Thank you for choosing The Christ Hospital Physicians – Spine Surgery. 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 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 The Christ Hospital Physicians – Spine Surgery
Where is your pain now?

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leg Pain</td>
<td>______%</td>
</tr>
<tr>
<td>Arm Pain</td>
<td>______%</td>
</tr>
<tr>
<td>Neck Pain</td>
<td>______%</td>
</tr>
<tr>
<td>Back Pain</td>
<td>______%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

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
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 caregiver 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 (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, Aleeve, 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): ____________________________________________________________________

---

The Christ Hospital Physicians™
Spine Surgery
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
- [ ] Pulling
- [ ] Other: ___________________________________________________________________________________

**What reduces your pain?**

- [ ] Nothing
- [ ] Lying down
- [ ] Sitting
- [ ] Standing
- [ ] Walking
- [ ] Medication
- [ ] Shifting/Changing positions
- [ ] Other: ___________________________________________________________________________________

---

**Past Medical History**

**Spine surgical history:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
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**Other surgical history:**

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<thead>
<tr>
<th>Date</th>
<th>Surgery</th>
<th>Complication</th>
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</table>

**Current or past illnesses:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Illness or hospitalization</th>
<th>Complication</th>
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<tbody>
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</table>
Patient Name: ___________________________________ Date: __________________________

Medication Allergies
Are you allergic to Latex?  □ Yes □ No

Medication and Dosage

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th># of pills per day</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>9.</td>
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<tr>
<td>10.</td>
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</tbody>
</table>

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 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? ____________

Drink Alcohol?  □ Daily □ 1-2 x/week □ 1-2 x/month □ 1-2 x/year □ Never
Patient Name: ___________________________________________ Date: __________________________

Family History

Arthritis  □ Yes  □ No  Blood clots/excessive bleeding  □ Yes  □ No
Hypertension  □ Yes  □ No  Diabetes  □ Yes  □ No
Cancer  □ Yes  □ No  Adverse reaction to Anesthesia  □ Yes  □ No
Mental Health Disorders  □ Yes  □ No  Cardiac Disorders  □ Yes  □ No
Other _____________________________________________________

Review of Systems

Are you currently or have you had problems with:

Please describe all yes answers

Skin  □ Yes  □ No
Ears, Nose, Throat  □ Yes  □ No
Cardiac/High blood pressure  □ Yes  □ No
Lungs (Asthma, Infection)  □ Yes  □ No
Stomach/Digestion  □ Yes  □ No
Bladder/Bowel problems  □ Yes  □ No
Hematologic/Bleeding problems  □ Yes  □ No
Diabetes  □ Yes  □ No
Cancer  □ Yes  □ No
Musculoskeletal  □ Yes  □ No
Neurological  □ Yes  □ No
Psychiatric problems  □ Yes  □ No
Reproductive/Sexual problems  □ Yes  □ No
Fever/Chills  □ Yes  □ No
Night pain  □ Yes  □ No
Unexpected weight loss  □ Yes  □ No

Patient signature: ___________________________________________ Date: __________________________
Grade Your Overall Pain

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

None  Mild  Moderate  Severe  Very Severe  Worst Possible

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

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?
   a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:
      □ Yes, limited a lot  □ Yes, limited a little  □ No, not limited at all
   b. Climbing several flights of stairs:
      □ Yes, limited a lot  □ Yes, limited a little  □ No, not limited at all

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?
   a. Accomplished less than you would like:
      □ All of the time  □ Most of the time  □ Some of the time  □ A little of the time  □ None of the time
   b. Were limited in the kind of work or other activities:
      □ All of the time  □ Most of the time  □ Some of the time  □ A little of the time  □ None of the time

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)?
   a. Accomplished less than you would like:
      □ All of the time  □ Most of the time  □ Some of the time  □ A little of the time  □ None of the time
   b. Didn’t do work or other activities as carefully as usual:
      □ All of the time  □ Most of the time  □ Some of the time  □ A little of the time  □ None of the time

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
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...
   a. Have you felt calm and peaceful?
      - All of the time   - Most of the time   - Some of the time   - A little of the time   - None of the time
   b. Did you have a lot of energy?
      - All of the time   - Most of the time   - Some of the time   - A little of the time   - None of the time
   c. Have you felt downhearted and blue?
      - All of the time   - Most of the time   - Some of the time   - A little of the time   - None of the time

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
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.**

### Section 1: Pain Intensity
0. ☐ I have no pain at the moment.
1. ☐ The pain is very mild at the moment.
2. ☐ The pain is moderate at the moment.
3. ☐ The pain is fairly severe at the moment.
4. ☐ The pain is very severe at the moment.
5. ☐ The pain is the worst imaginable at the moment.

### Section 2: Personal Care (washing, dressing, etc.)
0. ☐ I can look after myself normally without causing extra pain.
1. ☐ I can look after myself normally but it is very painful.
2. ☐ It is painful to look after myself and I am slow and careful.
3. ☐ I need some help but manage most of my personal care.
4. ☐ I need help everyday in most aspects of self-care.
5. ☐ I do not get dressed, wash with difficulty, and stay in bed.

### Section 3: Lifting
0. ☐ I can lift heavy weights without extra pain.
1. ☐ I can lift heavy weights but it gives me extra pain.
2. ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, *e.g.*, on a table.
3. ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed.
4. ☐ I can lift only very light weights.
5. ☐ I cannot lift or carry anything at all.

### Section 4: Walking
0. ☐ Pain does not prevent me from walking any distance.
1. ☐ Pain prevents me from walking more than 1 mile.
2. ☐ Pain prevents me from walking more than a quarter mile.
3. ☐ Pain prevents me from walking more than 100 yards.
4. ☐ I can only walk using a stick or crutches.
5. ☐ I am in bed most of the time and have to crawl to the toilet.

### Section 5: Sitting
0. ☐ I can sit in any chair as long as I like.
1. ☐ I can sit in my favorite chair as long as I like.
2. ☐ Pain prevents me from sitting for more than 1 hour.
3. ☐ Pain prevents me from sitting for more than half an hour.
4. ☐ Pain prevents me from sitting for more than 10 minutes.
5. ☐ Pain prevents me from sitting at all.

### Section 6: Standing
0. ☐ I can stand as long as I want without extra pain.
1. ☐ I can stand as long as I want but it gives me extra pain.
2. ☐ Pain prevents me from standing for more than 1 hour.
3. ☐ Pain prevents me from standing for more than half an hour.
4. ☐ Pain prevents me from standing for more than 10 minutes.
5. ☐ Pain prevents me from standing at all.

### Section 7: Sleeping
0. ☐ My sleep is never disturbed by pain.
1. ☐ My sleep is occasionally disturbed by pain.
2. ☐ Because of pain I have less than 6 hours' sleep.
3. ☐ Because of pain I have less than 4 hours' sleep.
4. ☐ Because of pain I have less than 2 hours' sleep.
5. ☐ Pain prevents me from sleeping at all.

### Section 8: Sex Life *(if applicable)*
0. ☐ My sex life is normal and causes no extra pain.
1. ☐ My sex life is normal and causes some extra pain.
2. ☐ My sex life is nearly normal but it is very painful.
3. ☐ My sex life is severely restricted by pain.
4. ☐ My sex life is nearly absent due to pain.
5. ☐ Pain prevents any sex life at all.

### Section 9: Social Life
0. ☐ My social life is normal and causes me no extra pain.
1. ☐ My social life is normal but increases the degree of pain.
2. ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, *e.g.*, sports, etc.
3. ☐ Pain has restricted my social life and I do not go out as often.
4. ☐ Pain has restricted my social life to my home.
5. ☐ I have no social life because of pain.

### Section 10: Traveling
0. ☐ I can travel anywhere without pain.
1. ☐ I can travel anywhere but it gives me extra pain.
2. ☐ Pain restricts me to journeys over 2 hours.
3. ☐ Pain restricts me to journeys less than 1 hour.
4. ☐ Pain restricts me to short necessary journeys less than 30 minutes.
5. ☐ Pain prevents me from traveling except to receive treatment.
Patient Registration Information: (please print)

Legal Name: ____________________________

Social Security #: ____________________________ Gender: M F Date of birth: ________________

Maiden Name: ____________________________ Other name(s) used/nicknames: ____________________________

Address: __________________________________________ City/State ___________ Zip Code ___________

Home #: ( ) __________________________ Work #: ( ) __________________________ Cell #: ( ) __________________________

Email address: __________________________________________________________

Language spoken (patient): ____________________________ Language spoken (caregiver): ____________________________

Need interpreter: Y N

Religion: ____________________________ Ethnicity: Non-Hispanic Hispanic PCP: Dr. ____________________________

Race: White African American American Indian Asian Native Alaskan Native Hawaiian Refused Other

EMERGENCY CONTACTS: please enter two

Name: __________________________________________ Name: __________________________________________

Address/Zip: __________________________________________ Address/Zip: __________________________________________

Relation to patient: ____________________________ Relation to patient: ____________________________

Home #: ( ) __________________________ Home #: ( ) __________________________

Work #: ( ) __________________________ Work #: ( ) __________________________

Cell #: ( ) __________________________ Cell #: ( ) __________________________

Is there a Legal Guardian: Y N Name: ____________________________ POA: Y N Name: ____________________________

EMPLOYMENT INFORMATION:

Retired: Y N Date of retirement: ________________

Patient’s Employer: ____________________________ Occupation: ____________________________

Employer’s Address: ____________________________ Full-time: _____ Part-time: _____

INSURANCE INFORMATION:

Primary Ins Name/Claims Address:

Policy/ID #: ____________________________ Group #: ____________________________ Pt. relationship to subscriber: Self Spouse Child Other

Subscriber Info: Name: ____________________________ DOB: ________________ SSN: ________________

Employer: ____________________________ Full-time: _____ Part-time: _____ Work #: ____________________________

Address: __________________________________________

Secondary Ins Name/Claims Address:

Policy/ID #: ____________________________ Group #: ____________________________ Pt. relationship to subscriber: Self Spouse Child Other

Subscriber Info: Name: ____________________________ DOB: ________________ SSN: ________________

Employer: ____________________________ Full-time: _____ Part-time: _____ Work #: ____________________________

Address: __________________________________________
Patient Information: (please print)  
Date: __________________________

Patient’s Legal Name:  
________________________________________________________________________________________

Date of birth:  
________________________________________________

Social Security #: ________________________________

Do you have a Living Will:     Y     N         Copy given to Primary Care Physician:     Y     N         In chart: (office use only)     Y     N 

Is there a Healthcare Power of Attorney:     Y     N 

Name:  
_____________________________________

Relationship: _________________  Phone #: (           ) ___________________

May we release test results to your: 

Spouse Y N Name:  

Parent Y N Name:  

Child(ren) Y N Name:  

Others Y N Name:  
Name:  

May we discuss billing questions with your: 

Spouse Y N Name:  

Parent Y N Name:  

Child(ren) Y N Name:  

Others Y N Name:  
Name:  

May we leave messages/test results on your answering machine?    Y    N      Phone #: (           )  

May we call you at your place of employment?    Yes    No       Phone #: (           )  

The following may pick up my written prescriptions for controlled substances: 

Name:  
_________________________________________________________  Relationship:  

Name:  
_________________________________________________________  Relationship:  

Name:  
_________________________________________________________  Relationship:  

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA) 

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHMA. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

☐ I have previously received a copy of the Notice of Privacy Practices

☐ I do not want a copy of the Notice of Privacy Practices

AUTHORIZATION OF MEDICAL AND RELATED HOSPITAL SERVICES 

1. CONSENT TO TREATMENT: I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by The Christ Hospital Physician Division or assistants or designated as may be needed. I understand that The Christ Hospital is a teaching hospital and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my doctor(s) in the performance of medical, surgical or diagnostic procedures/treatment that my doctor(s) consider necessary.

2. RELEASE OF RECORDS: I authorize the release of medical records information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be related to state, federal or other surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s) or agency for my follow-up care, and/or to the healthcare facility to which I am transferred from The Christ Hospital. I also authorize release of my medical record information as required by law.

3. NOTICE: I understand that certain physicians providing services to me, including Radiologists and Pathologists are independent contractors not employed by the hospital, and that I will be billed by the individual physician for services rendered to me by these physicians.

4. FINANCIAL AGREEMENT: I hereby authorize The Christ Hospital to submit a claim to my insurance carrier(s) or its intermediaries, to issue payment DIRECTLY to The Christ Hospital on behalf of such rendered services. I understand that I am financially responsible to The Christ Hospital for any balance not covered by my insurance carrier.

Patient signature: ___________________________________________  Date: __________________________
DIRECTIONS TO OUR OFFICES

9250 Blue Ash Road, Cincinnati OH 45242
ALFRED KAHN, III, MD, MICHAEL KRAMER, MD, JOHN M. ROBERTS, V, MD, MICHAEL T. ROHMILLER, MD, ANTHONY GUANCIALE, MD

From I-71: Take Ronald Reagan and head west. Take the Kenwood Road-Blue Ash Road exit. Turn left at first 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 first 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 I-71, take that, head south and follow the directions above. Ronald Reagan is the second exit when you get on I-71 south. If you are far enough west and can easily get on Ronald Reagan, take that and follow directions for I-75.

2123 Auburn Ave., Suite 201, Cincinnati, OH 45219
ALFRED KAHN, III, MD

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. The Christ Hospital will be on your left about 2 blocks. Park in main lot/garage. MOB is on hospital grounds across from the main entrance.

From North I-75 through KY: Follow signs for I-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. The Christ Hospital will be on your left about 2 blocks. MOB is on the hospital grounds across from the main entrance.

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

From East I-74: Take I-74 to I-75 south. First 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. Fifth light will be Auburn. Turn right on Auburn. The Christ Hospital will be on your right about 3 blocks. Park in main lot/garage. MOB is on hospital grounds across from the main entrance.
7545 Beechmont Ave., Suite J, Cincinnati, OH 45255
MICHAEL KRAMER, MD

From I-275: Take exit 69 for Five Mile Road. Turn left onto Five Mile Road for one mile. Turn right onto Beechmont Ave. The office is on the right.

From Five Mile Road: Road: Turn east onto Beechmont Avenue. Location is on the right.

1955 Dixie Highway, Suite F, Fort Wright, KY 41011
ALFRED KAHN, MD, MICHAEL ROHMILLER, MD

From I-75 South: Take the KY-1072 / Kyles Lane exit, EXIT 189, toward Fort Wright / Park Hills. Turn right onto Kyles Lane / KY-1072. Turn sharp left onto Dixie Highway / US-25 / US-42 / US-127. 1955 Dixie Highway is on the left.


5885 Harrison Ave., Suite 2300, Cincinnati OH 45248
JOHN M ROBERTS, MD, GREEN TOWNSHIP

From I-74 East: Take exit 11, Rybolt Road/Harrison Avenue. At Exit 11, take the ramp to the right for Rybolt Road toward Harrison Ave. Turn left onto Old Rybolt Road, then take an immediate right onto Harrison Ave. The Outpatient Center is approximately 2 miles on the right, across from the Rave Motion Cinemas and Kroger.

From I-74 West: Take exit 11, Rybolt Road/Harrison Avenue. Turn left onto Harrison Avenue. The Outpatient Center is approximately 2 miles on the right, across from the Rave Motion Cinemas and Kroger.

7981 Beechmont Ave., Cincinnati, OH 45255
ANTHONY GUANCIALE, MD

From I-275: Take the OH-125/Beechmont Ave. exit, Exit 65, toward Amelia/ Turn right onto OH-125/State Route 125/ Beechmont Ave. 7981 Beechmont Ave. is on the left.
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 patience.

Sincerely,
The Christ Hospital Physicians - Spine Surgery