

Loudoun Spine & Rehabilitation

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Social Security #	
Sex: Male / Female	Prefix	Suffix	Date of Birth (mm,dd,yy)	Student: No/ Full Time/ Part Time
Street Address	City/State	Zip Code	Emergency Contact	
Home Telephone	Work Phone	Cell. Phone	Email Address:	
Race:	Marital Status: Single/Married/Divorced/ Widowed			
Assigned Preferred Provider (PCP)			Preferred Pharmacy Name/Phone Number	
Employer		Employer Address/Phone Number		

RESPONSIBLE PARTY/BILLING INFORMATION

Last Name	First Name	Middle Initial	Prefix	Suffix
Date of Birth	Sex: Male/ Female	Social Security #	Relationship to Patient:	
Street Address (if different from above)		City/State	Zip Code	
Home Telephone	Work Telephone	Employer Name	Job Title	
Employer	Employer Address			

PRIMARY INSURANCE INFORMATION

Policy #	Group #	Effective Date	Primary Insurance: Yes / No	
Name of Insurance Company/Plan		Office Co-Pay \$	Specialist Co-Pay \$	
Insurance Co. Address		City/State	Ins. Co. Telephone	
Insured's Name		Date of Birth	Home Telephone	Social Security Number
Insured's Employer	Address/State/Zip Code			Employer Telephone

SECONDARY INSURANCE INFORMATION (If Applicable)

Policy #	Group #	Effective Date		
Office Co-Pay \$ Specialist Co-Pay \$		Name of Insurance Company/Plan		
Insurance Co. Address		City/State	Insurance Co. Telephone	
Insured's Name		Date of Birth	Home Telephone	Social Security Number
Insured's Employer	Address/State/Zip Code			Employer Telephone

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG,PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC, or any of its affiliates.

LOUDOUN SPINE & REHABILITATION

Michael Kuo, M.D.

Fernando F. Mendez, PA-C

224-D Cornwall Street, NW, Suite 202, Leesburg, VA 20176 ● 703-443-8110 ● Facsimile 703-443-2714

NEW PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____ INJURY DATE: _____

Height: _____ Weight: _____ Age: _____

Why were you referred to Loudoun Spine and Rehabilitation? _____

Who Referred you to Loudoun Spine and Rehabilitation? _____

Who is your primary care physician (PCP)? _____

Is there a Workers Compensation claim involved? YES NO

List any **drug allergies or contrast/dye allergies**:

Current medications (including dose and frequency):

Please list any previous pain medications you have taken in the past and note if they helped or not:

Please list any serious/chronic illnesses you may have or have had (i.e. high blood pressure):

Please list any surgeries that you have had for this problem:

Please list the physicians, therapists, chiropractors and other health care providers you have seen for your pain, along with the approximate dates:

If you have any of the following diagnostic tests please indicate the date of the test and the results:

Regular x-ray _____ CT Scan _____

Myelogram _____ MRI _____

Discogram _____ Bone Scan _____

EMG _____ Nerve Block _____

Other _____

If you have any of the following, please circle: PACEMAKER NEUROSTIMULATOR
ANEURYSM CLIPS

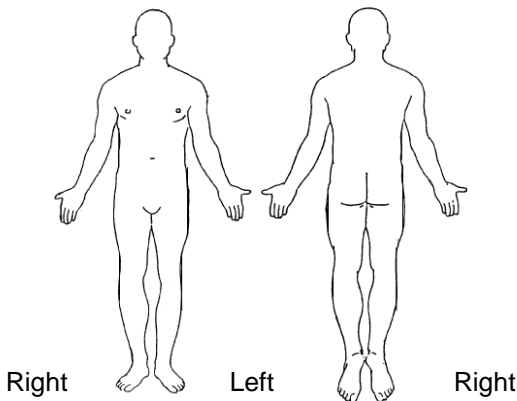
Do you have any metal in your body from a medical procedure? YES NO
Have you ever been a welder, grinder, or done any metalworking? YES NO

Please answer the following questions about your symptoms:

1. When did they begin?
2. Was there an injury or accident that initiated the symptoms?
3. What have you tried to relieve your symptoms?
4. How often do you experience these symptoms?
CONTINUOUSLY DAILY WEEKLY MONTHLY
OTHER: _____
5. Which positions **INCREASE** your pain?
STANDING SITTING LYING WALKING TWISTING REACHING LIFTING
BENDING
6. Which positions **REDUCE** your pain?
STANDING SITTING LYING WALKING TWISTING REACHING LIFTING
BENDING
7. Please list any surgeries that you have had for this problem:
8. Please list any diagnostic tests that you have had done for this problem:

Please mark on the figure the location of your symptoms:

Pain = XXX Numbness/tingling = OOO



PAIN SCALE: (circle your pain intensity)

- 0 = No pain
- 1
- 2 = Tolerable (no activities prevented)
- 3
- 4 = Tolerable (some activities prevented)
- 5
- 6 = Intolerable (but can watch TV, read, etc.)
- 7
- 8 = Intolerable (can't watch TV, read, etc.)
- 9
- 10 = Intolerable (can't even talk)

Family History: Any illnesses in your family (mother, father, brother, sister)?

Social History:

Occupation: _____ Are you currently working? YES NO

Marital status: DIVORCED MARRIED SEPARATED SINGLE WIDOWED

Cigarette use: NEVER FORMER SMOKER CURRENT SMOKER (_____packs per day)

Alcohol consumption: NEVER RARE OCCASIONALLY FREQUENTLY (_____drinks per day)

Recreational drug use: NEVER RARE OCCASIONALLY FREQUENTLY

What type of exercise/sports do you perform and how often?

Review of Symptoms: Have you recently had any of the following?

_____ Change in appetite or weight

_____ Fevers

_____ Chills

_____ Night sweats

_____ Headaches

_____ Visual changes

_____ Double vision

_____ Ringing in your ears (tinnitus)

_____ Hearing deficit

_____ Gum bleeding

_____ Hoarseness

_____ Difficulty swallowing

_____ Difficulty sleeping

_____ Frequent urination

_____ Blood in urine

_____ Burning urination

_____ Need to urinate urgently

_____ Mental problems

_____ Anxiety

_____ Depression

_____ Gout

_____ Diabetes

_____ Rashes

_____ Other symptoms not asked above: _____

_____ Difficulty with breathing

_____ Cough

_____ Blood in your sputum

_____ Wheezing

_____ Lung disease

_____ Palpitations

_____ Chest pain

_____ Passing out

_____ Abdominal pain

_____ Bloating

_____ Constipation

_____ Diarrhea

_____ Dark or blood stools

_____ Convulsions or seizures

_____ Heart murmur

_____ High cholesterol

_____ Ulcer

_____ Liver problems or hepatitis

_____ Pregnancy

_____ AIDS or HIV positive

_____ Pregnancy

_____ Skin breakdown

_____ Excessive sweating

Other comments:

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General Waiver

If our staff become exposed to your bodily fluids, we have implied consent to test your bodily fluid in the necessary way to limit the staff's health risk.

If your insurance company issues payment to you in form of check, you will either endorse the check to our office or immediately make payment in full of the amount issued to you by the insurance company for services rendered by our office to you.

Payment is due at the time of service, we accept cash, check, MasterCard and Visa.

Regarding insurance in which we participate:

If we are a participating provider, we expect payment in full of any co-pays, deductibles or co-insurance at the time of your visit. We will file the claim to your insurance company on your half, as a courtesy to you.

If a referral or pre-authorization is needed, it is your responsibility to be aware of that and obtain it before your visit. Failure to obtain a referral or pre-authorization, if needed, will result in your being responsible for our fees in full for that visit.

We must verify all insurance benefits prior to any medical treatment. Some services require pre-authorization. If you request such a service before pre-authorization is obtained, payment in full of our fees is expected at the time the service is rendered.

If any service submitted to your insurance company is rejected due to "non-covered service", or "not medically necessary", the bill then becomes your responsibility.

Regarding insurance in which we do not participate:

Payment of our fees is due in full at the time of service. It is your responsibility to submit the bill to your insurance company so that they may reimburse you.

General Information:

Your insurance policy is a contract between you and your insurance company. We are not party to that contract.

Accounts that are over 90 days past due, which are not paid in full, will be turned over to collections. You will then be responsible for any collection/attorney fees and/or interest expenses that are incurred in an attempt to collect this debt.

Medicare and or your private insurance carrier will only pay for services that determines to be 'reasonable and customary under Section 1862 (a) (1) of the Medicare law.

It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting to be done or that we provide.

Private and Commercial insurances will deny coverage for the following reasons:

- A. Patient is not listed as a covered dependent on said plan
- B. Patient policy has terminated at time of service and/or patient did not present front desk with a current insurance card
- C. Acupuncture
- D. Botox Medication/ Injection procedure
- E. Non-covered Medicare procedures (see ABN form)

You may receive a statement/invoice if you (do not present the following at the time of your visit):

- A referral/referring script from your Primary Care Physician.
- An Insurance Company issued referral or authorization
 - If you have exceeded the number of visits allowed by your pre-authorization or insurance referral
 - If you have reached the cap on the allowed amount of any certain approved benefit
- If we have not been given a current insurance card anytime you receive a new card (regardless of whether it appears any information has changed)
- Are a self pay patient.
- If the insurance determines that the procedure we perform is not medically necessary despite our indications or the judgment call by our provider deeming it medically necessary

If Medicare and/or my commercial insurance should deny any or all charges and/or I do not present any of the items above, I agree to be personally and fully responsible for any and all balances due.

Signature

Date

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PROVIDER BIOGRAPHIES

Michael K. Kuo, M.D., is board-certified in physical medicine and rehabilitation, the subspecialty of pain medicine, and in electrodiagnostic medicine. He graduated from the University of Maryland School of Medicine. He completed his residency at National Rehabilitation Hospital, Physical Medicine & Rehabilitation. Dr. Kuo is a Fellow of the American Academy of Physical Medicine and Rehabilitation; Fellow of the American Association of Electrodiagnostic Medicine; Fellow of the Physiatrix Association of Spine, Sports, and Occupational Rehabilitation. He is also a member of the International Spinal Intervention Society, American Society of Interventional Pain Physicians, and American Academy of Pain Medicine.

Fernando Mendez received his second Bachelor of Science degree in the Physician Assistant Program from the George Washington University School of Medicine and Health Sciences in Washington, D.C. He received his Bachelor of Science degree in Physical Therapy from the University of Maryland. Mr. Mendez practiced in orthopedics for six years before joining Loudoun Rehabilitation in 2001, and specializing in physical medicine and rehabilitation.



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DIRECTIONS TO OUR OFFICE

From Points East of Leesburg:

Take Route 7 West. When road splits, bear right continuing on Business Route 7. At 2nd intersection make a Right onto Memorial Drive. This turns into Cornwall Street. We are in the large 4 story brick building, 2nd floor, Suite 202. We share a waiting room with Leesburg Orthopedics.

From Points West of Leesburg:

Take Route 7 East. Take first Leesburg exit, Business Route 7. Stay straight on Business Route 7 (bearing Left when road splits). Make a Left at the first intersection onto Memorial Drive/ Cornwall Street. We are in the large 4 story brick building, 2nd floor, Suite 202. We share a waiting room with Leesburg Orthopedics.

