Kenai Spine

Soldotna Office:
240 Hospital Place, Suite 103
Soldotna, Alaska 99669
Phone: 907-260-5455

PLACE LABEL HERE

1 Patient information

☐Mr. ☐Mrs. ☐Ms. Last Name:____________________ First Name:_______________________ Middle Initial: ______

Mailing Address:____ City:______________ State:_____ Zip:________

CIRCLE ONE

Primary Phone: _______________________ Is it OK to leave a message about your care? ☐YES ☐NO Brief or Extended

Secondary Phone: _____________________ Is it OK to leave a message about your care? ☐YES ☐NO Brief or Extended

Work Phone: _________________________ Is it OK to leave a message about your care? ☐YES ☐NO Brief or Extended

Doctor that sent you here: _______________________ Your regular/primary care Doctor: _________________________

Other Doctors you are seeing: ____

Date of Birth (MM/DD/YYYY):___________________ Age: _______ Sex: M F Social Security:_________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Student: Full-time_____ Part-time_____

Occupation: __________________________________ Employer: ____

Employer's Address: ______________________________ City: ____________ State: _______ Zip Code: ___________

Employer's Phone_____________________________

Emergency Contact: ___________________________________ Phone: _________________ Relation: ____________

Patient's Email:____ Language: English Other: __________

Race: ☐Indian/AK Native ☐Asian ☐Native Hawaiian/Other Pacific Islander
☐African American ☐Caucasian ☐Hispanic ☐Other ☐Decline

Ethnicity: ☐Hispanic/Latin American ☐Not Hispanic/Latin American ☐Decline

2 Person responsible for the bill

☐ check here if same as above

Full Name:_________________________________ Primary Phone: _________________Secondary Phone: ______________

Address: ____ City: _________________ State: ______ Zip Code: ___________

Date of Birth (M/D/Y):_____________ Sex: ☐ Male ☐ Female

3 Insurance information

Workers Comp/Motor Vehicle Accident: Date of injury______________ Claim#:______________________________

Workers Comp/ Motor Vehicle Insurance:________________________ Adjustor Name:__________________________

Adjustor's Phone: _____________________________

Primary Insurance:______________________________

Policy #: _______________ Group #: _______________

Insurance Phone: _______________________________

Name of Policy Holder: __________________________

Date of Birth (MM/DD/YYYY): ____________________

Relationship to Patient:___________________________

Secondary Insurance:______________________________

Policy #: ________________ Group #: ________________

Insurance Phone: __________________________________

Name of Policy Holder:_____________________________

Date of Birth (MM/DDYYYY):___________________

Relationship to Patient:______________________________

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4 Patient financial policy

Thank you for choosing Kenai Spine. We understand that many patients find financial matters surrounding their medical care to be complex and sometimes confusing. If you have any questions regarding our billing policies, we will be happy to assist you.

Private Health Insurance	Initial Here _______	We are contracted, "preferred", and considered In-Network with most private health insurance plans. As the patient, you are responsible for requesting prior approval and benefit level exceptions from your insurance company as required. Our office collects a standard 20% of amount due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicare	Initial Here _______	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient-notified non-covered services after Medicare processes your claim. No payment is required at the time of service.
Medicaid	Initial Here _______	We are a contracted provider with Medicaid. Please note, a referral is required if you are in the Lock-in Program; without a referral you will be considered a self-pay patient. Your co-pay is due at the time of service and failure to make payment may result in delayed future appointments.
Tricare Triwest / VA	Initial Here _______	VA and Tricare visits must be preauthorized by your referring physician. We will bill Tricare on your behalf, however, you are responsible for your deductible/Co-pay and Co-insurance amounts as determined by Tricare.
Workers Compensation	Initial Here _______	We only accept Workers' Compensation claims that were filed with the Alaska or Washington Departments of Labor. Your claim must be open and accepted. You must complete a Physician Report as well as provide your carrier's information including claim number and date of injury. No payment is required at the time of service.
Self-Pay Uninsured	Initial Here _______	Payment is due in full at the time of service unless other billing arrangements have been approved by the Kenai Spine Billing Department.
Auto Accident	Initial Here _______	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt unless other billing arrangements have been approved by the Kenai Spine Billing Department.
Payment Plan	Initial Here _______	Payment plans must be established through the Kenai Spine Billing Department. Please note our payment plans are determined on an individual bases. All payments will be applied to the oldest date of service first.
Other	Initial Here _______	

I have read, understand and agree to this financial policy.

- I understand that I am ultimately responsible for my balance, not my insurance carrier.
- I authorize Kenai Spine LLC to release medical information to my insurance carrier to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Kenai Spine LLC.
- I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- I will be held responsible for all fees associated with the collection of my account balance.

Patient name:_______________________________ Signature of Patient:________________________________

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5 Your medical history (page 1)

YOUR SYMPTOMS

Are your symptoms mostly in the back, neck, or elsewhere?

____

How long have you had these symptoms? _____________

Does your pain radiate? ☐Yes ☐No

Do you have numbness? ☐Yes ☐No

Do you have weakness? ☐Yes ☐No

Have you lost bladder or bowel control? ☐Yes ☐No

The pain is: ☐Constant ☐Comes and goes

How many hours of sleep do you average per night? ____

Does your pain wake you up at night? ☐Yes ☐No

If so, how many times per night does pain wake you? _____

What things make the pain better?

☐Rest ☐Ice ☐Heat ☐Medication

What makes the pain worse?

☐Sitting ☐Standing ☐Lifting

Is your pain the result of:

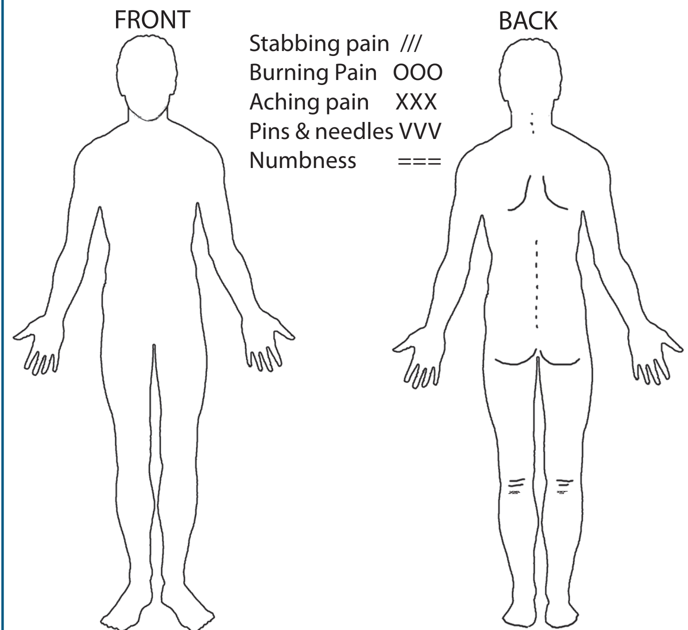
☐Fall ☐AutoAccident

☐Other (List) ___________________________________

____

YOUR PAIN

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



Rate your pain: 0-10 (0= no pain, 10 = worst pain)

Pain level on your best days: ________

Pain level on your worst days: ________

CURRENT WORK STATUS

Is there a law suit pending on your problem? ☐Yes ☐No

Which of the following describes your current status?

☐Employed ☐Full Time ☐Part Time ☐Unemployed

☐Homemaker ☐Retired

What is your occupation?__________________________

How long have you been at that job? ________________

Does your job require:

☐Lifting ☐Prolonged Standing ☐Prolonged sitting

Not working because of: ☐Neck problem ☐Back Problem

Explain: ____________________________________

How long off work? ___________________________

☐Not working because of another health problem

Explain: ____________________________________

How long off work? ___________________________

YOUR HEALTH

Are you a tobacco user? ☐Yes ☐No

Former tobacco user: When did you quit?_____________

Do you smoke? ☐Yes ☐No

If yes, how many cigarettes per day? _______

Are you ready to quit?

☐Ready to quit ☐Thinking about quitting

☐Not ready to quit

Do you drink alcohol? ☐Yes ☐No

If yes, how many drinks do you have per day? ________

Do you have a pacemaker ☐Yes ☐No

Do you have an implanted device or metal in your body?

☐Yes ☐No

Specify:______________________________

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5 Your medical history (page 2)

YOUR HEALTH

Do you have any of the following medical problems?

- ☐ AIDS / HIV
- ☐ Anemia or Bleeding disorders:
  Specify_______________________________________
- ☐ Arthritis
- ☐ Cancer: Specify_________________________________
- ☐ Coronary Artery Disease
- ☐ Connective Tissue Disease:
  Specify_______________________________________
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Epilepsy/Seizures
- ☐ Gastric Reflux/Heartburn
- ☐ Headaches
- ☐ Heart disease
- ☐ Hypertension (High blood pressure)
- ☐ Hypercholesterolemia
- ☐ Immune disorder
  Specify_______________________________________
- ☐ Infection:
  ☐ Spine Infection ☐ Non-spine Infection
- ☐ Kidney Problems: Specify ______________________
- ☐ Liver Problems/Hepatitis:
  Specify_______________________________________

Lung Problems:
  ☐ COPD ☐ Other:____________________________

- ☐ Migraines
- ☐ Muscle disease: Specify:_________________________
- ☐ Nerve disorder: Specify: _________________________
- ☐ Peripheral Vascular Disease
- ☐ Psychiatric problems
- ☐ Anxiety Depression
- ☐ Other:_________________________________
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid Problems? ☐ Hyper ☐ Hypo
- ☐ Are you pregnant? ☐ Yes ☐ No ☐ Possibly

PREVIOUS TREATMENTS & TESTS

Have you had previous back or neck surgery: ☐ Yes ☐ No

Year:____Surgery:________________Dr:______________

Year:____Surgery:________________Dr:______________

Have you had any other previous surgeries: ☐ Yes ☐ No

Date:______ Surgery:____________________________

Date:______ Surgery:____________________________

Date:______ Surgery:____________________________

Date:______ Surgery:____________________________

Have you ever had an adverse reaction to anesthesia?
  ☐ Yes ☐ No Describe________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No
  Describe________________________

Previous imaging studies or other studies:

CT SCAN: Date:______Location:____________________

MRI : Date:______Location:____________________

X-RAY: Date:______Location:____________________

EMG: Date:______Location:____________________

Have you had any of the following treatments prescribed for your back or neck pain?

- ☐ Chiropractic Care: Duration____ Doctor_____________
  Results?_______________________________________
- ☐ Physical Therapy: Duration____ Where_____________
  Results?_______________________________________
- ☐ Massage Therapy: Duration____ Where_____________
  Results?_______________________________________
- ☐ Steroid Injection: Duration____ Doctor _____________
  Results?_______________________________________
- ☐ Anti-inflammatories: Type_______________________
  Duration:______ Results? ______________________
- ☐ Other: Results?___________________________________
  Results?_______________________________________

Have you recently had:

- ☐ Fever or chills
- ☐ Weight Loss
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Night sweats
- ☐ Dizziness/Lightheadedness
- ☐ Worse pain at night
- ☐ Nausea/Vomiting

FAMILY HISTORY:

Please indicate whether relationship is:

Father (F), Mother (M), Daughter (D), Son (S)

Diabetes: (Type) _________________ ☐ F ☐ M ☐ D ☐ S

Hypertension (high blood pressure): ☐ F ☐ M ☐ D ☐ S

Heart Disease: ☐ F ☐ M ☐ D ☐ S

Stroke: ☐ F ☐ M ☐ D ☐ S

Cancer: (Type) ______________ ☐ F ☐ M ☐ D ☐ S

Back/Neck Problems: ☐ F ☐ M ☐ D ☐ S

Arthritis: ☐ F ☐ M ☐ D ☐ S

Please list any other pertinent family history:

____

____

____

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6 Safety / Fall Assessment

Do you have any difficulty following directions? ☐Yes ☐No

Have you fallen in the last year? ☐Yes ☐No

Do you have problems with loss of balance? ☐Yes ☐No

Do you require an assistive device (walker, cane, crutches) to walk? ☐Yes ☐Full Time ☐Part Time ☐No

Do you have a history of any of the following?

☐Seizures ☐Low blood pressure ☐Stroke

Do you take any diuretic medications, anti-convulsants, sedatives, narcotics or other medication that has a warning from the pharmacy that it may cause any of the following symptoms?

☐Dizziness ☐Lightheadedness ☐Fainting

7 Functional level

Please rate your functional level prior to developing this injury/illness/condition:

☐No Difficulty ☐Mild Difficulty

☐Moderate Difficulty ☐Severe Difficulty

Please rate your current functional level:

☐No Difficulty ☐Mild Difficulty

☐Moderate Difficulty ☐Severe Difficulty

Please check the activities that are currently restricted due to this injury/illness/condition:

☐Walking ☐Driving ☐Working ☐Gripping Overhead

☐ Activities ☐Sitting ☐Stairs ☐Sleeping ☐Leisure

☐Bending ☐Standing ☐Eating ☐Bathing ☐Grooming

Social Other: ______________________________

Other: ___________________________________

8 Living situation

With whom do you live?

Do you have part-time assistance from a caregiver?

☐Yes ☐No

If yes, how many hours per week?______

Do you have any of the following obstacles in the home that limit or challenge mobility?

☐Stairs without rails ☐Stairs with rails

☐Split Level ☐Other (Please specify)

Do you have any adaptive equipment in the bathroom like:

☐Raised toilet seat ☐Grab bars ☐Shower seat

☐Hand held shower head

☐Other (please specify)________________________

Do you use any of the following assistive devices to help you walk or get around?

☐Cane: ☐Part time ☐Full time

☐Crutches: ☐Part time ☐Full time

☐Front wheeled walker: ☐Part time ☐Full time

☐Manual Wheel Chair: ☐ Part time ☐Full time

☐Power wheel chair: ☐Part time ☐Full time

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9 Allergy

Please list any type of allergy and associated reaction (i.e. medication, food, latex, etc.)

Allergy: ______________________ Reaction: ______________________

Allergy: ______________________ Reaction: ______________________

Allergy: ______________________ Reaction: ______________________

Allergy: ______________________ Reaction: ______________________

Allergy: ______________________ Reaction: ______________________

Do you have a metal sensitivity? ☐ Yes ☐ No

10 Medication information

Please list all prescription and non-prescription medications you are currently taking as well as vitamins.

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Medication: ______________________ Prescribing physician: ______________________
Dose: ______________________ Frequency: ______________________

Ask for an additional page if necessary

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Protected Health Information Authorization

Personal Health Information:

I, _______________________________, Date of Birth______________, authorize Kenai Spine to speak to the person(s) listed regarding any and all of my medical and personal information:

- _____________________________________ Relationship to Patient ______________________
- _____________________________________ Relationship to Patient ______________________
- _____________________________________ Relationship to Patient ______________________

I, _______________________________, authorize Kenai Spine to release and dispense my medications to:

- _____________________________________ Relationship to Patient ______________________
- _____________________________________ Relationship to Patient ______________________
- _____________________________________ Relationship to Patient ______________________

I understand and assume responsibility of notifying Kenai Spine whenever the listed information changes. I understand this excludes insurance companies, attorneys and other health care providers.

Patient signature: ________________________________ Date: _________

Witness/Staff Signature: ___________________________ Date: _________

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OUR PAIN MEDICATION POLICY

NARCOTICS / CONTROLLED SUBSTANCES

The providers of Kenai Spine do not routinely prescribe narcotics on a long-term basis. Individuals who are seeking "pain killers" for chronic use are hereby advised to seek treatment with an appropriate pain management provider. When indicated, long-acting opiates are prescribed in extremely limited quantities without automatic refills. Narcotic prescriptions will not be refilled after office hours or on weekends. By signing this policy, you agree to stay consistent with the use of the one pharmacy as listed below. If you have a current pain control contract in place please provide the name of the provider with whom you have the contract and bring this to our attention at the time of your first appointment. We will assist you in arranging for postoperative pain control through that provider.

NAME OF PAIN CONTRACT PROVIDER: ______________________________ ☐ Not applicable

N/A PHARMACY: ____

We ask that you report either lost or stolen medications to the police immediately and that you provide a copy of the police report for our records. We will not replace lost or stolen pain medications without a copy of a valid police report. Having a copy of a valid police report does not guarantee that we will replace your prescription and each situation will be assessed on a case-by-case basis. It is an inherently dangerous practice to receive prescriptions for narcotics and other controlled substances from several physicians at the same time. Therefore you agree that, unless otherwise authorized, the physicians at Kenai Spine will be the sole narcotic prescribing source for you at this time. Furthermore, by accepting controlled substances from Kenai Spine, you agree to grant us permission to contact pharmacies and other physicians in order to ensure compliance with this policy. If we determine multiple physicians are ordering prescriptions for pain medications, we will immediately cease all orders for such treatments from our office.

In the postoperative period, we may continue to aid you in pain control with the goal that you will taper and eventually discontinue your pain medications. If this cannot happen in a timely manner, you will be referred to a provider who can aid in this process.

REGARDING PRESCRIPTION REFILLS

Kenai Spine has a 48 hour medication turn-around. Prescription requests submitted after 3 pm may not be called in until 2 business days later. Please allow ample time for this process. We do not refill prescriptions over the weekend. Be sure to submit your request before noon on Friday if you need your prescription filled on Monday. This is not guaranteed. For your own convenience, call your pharmacy before leaving home to make sure they have your prescription ready. Kenai Spine providers will not refill prescriptions for patients not seen in the past 90 days by a Kenai Spine provider.

ACKNOWLEDGEMENT OF PRESCRIPTION POLICY:

I have read and understand Kenai Spine's policy regarding prescription medications.

I agree to the terms involved in the Medication Policy.

Patient Name (printed)___________________________________

Signature of Patient or Patient Representative ____________________________________Date__________

A copy of this policy will be provided if requested.

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PRIVACY NOTICE | YOUR PERSONAL HEALTH INFORMATION

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment and as such would like to inform you of our privacy practices and procedures. This privacy notice describes how your personal and health information will be used and disclosed and how you can gain access to this information. Please read it carefully. Should you have any questions regarding these policies please do not hesitate to ask.

As part of our registration process, you and your family's personal and health information will be collected. This information is very important in the development of an effective treatment plan and we ask that you provide the most complete and accurate information as possible. Information such as; name, address, phone number, birth date, social security number, employer information, health history, insurance policy and coverage information will be collected from you and other health care entities you utilize. Throughout the course of your treatment we will also collect your health information regarding diagnosis, outside treatment plans, progress reports and any test lab results and or imaging studies you obtain from other health care facilities such as hospitals, laboratories, other physician offices, and imaging facilities.

HOW YOUR INFORMATION WILL BE USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of personal and health information will only be used upon receipt of your written authorization. We do not sell your personal and health information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed): ____________________ Signature: ____________________ Date: __________

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PHYSICIAN OWNERSHIP DISCLOSURE

Dear valued patient:

We are honored that you have selected Kenai Spine as your spine care provider. As a spine Center of Excellence, the physicians have published scientific papers and books on spine care and have invented medical implants that improve spine care. Our physicians may have obtained patents on medical inventions and developed spinal implants and have an involvement in companies that have medical products, surgery centers and diagnostic centers. Some of these efforts finance charitable mission programs that bring new spine technology to Africa to benefit the population there.

Consequently, during the course of your treatment with Kenai Spine, you may be referred to any of the following centers, or you may be prescribed treatment involving medical technology that we may have invented. With the above said, federal law requires physicians to notify a patient if a physician has an ownership or financial interest in any entity to which the physician is referring the patient. We are hereby disclosing to you that Kenai Spine or one of its physicians may have an investment interest in the following entities:

Muldoon Ambulatory Surgery Center
6911 Debarr Rd.
Anchorage, AK 99504

Kenai Surgery Center
100 Trading Bay Dr., Suite 9
Kenai, AK 99611

Revolution Sport and Spine Therapy
35249 Kenai Spur Highway, Suite C
Soldotna, AK 99611

Kenai Peninsula Imaging Center
100 Trading Bay Dr., Suite 7
Kenai, AK 99611

Meditech CURE Plate / Spinal implant

Zimmer Biomet Solitaire/Spinal implant

Balanced Back Artificial Disc/Joint Replacement

This information is being provided to you to help you make an informed decision about your healthcare. You have the right to choose your health care provider and the option of obtaining health care ordered by your physician at another location or with other medical technology. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers or alternative medical technology. If you have any questions concerning this notice, please feel free to contact our office manager. Your signature below documents your informed decision to decline the option to have your health care provided at another health care facility or with different medical technology.

Signature of Patient ____________________________________Date__________

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24 HOUR & "NO SHOW" FEE POLICY

Every time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Therefore, Kenai Spine reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments that, are without a compelling reason, and are not cancelled with a 24 hours' advance notice.

"No Show" fees will be billed to the patient. These expenses will not be covered by insurance, and must be paid prior to scheduling your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Please be advised that the staff at Kenai Spine reserves the right to reschedule patients who arrive late for their scheduled appointment time and impose a cancellation fee, as outlined above.

Thank you in advance for your understanding and cooperation as we strive to best serve the needs of all of our patients.
By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name (printed): ______________________________ Signature: ____________________________ Date: __________

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Patient severity: For new spine patients on first visit only.

First name ______________ Last name ____________________ ☐ Male ☐ Female Today's Date: __ /__ /___

Your age: ☐ ≤18 ☐ 19-64 ☐ ≥65 Doctor you are seeing today: ______________________________

Do you have pain radiating PAST your knee or elbow? ☐ Yes ☐ No

Do you have NUMBNESS or WEAKNESS in a foot or hand? ☐ Yes ☐ No

How long have you suffered from these symptoms? ☐ ≤ 6 weeks ☐ 7 to 12 weeks ☐ longer than 3 months

Have you had back or neck surgery before? ☐ Yes ☐ No

How many pills do you take each day for pain relief? ☐ No pills ☐ 1 to 4 pills ☐ 5 or more pills daily

Did your back or neck injury happen at work? ☐ Yes ☐ No

Does your back or neck pain limit you in the following daily activities?

Lifting or carrying groceries	☐ Yes, limited a lot	☐ Yes, limited a little	☐ No, not limited at all
Climbing several flights of stairs	☐ Yes, limited a lot	☐ Yes, limited a little	☐ No, not limited at all
Standing for 30 minutes	☐ Yes, limited a lot	☐ Yes, limited a little	☐ No, not limited at all

Is it okay for us to have a nurse contact you 3 months from now to check your progress?

☐ Yes ☐ No Contact phone number: ___ - ___-____ Best time to call: ☐ Day ☐ Evening ☐ Weekend

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