



Date: _____ Physician to be seen: _____

Name (First, MI, Last): _____

DOB: _____ Age: _____ Gender (Circle One): MALE FEMALE

Primary Phone#: _____ Secondary Phone#: _____

Address (Street, City, State, Zip): _____ Job/Occupation: _____

SSN: _____ Email Address: _____

Emergency Contact Name: _____

Phone#: _____ Relation: _____

Referring Physician: _____ How did you hear about us? _____

Primary Care Physician: _____

Pharmacy: _____ Pharmacy Phone#: _____

Please Circle One: SINGLE MARRIED DIVORCED WIDOWED

Race (Circle): ASIAN AFRICAN/AMERICAN HISPANIC INDIAN LATINO WHITE

OTHER: _____

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Refuse to Report

Is this a work related/motor vehicle injury? (Circle) YES NO Adjuster Name: _____ Phone#

Insurance (Check which applies): Insurance _____ Self Pay _____

Primary Insurance Company: _____ Relationship to Insured: _____

Policy Holder: _____ Policy Holder DOB: _____

Member ID#: _____ Group #: _____

Secondary Insurance Company: _____ Relationship to Insured: _____

Policy Holder: _____ Policy Holder DOB: _____

Member ID#: _____ Group #: _____

Please be advised that Texas Spine Associates does not treat injuries acquired by an accident where a third party entity is held liable for the incident (i.e. homeowner's insurance, auto insurance, etc.). Texas Spine Associates only files claims on personal insurance and worker's compensation and any appointments made under any other circumstances will be cancelled. I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

PLEASE FILL OUT COMPLETELY PAGES ARE FRONT AND BACK!!

IF YOU HAVE PCP, PLEASE PROVIDE FULL NAME; IF YOU DO NOT PLEASE MARK "N/A"

Patient Name: _____

Date of Birth: ____/____/____

Please list any known allergies and types of reactions:

Are you allergic to Latex: Yes No

Past Medical History and current medical condition: None

Please mark any of the following symptoms that you currently or chronically experiencing with a Yes or No:

Y	N	<u>Constitutional Symptoms</u>	Y	N	<u>Eyes</u>	Y	N	<u>Gastrointestinal</u>	Y	N	<u>Genitourinary</u>
		Fatigue			Vision loss			Diarrhea			Incontinence
		Fever/chills			Wears glasses/contacts			Heartburn/reflux			Kidney problems
		Recent weight gain	Y	N	<u>Endocrine</u>			Liver problems			Menopausal
		Recent weight loss			Always thirsty			Nausea/vomiting	Y	N	<u>Neurological</u>
Y	N	<u>Ear, Nose, Mouth, & Throat</u>			Appetite increase/decrease			Ulcers			Fainting/blackouts
		Dentures/bridges/braces			Sensitivity to heat/cold	Y	N	<u>Hematologic/Lymphatic</u>			Poor coordination
		Hearing loss			Thyroid disease			Anemia			Seizures
		Mouth lesions			Diabetes			Bleeding problems			Stroke/paralysis
		Nose bleeds	Y	N	<u>Cardiovascular</u>			DVT/blood clots			Weakness
		Ring in ear			Ankle Swelling			Easy bruising	Y	N	<u>Psychiatric</u>
		Sinus infections			Chest pain/heart attack			Lupus			Anxiety
Y	N	<u>Integumentary (skin)</u>			High/low blood pressure	Y	N	<u>Musculoskeletal</u>			Depression
		Cancer			Irregular heartbeat			Broken bones			Substance dependence
		Itching	Y	N	<u>Respiratory</u>			Difficulty walking			Trouble sleeping
		Rash			Asthma			Joint pain			
		Skin-related problems			Bloody cough			Joint stiffness			
					Shortness of breath			Joint swelling			
					Sputum in cough			Uses cane/walker/wheelchair			
					Waking up short of breath						

Family Medical History:

No Known History

Social Lifestyle:

- Alcohol Use Y N If yes, amount: _____
- Illegal Drug Use Y N If yes, what type: _____
- Prescription Drug Abuse Y N If yes, what type: _____
- Tobacco Use Y N If yes, amount daily _____ / yrs _____
- Interested in quitting tobacco? Y N

PLEASE FILL OUT COMPLETELY

PAGES ARE FRONT AND BACK!!

Patient Name: _____

Date of Birth: ____/____/____

List of Medications and Dosage:

See list provided by patient

List of Surgeries:

See list provided by patient

Procedure	Year

Have you had any past problems with anesthesia? Y N

If yes, please explain: _____

Height: _____

Weight: _____

Chief Complaint:

Reason for your visit today: _____

Symptoms: _____

Date of Injury or when symptoms started: _____

Describe how the injury or problem occurred: _____

What treatment have you already tried? : _____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or Guardian) Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

PLEASE FILL OUT COMPLETELY PAGES ARE FRONT AND BACK!!

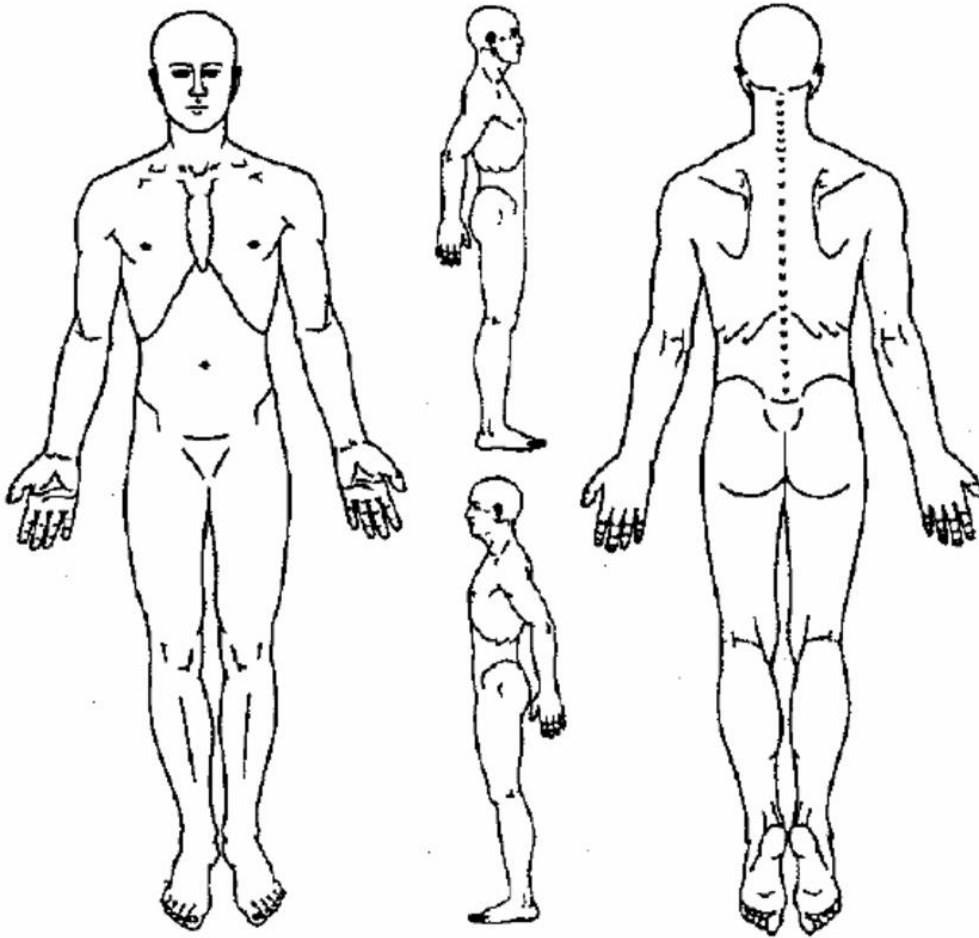
Patient Name: _____

Date of Birth: ____/____/____

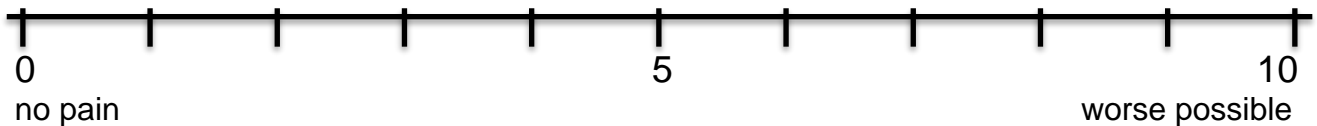
Pain Diagram

Please mark the area of injury or discomfort on the chart below using the appropriate symbols.

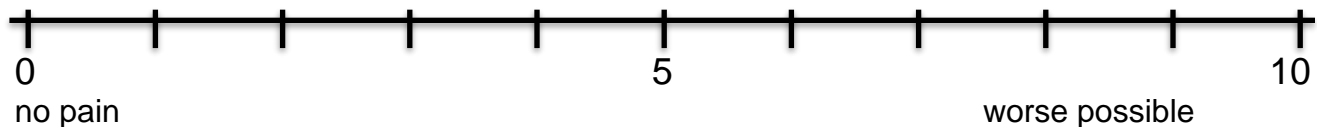
Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	0 0 0 0	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	0 0 0 0	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	0 0 0 0	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



PLEASE MARK ON THE LINE: How bad is your neck/back pain now?



How bad is your arm/leg pain now?



PAGES ARE FRONT AND BACK!!



Patient Name: _____

Date of Birth: ____/____/____

Acknowledge and Acceptance of Privacy Notice and Practice (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practice. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person (s) permitted to receive my medical records other than listed in the paragraph one:

- No restrictions – may release information if required to anyone.
- Restrictions: List who we may release information to regarding your healthcare:

I wish to be contacted in the following manner (Check all that applies):

Home Phone #: ____/____/____

Cell #: ____/____/____

- O.K. to leave message with detailed information.
- Leave message with call back number only.

Work Phone #: ____/____/____

- O.K. to leave message with detailed information.
- Leave message with call back number only.

Patient (or Guardian) Signature: _____ **Date:** _____

PLEASE FILL OUT COMPLETELY

PAGES ARE FRONT AND BACK!!



Patient Name: _____

Date of Birth: ____/____/____

Office Policies:

Welcome to Texas Spine Associates. We realize you have a choice for your medical care and we are pleased you have chosen us. Please be advised that our offices house two surgeons. Due to services being rendered, the wait times vary based on each specific patient's needs. Please do not be alarmed if someone who comes in after you is called back before you as they may be being seen in a different area. As long as you sign in, our receptionist will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionist of any address changes, phone number changes, or change in insurance **before** you are seen.

In order to ensure the quality of care received by our patients and assist in regulating the overall cost to the patient, the physicians at Texas Spine Associates have varying levels of ownership in the following: Baylor Surgical Hospital of Fort Worth, Baylor Surgical Hospital at Las Colinas, Baylor Oakmont ASC, Captive Medical, RMR Medical, KAR Medical, LoneStar Medical, HTC Medical, and HD Lifesciences. You have the right to select any health care facility or provider of your choice. It is not mandatory that you select any of the above referenced facilities or providers. By using the providers on this list, it is your physician's belief that your medical needs will be best served in the most convenient and efficient way possible. Referrals are in no way being made with an intent to financially benefit the physician.

Prescription request:

Please contact your pharmacy to request medication refills. Your pharmacy will notify our office of your refill request. We require 24 hours for refill request. Please be aware that refills received on Fridays or holidays may not be authorized until the next business day. (NOTE: Doctors do not refill narcotic prescriptions without seeing you in the office.)

Clinical Questions:

Please be aware if you call our office with a clinical question, our physicians and nursing staff are in clinic during the day and cannot be called away from patients to speak to you. Our receptionist will get your message to our clinical staff and they will return your call as soon as possible. (NOTE: if you have recently had surgery, please notify our receptionist of any problem you are experiencing and she will immediately notify a member of our clinical staff.)

Patient Forms:

Please be aware that we charge \$25.00 to complete the following paperwork:

AFLAC

FMLA

Disability

We require 4-5 business days to complete any paperwork given.

Patient (or Guardian) Signature: _____ **Date:** _____

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Texas Spine Associates and its representatives (hereinafter, “My Authorized Representatives”) and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Divulge items of personal health information pertaining to the authorization of and payment for treatment received by this practice

I certify that the health insurance information that I provided to Texas Spine Associates is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Texas Spine Associates are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____ . I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date

PAGES ARE FRONT AND BACK!!



Network Participation Notice

Texas Spine Associates is a participating partner with most major health insurance carriers and many of the smaller area plans as well. If you have questions about the services you will receive or your out of pocket responsibility, please speak with a member of our team prior to your appointment.

In order to provide the best care possible, our office may need to refer you outside of the practice for additional attention. Services that our providers may recommend include advanced imaging, physical therapy, pain management, intraoperative services, and home health care. While our practice makes a great effort to work with companies that are partnered with many major health insurance carriers, some health care professionals may not be participating with the same insurance plans and networks as Texas Spine Associates. This means the doctor or provider may not have a contract with your plan. Additionally, you may receive a separate invoice for any service not provided by Texas Spine Associates.

Our practice makes a great effort to ensure that we work with groups who maintain fair and accurate billing practices. In Texas, a healthcare provider is required notify a patient if they intend to balance bill for any services that are out of network. The term “balance billing” refers to the process of billing a patient for the difference between the charged amount and any amounts paid by the patient’s insurer or applied to a patient’s deductible, coinsurance, or copay. Thus, while you may receive an invoice for the copay/coinsurance determined by your benefit plan, as required by law, you should not receive a balance bill for services rendered unless you have first agreed to such invoicing in writing.

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. If you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a non-participating provider, you may be responsible for the cost of the services.

I am aware that I may be referred for services not provided by Texas Spine Associates and that these services may not be covered by my insurance plan.

Patient Name: _____

DOB: _____

Signature: _____

Date: _____