



Texas Spine
Consultants, LLP

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

Andrew E. Park, M.D.

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

Chief Complaint/Main Problem: _____

When did your current problem start? ____/____/____ (month/day/year)

Have you ever had similar problems before? yes no If yes, please explain: _____

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

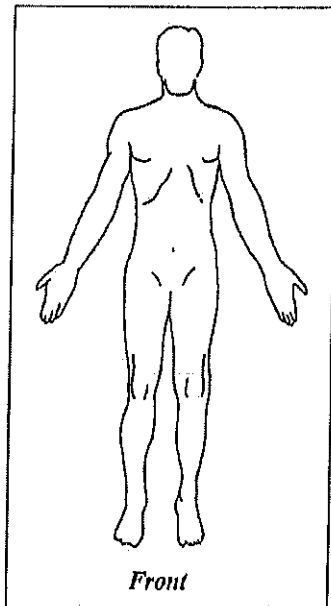
ache/sore: >>>
cramping: ccc

dull: DDD
pressure: ppp
burning: BBB

sharp: sss
tingling: xxx
shooting: +++

throbbing: TTT
pins/needles: ooo

numb: nnn
stabbing: ///



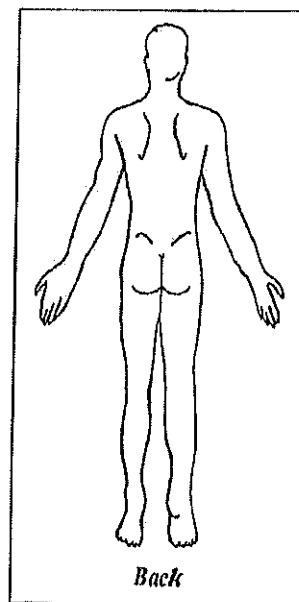
Neck Pain: Circle Severity
Pain Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

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

ARE YOU GETTING:

- Better
 Worse

ARE YOU USUALLY IN:

- Mild discomfort
 Moderate discomfort

PAIN IS WORSE IN THE:

- Morning (6am - Noon)
 Afternoon (1 - 8)

Unchanged Severe discomfort Night (8 pm – 6am)

DOES PAIN COME ON:

Suddenly
 Gradually

PAIN IS:

Constant
 Good & bad days

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)
 Motorcyclist (E810.2)
 MVA vs. Bike (E813.6)

MVA/Passenger (E812.1)
 Motorcycle/Passenger (E810.3)
 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)
 Sidewalk/Curb (E880.1)
 Snow Skis (E885.3)
 Water Skis (E835.4)

Stairs (E880.9)
 Tree (E884.9)
 Snowboard (E885.4)

Chair (E884.2)
 Ladder (E881.0)
 Inline Skate (E885.1)

Commode (E884.6)
 Scaffolding (E881.1)
 Skateboard (E885.2)

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"/> |

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin and heart medications.

| Name | Strength | Frequency | Name | Strength | Frequency |
|------|----------|-----------|------|----------|-----------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |

Pharmacy Name/Number: _____

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:



Texas Spine Consultants, LLP

| | | | | | | |
|--|---|--|--|--|-----------------------------------|---|
| PLEASE PRINT | | PATIENT INFORMATION | | Sex | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| NAME - Last, First, Middle Initial: | | | | | | |
| Age: | Birth date: | Home Ph: | Mobile Ph: | Email: | | |
| ADDRESS - Number and Street: | | | City: | State: | Zip: | |
| Employer: | Occupation: | Drivers Lics. No.: | Soc. Sec. No.: | | | |
| Employer Address: | City: | State: | Zip: | Business Ph: | | |
| Relationship to Responsible Party | <input type="checkbox"/> Self | <input type="checkbox"/> Husband | <input type="checkbox"/> Wife | <input type="checkbox"/> Child | <input type="checkbox"/> Other | |
| Marital Status: | <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widow/Widower | | |
| Ethnicity: | <input type="checkbox"/> African American | <input type="checkbox"/> American Indian/Eskimo | <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other <input type="checkbox"/> No Response |
| NEAREST LOCAL RELATIVE OR FRIEND (NOT LIVING WITH YOU) | | | | | | |
| Name: | Relationship: | Home Ph: | Business Ph: | | | |
| ADDRESS - Number and Street: | | | City: | State: | Zip: | |
| MEDICAL INFORMATION | | | | | | |
| IMPORTANT - Please list all allergies to medications of any kind, or write none: | | | | | | |
| | | | | | | |
| | | | | | | |
| PRESENT COMPLAINT: <input type="checkbox"/> Neck <input type="checkbox"/> Upper Back <input type="checkbox"/> 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 | | | |
| INSURANCE INFORMATION | | | | | | |
| PRIMARY CARRIER | | | | | | |
| Insurance Company Name: | | | Address: | | | |
| Employer, If Group Coverage: | | | Policy No.: | Group No.: | | |
| Subscriber's Name: | Date of Birth: | Patient Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | | |
| SECONDARY CARRIER | | | | | | |
| Insurance Company Name: | | | Address: | | | |
| Employer, If Group Coverage: | | | Policy No.: | Group No.: | | |
| Subscriber's Name: | Date of Birth: | Patient Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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: _____



TEXAS SPINE CONSULTANTS, L.L.P.
17051 DALLAS PARKWAY
SUITE 400
ADDISON, TX 75001

PHONE: (214) 370-3535
FAX: (214) 370-0004

DISCLOSURE AUTHORIZATION FORM

| | | |
|---------------|--------|------|
| PATIENT NAME: | | |
| DOB: | SSN: | |
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |

I authorize Texas Spine Consultants, L.L.P ("Practice") to disclose my protected health information to those listed below (specify name, relationship and contact information if applicable)

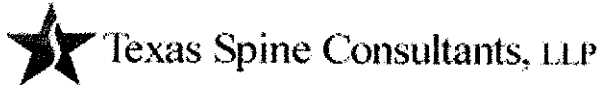
Please let us know how you would like to receive your messages

- Text
- Email
- Phone

The protected health information to be disclosed is

- Entire medical record
- Only information relating to _____
- Only information occurring from _____ to _____
- Other (specify) _____

The protected health information is being disclosed for the following purpose (write "at my request" if there is no specific purpose or you do not wish to specify the purpose)



TEXAS SPINE CONSULTANTS, L.L.P.
17051 DALLAS PARKWAY
SUITE 400
ADDISON, TX 75001

PHONE: (214) 370-3535
FAX: (214) 370-0004

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that, except as otherwise provided in this authorization, the Practice may use or disclose my protected health information in accordance with Practice's Notice of Privacy Practices.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

I understand that the Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE)

DATE

PRINTED NAME

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

The authorization provided with this signature will expire in 90 days. Texas Spine Consultants, L.L.P. will require an updated form after this period.

Texas Spine Consultants
TSC Policies & Consent to Treat
(Please initial all sections, sign and date form)



Initials _____ **FINANCIAL RESPONSIBILITY AGREEMENT:**

I agree to assign insurance benefits to Texas Spine Consultants. We bill all primary insurance companies that we are contracted with as "network" providers as a courtesy to our patients.

I acknowledge full financial responsibility for services rendered by Texas Spine Consultants and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility.

I further authorize and request all insurance payments be made directly to Texas Spine Consultants.

Initials _____ **CONSENT OF TREATMENT:**

I authorize Texas Spine Consultants Physicians and the Physician's Assistants to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies.

Initials _____ **PHYSICIAN ASSISTANT CONSENT:**

This facility has on staff Certified Physician Assistants (PA-C) to assist in the delivery of orthopedic medical care. I acknowledge a Physician Assistant is not a physician. A PA-C is licensed by the state medical board and under the supervision of a physician can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does NOT require constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. A list of services may be provided that are within the scope of practice for a PA-C upon request. I hereby acknowledge the above information and consent to the services of a Certified Physician Assistant for my health care needs. I understand that at any given time I can request to see the Physician instead of the PA-C.

Initials _____ **MEDICATION POLICY CONSENT:**

I authorize Texas Spine Consultants Physicians and the Physician's Assistants to obtain a medication history and/or list of current medications via my pharmacy for medical records.

Initials _____ **HIPAA Policy:**

I have read and acknowledge the HIPAA Policy.

Initials _____ **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. If you miss your scheduled appointment you will receive a \$25.00 charge at your next scheduled appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

Initials _____ **Returned 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.

Initials _____ **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.

Signature: _____

Date: _____

PHYSICIAN FINANCIAL DISCLOSURE FORM

Pursuant to Federal and Texas Law, please note that Dr. Andrew Park has either an ownership interest in or a financial/consulting agreement with the following entities:

Allez Spine aka Phygen
Alphatec
Arapaho Financial, LLC
Cobalt Medical Opportunity Fund I
DiFusion
Houston Lab
Methodist Hospital for Surgery
Methodist Hospital Real Estate
Methodist MOB
MONRV, PLLC
National Neuromonitoring
Neuro Pro, LLC
New Era Orthopedics
Opargo
PDP Holdings
Pine Creek Medical Center
Play Safe Skin Care, LLC
Safe Guidance, LLC
Saint Camillus Medical Center
St. Teresa Medical, Inc.
Titan Spine
Ulrich USA
Ultra-Management, LLC
Wade Pain
Zimmer Spine

You may be referred to a facility on the above list for services related to your care. Also, based on clinical indications equipment from or services from some of these companies may be used during your surgery. Dr. Andrew Park may receive direct or indirect remuneration. If you have questions regarding this page, please discuss with Dr. Park directly.

ACKNOWLEDGEMENT

I acknowledge and agree that I have reviewed this disclosure in its entirety which has been given to me at the time of initial contact. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE)

DATE

PRINTED NAME

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)