

FROM THE OFFICES OF
CHRISTOPHER F. AMSDEN, M.D.

MODESTO OFFICE

1524 McHenry Avenue
Suite 470
Modesto, CA 95350
Tel: 209-525-8292
Fax: 209-525-8295

SAN PEDRO OFFICE

1360 West 6th Street
Suite 150
San Pedro, CA 90732
Tel: 310-831-8785
Fax: 310-831-8729

Date: _____

Dear New Patient:

I would like to take this opportunity to welcome you to our practice and trust that you have called the office to confirm your appointment with Dr. Christopher F. Amsden on _____ at _____.

Enclosed you will find a **Financial Policy Statement** (if applicable) and **Patient Questionnaire** for you to review and complete prior to your arrival. If you have any questions regarding the forms, please call us for explanations. Please bring in the completed paper work on the day of your visit, (or you will have to fill them out again) If you cannot complete your paperwork before your arrival, please arrive 30 minutes before your scheduled appointment time, to do so. If you are slowed by hearing, writing, or speaking problems, or if you do not read and write English quickly, please come in an extra 15 minutes early for each of these “conditions.”

NOTE: If you are having a Procedure such as an injection, spinal block, discogram, or electro diagnostic (EMG/NCS), please read and follow instructions from the separate “**PREPARATIONS FOR DIAGNOSTIC OR PAIN TREATMENT PROCEDURES**” sheet.

OFFICE POLICIES

We need your full attention throughout the evaluation process. We also need a calm office, where you, as well as other patients and my staff, can feel relaxed and confident enough to get things done smoothly. Because of this, please do not bring in children or adults that you alone must take care of, or pay attention to. That way, you can pay attention to the evaluation process, and there won't be other people who will potentially become disruptive if you cannot pay attention to them. You may have one acquaintance or family member in the examination room with you. We actually encourage you to bring someone with you, especially if that person wants to give you, or us, a lot of advice. Please also strive to be as clean as possible, as well as sensitive to others in the waiting room regarding noise, and so forth.

We cannot guarantee that Dr. Amsden will prescribe any medications at all for your problem. If you want that guarantee, perhaps a different physician can give it to you, but probably not. Patients who lose medications or prescriptions, or have them lost or stolen will not receive “early” refills. In addition, refill requests will not be processed other than during regular business hours which are usually 8:30 a.m. to 4:30 p.m., Monday through Friday, and may vary without notice.

Dr. Amsden attempts to provide continuous on-call availability for all patients, that he is a treating physician for, should after-hours problems arise. However, for sudden onset of new problems or severe headaches, breathing problems, chest pains (especially if the pain is a crushing, duller pressure like as opposed to sharp or burning), irregular heartbeat, high fever, disorientation or other mental status changes, and other severe changes in medical status you should consider these an emergency and dial 911. In addition, if you cannot reach Dr. Amsden for after-hours problems by phone, then you should within one hour go to urgent care instead for your problem. Dr. Amsden can usually be reached through our office numbers above. Should they fail, his exchange number of (209) 575-1040 may be used in an emergency.

If we schedule an appointment either to see us, or another doctor, or to get a diagnostic test done, and you fail to accomplish this, you must realize that this could place you at increased risk for health problems. It is your responsibility to make these appointments, or contact our office to inform us that you no longer wish to follow the treatment protocol. We do not have a monitoring system to make sure patients get to their recommended destinations. If you do not like the professional recommendations Dr. Amsden is making, and do not wish to follow them, then you should immediately see another medical doctor in a similar area of practice, to have them take over your care and possibly make different recommendations.

Please call us with any additional questions you may have, to make your arrival into our medical clinic as smooth as possible.

We look forward to seeing you.

Sincerely,

The Office Staff

I have read, or heard, the information above. I believe that I understand this information.

Print Name

Signature

Date

Christopher F. Amsden, M.D.
PHYSICAL MEDICINE AND REHABILITATION (BC-ABPMR)
PAIN MEDICINE (BC - ABPMed + ACoIPMed)
ELECTRODIAGNOSIS (BE)

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NEW PATIENT REGISTRATION

YOUR NAME _____ HOME PHONE # _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

MESSAGE PHONE # _____ BIRTHDATE _____ Age _____

Social Security # _____

Who should we contact in case of an emergency? _____

1st Phone # _____ 2nd Phone # _____

REASON FOR MEDICAL SERVICES

WHO SENT YOU HERE? _____

FOR WHAT type of evaluation or treatment? _____

Regarding which symptoms, in which parts of your body?

BODY REGIONS	SYMPTOMS Felt in each BODY REGION	DATES OF ONSET OR EXACERBATION of these Symptoms

*"Times of onset or exacerbation" need to be filled in only if a disputed claim, or if Dr. Amsden will be the Work Comp Treating Physician for this patient.

METHOD OF PAYMENT FOR SERVICES

___ 1st PRIVATE INSURANCE COMPANY: _____

Insured Person's Name: _____ Phone: _____

_____ Policy #: _____

Contact Person: _____

___ 2nd PRIVATE INSURANCE COMPANY: _____

Insured Person's Name: _____ Phone: _____

_____ Policy #: _____

Contact Person: _____

___ WORKER'S COMPENSATION INSURANCE: _____

Date Of Injury: _____ Address: _____

Claim #: _____

Adjuster: _____ Phone: _____

Employer: _____ Phone: _____

Supervisor: _____ Address: _____

___ PERSONAL INJURY INSURANCE AND/OR LIEN

Insurance Company: _____ Your Attorney: _____

Address _____ Address: _____

Phone # _____ Phone: _____

Claim # _____

Contact Person: _____ Contact Person: _____

___ SELF-PAY CASH (\$350.00 prior to scheduling an initial consultation; first evaluation visit, or \$550.00 prior to scheduling a spine procedure visit)

I have read and now agree to the terms of the financial policy for this clinic. I authorize and direct my insurance company to receive medical and billing reports, and to pay my medical insurance benefits directly to Dr. Christopher F. Amsden, MD. I hereby consent and authorize Dr. Amsden to obtain any and all x-ray and medical records from other physicians. This authorization shall become effective immediately and unless specifically rescinded, shall remain in effect indefinitely.

Patient's Name _____

Patient's Signature _____

Date: _____

(if patient is a minor, or not competent to sign alone)

Name of Parent/Guardian _____

Signature of Above _____

Date: _____

Christopher F. Amsden, M.D.
PHYSICAL MEDICINE AND REHABILITATION (BC-ABPMR)
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AMBULATORY CARE CENTER OF MODESTO - FINANCIAL POLICY

We are committed to providing you optimum treatment. Payment of your bill is considered a part of your treatment. This Financial Policy must be signed prior to any treatment. Dr. Christopher F. Amsden is the sole owner of both NMS Rehab as well as Ambulatory Care Center of Modesto (ACCOM). If he referred you to ACCOM, this could be seen as a financial "conflict of interest." You have tie right to refuse this planned procedure and instead pursue a different Surgery Center or hospital, and/or a different physician.

Private Insurance:

We may accept assignment of insurance benefits. However, we do require 20% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment.

Personal Injury Liens:

We may accept a lien; prior authorization is required and a signed lien must be on file prior to your first visit. Please do not miss appointments without providing 24-hour prior notice. The lien will be billed and further treatment will require payment of 30% of the previously planned treatment charges.

Workers' Compensation Cases:

A Green Lien must be signed by the patient regarding any potentially work-related cases.

Usual and Customary Rates:

We charge what is usual and customary for our area, and our rates are not subject to any insurance company's arbitrary determination of usual and customary rates, within the extent of the law.

Missed Appointments:

We reserve the right to charge in full for missed appointments. To reschedule after your no-show or late cancellation, please come in to do so, or you may mail or fax us your request to reschedule.

Minor Patients:

The parents or guardian of the minor are responsible for full payments.

I, the patient whose name is entered below, understand and agree to this Financial Policy.

Name _____ Date _____

Signature of Responsible Party _____

Medications used previously for this problem (Name only, including any aspirin, anti-inflammatory, muscle relaxants, or narcotics): _____

All current medications of any kind (Name only): _____

Allergies / Reactions (example: iodine/radiographic contrast, pain medications, anti-inflammatory, aspirin or acetaminophen or Tylenol, Valium/Versed, Demerol/Meperidine/Fentanyl Reglan/Metoclopramide, Cortisone, DepoMedrol, Xylocaine/Lidocaine or other numbing “-caine” medicines, or anything else):

PAST MEDICAL HISTORY:

Unrelated Operations: _____

Related Injuries (including motor vehicle, work, home injuries): _____

Current medical problems: _____

HABITS: (Please quantify)

Tobacco: Now _____ Past _____

Alcohol: Now _____ Past _____

Caffeine: Now _____ Past _____

What is most painful?

_____ Spine

_____ Extremities (R_____ L _____)

_____ About equal pain in spine and extremities

Do you have weakness? No / Yes Where? _____

Do you have burning pain? No / Yes Where? _____

Do you have sharp pain? No / Yes Where? _____

How do activities affect this specific problem/pain? Sometimes knowing what makes this specific pain better or worse will help with diagnosis and treatment.

Activity	Helps the Pain	No Change Noted	Worsens the Pain	How much of this can you perform?
Sitting				Minutes
Driving				Minutes
Lifting				Pounds
Standing				Minutes
Walking				Blocks
				Or minutes
Your job				Hours/day
Squatting				Minutes
Straightening up				N/A
Bending Backwards				
Bending Forwards				
Twisting				
Straining, Grunting				
Your Job				Hours/day
Lying Down				

Do you ever get “stuck” forward, unable to straighten up? _____ yes _____ no

Have you ever had:

Bleeding Problems? _____ yes _____ no

Alcohol Withdrawal Problems? _____ yes _____ no

Any Reactions to Medications? _____ yes _____ no

Heart Problems? _____ yes _____ no

Kidney Problems? _____ yes _____ no

Breathing or Lung Problems? _____ yes _____ no

INITIAL DETAILED HISTORY

PERSONAL HISTORY

Some of the questions below are personal and you may decline to answer if you wish. Your answers help to give us a fuller view of you as a person.

Birthplace _____

	Age	Vocation	Living
Parents: Mother	_____	_____	Yes / No
Father	_____	_____	Yes / No
Step-Parent	_____	_____	Yes / No

Number of your Brothers / Sisters: Alive _____ Deceased _____

Number of Your Children: _____ Age(s), oldest to youngest: _____

Number of Step-Children: _____ Age(s), oldest to youngest: _____

Who do you live with? _____

You are currently: _____ Single/ _____ Married/ _____ Separated/ _____ Divorced

You have been married a total of _____ times.

Your life is: _____ Great/ _____ Good/ _____ Fair/ _____ Difficult/ _____ Tough

Current Employer: _____ Start Date: _____

Job Duty (Circle One): Regular Duty or Modified Duty

EDUCATION AND CAREERS / VOCATIONS

Education: Grades Completed: _____ Degrees Completed: _____

If you had a work injury:

Employer you were injured at? _____

Years worked there before your injury: _____ Time off due to pain: _____

Last period worked there: Start Date _____ Last date of work _____

Past Careers / Vocations:

Number of Years:

_____	_____
_____	_____
_____	_____

Other career(s) you might like to pursue: _____

PATIENT INJURY

Name: _____

Date or range of dates that injury developed: _____

General Description of Accident: _____

What was the immediate Effect to yourself? (Bruising, bleeding, pain, weakness, loss of consciousness, loss of memory...) _____

SYMPTOM DEVELOPMENT

Rate pain on a scale from 0 - 10, 10 being the worse pain imaginable, 0 being no pain. (Example: first noticed pain 2 days post accident, started 2/10, reached 5/10, now 3/10.)

Body Region/Symptom	Amount of time when first noticed injury	Your worst level of pain was	Length of time it took to achieve that pain level