



Cincinnati Spine Institute

9250 Blue Ash Road
Cincinnati, Ohio 45242

ALFRED KAHN, III, MD
JOHN M. ROBERTS, V, MD
MICHAEL KRAMER, MD
MICHAEL T. ROHMILLER, MD

PHONE (513) 792-7445
FAX (513) 792-7451

Thank you for choosing Cincinnati Spine Institute. Our first priority is you, our patient. Our highly trained physicians and professional staff are always available to assist you with questions regarding your care, medications, insurance or billing. Welcome to our practice.

Enclosed you will find some forms that we ask you to please fill out beforehand and bring with you to your first scheduled appointment. We also ask that you only use **black ink** when filling out these forms. You will also find a directions form which will direct you to all 4 of our office locations. **Please do not mail these forms to our office prior to your appointment.**

Please call our main phone number at 513-792-7445 if you have any questions or if you are unable to keep your appointment.

Thank You,
The Staff at Cincinnati Spine Institute

OFFICE LOCATIONS:

9250 Blue Ash Road
Cincinnati, OH 45242

2123 Auburn Avenue, #201
Cincinnati, OH 45219

8000 Five Mile Road, #205
Cincinnati, OH 45230

500 Thomas More Parkway
Crestview Hills, KY 41017

www.cincinnati-spineinstitute.com



Patient Name: _____

Date: _____

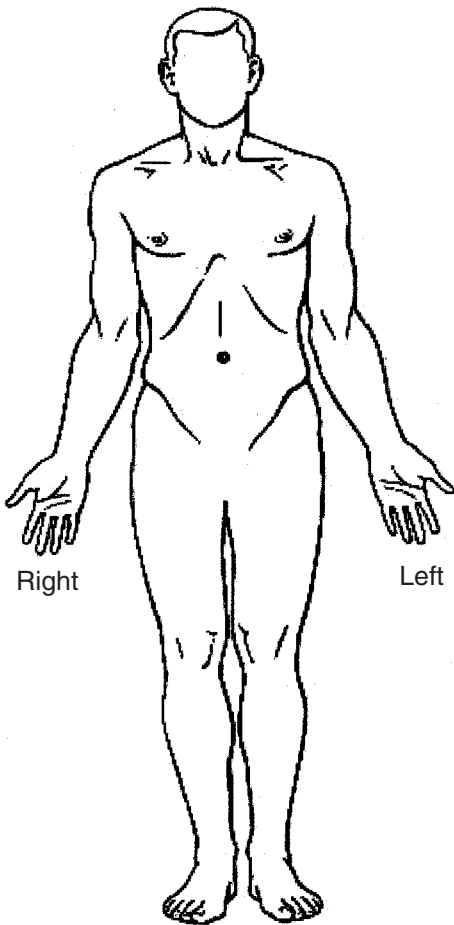
Print Patient Name: _____

Physician Signature _____

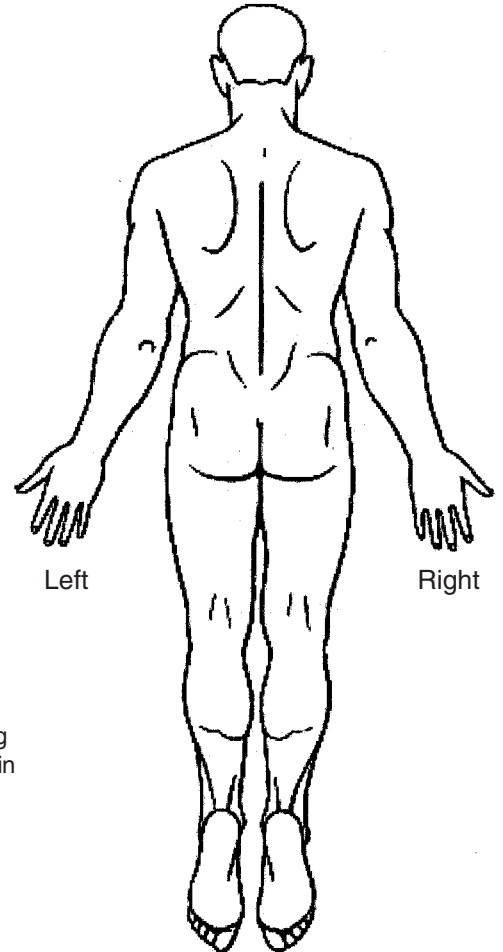
Spine Surgery New Patient Questionnaire

WHERE IS YOUR PAIN NOW?

Front



Back



Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	%

Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.

**Ex: back and leg pain are equal--
50% back, 50% leg**

Please place an X where you are having pain
Please place an O where you are having numbness
Please place a T where you are having tingling
Please place an S where you feel stabbing pain



Patient Name: _____
Date: _____

Date of birth _____

Primary Care Physician _____

Referring Physician _____

Could you please complete this Questionnaire?
It is designed to give us information about your health that will allow us to better understand and assist you.

CURRENT HISTORY

What is the main reason for your visit today? (Check all that apply)

- Back Pain Leg Pain Neck Pain Arm Pain
- Other: _____

How long has this been a problem?

- Less than 2 Months 2-6 months 6-12 months Greater than 1 year
- Further Comments: _____

Have you been treated by any other Care Giver for this condition? YES NO

If yes, please list: _____

What treatments have you had for this problem? (Check all that apply):

- Nothing Chiropractic Care Acupuncture Injections
- Physical Therapy (Please check all that apply)
 - Stretching* *Strengthening* *Traction* *Iontophoresis/Topical Steroid* *TENS*
 - Massage* *Ultrasound* *Heat/ice* *Therapeutic Ball*
- Medications
 - Muscle Relaxants* *Pain Medications* *Anti-Inflammatory (Prescription)*
 - Anti-Inflammatory Over the Counter (Aspirin, Tylenol, Advil, Aleve, etc)*
- Other: _____

Have you had any tests for this problem? YES NO

- X-Ray MRI Discography CT EMG
- CT/Myelogram Bone Scan Other (Please Specify): _____



Patient Name: _____

Date: _____

Current problem is the result of a(n): (Check all that apply)

Injured at work Auto Accident Sports No apparent cause

Other: _____

Is there any litigation pending? Lawsuit Workers Comp Disability Claim Social Security Claim

Current problem began: (Check all that apply)

Suddenly Gradually Lifting Twisting Fall

Bending Pulling Other _____

What makes the pain worse?

During Exercise After Exercise Prolonged Sitting Prolonged Standing Walking

Bending Forward Bending Backward Pushing Pulling Squatting

Night Pain Other: _____

What reduces your pain?

Nothing Lying down Sitting Standing Walking

Medication Shifting/Changing positions

Other _____

PAST MEDICAL HISTORY

SPINE Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current or Past Illnesses:

Date	Illness or Hospitalization
_____	_____



Patient Name: _____
Date: _____

Medication Allergies

Are you Allergic to Latex:

YES NO

Medication and Dosage:

	Medication	Strength	# of pills per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SOCIAL HISTORY

Age: _____

Occupation: _____

Are you? Single Married Divorced Widowed

Are you working? Full Time Part Time Disabled Retired Not working

Do you exercise? Daily Weekly Monthly Rarely Never

Type of exercise/activity? _____

Do you have children? Yes No How many? _____

Do you live alone? Yes No

Do you have lots of stairs? Yes No

Do you smoke? Yes No Packs per day ____ for ____ years.

Use other nicotine products? Yes No

Which products do you use? Chew Gum Patch Cigars Other _____

Have you Quit smoking? Yes No How long ago? _____



Patient Name: _____
Date: _____

Drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year Never

FAMILY HISTORY

Do you have a family history of:

Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Blood clots/excessive-bleeding	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hypertension	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Adverse Reaction to Anesthesia	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mental Health Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cardiac Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Other _____

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

Please describe all yes answers

Skin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ears, Nose, Throat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cardiac/High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Lungs, (Asthma, Infection)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Stomach/Digestion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Bladder/Bowel problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Hematologic/Bleeding problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Musculoskeletal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Neurological	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Psychiatric problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Reproductive/Sexual Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Fever/Chills	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Night Sweat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Night Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Unexpected Weight Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Patient Signature: _____

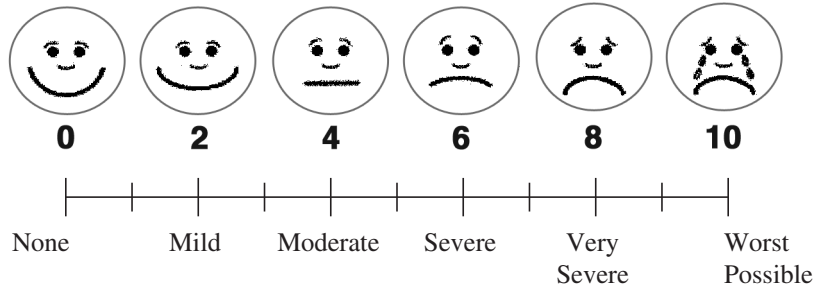
Date: _____



Patient Name: _____
Date: _____

Grade your overall Pain

Please place an X on the hash mark that most accurately describes your overall degree of pain now.



SF-12v2™ Health Survey

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

	Excellent	Very Good	Good	Fair	Poor
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The following questions are about activities you might do during a typical day. Does your health *now* limit you in these activities? If so, how much?

	Yes, Limited a lot	Yes, Limited a little	No, not limited at all
a. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Patient Name: _____
Date: _____

4. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. During the *past 4 weeks*, how much did pain interfere with your normal work (including both work outside the home and housework)?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Patient Name: _____
Date: _____

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

6. How much of the time during the *past 4 weeks*...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. During the *past 4 weeks*, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Patient Name: _____

Date: _____

Could you please complete this questionnaire? It is designed to give us information as to how your spine trouble has affected your ability to manage in everyday life. Please answer every section.

Mark one box only in each section that most closely describes you Today

<p><u>Section 1: Pain Intensity</u></p> <p>0. <input type="checkbox"/> I have no pain at the moment.</p> <p>1. <input type="checkbox"/> The pain is very mild at the moment.</p> <p>2. <input type="checkbox"/> The pain is moderate at the moment.</p> <p>3. <input type="checkbox"/> The pain is fairly severe at the moment.</p> <p>4. <input type="checkbox"/> The pain is very severe at the moment.</p> <p>5. <input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p><u>Section 6: Standing</u></p> <p>0. <input type="checkbox"/> I can stand as long as I want without extra pain.</p> <p>1. <input type="checkbox"/> I can stand as long as I want but it gives me extra pain.</p> <p>2. <input type="checkbox"/> Pain prevents me from standing for more than 1 hour.</p> <p>3. <input type="checkbox"/> Pain prevents me from standing for more than half an hour.</p> <p>4. <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes.</p> <p>5. <input type="checkbox"/> Pain prevents me from standing at all.</p>
<p><u>Section 2: Personal Care (Washing, dressing, etc)</u></p> <p>0. <input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p>1. <input type="checkbox"/> I can look after myself normally but it is very painful.</p> <p>2. <input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p>3. <input type="checkbox"/> I need some help but manage most of my personal care.</p> <p>4. <input type="checkbox"/> I need help everyday in most aspects of self-care.</p> <p>5. <input type="checkbox"/> I do not get dressed, wash with difficulty, and stay in bed.</p>	<p><u>Section 7: Sleeping</u></p> <p>0. <input type="checkbox"/> My sleep is never disturbed by pain.</p> <p>1. <input type="checkbox"/> My sleep is occasionally disturbed by pain.</p> <p>2. <input type="checkbox"/> Because of pain I have less than 6 hours' sleep.</p> <p>3. <input type="checkbox"/> Because of pain I have less than 4 hours' sleep.</p> <p>4. <input type="checkbox"/> Because of pain I have less than 2 hours' sleep.</p> <p>5. <input type="checkbox"/> Pain prevents me from sleeping at all.</p>
<p><u>Section 3: Lifting</u></p> <p>0. <input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p>1. <input type="checkbox"/> I can lift heavy weights but it gives extra pain.</p> <p>2. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table.</p> <p>3. <input type="checkbox"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed.</p> <p>4. <input type="checkbox"/> I can lift only very light weights.</p> <p>5. <input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><u>Section 8: Sex Life (if applicable)</u></p> <p>0. <input type="checkbox"/> My sex life is normal and causes no extra pain.</p> <p>1. <input type="checkbox"/> My sex life is normal but causes some extra pain.</p> <p>2. <input type="checkbox"/> My sex life is nearly normal but it is very painful.</p> <p>3. <input type="checkbox"/> My sex life is severely restricted by pain.</p> <p>4. <input type="checkbox"/> My sex life is nearly absent due to pain.</p> <p>5. <input type="checkbox"/> Pain prevents any sex life at all.</p>
<p><u>Section 4: Walking</u></p> <p>0. <input type="checkbox"/> Pain does not prevent me from walking any distance.</p> <p>1. <input type="checkbox"/> Pain prevents me from walking more than 1 mile.</p> <p>2. <input type="checkbox"/> Pain prevents me from walking more than a quarter of a mile.</p> <p>3. <input type="checkbox"/> Pain prevents me from walking more than 100 yards.</p> <p>4. <input type="checkbox"/> I can only walk using a stick or crutches.</p> <p>5. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</p>	<p><u>Section 9: Social Life</u></p> <p>0. <input type="checkbox"/> My social life is normal and causes me no extra pain.</p> <p>1. <input type="checkbox"/> My social life is normal but increases the degree of pain.</p> <p>2. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.</p> <p>3. <input type="checkbox"/> Pain has restricted my social life and I do not go out as often.</p> <p>4. <input type="checkbox"/> Pain has restricted my social life to my home.</p> <p>5. <input type="checkbox"/> I have no social life because of pain.</p>
<p><u>Section 5: Sitting</u></p> <p>0. <input type="checkbox"/> I can sit in any chair as long as I like.</p> <p>1. <input type="checkbox"/> I can sit in my favorite chair as long as I like.</p> <p>2. <input type="checkbox"/> Pain prevents me from sitting for more than 1 hour.</p> <p>3. <input type="checkbox"/> Pain prevents me from sitting for more than half an hour.</p> <p>4. <input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes.</p> <p>5. <input type="checkbox"/> Pain prevents me from sitting at all.</p>	<p><u>Section 10: Traveling</u></p> <p>0. <input type="checkbox"/> I can travel anywhere without pain.</p> <p>1. <input type="checkbox"/> I can travel anywhere but it gives extra pain.</p> <p>2. <input type="checkbox"/> Pain is bad but I manage journeys over 2 hours.</p> <p>3. <input type="checkbox"/> Pain restricts me to journeys less than 1 hour.</p> <p>4. <input type="checkbox"/> Pain restricts me to short necessary journeys less than 30 minutes.</p> <p>5. <input type="checkbox"/> Pain prevents me from traveling except to receive treatment.</p>

Patient Name _____

Address _____ City/State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____ SS# _____

Medication allergies _____

Sex _____ Birthdate _____ Age _____ Marital Status _____

Emergency Contact _____ Phone Number _____

Patient's employer or school _____ Occupation _____

Spouse's name _____ Spouse's Date of Birth _____

Spouse's employer _____ SS# _____ Phone _____

Referred by _____ Family physician _____

How did you find us: Yellow Pages Internet Advertisement Other _____

INSURANCE CARDHOLDER OR RESPONSIBLE PARTY INFORMATION

Mother/Wife _____ Date of Birth _____ Home Phone _____

Mother's employer _____ SS# _____ Work Phone _____

Father/Husband _____ Date of Birth _____ Home Phone _____

Father's employer _____ SS# _____ Work Phone _____

INSURANCE INFORMATION: Please give the receptionist your card. If you do not have your card with you, we cannot bill your insurance until we receive a copy of both sides of the card.

Primary insurance _____ Secondary insurance _____

INJURY INFORMATION - *Work related injuries must* fill this out completely or you will be responsible for your bill at the time of service.

Date of Injury _____

Type of Injury (ex. auto, fell, bicycle) _____

Are you working at this time: Yes _____ No _____ If no effective date of disability: _____

IS THIS A WORK RELATED INJURY ? YES _____ NO _____

Claim number _____ Claim rep _____

Employer at time of injury _____ Date of injury _____

Do you have an Attorney representing you with your W.C. claim? Yes _____ No _____

Attorney Name _____ Phone _____

Work Comp carrier _____ or Employer's name _____

Address _____ Address _____

City/State _____ City/State _____

Zip _____ Phone _____ Zip _____ Phone _____

AUTHORIZATION, RELEASE, & GUARANTEE OF ACCOUNT

I acknowledge that I am responsible for payment in full to Drs. Kahn, Roberts, Kramer or Rohmiller, for services rendered. I also authorize that benefits from insurance companies be paid directly to Drs. Kahn, Roberts, Kramer or Rohmiller. I authorize my attending physician to release any information required by my insurance carrier.

Date _____ Signature _____



FINANCIAL POLICY

Welcome to the Cincinnati Spine Institute, the practice of Alfred Kahn III, MD, John M. Roberts, MD, Michael Kramer, MD, and Michael T. Rohmiller, MD. We are pleased to provide excellence in orthopaedic and neurologic spinal care to you, as our patient.

We dislike discussing the financial aspects of our practice, but because of the large number of insurance companies, each with their own set of rules, billing has become a major part of our overhead.

As a courtesy to our patients, we file insurance with all insurance companies, except third-party, such as auto or personal injury claims. For those that we cannot file, we will provide you with an itemized form to turn in to your insurance company. Please be aware, though, if your insurance company refuses to pay, for any reason other than our error, the bill will become your responsibility.

We are contracted with many insurance companies. It is the responsibility of the patient to obtain the proper referrals from their primary care physicians if your insurance company requires this. Please make sure that we are in the network for your insurance company if your company has a network.

You are responsible for all co-pays and deductibles for both your primary and, if you have one, secondary insurance. If you do not have insurance, payment is expected at the time of the visit. If you are being seen for injuries as a result of an accident, we will not bill another person's insurance.

If your injury is work-related, we will bill your work comp carrier for all charges, but if your claim is disallowed, you will be responsible for all charges. Your claim is between you and your employer, not your employer and our office.

Thank you for choosing our practice to provide your orthopaedic and neurologic needs. We hope that this information is helpful to you.

.....

By signing below, I acknowledge that I have read the above and understand it.

Patient signature

Date



Cincinnati Spine Institute

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to Cincinnati Spine Institute/ Dr. Alfred Kahn, Dr. John Roberts, Dr. Michael Kramer, and/or Dr. Michael Rohmiller using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that **Cincinnati Spine Institute/ Dr. Alfred Kahn, Dr. John Roberts, Dr. Michael Kramer, and/or Dr. Michael Rohmiller** reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying **Cincinnati Spine Institute/ Dr. Alfred Kahn, Dr. John Roberts, Dr. Michael Kramer, and/or Dr. Michael Rohmiller** in writing, except to the extent that **Cincinnati Spine Institute/ Dr. Alfred Kahn, Dr. John Roberts, Dr. Michael Kramer, and/or Dr. Michael Rohmiller** has taken action in reliance on my consent.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or
Representatives authority to act
For the patient



Cincinnati Spine Institute

April 14, 2003

Because we value your privacy, please list the names of any family member or friend who is permitted to discuss your care.

Is it okay if we leave a message on your answering machine? _____

Is it okay if we call you at work? _____

Do you have a cellphone? If so, please provide the number if it is okay to contact you by cellphone _____

Patient signature _____ Date _____



Cincinnati Spine Institute

Directions to offices

CHRIST OFFICE—MOB-Suite 201 2123 AUBURN AVE.

From I-471: Take the Liberty Street exit. Go to the second light and turn right onto Sycamore. At the top of the hill, veer left onto Auburn. Christ Hospital will be on your left about 2 blocks. Park in main lot/garage. MOB I is on hospital grounds across from the main entrance.

From North 75 through KY: Follow signs for 71 North. Take the Reading Road/Eden Park exit. **This is a left-side exit.** Take the Florence/Dorchester lane to the right. Turn left at the first light onto Dorchester. At top of hill, turn right on Auburn. Christ Hospital will be on your left about 2 blocks. MOB I is on the hospital grounds across from the main entrance.

From South 71: Take the William Howard Taft Road exit. The 4th light will be Auburn Ave. Turn left. Christ Hospital will be on your right about 4 blocks. Park in main lot/garage. MOB I is on hospital grounds across from the main entrance.

From East 74: Take 74 to 75 South. 1st exit on right will be Hopple Street. At light, turn left on Hopple. Continue on Hopple, which will change names to Martin Luther King Drive. At top of hill, turn right on Clifton. Clifton dead-ends at McMillan. Turn left. 5th light will be Auburn. Turn right on Auburn. Christ Hospital will be on your right about 3 blocks. Park in main lot/garage. MOB I is on hospital grounds across from the main entrance.

BLUE ASH OFFICE—9250 BLUE ASH ROAD

From I-71: Take Ronald Reagan and head west. Take the Kenwood Road-Blue Ash Road exit. Turn left at 1st light, which will take you to Blue Ash Road. Turn right on Blue Ash, then an immediate right into our lot.

From I-75: Take Ronald Reagan and head east. Take the Kenwood Road-Blue Ash Road exit. Turn right at 1st stop sign. This will take you to Blue Ash Road. Turn right on Blue Ash. Cross back over Ronald Reagan and we are on your right immediately past the light.

From I-275: If you are coming from the east or anywhere close to 71, take that, head south and follow the directions above. Ronald Reagan is the second exit when you get on 71 S. If you are far enough west and can easily get on Ronald Reagan, take that and follow directions for I-75.

MERCY ANDERSON OFFICE—8000 FIVE MILE SUITE 205 (Hospital is 7500 Medical Blvd)

Take I-275 to Beechmont exit. Go west on Beechmont to Five Mile Road. Turn right on Five Mile, then right onto State Road. Office building is on left behind hospital.

Or, take I-275 to Five Mile Road. Take Five Mile Road towards Beechmont Ave. Cross Beechmont and stay on Five Mile to State. Turn right on State. Office building is on left behind hospital.

NO. KY OFFICE—2845 CHANCELLOR DRIVE

Take I-275 to Turkeyfoot exit. Go south on Turkeyfoot to Thomas More Parkway. Turn left. Turn left on Chancellor Drive. 2845 is large building 100 yards off Thomas More Parkway.



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To Our Valued Patients:

Effective August 1, 2008, a \$10.00 pre-payment is required per form for completion of all disability forms.

No pre-payment is required for forms provided by your workers' compensation carrier such as C-84s.

We can accept payments by cash, check, money order and credit cards.

We will not bill you for payment of forms. Forms must be pre-paid prior to completion.

We know this time is difficult for you and we strive to complete your forms in the prompt, attentive manner you deserve.

If there is an error on any form we have submitted, please make the needed correction and resubmit the form to our office for authorization. No fee is required for correction.

Thank you for your time and practice.

Sincerely,

The Disability Department

OFFICE LOCATIONS:

9250 Blue Ash Road
Cincinnati, OH 45242

2123 Auburn Avenue, #201
Cincinnati, OH 45219

8000 Five Mile Road, #205
Cincinnati, OH 45230

500 Thomas More Parkway
Crestview Hills, KY 41017