THE AMERICAN CENTER FOR
SPINE & NEUROSURGERY
Excellence in Minimally Invasive Care

Patient Registration Form

Please complete all fields so we can serve you better.

Patient Information

Last Name ______ First Name (legal) ______ M.I. ______

Street ______

City ______ State ______ ZIP ______

Cell # ______ Home # ______ Work # ______

Email ______ Your email address will be used solely to communicate with you about your care, account, and ACSN education

SSN ______ DOB ______ Gender ______ Marital Status ______

Employer ______ Occupation ______

Employer ______ Employer Phone ______

City ______ State ______ ZIP ______

Is your injury due to: ☐ Work Accident ☐ Auto Accident ☐ 3rd Party Liability

Questions about race, ethnicity, and language are required due to ACSN's participation in a government program. You can opt not to respond by selecting here: ☐ Not responding

Race ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Native Hawaiian ☐ Other

Preferred Language ______ Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Health Insurance

Primary Insurance Company ______ Policy # ______

Policyholder's Name ______ DOB ______

Relationship to Patient ______

Secondary Insurance Company ______ Policy # ______

Policyholder's Name ______ DOB ______

Relationship to Patient ______

Pharmacy Information

Pharmacy Name ______ City ______

Address/Cross Streets ______ State ______

Revised 05/14

How did you hear about us? *Check all that apply*

☐ Chiropractor ☐ ACSN Website ☐ Case Manager
☐ Friend/Family ☐ Internet Search ☐ Emergency Room
☐ Physical Therapist ☐ Print Ads/Directory ☐ Insurance Company
☐ Referring Doctor

Have you previously, or are you currently treating with another neurosurgeon? ☐ Yes ☐ No Doctor's name: ______

Primary Care Physician Information		Referring Physician Information (if different from PCP)	
Name		Name	
Address		Address	
Phone		Phone	

Please complete if patient is a minor

Mother/Legal Guardian's Last Name ______ Mother/Legal Guardian's First Name ______

☐ Responsible for payment (if checked, please provide SSN & DOB) SSN ______ DOB ______

Address ______

Phone ______ Email ______

Father/Legal Guardian's Last Name ______ Father/Legal Guardian's First Name ______

☐ Responsible for payment (if checked, please provide SSN & DOB) SSN ______ DOB ______

Address ______

Phone ______ Email ______

Please complete if you are permanently or temporarily residing in a nursing home or rehab facility

Facility Name ______

Address ______

City ______ State ______ ZIP ______

The information provided above is true and accurate.

Name of person completing this form ______ Relationship to patient ______

Signature ______ Date ______

Financial Policy

Your clear understanding of our Financial Policy is important to our professional relationship. Timely payment of your bill is considered part of your treatment. If you have any questions about the policy or your bill, please contact our billing office at 847.362.1848, option 6.

The patient, or legal guardian, is always responsible for payment. In consideration of services rendered (or to be rendered), you, the undersigned, agree to pay American Center for Spine & Neurosurgery LLC (ACSN) for all services and supplies provided to you at the established rates, including any deductibles, co-payments or other charges, as permitted by third party payors. By signing this financial policy, you accept responsibility for any costs, including attorney's fees incurred by ACSN in the collection of these charges for services rendered. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.
Additionally:

- If no insurance information/card is provided upon registration, full payment is due at the time of service.
- Completion of ACSN registration forms is required of all patients.
- You must present a copy of your insurance card(s) at each visit.
- Please notify us immediately of any changes in your insurance information or coverage.
- If you have a workers' compensation or accident claim, ACSN will require your health insurance information as well and will bill that insurance if we do not receive proper documentation and/or payment from the workers' compensation or accident insurance carrier.
- Pending/disputed workers' compensation or accident claims are not valid forms of payment. ACSN will require full payment at the time of service if no health insurance information is provided.
- Appointments not cancelled with 24 hours' notice will result in a "no show" fee of $30 ($50 for imaging appointments). This fee is the patient's responsibility.
- Returned checks are subject to a fee of $30 which will be billed directly to you, the patient.
- You are ultimately responsible for payment of all services.

We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible, and charges for any service not covered by Medicare. If you have supplemental insurance and provide that information, we will bill it directly for you. You will receive a bill after your insurance has paid.

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. As the owner of your policy, you are responsible for verifying that we are an in-network provider under your plan. HMO members are responsible for obtaining the appropriate referrals. Failure to obtain the necessary referrals will cause the member to be billed for services rendered.

If there is a dispute regarding the payment of your insurance, workers' compensation, or accident claim, ACSN may bill you directly for timely payment.

I understand that the office agrees to bill my insurance carrier as a courtesy. I must submit information as needed by my insurance company or ACSN to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

Name of person completing this form

Relationship to patient

Signature

Date

Consent for Treatment

I, for myself or for the patient above, hereby consent to such medical evaluation and/or treatment and diagnostic procedures as necessary and appropriate for my condition based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), or other healthcare providers. I have had, and will continue to have, an opportunity to discuss treatment options with my healthcare provider, ask questions regarding the treatment options, and understand the options discussed.

Patient/Authorized Representative Signature

Authorized Representative Name

Date

Notice of Privacy Practices

The Notice of Privacy Practices (NPP) describes how your health information may be used or disclosed and how you can access it. The NPP is displayed in our office and on our website (www.ACSNeuro.com).

I acknowledge receipt of the American Center for Spine & Neurosurgery Notice of Privacy Practices.

Patient Signature ____________________ Date [ ]

Authorized Representative Signature ____________________ Date [ ]

Authorized Representative Name [ ] Relationship [ ]

Patient Disclosure Authorization

Do the physicians and staff at ACSN have permission to leave messages containing medical and/or billing information on your answering machine/voicemail? *Please select a response for each phone type.*

Home Phone	☐ Yes	☐ No
Cell Phone	☐ Yes	☐ No
Work Phone	☐ Yes	☐ No

Please note: If you select no, a message will still be left to confirm appointments.
This message will contain the date, time, and location of your appointments.

I authorize the physicians and staff of ACSN to disclose medical/billing information to the following individuals:

Name [ ] Relationship [ ] Phone [ ]

Name [ ] Relationship [ ] Phone [ ]

Name [ ] Relationship [ ] Phone [ ]

I understand that it is my responsibility to notify ACSN of any changes to this authorization.

Patient Signature ____________________ Date [ ]

Authorized Representative Signature ____________________ Date [ ]

Authorized Representative Name [ ] Relationship [ ]

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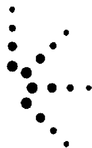

712 S. Milwaukee Avenue
Libertyville, IL 60048

Past Medical History

Patient Name ______________________ DOB ____________ Date ____________

Do you have or have you had:

☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Cancer ☐ Epilepsy/Seizure ☐ Heart Problems
☐ Depression or Psychiatric Disease ☐ Thyroid Problems ☐ None of these

Have you done physical therapy for the issue you are seeing the doctor for? ☐ Yes ☐ No If yes, indicate how many sessions/how long and name of therapist: ____________

Past Surgical History

Previous Spine Surgery? ☐ Yes ☐ No If yes, please indicate type and year ____________

Other Previous Surgeries (indicate type and year): ____________

Allergies

Do you have any allergies? ☐ Yes ☐ No If yes, please describe ____________

Medications

List medications you are currently taking

Medication Name	Dose/Frequency

Social History

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes do you smoke per day? ____________

☐ Yes ☐ No If yes, are you interested in quitting?

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ____________ How many drinks? ____________

Family History

	Living (Age)	Health Status	Deceased (Age)	Cause of Death
Mother				
Father				

	Number	Age(s)	Serious Illness	Number Deceased	Age at Death
Brother(s)					
Sister(s)					
Child(ren)					

Work History

Occupation: ____________ Are you still working? ☐ Yes ☐ No

If no, what is the date you last worked? ____________

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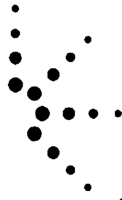

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Systems Review

Patient Name ______________________ DOB ______________ Date ______________

As you review the following list, please check any problems that you may be currently experiencing or have experienced in the past. If you do not have any of the problems listed in a section, please select "None."

General

- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Bleeding, low blood

Lymphatic

- ☐ Swollen glands
- ☐ Tender glands
- ☐ None

Skin

- ☐ Bruise easily
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Sun sensitivity
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands/feet in cold
- ☐ None

Eyes

- ☐ Pain
- ☐ Loss of vision
- ☐ Double/blurred vision
- ☐ Dryness
- ☐ None

Heart & Lung

- ☐ Pain in chest
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Swollen legs/feet
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Cough
- ☐ Coughing of blood
- ☐ Wheezing
- ☐ Night sweats
- ☐ None

Muscles/Joints/Bones

- ☐ Morning stiffnes
- ☐ Joint pain
- ☐ Muscle tenderness
- ☐ Other ___________
- ☐ None

Ears/Nose/Mouth/Throat

- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Bleeding gums
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ None

Stomach & Intestines

- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach pain
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black in stools
- ☐ Heartburn
- ☐ None

Endocrine

- ☐ Thyroid problems
- ☐ Other___________
- ☐ None

Kidney/Urine/Bladder

- ☐ Urinary tract infection
- ☐ Urgency
- ☐ Incontinence
- ☐ Retention
- ☐ Discharge from penis/vagina
- ☐ Rash/ulcers
- ☐ Prostate trouble
- ☐ None

Sleep

- ☐ Problems sleeping
- ☐ Fall asleep during day
- ☐ Snore loudly

Mood

- ☐ Depression
- ☐ Anxiety
- ☐ None

PHYSICIAN'S STATEMENT: I have reviewed the above with the patient. ______________

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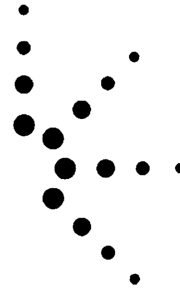

Opiate Usage Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain. This is to help you and your doctor comply with the law regarding controlled pharmaceuticals.

____ I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

____ I understand that if I break this Agreement, my doctor will stop prescribing these pain control medications.

____ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and these will be infrequent.

____ I will not share my medication with anyone.

____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other doctor.

____ I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced.

____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use: ________________________________ (pharmacy name), located at ______________________________.

____ I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, primary care physician, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____ I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with this agreement.

____ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

____ I agree to follow these guidelines that have been fully explained to me.

____ A copy of this document has been provided to me.

This agreement is entered into this _____ day of ____________________, ___________.

Patient Signature : ____

Physician Signature: ____

Witness: ____

ACSN Surgery Screening Form

Name: ______________________________ Date of birth: ______________

Cardiologist: ______________________________ P: ______________ F: ______________

Pulmonologist: ______________________________ P: ______________ F: ______________

Latex Allergy? **Yes** **No** Tape/Adhesive Allergy? **Yes** **No** Drug Allergies? **Yes** **No**

Have you had surgery performed on same area of the spine previously? **Yes** **No**

Have you done physical therapy for the area requiring surgery? **Yes** **No**

Approximately how long ago did you do therapy? ______________

How long/how many sessions completed? ______________

Did your symptoms improve with therapy? ______________

Clinic name and location: ______________

Have you had injections to treat this issue? Yes **No**

How many injections? ______________

How long ago? ______________

Did your symptoms improve with injections? ______________

Physician/Clinic name & Location: ______________

If you recently quit smoking, how long have you been smoke-free? ______________

	Yes	No
Do you have a pacemaker?	☐	☐
Are you diabetic?	☐	☐
Are you taking blood thinners*?	☐	☐
*Aspirin, Eloquis, Xarelto, Coumadin, Lovenox, etc.		
Have you been diagnosed with sleep apnea?	☐	☐
Do you use a C-Pap machine?	☐	☐
Do you have a history of kidney problems?	☐	☐

*Please be advised, if surgery is scheduled, your insurance company may require a pre-authorization. This process will include submission of these records. Please obtain copies of all reports/progress notes from each facility and send them to the office or fax them to us at 847-362-3351. Insurance companies may deny authorization for surgery if conservative treatment has not been completed and/or if the records are not submitted. Thank you for your time and patience with this process. Questions may be directed to the surgical scheduling department.

FOR OFFICE USE ONLY Medications to begin post-operatively

- ☐ Nabumetone – 750mg PO BID with food #60 (MCR does not cover)
- ☐ Mobic (Meloxicam) – 15mg 1 PO Q Day PRN #30
- ☐ Cyclobenzaprine – 5mg PO Q 8hrs PRN for spasms #60
- ☐ Celebrex – 200mg PO BID #60

Other: ______________

______________ Prescriber Signature

______________ Date