Dear Patient,

Welcome to the Spine Practice of J. Patrick Johnson, MD. Our staff at the Spine Practice is happy to assist you with making an appointment with Dr. Johnson.

All new patients are asked to complete the attached New Patient Forms. Please return the packet to our office including CD's with the imaging studies you have had ie; MRI, possibly CT and X-Rays and include the imaging reports with your images. Please be advised we prefer to have studies completed within the past year. We suggest you make a copy of these for your own records. Printed records may be sent by either: email, fax (310) 423-9767 or mail to: J. Patrick Johnson, MD, 444 South San Vicente Blvd., Suite 800, Los Angeles, CA 90048

If you have additional reports in the past year regarding: EMG Reports, Physical Therapy Reports, Injection Reports, Operative Reports or Radiology Reports please provide these as they are helpful for evaluation and /or authorization for subsequent diagnostic test or procedures.

Insurance

Patients with Commercial Insurance: (ie; Blue Cross, Blue Shield, Aetna etc.): We accept all insurance carriers, however Dr. Johnson is not a provider for most medical insurance (ie: out-of-network provider). We do accept your insurance as a partial payment, and you may be responsible for portion of your bill both consultation and surgery. The Consultation fee is $500 and is due on the day of your visit. Your insurance may pay a portion of your initial consultation fee, and you may be refunded the amount that your insurance pays to us.

Patients with Medicare: Dr. Johnson is not a Medicare provider but he does see and treat many patients with Medicare. The Consultation fee is $400 and is due on the day of your visit. If surgery is needed your consultation fee is applied to your surgical fee.

Follow up visits are $100 (excluding post-operative visits for the 90 days after surgery).

Worker's Compensation patients are accepted for consultation upon special request.

Surgical fees are provided by the surgical scheduler or in a fee schedule provided by our billing office at Mednet Billing Inc. Surgical fees are paid prior to surgery by arrangement with our Mariela at Mednet at (310) 322-4278 Ext. 112

The Spine Practice of J. Patrick Johnson, MD and our entire team look forward to meeting you and providing the utmost personal medical spine care.

Identify Symptoms

Select the number how much pain in general you tolerate on a scale from 1 - 10?

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No Pain — Most Pain

Currently how much pain are you feeling by circling the numbers 1 - 10?

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No Pain — Most Pain

☐ Continuous ☐ Positional ☐ Intermittent (On & Off) ☐ Unable to Rate

Percentage of pain you have?

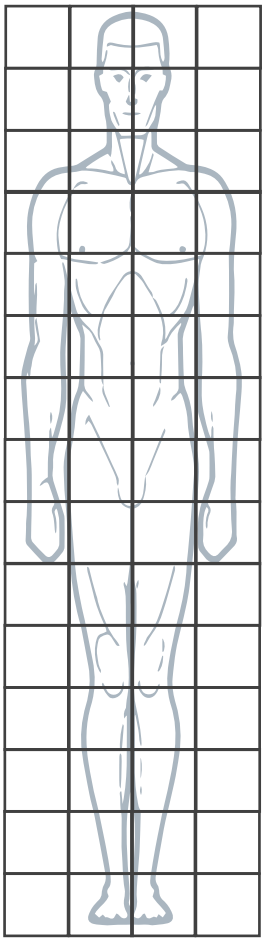
Neck Pain _____ %
Arm Pain _____ %
Total 100%

Back Pain _____ %
Leg Pain _____ %
Total 100%

Identify Symptoms Cont'd

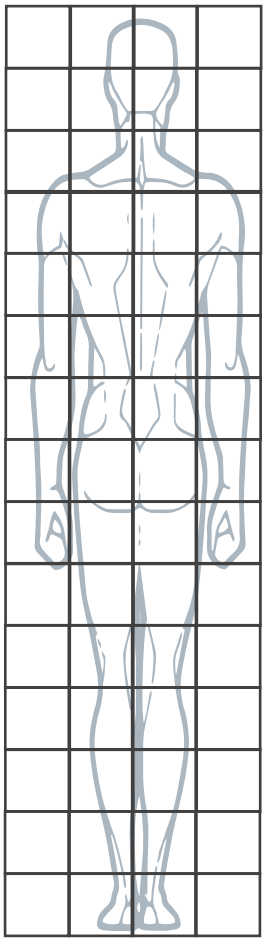
Mark the areas on the diagram using the appropriate number to describe the symptoms on your body.

Ache	Numbness	Pins & Needles	Burning Radiating	Pain
A	N	P	B	X



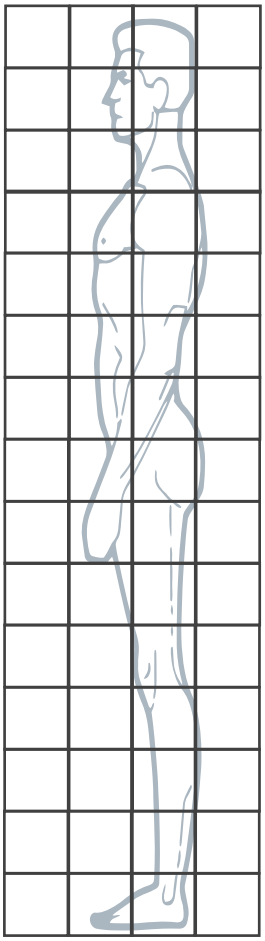
Front

Right Left



Back

Left Right



Side

Patients Physician Information

Referring Physician

Name:
Specialty:
Address:
State: Zip Code:
Phone: Fax:

Internist/ Primary Care Physician

Name:
Specialty:
Address:
State: Zip Code:
Phone: Fax:

Any Other Physician Involved in Your Care

Name:
Specialty:
Address:
State: Zip Code:
Phone: Fax:

Workman's Compensation
(if applicable)

Name:
Specialty:
Address:
State: Zip Code:
Phone: Fax:

Patient Information Sheet

Last Name: First Name: MI:

Age: Occupation: ○ Right-handed ○ Left-handed

Current Concerns

Symptoms and Duration:

Past Medical History

Previous Operations and Dates

Other Current and Past Medical Problems (example; hypertension, stroke, diabetes, cancer, etc):

Family Medical History (if deceased, list cause):

Current Medication including over-the-counter medicines:

Allergies:

Other Information

Smoke: /Day Alcohol Usage:

Recent X-rays, CT's, MRI's including dates:

Do you get claustrophobic? ○ Yes ○ No Do you have metal implants? ○ Yes ○ No

Demographic Intake Sheet for Consultation

Appointment Date: Appointment Time: Authorization #

Referred by: Address:

Patient Information

Last Name: First Name: Gender: ○ Male ○ Female

Address: City: State: Zip:

Home Phone: Cell Phone: Email:

Date of Birth: S.S. #:

Employment Information

☐ Retired ☐ Student ☐ Disability ☐ Unemployment

Company Name: Occupation:

Address: City: State: Zip:

Insurance Information

☐ PPO ☐ POS ☐ Medicare ☐ Workcomp ☐ Cash

Primary Insurance: Home Phone:

Address: City: State: Zip:

Group: ID#: Medicare ID#:

Effective Date: ○ A ○ B ○ A & B

If pateint is not the subscriber, provide the subscriber's informations below

Last Name: First Name: Date of Birth:

S.S. #: Gender: ○ Male ○ Female

Secondary Insurnace: Address:

Primary Holder's Name: Group #: ID#:

Workman's Compensation

Company Name: Address:

Date of Injury: Claim #: Adjuster:

Employer name at the time of injury: State: Zip:

Phone #: Fax #:

Attorney Information for Workman's Compensation:

Name of Attorney: Name of Firm: Fax #:

Address: Phone #:

Office Policies

MISSED APPOINTMENT POLICY

If you are unable to make your scheduled appointment, please call our office at (310) 423-9792 with a minimum of 24 hour notice. Those patients who do not contact the office will be charged a missed appointment fee of $100.00.
Please be advised that insurance companies DO NOT pay for missed appointments.

OFFICE VISIT FEES

New Patient Consultation $500.00 first visit
New Patient with Medicare $400.00 first visit
Follow up appointments $100.00 after first visit

ALL FEES ARE DUE AT THE TIME OF YOUR DOCTORS CONSULTATION

FORM COMPLETION & PROCESSING FEES

Initial State/Employee Disability Form $50.00
Our office will mail disability forms on your behalf
DMV Placard Form $20.00
You need to pick up the DMV form or our office will mail the form to you

We appreciate your cooperation working with us and if you have any questions please don't hesitate to contact our office at (310) 423-9792.

Please sign and return with forms.

☐ I have read and agreed to The Spine Practice office policies.

Patient Signature

Date

Acknowledgement and Consent to Receive Clinical Services

Dear Patient,

This letter will serve as acknowledgement and consent that you are notified of the following:

- J. Patrick Johnson, MD ("physician") is not contracted with your insurance company and in consider an out of network provider. You are giving consent to receive medical services by J. Patrick Johnson, MD.
- Patient is responsible for payments due at the time of scheduled office visit, not to exceed $500.00 for a new patient visit, $400.00 for a medicare new patient visit and $100.00 for each follow-up visit thereafter.
- Patient acknowledges that they may seek the same or reasonably similar care from a contracted insurance provider and/or may seek assistance from their health plan in finding a contracted provider; nonetheless you have chosen to receive medical service from J. Patrick Johnson, MD.
- Any costs incurred from receiving medical services from J. Patrick Johnson, MD. will likely be above the costs you would have incurred had you chosen an in-network medical provider. All costs may not count toward your annual in- network deductible or out-of-network pocket maximum.
- I ("Patient") understand and agree that by signing below I am financially responsible for all charges regarding the medically necessary and related medical services rendered to me by "Physician".
- I understand that this form must be signed and returned to the office at least 24 hours prior to receiving medical services. Failure to do so will result in withdrawal and cancellation of my scheduled appointment.

Patient Signature

Date

Patient Printed Name

Date of Birth

noridian
Healthcare Solutions

Medicare Private Contract

Section 4507 of the 1997 Balanced Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary. Enter the provider's name and the beneficiary's name in the appropriate boxes. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below. The supplier must submit an affidavit to Medicare expressing his/her decision to opt-out.

I J. Patrick Johnson **(provider's name)** have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act 1881628352 **(provider's NPI)**

I (the Medicare beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by J. Patrick Johnson **(provider's name).**

I (the Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what J. Patrick Johnson **(provider's name)** may charge for items or services furnished.

I (the Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask J. Patrick Johnson **(provider's name)** to submit a claim to Medicare.

I (the Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by J. Patrick Johnson **(provider's name)** that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I (the Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The expected or known effective date and expected or known expiration date of the opt-out period is 01/20/2016 **(effective date)** and 01/19/2021 **(expiration date).**

I (the Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by me, (the Medicare beneficiary), or by my legal representative during a time when I, (the Medicare beneficiary), require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual)

I (the Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

I J. Patrick Johnson **(provider's name)** will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

I J. Patrick Johnson **(provider's name)** will supply CMS with a copy of this contract upon request.

I J. Patrick Johnson **(provider's name)** understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Provider's NPI: 1881628352

Provider's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Legal Representative Signature: _____ Date: _____

Witness: _____ Date: _____

Contact Name: James Turner Phone #: (310) 335-6840

Contact Email: James@med-net.info