Christopher K Mocek, MD
Changing Lives Here

Dear _____,

Your physician, _____, has referred you to Christopher K. Mocek, MD for pain management. We have scheduled your appointment on _____ at _____at our _____ location.

***If you need to cancel or reschedule, please contact our office at least 24 hours in advance of your appointment time to avoid a $50.00 no show/late cancel fee.**

Please complete your patient portal questionnaire before you arrive. We request that arrive a minimum of 30 minutes early to allow time for your check in process. Please be aware that if you are late, you may be rescheduled. If your insurance company requires a referral, please bring one with you. All copays and coinsurance are due at the time of service.

Items to bring with you to your appointment:

- Picture ID
- Insurance card(s)
- Printed medication list
  - *Or have your pharmacy fax a copy to 501-224-4003*
- **Reports** (not the CD) of all spine imaging (x-ray, MRI, CT, etc.)
  - *Or have the facility fax a copy to 501-224-4003*

Please submit any questions via email to *one* of the departments below as our phone lines are very busy throughout the day. scheduling@mocekspine.com nursing@mocekspine.com billing@mocekspine.com newpatient@mocekspine.com

Phone: 501-224-4001 **Fax**: 501-224-4003 **Phone hours**: M-F 8:00am-5:00pm

LOCATIONS:

Little Rock (main office):	9101 Kanis Rd Suite 400	Little Rock, AR 72205
CARTI Little Rock:	8901 Carti Way Suite 301	Little Rock, AR 72205
CARTI Conway:	2605 College Avenue	Conway, AR 72034
CARTI Bryant	3121 N. Reynolds Rd	Bryant, AR 72022
Stuttgart:	1703 N Buerkle St Suite 5	Stuttgart, AR 72160

Mocek Spine

Profile Sheet

PLEASE PRINT

Patient Name: _____ **D.O.B.:** _____

Patient Address: _____

City, State, and Zip: _____

Social Security #: _____ **Sex: () M () F** **Marital Status:** _____

Phone Number: _____ **Cell Number:** _____

2nd Cell Number: _____

Email Address: _____

Emergency Contact:

Print Name: _____ **Phone Number:** _____

Print Name: _____ **Phone Number:** _____

Primary Physician:

Print Name: _____ **Phone Number:** _____

Pharmacy:

Name: _____ **City & Phone Number:**_____

Insurance:

Primary: _____

Secondary: _____

Signature: _____ **Date:** _____

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Mocek Spine Policies and Financial Agreement

Health Insurance
We accept most major insurances. However, we highly recommend you check with our clinic before switching insurance companies to verify that we accept your new insurance. It is the patient's responsibility to update their insurance information with our clinic. If your insurance cannot be verified by the time of your appointment, you are expected to be personally responsible for the payment of the bill in full at the time of service.

Your copay, coinsurance and deductible are due at the time of service. If your check is returned, Mocek Spine reserves the right to assess a $30 fee and will no longer accept payments made by check.

After an insurance company processes our claim, a statement will be sent out. **Balances are due in full within 30 days of receipt of statement.** Any questions on the statement should be directed towards the billing office utilizing the number listed on the statement. In-house payment arrangements are available on a limited basis if you are unable to pay your bill in full. You can speak with a clinic representative to sign a payment plan agreement.

If your account becomes more than 60 days delinquent and you do not contact us to make arrangements to pay your bill or you default on your Payment Plan Agreement, your account may be turned over to our collection agency and you may be discharged from the clinic.

Mocek Spine reserves the right to assess a **$50 (procedure)** or **$30 (clinic visit) fee** if you fail to keep your appointment without notifying the office or fail to provide notice that you need to cancel/reschedule **at least 24 hours in advance**. This fee must be paid before any future appointments, cannot be billed to any insurance, and will not be included in any payment plans. If the patient accrues **THREE** "**no shows**" or **late cancellations**, Mocek Spine reserves the right to discharge the patient from the clinic.

For insurance questions, please call 501-801-1073 or email billing@mocekspine.com.

Print Patient Name	Patient's Date of Birth
Patient Signature	Date

Christopher K Mocek, MD
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GENERAL RELEASE

Release of Information Agreement:
By signing this form, I am granting consent to Christopher K Mocek, MD, PA to use and disclose my protected health information for the purposes of treatment, payment and health care operations. This document shall permit the clinic representative ; physician and other licensed providers participating in my care, at their discretion, to disclose all or part of my medical records to any person or corporation which is liable for all or part of the clinic's charge, including insurance companies, worker's compensation carriers, welfare funds, Social Security Administration or its intermediaries or carriers, as well as to any corporation engaged by the clinic to make collection of any unpaid clinic charges. They may also disclose medical information to third parties to assist in collection of any unpaid balance due on this account. My employer may obtain information only when actually liable for the clinic charges incurred during this visit. I also understand and agree that, unless I request to the contrary, in writing, the clinic may release certain information about me without my specific consent including my name, age, verification of treatment, address at time of visit, and name of attending physician. By signing this consent form, I also agree that Christopher K Mocek, MD PA can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Referring Physician/Patient Care:
I authorize any employee, physician or representative of this clinic, at their discretion, to release any of my medical information to any referring physician or any other physician that is participating in my care at any time. I also authorize any employee, physician or representative of this clinic, at their discretion, to obtain any of my medical information from any referring physician or any other physician that has participated in my care at any time.

Insurance Authorization & Assignment:
I authorize Christopher K Mocek, MD PA to furnish information concerning the illness and treatment of the patient named below to the insurance carriers or other responsible parties. I assign to the clinic all payments for medical services and supplies arising from the patient's treatment by the clinic. I am aware that if requested the clinic will file insurance claims for the patient. BUT I understand that I am responsible for all charges regardless of whether the patient is entitled to insurance benefits, worker's compensation benefits or reimbursement from any other third party.

Consent & Financial Agreement:
I authorize the treatment of the patient named below by Christopher K Mocek, MD PA. I agree to pay all fees and charges for such treatment promptly upon presentation of a statement thereof. If the insurance carrier does not remit payment within 90 days, the balance will be due in full from the patient.

Receipt of Notice of Privacy Practices Written Acknowledgement Form:
I agree that I have received a copy of Christopher K Mocek, MD PA's Notice of Privacy Practices.

I am aware that if should I refuse to sign this agreement, I am waiving the privilege to be treated at this clinic.

Should I wish to avoid an existing agreement, I understand that my request must be submitted in writing to be honored by the clinic as of the date of receipt. I am aware that revoking this agreement will result in termination of my care.
This agreement shall be valid for one year from the date of treatment.

_____ _____
Print Patient Name Patient's Date of Birth

_____ _____
Signature of Patient or Guardian Date

Christopher K Mocek, MD
Changing Lives Here

Medication Agreement

Patient Name (Print): _____ Patient DOB: _____

Pharmacy Name: _____ Pharmacy Phone: _____

I will not:

1) Use ANY illegal substances.
2) Use medication not legally and currently prescribed to me or in a way other than instructed.
3) Give away or sell my medication to anyone else.

I will:

1) Notify the clinic immediately if in an emergency another physician prescribes 'PAIN' medication.
2) Notify the clinic at least 5 days before I run out of my medication.
3) File a police report if my medication is lost or stolen.
4) Bring all my 'PAIN' medication to every clinic visit.
5) Secure all my prescriptions and medications in a safe place.
6) Notify the clinic BEFORE I attempt to modify medication instructions.
7) Agree to routine or random urine or blood testing when requested.
8) Fill the prescriptions for 'PAIN' medication from the following one pharmacy only *(*except in the event of an emergency, immediately after which I will notify the clinic):*
9) (For females only): To the best of my knowledge, I am NOT pregnant. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant or uncertain if I am pregnant.

As your physician, Dr. Mocek makes these commitments to his patients:

- I vow to follow the Hippocratic Oath.
- I will always treat my physician-patient relationship as cherished.
- I will always safeguard the privacy of my patient's medical information.
- I will always try to provide the best available and most affordable care and medications to my patients.
- I will provide **EMERGENCY** after-hours patient access via Doctor's Exchange (501-372-6789).
  Please note billing issues, scheduling, and medication refills are not emergencies

Unfortunately, Dr Mocek will resign from your care if any of the following occurs:

- The use of any illegal substance such as marijuana, cocaine, or methamphetamine.
- The use of prescription drugs obtained without a prescription; this is illegal.
- Giving away or selling your own prescription medications to others; this is illegal.
- Refusing to submit to a routine or random drug test.
- Violating this Medication Agreement.
- Threatening behavior.
- Dishonesty.

Signature: _____ Date: _____

Christopher K Mocek, MD
Changing Lives Here

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

I authorize the use or disclosure of the above-named individual's health information as described below. The following individual/organization and/or representative is authorized to make the disclosure:

Christopher K Mocek, MD PA
9101 Kanis Road, Suite 400 Little Rock,
AR 72205

The type and amount of information to be used or disclosed includes, but is not limited to:

My entire record: i.e. problem/diagnosis list, medication list, list of allergies, immunization record most recent history and physical, most recent discharge summary, laboratory results, x-ray and imaging reports, consult at ion reports, scheduled appointments, accounts receivable information.

I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

This information may be disclosed to the following individual(s):

_____

Name Relationship to Patient

_____

Name Relationship to Patient

I understand have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the clinic manager or assistant manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that this authorization will remain in effect until I revoke this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can choose to list no authorized individual(s). I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand any disclosure of information carries with it the potential for an unauthorized
re-disclosure and the information may not be protected by the federal confidentiality rules.

_____

Print Patient Name Date of Birth

_____

Signature of Patient/Legal Representative Date

Christopher K Mocek, MD
Specializing in Minimally Invasive Spinal Medicine

MOCEK SPINE QUESTIONNAIRE – PFSH

Place a check mark next to the medical history that applies to you. Add a relative (e.g., Mom, Dad, Sister, Grandfather) next to the medical history if it applies to a family member.

1. Medical History	✓ You	Family Member
Anemia		
Alzheimer's Disease		
Anxiety/Depression		
Aortic Aneurysm		
Asthma		
Bleeding/Blood disorder		
Bronchitis		
Cancer History		
Chronic Sinusitis		
Circulation Problems		
COPD		
DVT		
Fibromyalgia		
Enlarged Prostate		
Congestive Heart Failure		
Diverticulitis		
Emphysema		
Gastric Reflux		
Gastric Ulcer		
Gout		
Head Injury		
Heart Attack		
Hepatitis A, B, C		
Heart Disease		
Heart Failure (CHF)		

Heart Valve Condition		
Hernia		
Narcolepsy		
High Cholesterol		
Irregular Heartbeat		
Irritable Bowel Syndrome (IBS)		
Kidney Disease		
High Blood Pressure		
HIV/AIDS		
Liver Disease		
Lupus		
Migraine/Headache		
Multiple Sclerosis (MS)		
Rheumatoid Arthritis / Osteoarthritis		
Osteopenia/Osteoporosis		
Diabetes		
Pacemaker/Defibrillator		
RSD: Reflex Sympathetic Dystrophy		
Seizure		
Stroke/TIA		
Neuropathy		
Sleep Apnea/CPAP Use		
Thyroid Disease		

2. **SURGICAL HISTORY** – Please circle any surgeries you may have had and indicate what year you had them:

Back/disc surgery _____
Neck surgery _____
Tonsillectomy _____
Appendix Removal _____
Gallbladder Removal _____
Tubal Ligation _____
Hysterectomy _____
Hemorrhoid Repair _____
Hernia Repair _____
Cataract _____

Other: _____

_____

3. On an average daily basis, how far do you walk?

Household Level 1 block 1 mile 1+ miles

4. Do you smoke? YES NO
If YES, how much do you smoke daily? _____
If YES, at what age did you start smoking? _____

If NO, have you ever smoked? YES NO
If YES, what year did you quilt? _____

Are you exposed to secondhand smoke? YES NO

5. Do you drink alcohol? YES NO
If YES, how often? _____

6. Do you do any **ILLEGAL SUBSTANCES**? YES NO
If YES, what? _____

7. Do you drink caffeinated beverages? YES NO
If YES, how many drinks per day? _____

8. Have you ever had a mammogram? YES NO
If YES, when was most recent? _____
If YES, were the results normal? YES NO

9. Have you ever had a colonoscopy? YES NO
If YES, when was most recent? _____
If YES, were the results normal? YES NO

10. If over the age 40, do you have yearly examinations with your Primary Care Physician?
YES NO

11. Have you ever had a Bone Density Scan?
YES NO
If YES, when was the most recent scan? _____

12. Are you allergic to any medications? YES NO
If YES, please list: _____
_____
_____
_____
_____

13. Have you ever had a neurological consult?
YES NO

14. Have you ever has a surgical consult for spine surgery? YES NO
If YES, with whom? _____

15. Please list your current medications (prescription and over the counter) along with dosages and how often you take them. If you brought a list, you do not have to fill this out.

16. Please circle the medications below you have tried in the past for pain relief:

Avinza	Kadian	Oxycodone/Oxycontin	Ibuprofen
Butrans	Methadone	Oxymorphone	Aleve
Exalgo	Morphine Extended Release	Percocet	Flexeril
Fentanyl Patch	Morphine Immediate Release	Soma	Ultram
Hydrocodone	Nucynta	Hydromorphone/Dilaudid	
Tylenol	Opana	Tramadol	

17. Please circle the following therapies you have tried in the past:

Physical therapy Chiropractor Epidural Steroid Injections

Pain management clinic Radiofrequency/Facet Injections Other: _____

18. Where is your pain located at today? If more than one location, please list from <u>most</u> painful to <u>least</u> painful:

Name: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "√" to indicate your answer.)

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	_____	_____	_____	_____
2.	Feeling down, depressed or hopeless	_____	_____	_____	_____
3.	Trouble falling or staying asleep	_____	_____	_____	_____
4.	Feeling tired or having little energy	_____	_____	_____	_____
5.	Poor appetite or overeating	_____	_____	_____	_____
6.	Feeling bad about yourself or that you are a failure or have let yourself or your family down	_____	_____	_____	_____
7.	Trouble concentrating on things, such as reading the newspaper or watching television	_____	_____	_____	_____
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	_____	_____	_____	_____
9.	Thoughts that you would be better off dead or of hurting yourself in some way				

To be completed by healthcare professional:

Add columns: _____ + _____ + _____ + _____

Total: _____

(Healthcare professional: For interpretation of TOTAL please refer to instruction sheet.)

10. IF you checked off *any* problems, how difficult Have these problems made it for you to do Your work, take care of things at home, or Get along with other people?

_____ Not difficult at all _____ Somewhat difficult

_____ Very difficult _____ Extremely difficult

Patient Signature: _____ Date signed: _____

Name: _____ Date: _____

DAST - 10

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include : cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulates (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months	**Circle Your Response**
1. Have you used drugs other than those required for medical reasons?	Yes No
2. Do you abuse more than one drug at a time?	Yes No
3. Are you always able to stop using drugs when you want to?	Yes No
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes No
5. Do you ever feel bad or guilty about your drug use?	Yes No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
7. Have you neglected your family because of your use of drugs?	Yes No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes No
9. Have you ever experienced withdrawal symptoms (felt sick) when you Stopped taking drugs?	Yes No
10. Have you had medical problems as a result of your drug use? (E.g., memory loss, hepatitis, convulsions, bleeding, etc.)	Yes No

Patient Signature: _____ Date: _____

Name: _____ Date: _____

CAGE-AID

When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed.

Questions	**Circle your Response**
1. Have you ever felt like you ought to cut down on your drinking and drug use?	Yes No
2. Have people annoyed you by criticizing your drinking and drug use?	Yes No
3. Have you ever felt bad or guilty about your drinking or drug use?	Yes No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes No

_____ _____

Patient Signature Date signed