



SEQUOIA ORTHOPAEDIC
& SPINE INSTITUTE, INC.
Frank L. Feng, D.O.

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____

SS # _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE (_____) _____

OCCUPATION _____

MALE ☐ FEMALE ☐ STUDENT: FULL ☐ PART TIME ☐

SINGLE ☐ MARRIED ☐ WIDOWED ☐ WHO CARRIES THE PRIMARY INSURANCE: _____

Email: _____

SPOUSE / PARENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____

SS # _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

EMPLOYER _____

ADDRESS _____

CITY _____

WORK PHONE (_____) _____

OCCUPATION _____

EMERGENCY CONTACT (_____) _____

DO YOU HAVE A COPAYMENT? ☐ YES ☐ NO AMOUNT: \$ _____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

I HEREBY AUTHORIZE DIRECTLY TO SEQUOIA ORTHOPAEDIC & SPINE INSTITUTE, INC. ALL SURGICAL AND MEDICAL BENEFITS AND OTHERWISE PAYABLE TO ME FOR SERVICES PERFORMED. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

X SIGNED _____ RELATIONSHIP _____ DATE _____

*NOTE: Please notify us if any of the above information changes during the course of your treatment.

BILLING INFORMATION

(OFFICE USE ONLY)

PRIMARY INSURANCE

PLAN NAME _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

GROUP # _____

SUBSCRIBER # _____

EFFECTIVE DATE _____

INSURED NAME _____

SECONDARY INSURANCE

PLAN NAME _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

GROUP # _____

SUBSCRIBER # _____

EFFECTIVE DATE _____

INSURED NAME _____

DOI _____ BODY PART _____

WORKERS COMPENSATION INSURANCE INFORMATION

INSURANCE NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____

ADJUSTER _____

PHONE (_____) _____

FAX (_____) _____

NCM _____

PHONE (_____) _____

EMPLOYER AT TIME OF INJURY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____

DOI _____ CL # _____ BODY PART _____

DOI _____ CL # _____ BODY PART _____

INT. NEEDED? ☐ YES ☐ NO PHONE _____

NAME OF AGENCY _____

RECEPTIONIST INITIALS _____



SEQUOIA ORTHOPAEDIC
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SEQUOIA ORTHOPAEDIC & SPINE INSTITUTE, INC.
SPINE QUESTIONNAIRE

Name: _____

Date: _____

Height: _____ Weight: _____

Date of Birth: _____ Age: _____

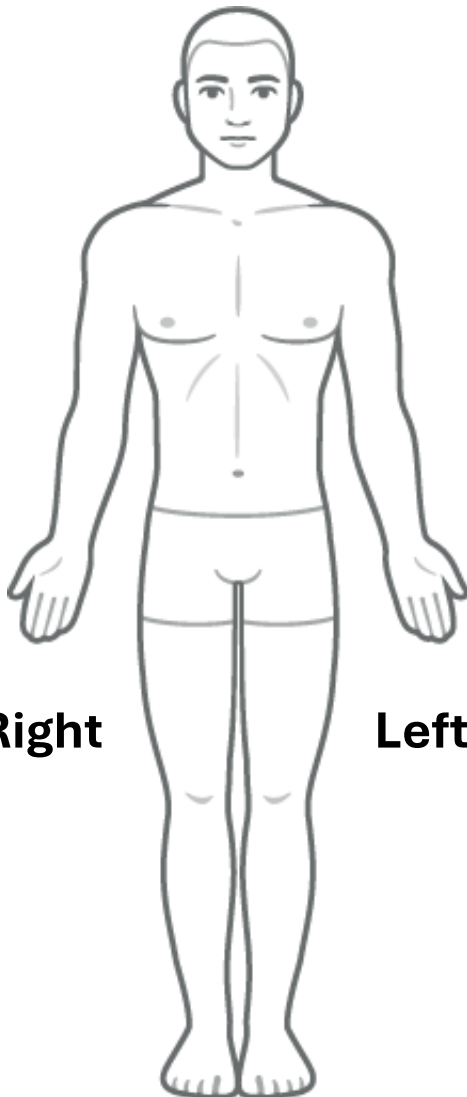
Gender: ☐ Male ☐ Female

Referring Doctor: _____

Pain Drawing

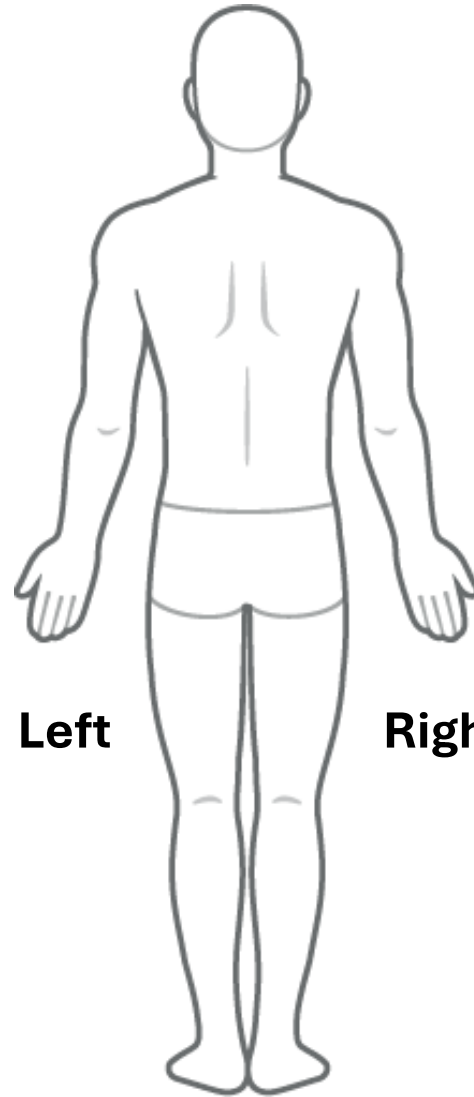
Mark these drawings using the symbol that best describes your pain quality.

Numbness = = = Ache ^ ^ ^ Pins & Needles o o o Stabbing / / / Burning x x x Cramping + + +



Right

Left



Left

Right

1. Which hurts more, your legs or your back? (Check only ONE statement)

_____ 1. Legs hurt much more than back	_____ % Back Pain
_____ 2. Legs hurt somewhat more than back	
_____ 3. Arms and neck hurt about the same	_____ % Leg Pain
_____ 4. Neck hurts somewhat more than arms	(Total of leg & back pain
_____ 5. Back hurts much more than legs	should equal 100%)

2. Which hurts more, your neck or your arms? (Check only ONE statement)

_____ 1. Arms hurt much more than neck	_____ % Neck Pain
_____ 2. Arms hurt somewhat more than neck	
_____ 3. Arms and neck hurt about the same	_____ % Arm Pain
_____ 4. Neck hurts somewhat more than arms	(Total of neck & arm pain
_____ 5. Neck hurts much more than arms	should equal 100%)

3. Please circle the ONE number which best describes your current pain level.

0	1	2	3	4	5	6	7	8	9	10
-----			-----			-----				
No pain			Moderate pain					Worst pain imaginable		

Severity of Pain: Minimal / Slight / Moderate / Severe

Duration of Pain: Occasional / Intermittent / Frequent / Constant

4. How did your current episode begin?

_____ Suddenly _____ Gradually Describe: _____

5. How long ago did your current episode begin?

Date: _____

6. Have you had back or neck symptoms before your current episode?

_____ Yes _____ No Describe: _____

7. Is this a work-related injury?

_____ Yes _____ No Describe: _____

If yes, date of injury: _____

8. Have you ever received Worker's Compensation for your PAST spine symptoms?

_____ Yes _____ No

9. Is your problem due to a car accident?

_____ Yes _____ No Describe: _____

If yes, date of injury: _____

10. Mark the effects of each of the following on your pain:

	Increases	Decreases	No Change
Sitting	1	2	3
Standing	1	2	3
Rising from sitting	1	2	3
Bending forward	1	2	3
Bending backward	1	2	3
Walking	1	2	3
Lying on your back	1	2	3
Lying on your stomach	1	2	3
Driving	1	2	3
Coughing	1	2	3

11. Please list all medications and doses that you are currently taking:

[illegible]

12. Please list all of your medication allergies: _____

Past Medical History

13. Please check any of the following medical problems you have had:

_____ Ulcers	_____ HIV Positive	_____ Diabetes
_____ Ulcerative Colitis	_____ Seizure	_____ Heart Disease/Attack
_____ Psoriasis	_____ Kidney/Bladder Infections	_____ Stroke
_____ Arthritis	_____ Kidney Stones	_____ Asthma
_____ Cancer	_____ Prostate Problem	_____ Depression
_____ Tuberculosis	_____ Hepatitis	_____ Hypertension

14. List all previous surgeries:

Date of Surgery	Type of Surgery	Describe Recovery

Family History

15. Please check conditions in your immediate family:

_____ Cancer	_____ Diabetes	_____ Heart Disease	_____ Stroke
_____ Arthritis	_____ Back Pain	_____ Bleeding Tendencies	_____ Anesthesia Difficulties
_____ Malignant Hyperthermia			

16. Do you currently smoke cigarettes? (Check only ONE statement)

- _____ 1. I have never smoked
_____ 2. Yes: _____ pack per day
_____ 3. No, I quit in the last 6 months ago
_____ 4. No, I quit more than 6 months ago

17. Do you drink alcoholic beverages (beer, wine, liquor)?

- _____ 1. No
_____ 2. Yes, once in awhile
_____ 3. Yes, often

If yes, type of alcoholic beverages _____ Amount _____

18. Please choose ONE of the following that best describes your current situation:

- _____ Married/Living with significant other _____ Widowed
_____ Divorced _____ Single

19. How many children are living with you? _____

Review of Systems

Skin

- _____ Rashes
_____ Psoriasis
_____ Bruise easily
_____ Abnormal lumps
_____ Painful breasts

Eyes

- _____ Visual loss
_____ Double vision

Ears

- _____ Decreased hearing
_____ Ringing in ears

Nose

- _____ Sinus problems
_____ Breathing problems

Throat

- _____ Sore throat
_____ Hoarseness
_____ Snoring

Cardiovascular

- _____ Palpitations/Irregular
heartbeat
_____ Hear murmur/
Rheumatic fever
_____ Chest pain

Respiratory

- _____ Short of breath
_____ Wheezing
_____ Cough/Sputum

Gastrointestinal

- _____ Weight loss
_____ Abdominal pain
_____ Nausea/Vomiting
_____ Diarrhea or
Constipation
_____ Blood in stool
_____ Loss of bowel control

Musculoskeletal

- _____ Fractures/Sprains
_____ Osteoporosis
_____ Joint swelling

Endocrine

- _____ Enlarged thyroid/goiter
_____ Excessive thirst/appetite
_____ Diabetes

Genitourinary

- _____ Blood in urine
_____ Increased urination
_____ Painful urination
_____ Loss of bladder control
_____ Kidney stones

20. Check only ONE statement.

Are you a very nervous person? ☐ Yes ☐ No

Have you been a happy person? ☐ Yes ☐ No

Have you had a happy childhood? ☐ Yes ☐ No

Have you felt downhearted and blue? ☐ Yes ☐ No

Work Status

21. Please check ONE statement that best describes your current employment status:

☐ Currently Working ☐ On Paid Leave ☐ On Unpaid Leave ☐ Unemployed

☐ Homemaker ☐ Student ☐ Retired (not due to health)

☐ Disabled and/or retired because of my back or neck problems ☐ Disabled due to a health problem not related to my neck or back

☐ Other, please specify _____

22. When was the last date you worked? _____

Work History

23. What is your usual occupation? _____

Name of Employer: _____

Last date worked: _____

24. Who do you think is at fault for your current spine condition? (Check ALL that apply)

☐ Yourself ☐ A Co-worker ☐ Nobody

☐ Employer ☐ Another person

25. Have you hired a lawyer because of your condition?

☐ 1. No, I have not hired a lawyer

☐ 2. Yes, I have and the case is in litigation

☐ 3. Yes, I have and the case has been settled

If yes, do you want your lawyer to receive a copy of your medical report?

☐ Yes ☐ No If yes, send to: Name _____ Phone _____

Address _____

Please check ONE of the following statements:

26. Walking

- ☐ 1. Pain doesn't prevent me from walking
- ☐ 2. Pain prevents me from walking more than 1 hour
- ☐ 3. Pain prevents me from walking more than 30 minutes
- ☐ 4. Pain prevents me from walking more than 10 minutes
- ☐ 5. I am unable to walk

27. Sitting

- ☐ 1. I can sit in any chair as long as I like
- ☐ 2. I can only sit in a special chair for as long as I like
- ☐ 3. Pain prevents me from sitting more than 1 hour
- ☐ 4. Pain prevents me from sitting more than 30 minutes
- ☐ 5. Pain prevents me from sitting more than 10 minutes
- ☐ 6. Pain prevents me from sitting at all

28. Standing

- ☐ 1. I can stand as long as I want
- ☐ 2. I can stand as long as I want but it gives me pain
- ☐ 3. Pain prevents me from standing for more than 1 hour
- ☐ 4. Pain prevents me from standing for more than 30 minutes
- ☐ 5. Pain prevents me from standing for more than 10 minutes
- ☐ 6. Pain prevents me from standing at all

29. Dressing

- ☐ 1. I can usually dress myself without pain
- ☐ 2. I can dress myself without increasing pain
- ☐ 3. I can dress myself but the pain increases
- ☐ 4. I can dress myself but have significant pain
- ☐ 5. I can dress myself but with very severe pain
- ☐ 6. I cannot dress myself

30. Lifting

- ☐ 1. I can lift heavy objects without pain
- ☐ 2. I can lift heavy objects but it is painful
- ☐ 3. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are on a table
- ☐ 4. Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium objects if they are on a table
- ☐ 5. I cannot lift anything

31. Social and Recreational Life

- ☐ 1. My social and recreational life is unchanged
- ☐ 2. My social and recreational life is unchanged but it increases pain
- ☐ 3. Pain has restricted my social and recreational life
- ☐ 4. I have essentially no social and recreational life because of pain

32. Traveling

- _____ 1. I can travel anywhere
- _____ 2. I can travel anywhere but it gives me pain
- _____ 3. Pain restricts me to trips of less than 1 hour
- _____ 4. Pain restricts me to trips of less than 30 minutes
- _____ 5. Pain prevents me from traveling

33. Sex Life

- _____ 1. My sex life is unchanged
- _____ 2. My sex life is unchanged but causes extra pain
- _____ 3. My sex life is nearly unchanged but it is very painful
- _____ 4. My sex life is nearly absent because of pain
- _____ 5. Pain prevents any sex life at all

34. Sleeping

- _____ 1. I sleep well
- _____ 2. Pain occasionally interrupts my sleep
- _____ 3. Pain interrupts my sleep half of the time
- _____ 4. Pain always interrupts my sleep
- _____ 5. I never sleep well

SEQUOIA ORTHOPAEDIC & SPINE INSTITUTE, INC.

Frank L Feng, D.O.

Financial Agreement and Policy

I am hereby opening an account at Sequoia Orthopaedic & Spine Institute, Inc. (SOSI). I realize this is necessary because payment for medical care may not be timely due to insurance delays or disputes. I will assist SOSI in securing payment from my carrier if needed, but I am ultimately responsible for deductibles, co-insurance, or co-payment not covered by my insurance. I agree to pay the above in full at the time of each visit.

If I am a new patient to this clinic and I do not have medical insurance, I agree to pay the full cost of each visit at the time of service. If this is not possible, I understand that I may speak with the billing department to see if payment arrangements can be made before I am seen by the doctor on each date of service.

I am responsible for providing all current, accurate insurance information and any change of address to SOSI's billing department so they can bill my insurance without delay.

If I have made payment arrangements and have an outstanding balance, I understand that my payment is due and payable upon receipt of my monthly statement. Payment is required each month in order to properly maintain my account. Non-payment on my account while awaiting insurance payment is not acceptable. SOSI accepts Visa, Discover, American Express, and Mastercard. I realize that I can call the SOSI billing department and authorize them to apply a payment using my credit card, or I can mail the authorization using the form attached to my monthly statement.

I understand that if I pay my account with a check, and the check is returned unpaid by the bank because of insufficient funds, I promise to pay a service charge of twenty-five dollars (\$25.00) for the first check, and a service charge of thirty-five dollars (\$35.00) for every other check returned by the bank unpaid.

I understand that there will be a \$50.00 fee charged if I cancel my appointment in less than 24 hours.

If I do not abide by the SOSI's payment policies, my account may be assigned to a collection agency. SOSI shall be entitled to reimbursement of attorney and/or court fees incurred to collect charges.

I have read this policy and accept its terms. I have received a signed copy of this agreement.

X

Signature of Financially Responsible Party

Date



**SEQUOIA ORTHOPAEDIC
& SPINE INSTITUTE, INC.**
Frank L. Feng, D.O.

NO SHOW & CANCELLATION POLICY

- **A \$50.00 NO SHOW fee will be billed to patients who fail to appear for their appointment without notice. This fee is the responsibility of the patient & is not billable to insurance.**
- **Appointments must be cancelled at least 24 hours prior to the scheduled appointment time.**
- **If a patient arrives more than 15 minutes late to their appointment and cannot be seen on the same day, the appointment will be rescheduled.**

Effective August 18, 2021



SEQUOIA ORTHOPAEDIC
& SPINE INSTITUTE, INC.
Frank L. Feng, D.O.

www.sequoiaspine.com

Notice to Consumers of Open Payments Database

Effective January 1, 2023

California Physicians & Surgeons are required by AB 1278 (Nazarian) to provide patients with the following information:

“The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at:

<https://openpaymentsdata.cms.gov>.”

By signing below, I acknowledge that I have read this written notification.

Printed Name

X _____

Signature

Date

Sequoia Orthopaedic & Spine Institute, Inc.

Frank L. Feng, D.O

Understanding Your Health Record Information

NOTICE OF PRIVACY PRACTICES

Each time you visit SOSI, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- Understanding of what is in your medical record and how your health information is used to help you to:
 - Ensure its accuracy
 - Better understand who, what, where, and why others may access your health information
 - Make more informed decisions when authorizing disclosures to others

Your Health Information Rights ~

Although your health record is the physical property of SOSI, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorizations to use or disclose health information except to the extent that action has already been taken

Our Responsibility ~

SEQUOIA ORTHOPAEDIC AND SPINE INSTITUTE, INC. IS REQUIRED TO:

- Maintain the privacy of your health information
- Provide you with a notice to its legal duties and privacy with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice

For More Information or to Report a Problem ~

If you have questions and would like additional information, you may contact the Medical Records/Credentialing Coordinator at **559-733-7888**

If you believe your privacy rights have been violated, you may file a complaint with the Administrator, Office Manager or the Medical Records/Credentialing Coordinator. There will be no retaliation for filing a complaint.



**SEQUOIA ORTHOPAEDIC
& SPINE INSTITUTE, INC.
Frank L. Feng, D.O.**

Disability Forms

- There will be a \$25.00 fee due prior to the completion of your forms.
- This fee must be paid for each FMLA, CA SDI, and other disability forms you submit.
- The claimant's portion of the form the form must be completed before the form can be accepted.
- Forms are processed within **1-4 business days minimum** after payment has been received.
- Once completed, forms are mailed or faxed to the company that requested them, unless otherwise specified by the patient. Please note if you would like to pick up your forms. We will contact the patient when they are ready to be picked up.

WE ACCEPT CASH, CHECKS, AND DEBIT OR CREDIT CARDS.

Effective February 1, 2020

SEQUOIA ORTHOPAEDIC AND SPINE INSTITUTE, INC., FRANK L. FENG, D.O.

I acknowledge that I have received a copy of the SEQUOIA ORTHOPAEDIC AND SPINE INSTITUTE, INC., FRANK L. FENG, D.O. Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how SOSI may disclose and use my protected health information.

Patient Name: _____

Signature: _____ Date: _____

If signed by the patient's personal representative, indicate:

Name of signer: _____

Relationship to patient: _____

If acknowledgement is not signed, indicate reason not signed and efforts made to have acknowledgement signed:

Attach original to patient's medical record