

# Disc-FX<sup>®</sup> Workshop Questionnaire

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

Practice Locations Name and Address			
Phone			
Contact Name:			
Facilities you operate in:			
Policies for bringing in new products:			
Contacts and phone numbers at the Facility for beginning the process:			
Rep Credentialing Organization:			

Have you and your staff reviewed CPT coding for discectomy and are you comfortable with it?  Yes  No

Disc-FX Reps's name? \_\_\_\_\_ If no rep, can you suggest a rep you like? \_\_\_\_\_

### CHECK ALL THAT APPLY

Insurances and Payment  Major Med's  Medicare  Personal Injury  Cash Pay  
 If personal injury was selected, what is your practice percentage?  Less than 10%  25%  50%  75%  100%  
 If cash was selected, what percentage of your practice is cash?  Less than 10%  25%  50%  75%  100%

### Procedural Experience & Volume

	Yes	No	Date of Last Case	# per month	# per year	Total # of cases	Anticipated Voume after training
<b>Injections</b>							
<b>Discograms</b>							
<b>Dekompressor</b>							
<b>IDET</b>							
<b>Nucleoplasty</b>							
<b>Disc-FX</b>							
<b>Laminectomies</b>							
<b>Spine Fusions</b>							
<b>Microdiscectomy</b>							
<b>Endoscopic Spine</b>							

Please Fax or email completed workshop questionnaire and registration form to: Fax: (516) 277-9001 / Email: discfx@elliquence.com