REGISTRATION

Date ____________________ Home Phone___________________ Primary Care Physician__________________________

Patient____
Last Name First Name Initial

Street Address____

City____State______________________ Zip________________________________

Sex ☐ M ☐ F Age_______ Birthdate_______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security#____ E-mail Address ____
I give OSSI permission to e-mail me: ☐ Yes ☐ No

Insured's Name_______________________________________ Nearest Relative _______________________ Phone # ________________
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name____ Occupation____ Address____ City_______________________ State______________ Zip____________Phone______________________________
SPOUSE Or PARENT IF THE INSURED PARTY	Name____ Last Name First Name Initial Birthdate________________________________ Social Security#__________________________________ Employer Name____ Occupation________________________________ Address____ Phone_____________________________ City____State_____________ Zip_________________________
PATIENT INSURANCE INFORMATION	Please / any and all insurance coverage you or your spouse has applicable in this case. Medicare ___ Blue Shield ___ Auto Accident___ Medicaid ___ Major Medical ___ HMO/PPO ___ Blue Cross ___ Worker's Compensation ___ Other ___ Insurance ID#_______________________________ Insured’s Date of Birth: _____________________________ Major Medical or Auto Insurance: Date Of Accident ____ Insurance Company Name____ Address/Phone____ Claim#_____________________________ Policy#____Effective Date_________________________
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name______________________ Insured=s Date of Birth: _____________________________ Address/Phone____P olicy#____ Effective Date ___________________________
REFERRAL	How were you referred to this office? ☐ By a Patient-Name_____________________________ ☐ By a Physician-Name ___________________________ ☐ Phone Book ☐ Insurance Plan ☐ Employer ☐ Internet ☐ Radio ☐Other___________________________
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with ____ Name of Insurance Company and assign directly to the OHIO SPORTS & SPINE INSTITUTE LTD., or Drs. Cerimele, DiDomenico, Dunne, and Heldman, all my medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all 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 the use of this signature on all my insurance submissions. ____ Signature Of Insured/Guardian Date

OHIO SPORTS & SPINE INSTITUTE, LTD (OSSI)
CONSENT FORM

The purpose of this consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of this provider.

I understand that as part of my health care, this organization originates and maintains health record describing my health history, symptoms, test results, diagnoses, treatment and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis/es and other health information to my bill(s)
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.

I understand that:

- I have been provided the opportunity to review the complete Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by OSSI;
- I have the right to review the Notice of Information Practices prior to signing this consent;
- OSSI can change its Notice of Information Practices, but must notify me of those changes before they are put into practice and will mail me a copy of the Notice to the address that I have provided
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment of health care operation s and that OSSI is not required to agree to those restrictions;
- Any restriction to which OSSI agrees to will be respected;
- I may revoke this consent in writing at any time. Further, I am aware the OSSI can proceed with the uses and disclosures that pertain to treatment, payment, or health care issues that took place before the consent was revoked.

OHIO SPORTS & SPINE INSTITUTE, LTD (OSSI)
CONSENT CONT.

Date__________________________

I,___________________________, do______, do not_______ give my permission for any staff member of OSSI to leave messages on my answering machine / voice mail, and/or speak with a family member regarding appointment, prescriptions, referrals, or test results.   Please list family members that we may speak with:

1.__________________________ Date of Birth __________________

2.__________________________ Date of Birth___________________

3.__________________________ Date of Birth___________________

4.__________________________ Date of Birth___________________

In addition, I do_____, do not ______ give permission for any staff member of OSSI to fax any necessary information to a specialist / hospital for referrals and/or review. I also give permission to call / fax prescriptions to pharmacies.

I further understand that if I do not give my permission, it is my responsibility to contact OSSI regarding any appointments, referrals, or test results.

______________________________________ Date______________________________
Patient Signature or Parent/Guardian

REVIEW OF SYSTEMS: Please check past or present to indicate whether you have any of the symptoms:

		Past	Present		Past	Present
GENERAL:	chills/fever	☐	☐	weight loss	☐	☐
	loss of appetite			excessive fatigue	☐	☐
ALLERGY:	seasonal allergies	☐	☐			
NEURO:	headache	☐	☐	dizziness	☐	☐
	numb/tingling	☐	☐	seizures	☐	☐
	incoordination	☐	☐	drop attacks	☐	☐
EYES:	eye pain	☐	☐	vision changes	☐	☐
	Blurred/double vision	☐	☐			
ENT:	hearing loss	☐	☐	ringing ears	☐	☐
	Difficulty swallowing	☐	☐			
RESP:	productive cough	☐	☐	wheezing	☐	☐
	coughing blood	☐	☐	trouble breathing	☐	☐
	asthma	☐	☐	COPD	☐	☐
CARD:	chest pain	☐	☐	palpitation	☐	☐
	ankle swelling	☐	☐	shortness of breath	☐	☐
	high cholesterol	☐	☐	high blood pressure	☐	☐
GI:	abdominal pain	☐	☐	difficulty swallowing	☐	☐
	nausea/vomiting	☐	☐	heartburn/indigestion	☐	☐
	blood in stool	☐	☐	bowel habit changes	☐	☐
	persistent diarrhea	☐	☐	dark black stools	☐	☐
GU:	painful urination	☐	☐	loss of bladder control	☐	☐
	frequent urination	☐	☐	blood in urine	☐	☐
	urinary incontinence	☐	☐			
HEME:	night sweats	☐	☐	bleeding problems	☐	☐
	easy bruising	☐	☐			
MUSCU:	joint pain	☐	☐	muscle pain/weakness	☐	☐
DERM:	rash	☐	☐	hives	☐	☐
	Itching	☐	☐	cancer	☐	☐
Psych	depression	☐	☐	claustrophobia	☐	☐
	unusual stress	☐	☐	difficulty sleeping	☐	☐
	anxiety	☐	☐			
Endocrine:	diabetes	☐	☐	thyroid disease	☐	☐

SOCIAL HISTORY:

Alcohol Use: ☐Yes ☐No Frequency____

Tobacco Use: ☐Yes ☐No Packs/day__________ Duration_________ Quit Date________

Caffeine Use: ☐Yes ☐No Frequency____

Drug Use: ☐Yes ☐No Frequency____

Marital Status:

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

EDUCATION: (Circle highest level attained) High School College Post Graduate Did not finish high school

PRIOR SURGERIES, INJURIES OR ACCIDENTS.

Type	Date	Type	Date

CURRENT MEDICAL CONDITIONS INCLUDING CANCER (PAST OR PRESENT)

MEDICATIONS: List all medications (prescription and non-prescription) you are currently take.

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

ALLERGIES: List all allergies to medication or environment.

MEDICATIONS	**ENVIROMENTAL**

FAMILY HISTORY:

	Current Age	**Health Conditions**	**Deceased Age**	**Cause of Death**
Father				
Mother				
Sibling				
Sibling				
Sibling				
Children				

Work History:

Employer______________________ Job Title___________________ Date Last Worked____________

Current Work Status:
___Retired ___Regular: full-time ___Regular: part-time ___Light duty
___Disability ___Unemployed ___Student

Job Demands:
___Very heavy (frequently lifting > 100 pounds)
___Heavy (frequently lifting > 60 pounds)
___Moderate (frequently lifting > 30 pounds)
___Light (frequently lifting <30 pounds)

How Satisfied are you with your job?
___Very Satisfied
___Satisfied
___Dissatisfied
___It is the worst job I've ever had

Before having back or neck pain, did you normally work: ____full time ____part time ____neither

Do you have any of the following problems?
Is your pain worse at night? ☐Yes ☐No
Does your pain awaken you from sleep? ☐Yes ☐No
Does coughing affect your pain? ☐Yes ☐No
Do your legs tire/hurt if you walk too far: ☐Yes ☐No
If yes, how far can you walk?
☐Less than 1 block ☐1-2 blocks ☐more than 3 blocks
Is this relieved by resting your legs? ☐Yes ☐No
Is this relieved by bending forward? ☐Yes ☐No

Bladder Control (Urine)
☐No problem
☐Can't empty bladder
☐Loss of urine (accidents)

Bowel Control:
☐No problem
☐Constipation
☐Loss of control (accidents)

Where is the problem? ☐ Right ☐ Left Area of body____

When did the problem begin? ____________________________

How did the problem start? ☐no specific injury ☐sports ☐fall ☐work related ☐car accident

Have you had any testing such as X-ray, MRI, CT etc? _____ If so, Date of test ________________________

Did you have similar symptoms or previous injury to this body area? ☐ Yes ☐No When________________

Describe your pain? ☐aching ☐sharp ☐dull ☐ burning ☐throbbing ☐aching ☐numbness ☐stiffness ☐burning

How severe are the symptoms? ☐mild ☐moderate ☐severe

How often do the symptoms occur? ☐on and off☐constant

What time of the day are your symptoms worse? ☐am ☐ afternoon ☐after work ☐evening ☐sleeping at night

What makes the symptoms worse? ☐exercise ☐lifting ☐pressure/stress ☐driving ☐change of position ☐sitting ☐standing ☐walking ☐lying down ☐rising from chair ☐overhead activity

Since the problem started, it is: ☐getting better ☐not improving ☐getting worse

My symptoms are better while: ☐walking ☐running ☐sitting ☐bending ☐driving ☐exercise ☐heat ☐ice ☐medication ☐change of positions ☐resting ☐recliner

OHIO SPORTS & SPINE INSTITUTE, LTD (OSSI)
FINANCIAL POLICY

PATIENTS WITH INSURANCE

If you carry health care insurance, we will file claims with your carrier on your behalf; however, to provide this service to you, we must have a copy of your current insurance card. If this information changes during treatment or at any time that you receive services from us, it is your responsibility to provide us with updated, accurate information. OSSI cannot be responsible for any penalties or denial of payment as a result of incorrect insurance information.

We agree to accept most insurance carriers' determination of usual and customary fees; however, you are responsible for co-payment, deductible, and any co-insurance amounts. Should your insurance carrier require a referral from your primary care physician, such referral must be obtained prior to being seen by one of our providers. If you arrive at our office without a referral and are unable to obtain one by phone at that time, it is your responsibility to pay the visit in full at the time of service. Your account will be charged $25 each time a check is returned for non-sufficient funds. Any future payments must be made with cash, money order, or credit card. Any patient without insurance must pay at the time of service.

PERSONAL INJURY / MVA

You must file a claim with ***your*** auto insurance, regardless of fault. Your health insurance will be billed second, and liable insurance will be billed third. If you have legal counsel, please inform our office staff.

WORKERS' COMPENSATION

Worker's Compensation pays for physician care; however, to assure coverage, the injury must be reported to your employer within 24 hours of occurrence. In the unlikely event that a claim is disallowed or goes to hearing, your health insurance will be billed, or if you do not have insurance you will be responsible for all charges incurred.

MEDICARE FOR CHIROPRACTIC CARE

Medicare will only pay for "manipulation" from our chiropractic physician, for a total of 12 visits per calendar year after you have met your annual deductible. Although we accept Medicare assignment, we are required by LAW to bill you for services we provide which may not be covered. You are further responsible for any co-payment of Medicare's assigned fee. If you have supplemental insurance, we will bill it for that amount.

RESPONSIBLE PARTY

You will be responsible for charges regardless of any divorce decree or court order regarding payment of medical bills. The parents or guardians of a minor are responsible for full payment. All minors must be accompanied by a parent or guardian.

APPOINTMENTS

Please provide at least 24 hours prior notice if you are unable to keep your scheduled appointment with us to avoid missed appointment charges. Consistently missing your appointments and neglecting to notify us could result in your being dismissed from the Practice and your care with OSSI being terminated. In an effort to maintain optimum efficiency in our busy clinic and in the interest of all patients, OSSI reserves the right to cancel an appointment if the patient arrives more than 15 minutes later than the scheduled time. If you are scheduled to have an EMG and miss your appointment, you will be charged a $100 "no show" fee as this test is very time consuming.

YOU'RE ACCOUNT BALANCE

OSSI's contract with your insurance carrier requires that your co-payment must be paid at the time that service is provided. Once our office has received payment from your insurance carrier, it is your responsibility to pay any remaining balances within 30 days. Finance charges may be incurred on any patient balance that is past due. We recognize that there are times when the balance cannot be paid within this time frame. To help you in those times, we can offer a payment plan. Please contact the OSSI Billing Department at (330) 758-9400 to discuss such arrangements.

You will be provided with a monthly statement. Should you notice any charges that are not being paid by your insurance carrier in a reasonable time we suggest that you contact your insurance carrier to determine what action is necessary to resolve those charges to minimize your financial risk. You will continue to receive billing statements until your account is paid. Increasing managed care and federal government billing guidelines have made medical service charging and patient billing very complicated. We will make every effort to ensure that your account is handled appropriately.

I have read and understand the above financial policy and also acknowledge that I was provided a copy of this financial policy for my records. I authorize payment of medical benefits to OSSI for any services rendered to the patient listed below.

____________________________________ ____________________________________

Patient name (Please print) Date of Birth

____________________________________ ____________________________________

RESPONSIBLE PARTY SIGNATURE DATE