SPINE CARE

7500 Beechnut, # 150 Houston, TX 77074

REFERRAL INFORMATION

REFERRAL INFORMATION: please let us know whom we can thank for your referral to Spine Care.

Physician Name: _____ **Address** _____ **Phone ( )** _____

Friend/Patient: _____ **Insurance:** _____ **Other:** _____

PATIENT INFORMATION

Name: _____

Address: _____

City, St, Zip: _____

Date of Birth: _____ Gender: M F

Marital Status: M S D W

Home Number: _____

Cell Number: _____

Email Address: _____

Drivers License Number: _____

SSN #: _____

Employer: _____

Work Phone: _____

Employer Address: _____

City, St., Zip: _____

Nearest Relative / Emergency Contact

Name/Relation: _____

Phone: _____

Please let us know the best way to get in touch with you during the day: home # email work # cell #

Is today's visit due to a ***work-related injury:*** ☐ *Yes* ☐ *No* ***Auto Accident:*** ☐ *Yes* ☐ *No* ***Fall:*** ☐ *Yes* ☐ *No*

Primary Insurance Name: _____

Address: _____

City, St, Zip: _____

Insured: _____ DOB: _____

Member #: _____ Group: _____

Insured's Employer: _____

Employer Phone#: _____

Employer Address: _____

City, St, Zip: _____

Secondary Insurance Name: _____

Address: _____

City, St, Zip: _____

Insured: _____ DOB: _____

Member #: _____ Group: _____

Insured's Employer: _____

Employer Phone#: _____

Employer Address: _____

City, St, Zip: _____

ASSIGNMENT OF BENEFITS & RELEASE AUTHORIZATION (EXCLUDING WORKER'S COMPENSATION)

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING PRIVATE INSURANCE, TO SPINE CARE, P.A. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED VALID AS ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION DEEMED NECESSARY FOR MY TREATMENT TO INSURANCE COMPANY AND TO ANY OTHER MEDICAL PROVIDER TO WHOM I AM REFERRED. IN ADDITION, I UNDERSTAND THAT I AM LIABLE FOR A $25.00 CHARGE IN THE EVENT OF A MISSED/BROKEN APPOINTMENT WITHIN LESS THAN A 24 HOUR CANCELLATION NOTICE.

SIGNATURE: _____ **DATE:** _____

Patient Name: _____

Date: _____

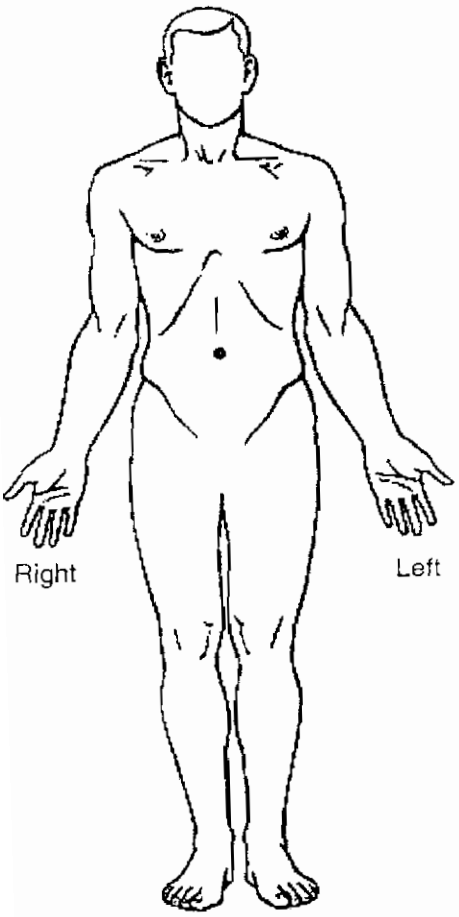
Print Patient Name: _____

Physician Signature _____

Spine Surgery New Patient Questionnaire

WHERE IS YOUR PAIN NOW?

Front



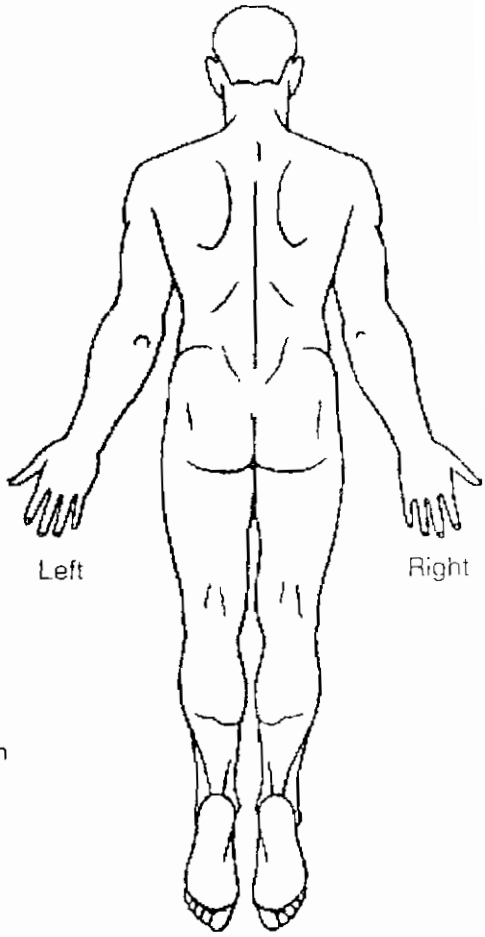
Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	**100**	%

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

Back



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 ☐	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 Sweat	Yes ☐	No ☐	_____
Night Pain	Yes ☐	No ☐	_____
Unexpected Weight Loss	Yes ☐	No ☐	_____

Patient Signature: _____ Date: _____

PRE-EXISTING CONDION STATEMENT

A pre-existing condition involves the diagnosis, care or treatment of a medical condition within one (1) calendar year (*varying between the different insurance policies*) **preceding the *effective date* of your current insurance coverage**. This also includes the existence of symptoms which would cause you to seek medical advice and/or treatment by a physician or professional provider within a one or two year period (*varying for each insurance policy*) *preceding the effective date* of your current insurance coverage.

To the best of my knowledge, I have NOT BEEN EXAMINED, RECOMMENDED TREATMENT OR TREATED for my current medical condition within the last two years for which I now require medical/surgical treatment.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE

If my insurance company *deems this condition as preexisting and denies payment* as a result, I understand I am financially responsible for all services rendered by Spine Care, PA.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE

7500 BEECHNUT, SUITE 150 HOUSTON, TEXAS 77074
PHONE - 713 773 2273 • FAX 713 773 0392

FINANCIAL POLICY STATEMENT

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. There is a service charge for returned checks.

It is the policy of Spine Care, PA to bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within sixty (60) days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Your time of service receipt includes all information necessary for submitting claims to your insurance company.

Patients with an outstanding balance sixty (60) days or more overdue must make arrangements for payment prior to scheduling appointments.

If you are enrolled in a managed care insurance plan (i.e., HMO), you must have a referral authorization from your primary care physician before you will be seen in our office. Retroactive referrals are not guaranteed.

PLEASE BE ADVISED THAT WE DO NOT TREAT AUTOMOBILE ACCIDENT INJURIES, WORKMANS COMPENSATION INJURIES/CLAIMS, OR INJURIES THAT ARE INVOLVED IN LITIGATION.

I have read and understand the Spine Care, PA financial policy. I agree to assign insurance benefits to the Spine Care, PA whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

I UNDERSTAND IT IS MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE

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FMLA AND DISABILITY DOCUMENTATION

Effective January 1, 2009, Spine Care, PA will require a fee of $75.00 for the completion of any FMLA or disability documentation requested or required by the patient.

If an addendum is required for an FMLA or disability document, a $50.00 fee will be required.

The forms will not be completed until the payment is made in full.

If medical records are requested, in addition to the documentation, we will abide by the policies of the State of Texas Health and Safety Codes. Payment for medical records will be required prior to the records preparation and/or submission.

I HAVE READ AND UNDERSTAND THE CHARGES FOR FMLA AND DISABILITY DOCUMENTATION.

_____
PRINTED NAME

_____ _____
SIGNATURE DATE

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by Spine Care, PA or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES
Spine Care, PA is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the Notice of Privacy Policies and Practices provided to you. ***PLEASE REVIEW IT CAREFULLY.***

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION
You may request a restriction on the use or disclosure of your protected health information. However, Spine Care, PA may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Spine Care, PA agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Policies and Practices, please consult with a practice representative at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime; however, Spine Care, PA requires that you must revoke this request in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the dates of your request.

CHANGES TO PRIVACY PRACTICES
Spine Care, PA reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Policies and Practices. Spine Care, PA will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

SIGNATURE
I have reviewed this consent form, received Notice of Privacy Policies and Practices, and given my permission to Spine Care, PA to use and disclose my health information in accordance with this consent and the notice provided.

PATIENT - PRINTED NAME | PATIENT REPRESENTATIVE - PRINTED NAME

PATIENT - SIGNATURE | PATIENT REPRESENTATIVE - SIGNATURE

DATE | PATIENT REPRESENTATIVE RELATION TO PATIENT

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