Texas Spine Consultants, LLP

Date: _____ Height: _____ Weight: _____

Name: _____
Last First M.I.

DOB: _____ Age: _____

Robert G. Viere, 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.

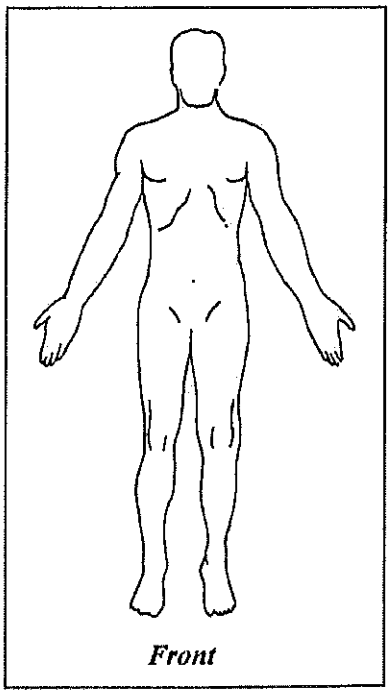
Chief Complaint/Main Problem: _____

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: **>>>**	dull: **DDD**	sharp: **sss**	throbbing: **TTT**	numb: **nnn**
cramping: **ccc**	pressure: **ppp**	tingling: **xxx**	pins/needles: **ooo**	stabbing: **/ / /**
	burning: **BBB**	shooting: **+++**		



Front

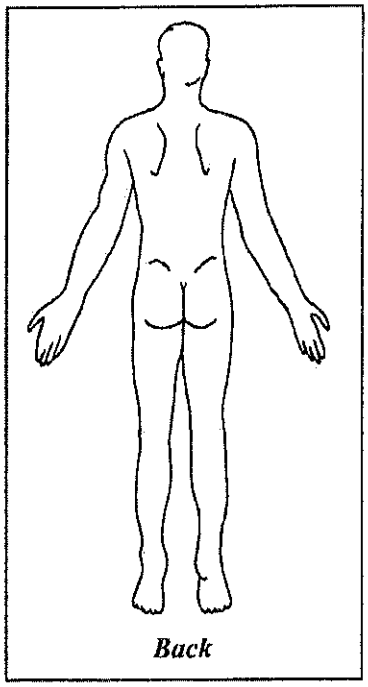
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

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 _____



Back

CHECK/CIRCLE/HIGHLIGHT ANY THAT APPLY

ARE YOU GETTING:
- ☐ Better
- ☐ Worse
- ☐ Unchanged

ARE YOU USUALLY IN:
- ☐ Mild discomfort
- ☐ Moderate discomfort
- ☐ Severe discomfort

PAIN IS WORSE IN THE:
- ☐ Morning (6am – Noon)
- ☐ Afternoon (1 – 8)
- ☐ 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) **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
☐	Physical/Occupational Therapy		☐	☐	☐
☐	Heat/Ice		☐	☐	☐
☐	Traction		☐	☐	☐
☐	Injections (back or neck only)		☐	☐	☐
☐	TENS		☐	☐	☐
☐	Ultrasound		☐	☐	☐
☐	Brace or collar		☐	☐	☐
☐	Massage		☐	☐	☐
☐	Psychotherapy		☐	☐	☐
☐	Chiropractic		☐	☐	☐
☐	Other _____		☐	☐	☐

Have you had surgery for this pain? Yes___ or No ___If yes, what procedure? _____

When? _____ Did it Help? Yes___ or No___

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:

_____
Signature—Robert G. Viere, MD

Texas Spine Consultants, LLP

PLEASE PRINT		PATIENT INFORMATION	Sex ☐ Male ☐ 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 ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Other			
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower			
Ethnicity: ☐ African American ☐ American Indian/Eskimo ☐ Asian or Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Other ☐ 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: ☐ Neck ☐ Upper Back ☐ Lower Back Date of injury/onset of symptoms:

Were X-Rays taken? ☐ Yes ☐ 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 ☐ Self ☐ Spouse ☐ Child ☐ 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 ☐ Self ☐ Spouse ☐ Child ☐ Other	

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION:

1. 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.
2. 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.
3. 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.
4. 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.
5. The foregoing information is true and correct to the best of my knowledge.

Date: _____ Patient or Guardian Signature: _____

Texas Spine Consultants

TSC Policies & Consent to Treat

(Please initial all sections, sign and date form)

Texas Spine Consultants, LLP

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: _____

Texas Spine Consultants, LLP

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

- o Text
- o Email
- o Phone

The protected health information to be disclosed is

- o Entire medical record
- o Only information relating to _____
- o Only information occurring from _____ to _____
- o 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, LLP

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.

PHYSICIAN FINANCIAL DISCLOSURE FORM

Pursuant to Federal and Texas Law, please note that Dr. Robert Viere has financial/consulting agreements with the following entities:

- Baylor Uptown Medical Center
- Medoc/Animo LLC
- Methodist Hospital for Surgery
- Methodist Office Building
- National Neuromonitoring
- Neuro Pro, LLC
- New Era Orthopaedics
- Safe Guidance LLC
- Ultra Management, LLC
- Wade Pain Group

If you are referred to any of these entities or any other entity related to Texas Spine Consultants, L.L.P., Dr. Robert Viere may receive direct or indirect remuneration. If you have any questions regarding this paragraph, please discuss them with Dr. Viere 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)