen. Other patients who arrive on time expect to be seen at their allotted appointment time. One late patient may make the schedule run late for the rest of the day. This is not considerate to other patients who arrive on time.

There are many things that can occur to make a patient late; i.e. car trouble, traffic, parking, etc… We understand that this can happen, but need you to understand we cannot change the schedule for the rest of the day to accommodate any of these reasons.

If you arrive late for any reason, please check in at the front desk. The staff will check the schedule for the rest of the day and if possible, offer you another available time the same day. If an appointment is not available that day, an appointment on a different day will be offered to you. Please remind the staff if your medication will run out prior to this new appointment date.

There may be times when we run late. This is due to some unforeseen patient clinical need that we must accommodate. We respect our patient's time and will do all that we can to be on schedule.

I have read, understand, and agree to abide by all of the above:

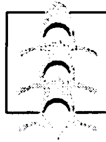
____________________________________ __________________

Patient/Responsible Party Signature Date

Rev 12/07/2010

____

Printed Name



Consent for Release of Information

*****(This release also includes release of confidential related information) *****

Patient Name:____
Address:______________________________DOB:________________
City, State, Zip______________________________Telephone:________________
Social Security # ____

I hereby authorize the above-named facility to release information from my medical record to: ☐ Healthcare Provider ☐ Patient

Name of Facility: ____

Address: ____

For the purpose of:______________________________________
The specific information requested is: (please check one)

☐ Confined to records regarding admission and treatment for the following medical condition or injury:

______________________________On or about (date)________________

☐ Covering records from (date)________________to (date)________________

☐ Confined to the following specific information:________________________

☐ Entire record

If the requested portion of the record contains information pertaining to drug or alcohol related diagnosis and treatment or contains HIV related information or information about mental health disorders or sexually transmitted diseases, you must specifically consent to the release of such information by signing one or more of the following:

I understand that if my records contain information concerning psychiatric, drug or alcohol related diagnosis and treatment, such information will be released pursuant to this consent form.

Signature of Patient or Representative: ________________________________

I understand that if my records contain confidential HIV related information, such information will be release pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Signature of Patient or Representative: ________________________________

I understand that if my records contain information concerning the diagnosis or treatment of sexually transmitted diseases, such information shall be released pursuant to this consent form.

Signature of Patient or Representative: ________________________________

I understand that this consent can be revoked in writing at any time before the records are released. Unless I revoke this authorization in writing, it shall expire when the information is released in reliance upon this consent or under the following circumstances:

____
(Date, event or condition of expiration)

________________________	____________	________________________
Signature of Patient or Representative	Date	If Representative, relationship to Patient

Patient must consent to release ENTIRE contents of a record containing HIV related information. If the patient named about is a minor, who does not have the legal right to consent to treatment, or has legally appointed guardian, this release must be signed by his/her parent/guardian.

Gateway Spine & Pain Physicians
Release of Information, Financial, & Medical Policies

Thank you for choosing Gateway Spine and Pain Physicians, LLC as your health care provider. The following is a statement of our Release of Information, Financial, and Medical Policies which we require you to read and sign prior to any treatment.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Gateway Spine and Pain Physicians rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information – For Billing Purposes
I hereby authorize Gateway Spine and Pain Physicians to release medical information to Medicare, my employer's benefits department, or my other insurance company for the sole purpose of obtaining payment for my medical care. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used I place of the original.

Authorization to Release Information – For Coordination of Care
I hereby authorize Gateway Spine and Pain Physicians to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating treatment. I understand that my medical information is confidential and that I have a chance to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician and any the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter.

Privacy Practice Notice
I have reviewed the Privacy Practice Notice for Gateway Spine and Pain Physicians that was provided to me. I acknowledge that the notice describes how this medical practice assures the safety of my protected health information, and also explains my rights and responsibilities to the privacy regarding the medical care that I am seeking. Our privacy Practice Notice states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail, or in person. By signing below, I acknowledge receipt of our Notices of Privacy Practices.

Payment for Medical Services
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with the business office. Necessary forms will b e completed to file for insurance carrier payments. I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles and balance of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the term of my insurance policy to be paid directly to Gateway Spine and Pain Physicians LLC or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I direct Gateway Spine and Pain Physicians LLC to bill, in the event of non-payment for whatever reasons in accordance with the benefits of my current insurance policy, I will pay immediately. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility form the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be discharged from Gateway Spine & Pain Physicians and be responsible for an additional 30% of the balance owed and/or all attorney fees and costs incurred to collect the unpaid debt.

Authorization to Discuss Information with Designated Person
It is often difficult to reach a patient to discuss appointments, medications, and other information pertinent to our patients' care. In this, event with your signed authorization, I give Gateway Spine and Pain Physicians permission to discuss such information to a person I have designated below.

Consent to Examination and Treatment
By my signature below I attest that I am capable of reading and comprehending this form without assistance, and I have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form, and declined any aid.

By my signature below, I hereby authorize the physicians of Gateway Spine and Pain Physicians with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me.

********************PLEASE COMPLETE BELOW SECTION************************

I authorize Gateway Spine and Pain Physicians to discuss any information required in the course of my treatment (when I cannot be reached) to the following designated person:

Name of Person Authorized to be reached if I cannot be contacted: ______________________________

Relationship to me:______________________________

Phone Number:______________________________

OR

_______ **INITIAL** here if you do not wish Gateway Spine and Pain Physicians to discuss your medical information with anyone but yourself.

I have read, understand, and agree to this entire Release of Information, Financial, and Medical Policies Form.

____
Patient/Responsible Party Signature

____
Date

____
Printed Name