

Texas Spine Consultants, L.L.P.

PLEASE PRINT		<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> M.D.		PATIENT INFORMATION			Mobile Phone
NAME - Last, First, Middle Initial				Age	Birthdate	Home Phone	
ADDRESS - Number and Street				City	State	Zip	Email
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to Responsible Party: <input type="checkbox"/> 0-Self <input type="checkbox"/> 1-Husband <input type="checkbox"/> 2-Wife <input type="checkbox"/> 3-Child <input type="checkbox"/> 4-Other Marital Status <input type="checkbox"/> 0-Married <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Divorced <input type="checkbox"/> 3-Widow/Widower					
Employer		Occupation	Drivers License No.	Soc. Sec. No.	Business Phone		
Employer Address		City	State	Zip			

SUBSCRIBER INFORMATION			
NAME - Last, First, Middle Initial		Birthdate	Home Phone
ADDRESS - Number Street		City	State
Res. Party Social Security No.		Driver's License No.	Employer
		State	Business Phone

NEAREST LOCAL RELATIVE OR FRIEND (NOT LIVING WITH YOU)			
Name	Relationship	Home Phone	Business Phone
ADDRESS - Number and Street		City	State
		Zip	

MEDICAL INFORMATION			
IMPORTANT Please list all allergies to medication of any kind, or write none.			
Have you ever been a patient of this Group in the past? Year _____ Doctor _____		Have you ever been treated by a physician from this Group in the hospital emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PRESENT COMPLAINT: (Please Check) Neck _____ Upper Back _____ Lower Back _____			
Date of injury/onset of symptoms	Were X-Rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where?	Doctor you are to see today
Patient's Personal Physician		Referred By	

WORKERS COMPENSATION			
Injury on the job: <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you claiming worker's compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If on the job injury, please describe how accident occurred.	
Treating Doctor		Have you notified your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	

AUTO INJURY			
Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident	Auto Ins. Carrier	Attorney's Name and Phone No.

INSURANCE INFORMATION			
PRIMARY CARRIER		SECONDARY CARRIER	
Insurance Company Name		Insurance Company Name	
Insurance Company Address		Insurance Company Address	
Employer, if Group Coverage		Employer, if Group Coverage	
Policy No.	Group No.	Policy No.	Group No.
Subscriber's Name/Date of Birth		Subscriber's Name	
Patient's Relationship to Subscriber <input type="checkbox"/> 0-Self <input type="checkbox"/> 1-Spouse <input type="checkbox"/> 2-Child <input type="checkbox"/> 3-Other		Patient's Relationship to Subscriber <input type="checkbox"/> 0-Self <input type="checkbox"/> 1-Spouse <input type="checkbox"/> 2-Child <input type="checkbox"/> 3-Other	

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION:

- I hereby have a right to privacy under HIPAA regulations. Therefore any information that I provide on this demographic sheet, grants Texas Spine Consultants permission to contact me via the information I have provided.
- I hereby authorize Texas Spine Consultants, L.L.P., to furnish to any designated attorney or insurance company all information necessary to file a health insurance claim form, or to obtain reimbursement. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Texas Spine Consultants, L.L.P. I understand that I am financially responsible for all charges whether paid or not paid by my insurance company.
- Also, I hereby authorize the disclosure of health information in any data format (including X-Ray) regarding my treatment, hospitalization, and/or outpatient care to Texas Spine Consultants, L.L.P. I understand that this facility will maintain medical records in accordance with state requirements and are hereby released from all legal responsibility or liability that may arise from this authorization. By my signature below, you are fully authorized to disclose such information when requested by Texas Spine Consultants, L.L.P.
- I authorize Texas Spine Consultants to be my personal representative, which allows Texas Spine Consultants to: (1) submit any and all appeals when my insurance company denies my benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company (excluding Workers Comp.) has refused to pay 100% of my benefits, with-in 90 days of any and all appeals or request information. I also agree that any fines levied against my insurance company will be paid to Texas Spine Consultants for acting as my personal representative.
- The foregoing information is true and correct to the best of my knowledge.

Date _____ Patient or Guardian Signature _____

Form 06 (02/09)

Office and Financial Policies

We would like to thank you for choosing Texas Spine Consultants, LLP (TSC) as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment.

All payment is expected at the time of service

Payment is required at the time services are rendered. This includes your applicable **co-payment, co-insurance and deductibles** for participating insurance companies. If your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. If you have not met your deductible, the full amount of the visit is due on the day of service. It is also expected that you will pay any remaining balance at the time of service.

The co-payment, co-insurance requirement can not be waived by our practice, as it is a requirement placed on you by your insurance carrier.

High Deductible Health Plans: If you have a high deductible plan, be prepared to pay for all services in full as you incur them. If surgery is requested you will be asked to pay in advance of booking a surgery time.

Medicare: If you do not have a secondary insurance you will be responsible for the 20% co insurance at the time services are rendered.

Statements: Itemized statement of charges can be requested by the patient and will be mailed within 10 days.

Insurance Card - You must present a current insurance card at each visit. If you do not present a current insurance card, you will be responsible for payment in full at the time of your visit.

Workers' Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our Workers' Compensation Department at 214-370-3535. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

No Insurance: Payment in full is expected at the time of your visit for an uninsured patient.

Estimates: An estimate of cost will be provided if requested by an uninsured patient, a patient not covered by a government program or an insured patient seeking out-of-network services.

Interest: This practice does not charge interest for amounts past due and left unpaid by a third-party payor.

Auto Accident Injury/Liability: If you are being treated as part of a personal injury lawsuit or claim, we require payment in full at the time of your visit. We will not bill your attorney or motor vehicle insurance for charges incurred due to a personal injury case.

Missed Appointments /Untimely Cancellations

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours notice to avoid being charged. We reserve the right to charge for missed or untimely canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Return Checks/Rejected ACH Withdrawals: A \$30.00 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you. These balances must be paid in full prior to your next appointment.

Disability or Insurance Forms: There will be a charge of \$10.00 per page for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7 - 10 days for the completion of these forms.

PROMPT PAYMENT - Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency and we will ask you to seek your medical care from another medical office. Please contact the billing department at 214-370-3535 to discuss payment.

Questions or concerns related to billed charges shall be directed to the Billing Office at 214-370-3535.

Thank you for allowing us to service you.

I have read the financial policy and agree to its terms.

Patient Signature

Date Signed

Revised 5/24/2010

**Texas Spine Consultants
Authorization of Use and Disclosure of Protected Health
Information**

Persons Authorized to Receive Information:

Health Information that *Texas Spine Consultants* collects or receives about you may be disclosed to the following persons:

Name of person/relation/organization

Name of person/relation/organization

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at **Texas Spine Consultants**.

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient (please specify):

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Texas Spine Consultants. You should contact the **PRIVACY OFFICIAL** or other authorized representative to terminate this authorization.

Potential for Re-disclosure

The person or organization to which health information is sent may be repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of patient—PRINT

Signature of patient

Date

Signature of patient representative

Relationship to patient

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a part of this practice) may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate officials.
6. TO federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions of law enforcement officials if you are inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issue in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to

Medical Records Dept., Texas Spine Consultants, 3900 Junius Street #705, Dallas, TX 75246.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Medical Records Dept., Texas Spine Consultants, 3900 Junius Street #705, Dallas, TX 75246. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice. You may ask us to give you a copy of this notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer, Texas Spine Consultants, 3900 Junius Street #705, Dallas, TX 75246. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice of permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Privacy Officer, Texas Spine Consultants, 3900 Junius Street #705, Dallas, TX 75246.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices.

Signature: _____

Print Name: _____

Date: _____

Name of Patient (if minor): _____

Texas Spine Consultants Prescription Policy

Texas Spine Consultants diagnoses and treats conditions of the spine. We may prescribe medications for you to help relieve the pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of medications. Texas Spine Consultants follows those laws.

Our policy:

1. Written prescriptions will not be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. In other words, do not change the frequency of the dose unless otherwise directed by a Texas Spine Consultants professional. If a change does occur, this will be noted in your chart.
3. Certain controlled substances such as Oxycontin, MS Contin and Percocet are written for a 30 day supply. It is necessary to make monthly follow up appointments in order to receive a refill. By law, controlled substance medications cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions cannot be refilled.
 - Sleep aids such as: Ambien
 - Anti-inflammatories such as: Vioxx, Bextra, Celebrex
 - Narcotics such as: Lortab, Vicodin, Darvocet, Hydrocodone
 - Muscle Relaxers such as: Soma, Robaxin, Flexeril
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will not be authorized at night, on weekends or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Texas Spine Consultants, please check your supply of medication. If you need a refill, please ask.
8. Refill requests for prescriptions not prescribed by a Texas Spine Consultants physician will not be authorized.
9. If you believe you may be pregnant, discover you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescription(s) refilled.

Patient

Date



Date: _____ Height: _____ Weight: _____
 Name: _____
 Last First M.I.
 DOB: _____ Age: _____

Kendall E. Carl, M.D.

Please complete this form carefully. Your answers will help us better understand your presenting problem and design the best treatment program for you.

Main Concern: _____

How long has this been an issue? _____

Was there a specific event that started it? yes no If yes, please explain: _____

USING SYMBOLS BELOW, MARK DRAWING ACCORDING TO YOUR PAIN. INCLUDE ALL AFFECTED AREAS (Please draw in your face):

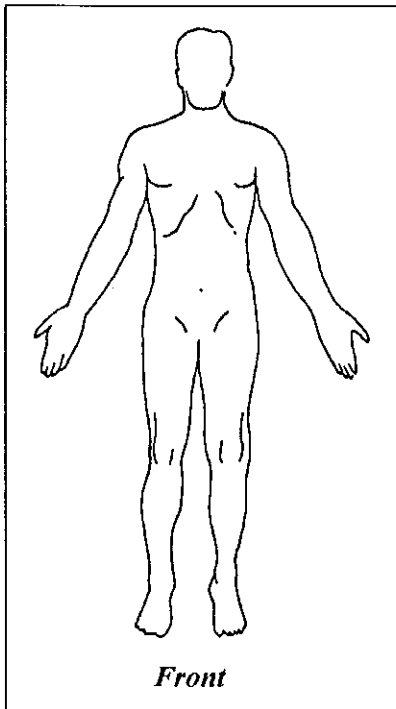
ache/sore: >>>
 cramping: ccc

dull: DDD
 pressure: ppp
 burning: BBB

sharp: sss
 tingling: xxx
 shooting: +++

throbbing: TTT
 pins/needles: ooo

numb: nnn
 stabbing: ///



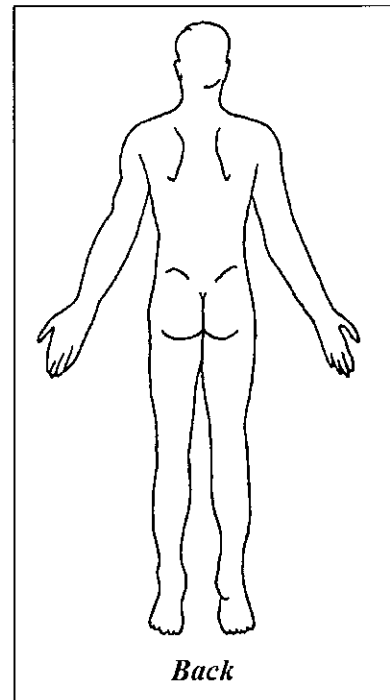
Neck Pain: Circle Severity Level
 0 1 2 3 4 5 6 7 8 9 10
 minor moderate severe

Pain in arm(s) compared to neck
 Worse than _____
 Same as _____
 Less than _____

Upper Back: Circle Severity Pain Level
 0 1 2 3 4 5 6 7 8 9 10
 minor moderate severe

Low Back Pain: Circle Severity Pain Level
 0 1 2 3 4 5 6 7 8 9 10
 minor moderate severe

Pain in leg(s) compared to back
 Worse than _____
 Same as _____
 Less than _____



Check / Circle / Highlight any that apply :
RATE YOUR USUAL PAIN:

NO PAIN 1 2 3 4 5 THE WORST PAIN IMAGINABLE

DOES PAIN COME ON:

- Suddenly
- Gradually

PAIN IS:

- Constant
- Good & bad days

PAIN IS WORST

- When I wake up
- After I have been active
- Before I go to sleep

ARE YOU GETTING

- Better
- Worse
- Unchanged

Are you working? yes no If not, when did you stop? _____

Is this problem the result of an on-the-job injury? yes no

Is this problem the result of a motor vehicle accident (MVA)? yes no If yes, please check, circle one of the following:

MVA/Driver (E812.0)

MVA/Passenger (E812.1)

Motorcyclist (E810.2)

Motorcycle/Passenger (E810.3)

MVA vs. Bike (E813.6)

MVA vs. Pedestrian (E814.7)

Pedestrian Hit By Car (E812.7)

Is this problem the result of a fall? yes no If yes, please check, circle one of the following:

At Home (E888.8)

Stairs (E880.9)

Chair (E884.2)

Commode (E884.6)

Sidewalk/Curb (E880.1)

Tree (E884.9)

Ladder (E881.0)

Scaffolding (E881.1)

Snow Skis (E885.3)

Snowboard (E885.4)

Inline Skate (E885.1)

Skateboard (E885.2)

Water Skis (E835.4)

Which **INCREASES** your pain/discomfort? Please check or circle.

Standing	Sitting	Walking	Bending forward	Bending backward
Lying on back	Lying on stomach		Lying on side	Rising from sitting
Coughing	Sneezing		Urination	Bowel movement

Which **DECREASES** your pain/discomfort? Please check or circle.

Standing	Sitting	Walking	Bending forward	Bending backward
Lying on back	Lying on stomach		Lying on side	Rising from sitting
Coughing	Sneezing		Urination	Bowel movement

What is the approximate amount of time you can perform the following activities?

Sit _____ minutes Stand _____ minutes Walk _____ minutes

Please check all of the treatments you have tried for your pain and then check the appropriate column:

	Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
<input type="checkbox"/>	Physical/Occupational Therapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heat/Ice		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Traction		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Injections (back or neck only)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	TENS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Ultrasound		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Brace or collar		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Massage		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Psychotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Chiropractic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had surgery for this pain? Yes ___ or No ___

If yes, what procedure? _____ When? _____

Did it Help? Yes ___ or No ___

MEDICATIONS: Circle the medication you are taking. Please list the names if you know them.

Antibiotics or Sulfa drugs Anticoagulants (blood thinners) High Blood Pressure Cortisone (steroids) Tranquilizers
Aspirin Insulin Digitalis/heart meds Nitroglycerin Hydrocodone Vicodin/Lortab Birth Control Meds
Soma Flexeril Coumadin/Warfarin Plavix HIV meds Robaxin Tylenol #3 Oxycontin Methadone
Fentanyl Patch Antidepressants Herbal Medications Vitamins Supplements Advil Aleve

What specific medications, by name, if you know them: (If you have a list already, please ask for us to copy for your chart)

Occupation _____

Highest Education Level _____

RECREATIONAL ACTIVITIES/EXERCISE/HOBBIES:

Running Walking Cycling Golf Yoga Treadmill Elliptical Machine Weightlifting
Aerobics class Other _____

Please do not write below this space

Physician has reviewed the form and acknowledges the findings:

Signature—Kendall E. Carl, MD