



bone
&
spine



Aaron Coats, MD
*Board certified
in Orthopaedics*

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Welcome to American Health Network Bone & Spine

CARMEL - ST VINCENT
13430 North Meridian
Suite 204, Entrance 4
Carmel, IN 46032

GEORGETOWN RD.
4880 Century Plaza Rd.
Suite 200
Indianapolis, IN 46254

KOKOMO
2330 South Dixon
Suite D
Kokomo, IN 46902

Dear New Patient:

We would like to take this opportunity to welcome you to our practice and thank you for entrusting us with your medical care. We want to share with you some information about our standard processes that we hope will be helpful to you throughout your care.

Phone Hours

In order to most efficiently handle patient care, we utilize a centralized call center. Our call center hours are Monday-Friday 8:05 am to 4:30 pm. Our phone number is (317)208-3866. If you have an urgent medical need outside of our normal business hours, the provider on call can be reached by calling our office; the answering service will contact the provider on call and have them call you.

Refill Requests

Please allow 72 hours for your refill request to be processed. Our office will call you when your prescription is ready to be picked up from our office. Please bring your photo ID with you to pick up prescription.

FMLA & Disability Paperwork

In order for us to accurately and thoroughly complete your paperwork for FMLA and/or disability, please allow us 14 business days to complete this paperwork. If for some reason you have waited longer than 14 business days, please contact our office to inquire about the status of your paperwork.

Effective January 1, 2017, Bone & Spine will charge a one-time fee of \$40 for FMLA/Disability paperwork per episode of care. Patients who have paid a lesser amount for initial paperwork prior to January 1, 2017 will be charged a one-time fee of \$10 for any additional paperwork. Please note, additional fees that may be billed are:

- returned checks \$25;
- copying of medical records (fees are set by Indiana statute; amount varies based on number of pages).

Arrival Time

If you have recent X-Rays please arrive **15 minutes early** and bring your paperwork along with your current insurance card(s). If you DO NOT have recent X-Rays please arrive **30 minutes early** for X-Rays and registration. If you are getting X-rays at St. Vincent, please arrive 1 hour prior to appointment. **If you have had any recent X-rays, MRIs, or CT scans pertaining to your visit with us you are responsible for bringing the images to your appointment.** You will also be asked to show your picture ID (driver's license, student ID card, Indiana ID card.) Anyone under the age of 18 years old must have a parent (or guardian) present. Also if you are under the age of 18 without a picture ID you parent (or guardian) must present their picture ID at the visit.

Insurance Card(s)

Please be prepared to present your insurance card(s) and pay any co-pay at each visit. Co-pays may be paid by cash, check, or credit card. We accept most credit cards and also accept Health Savings Account (HSA) cards. If you do not have insurance, we require a minimum payment of \$100.00 at the time of the service for each office visit. If you do not have insurance and pay in full for all charges at the time of service, you'll receive a 15% discount.

If you have any questions regarding payment please contact our office in advance. Please check with your insurance provider to be sure they have your doctor listed.

Cancellations: Appointment & Surgery

If you are unable to make your appointment time please contact our office at least 24 hours in advance to reschedule or cancel. There will be a \$250 fee for patient cancelling a surgery within 10 business days of the scheduled surgery. Three reschedules of the same surgery will be deemed as a cancellation.

Again, thank you for choosing American Health Network Bone & Spine for your health care needs. We look forward to treating you.

Sincerely,

Dr. Aaron Coats and Staff





bone & spine

AMERICAN HEALTH NETWORK
MEDICAL HISTORY SCREENING FORM orthopaedics

Date: _____

Name: _____ Family Physician: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Hand Dominance (Right or Left): _____

Expectations for Today's Visit: [] Explanation/Diagnosis [] Tests [] Medicines [] Therapy [] Injection [] Schedule Surgery

Body Part(s) Involved: _____ [] Right [] Left

Email: _____ Occupation: _____

Physical Therapy: [] Yes [] No; If yes, how long? _____ Medication for Pain: _____

Have you had any of these treatments? [] Injection [] Brace [] Crutches [] Sling

Have you ever had surgery for this problem? Yes No; If yes, surgery date(s)/Physician(s)/Procedure(s): _____

Are you currently under the care of a Pain Management physician? [] Yes [] No; If yes, Who? _____

Location of Pain: _____ Duration of Pain: _____ Work Related? _____

Did pain begin after a specific activity/injury? _____ [] Gradual [] Sudden Date/Length of injury: _____

Injury was due to: [] Sport/Exercise:(type) _____ [] Auto Accident [] Work Related [] Other: _____

Explain injury: _____

What activities worsen pain? _____

What activities improve pain? _____

Have you noted any arm or leg weakness/numbness? _____

Pain Scale (circle one): 0 (No Pain), 1 2 (Mild), 3 4 5 6 7 (Moderate), 8 9 10 (Severe)

Your pain is: [] Constant [] Intermittent Does your pain wake you from your sleep? [] Yes [] No

What best describes your pain? [] Sharp [] Dull [] Stabbing [] Throbbing [] Aching [] Burning

What makes your symptoms worse? _____

[] Standing [] Walking [] Running [] Getting Up [] Stairs [] Twisting [] Kneeling [] Squatting [] Lifting [] Reaching [] Gripping

If you are having knee pain: [] Catching [] Instability [] Swelling

Since your problem started, it is: [] Getting better [] Getting worse [] Unchanged

ANY RECENT IMAGING (with Dates and Location of Imaging)

Xray: _____

CT Scan: _____

MRI: _____

EMB/NCV: _____

CT Myelogram: _____

Bone Scan: _____

Other: _____

**PAST MAJOR
MEDICAL HISTORY**

- Aids
- Anemia
- Asthma
- Bleeding Disorders
- Blood Clots/DVT
- Cancer
- Diabetes
- Emphysema
- Fibromyalgia
- Gerd/Reflux
- HIV
- Gout
- Heart Attack
when: _____
- Heart Disease
- Hepatitis
- Hypertension
- Kidney Disease
- Osteoarthritis
- Respiratory Issues
- Rheumatoid Arthritis
- Seizure Disorder
- Strokes/TIA's
- Thyroid Disorder
- Ulcers (Stomach)
- Other:

**PAST MAJOR
SURGICAL HISTORY**

- Back or Neck Surgery
(Fusions, Etc.)
- Other _____
- CAGB (Bypass)
when: _____
- Gastric Bypass
- Pacemaker
- Stents
- None
- Arthroscopy
- Joint Replacement
by who/what/when: _____

Other: _____

ALLERGIES

**PERTINENT
FAMILY HISTORY**

SOCIAL HISTORY

Occupation: _____

- Currently Working
- Retired
- Disabled
- Unemployed

Marital Status:

- Single
- Married
- Divorced
- Widowed

Alcohol:

- Yes No

If yes, how much: _____

Illegal Drug Use:

- Yes No

If yes, drug: _____

Tobacco:

- Yes Chew
- Cigarettes

Packs/Cans Per Day: _____

How Many Years: _____

- No
- Quit (when) _____

PLEASE LIST ALL MEDICATIONS AND DOSAGES (Prescription and Over-the-Counter)

If your PCP is an AHN Provider you do not need to list meds.

Are you currently receiving or plan to apply for: Workmen's Comp Unemployment *FMLA/STD

* A \$40 fee will be charged accordingly for any FMLA or Short Term Disability paperwork submitted to us by you or your employer.

I HAVE RECEIVED A COPY OF THE BONE & SPINE WELCOME LETTER AND AGREE TO PAY CHARGES AS INDICATED:

Patient Signature: _____ Date: _____