Keystone Spine & Pain Management Center

A Division of Keystone Orthopaedic Specialists, LLC

Cervical and Lumbar Discectomy and Reconstruction • Scoliosis •Spinal Stenosis
Infections and Tumors of the Spine • Nonoperative Spine Care • Pain Management

Dear New Patient:

You have an appointment scheduled on _____/_____/_____.

- ☐ Please arrive 10 minutes prior so that we can complete your registration.
- ☐ Your X-Ray appointment is scheduled for ____:____ AM/PM.
- ☐ Your appointment is scheduled for ____:____ AM/PM.

Please fill out the enclosed forms before arriving for your appointment along with your insurance cards, photo ID and any co-pay which is due at time of service.

You MUST also bring the following (if applicable) to your appointment or your appointment will be rescheduled:

- Any recent EMG results, **ACTUAL CD OR FILMS OF ANY** X-rays, MRI scans, CT scans, or bone scans with written reports.
- Any workman's compensation information.
- Any auto insurance information.
- Insurance referral if required by your insurance plan.

Thank you,

Keystone Spine and Pain Management Center

2607 Keiser Blvd, Suite 200, Wyomissing, PA 19610
Phone 484-509-0840 | Fax 610-678-2100
Website: www.kos-spine.com

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Wyomissing, PA 19610
484-509-0840

Notice of Privacy Practices
Written Acknowledgment Form

I, _____, have received a copy of Keystone Spine and
Patient Name (please print)
Pain Management Center's Notice of Privacy Practices.

_____ _____/_____/_____
Patient Signature Date

I authorize the disclosure of my personal health information to the following individuals:

☐ **My spouse**
Spouse's name _____ Phone _____-_____-_____

☐ **Other**
Name _____Relationship _____ Phone _____-_____-_____
Name _____Relationship _____ Phone _____-_____-_____
Name _____Relationship _____ Phone _____-_____-_____
Name _____Relationship _____ Phone _____-_____-_____

I wish to be contacted in the following manner: (please check all that apply)

☐ **Home Telephone** _____-_____-_____
- ☐ You have my permission to leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

☐ **Cell Phone** _____-_____-_____
- ☐ You have my permission to leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

☐ **Work Telephone** _____-_____-_____
- ☐ You have my permission to leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

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READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

I, _____, understand that I am entering into a contractual relationship with Stephen Banco, M.D. and/or Keystone Spine and Pain Management Center. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Stephen Banco, M.D. and/or Keystone Spine and Pain Management Center, I, _____ agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against Stephen Banco, M.D. and/or the Keystone Spine and Pain Management Center.

Should I, _____ initiate or pursue a meritorious medical malpractice claim against Stephen Banco, M.D. and/or the Keystone Spine and Pain Management Center, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialists in the same or similar specialty as Stephen Banco, M.D. and/or Keystone Spine and Pain Management Center. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which Stephen Banco, M.D. belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by that physician's specialty society.

I _____ agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

I agree that if I bring a claim or legal action of any kind that relates to my care or the medical services provided by Stephen Banco, MD and/or Keystone Spine and Pain Management Center, their employees or agents, I will file those claims or actions only in the Commonwealth of Pennsylvania, Court of Common Pleas of the County in which the care and treatment took place.

In further consideration, Stephen Banco, M.D. also agrees to exactly the same above referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Signature:_____ Date_____

Effective from Date of Treatment: _____

Physician's Signature:_____

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KEYSTONE SPINE & PAIN MANAGEMENT CENTER MEDICATION CONTRACT

I, _____, understand and agree to the following guidelines for continuing pain treatment under the care of the physicians and providers at Keystone Spine and Pain Management Center.

1. I will take medication at the dose and frequency prescribed. I will not increase or change how I take my medications without approval of this health care provider.
2. I will protect my prescriptions and medications. I understand that lost, misplaced or stolen prescriptions will not be replaced.
3. I will arrange for refills at the prescribed interval only during our regular office hours. I will not ask for refills earlier than agreed, after hours, Fridays, weekends or holidays.
4. Pharmacy requests for refills will not be approved.
5. I will allow 24 hours for my prescriptions to be transferred to the pharmacy.
6. I will not request any pain medications or controlled substances from other providers. I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website.
7. I will have only one pharmacy. In the event that my pharmacy needs to be changed, I will do so only at my scheduled office visit.
8. I will keep medication only for my own use and will not give them to others. I will keep all medication away from children.
9. I will not use illegal or street drugs or other person's prescriptions.
10. I will consent to random urine drug screens and pill audits to determine my compliance with my program of pain control medications. Refusal to submit to the screening at the time specified may result in termination of service. I agree to pay any and all cost associated with drug testing not covered by my insurance company.
11. I will keep my scheduled appointments. No medication will be given if I miss or reschedule an appointment without a valid doctor's excuse.
12. I understand that my provider may stop prescribing opioids or change the treatment plan if I do not show improvement in pain from opioids, my activity level has not improved, or at any time at the discretion of my provider.
13. I understand there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances. I am aware that the use of controlled substances has certain risks associated with it, including but not limited to sleepiness, drowsiness, lightheadedness, dizziness, confusion, itching, nausea, vomiting, constipation, slowing of reflexes or reaction time and withdrawal. The overuse of narcotic medication can result in serious health risks including respiratory depression and even death.

I understand that failure to comply with any of the terms of this agreement may result in termination of prescription medication or termination of service.

Sign _____Date_____

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No Show Policy

When you schedule an appointment for an **injection** with one of our physicians that time is reserved exclusively for you. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment for the injection, we ask you to show consideration by calling our office 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time for an injection slot to another patient who needs to see the physician.

A $ 100.00 fee will be charged for a no show or for failing to give a 24-hour notice to cancel your appointment.

**These charges are not billable to your insurance or workers compensation insurance and will ultimately be the responsibility of the patient. All no show charges will need to be paid before you schedule your next appointment with the physician. **

Patient Name Date of Birth

Signature Date

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A $50 fee will be charged for a no show or for failing to give a 24-hour notice to cancel your appointment.

**These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no show charges will need to be paid before you schedule your next appointment with the physician. **

Patient Name Date of Birth

Signature Date

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Name _____ **Date** _____/_____/_____

Past medical history (circle all that apply)

Cardiac:	Heart attack	Murmur	Abnormal Rhythm	Other: _____
Pulmonary:	Asthma	COPD	Emphysema	Other: _____
Endocrine:	Diabetes	Hypothyroid	Pituitary Tumor	Other: _____
Circulatory:	Hypertension	Stroke	Aneurysm	Other: _____
Psychological:	Depression	Anxiety	Panic disorder	Other: _____
Other:	High cholesterol	Reflux	Coronary disease	Other: _____
Other:	Other: _____	Other: _____	Other: _____	Other: _____

Past surgical history

Procedure _____ Surgeon _____ Year _____

Procedure _____ Surgeon _____ Year _____

Allergies _____

Family History (please circle and list relationship)

Cardiac:	Heart attack	Hypertension		_____
Pulmonary:	Asthma	COPD	Emphysema	_____
Endocrine:	Diabetes	Hypothyroid		_____
Neurologic:	Stroke	Aneurysm	Tumor	_____
Cancer:	Lung	Breast	Intestinal	_____
Other:	_____	_____	_____	_____

Social History:

Occupation _____

Tobacco _____ Alcohol _____

(Packs per day) (Drinks per day)

Review of systems (do you experience problems with any of the following)

Memory	Contacts	Numbness	Double Vision	Other _____
Glasses	Rapid beat	Blurriness	Hoarseness	Other _____
Deafness	Wheezing	Swallowing	Cane/walker	Other _____
Skip beats	Edema	Bleeding	Nausea	Other _____
Cough blood	Arthritis	Chills	Vomit	Other _____
Diarrhea	Fevers	Birth marks	Fatigability	Other _____
Incontinence	Lesions	Transfusion	Insomnia	Other _____
Night sweats	Hepatitis			Other _____

Name _____ Date _____/_____/_____

Medication List

	Medication	Dosage	Frequency	Duration
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				