Texas Spine Consultants, LLP

Cameron Carmody MD
New Patient/New Complaint History Form

Date: _____ Patient Name: _____ DOB: _____

Age: _____ Male: _____ Female: _____ Height: _____ Weight: _____

Pharmacy: _____ Phone: _____

Referral Source: _____ Primary Physician: _____

Chief Complaint:

Neck ____ Upper Back ____ Mid Back ____ Low Back ____ Buttocks ____ Tail Bone ____

Right Arm ____ Left Arm ____ Right Leg ____ Left Leg ____ Other: _____

History of Present Illness:

1. Is your problem the result of :
Injury ____ No Injury ____ Injury at Work ____ Auto Accident ____ Sports Injury ____

2. How long have the symptoms been present: _____
Describe the onset: Sudden _____ Chronic (> 3 months) _____ Date of onset: _____

3. Have you had prior surgery to the area of your chief complaint: _____ yes _____ no
If so, when and what procedure was performed: _____

4. Do the symptoms wake you from sleep? ____ yes ____ no

5. What is the timing of your symptoms? ____ constant ____ intermittent (comes and goes)

6. Is the problem getting better or worse? ____ getting better ____ getting worse ____ unchanged

7. What makes the symptoms worse (-) or better (+)?
____ Standing ____ Sitting ____ Walking ____ Bending forward ____ Bending backward
____ Lying on back ____ Lying on stomach ____ Lying on side ____ Rising from a chair ____ Coughing
____ Sneezing ____ Urination ____ Bowel movement _____ Other

8. Is there any weakness or giving way? ____ yes ____ no If so, where: _____

Patient Name: _____

Prior Testing/Treatment

Have you had any tests for this problem?
____ None ____ X-rays ____ MRI ____ CT ____ EMG ____ Injection(s) ____ Other

Mark any prior treatment you have had for this problem:

				Dates
Ice	____ Improved	____ worsened	____ unchanged	_____
Heat	____ Improved	____ worsened	____ unchanged	_____
Rest	____ Improved	____ worsened	____ unchanged	_____
Anti-Inflammatories	____ Improved	____ worsened	____ unchanged	_____
Muscle Relaxers	____ Improved	____ worsened	____ unchanged	_____
Pain Medicine	____ Improved	____ worsened	____ unchanged	_____
Chiropractor	____ Improved	____ worsened	____ unchanged	_____
Physical Therapy	____ Improved	____ worsened	____ unchanged	_____
Home Exercises	____ Improved	____ worsened	____ unchanged	_____
Surgery	____ Improved	____ worsened	____ unchanged	_____
Injections	____ Improved	____ worsened	____ unchanged	_____

Injection type and date(s): _____

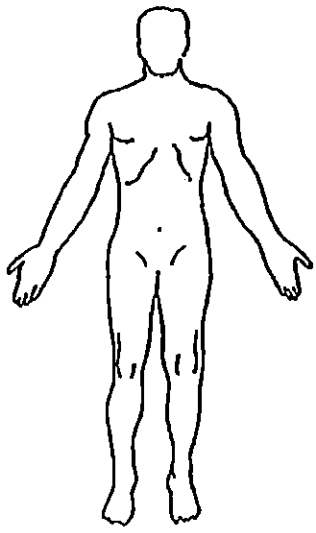
Rate your pain with 0 = no pain and 10 = severe pain: Neck (N) Upper Back (T) Lower Back (B)

_____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

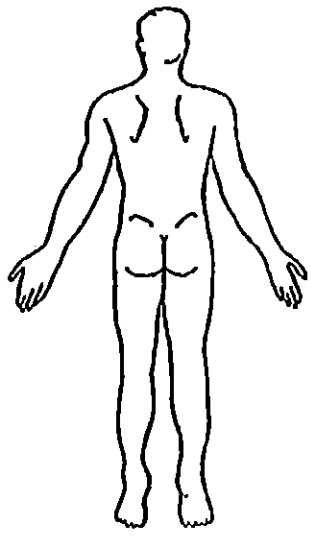
Pain in the arm(s) compared to the neck: _____ worse _____ same _____ less
Pain in the leg(s) compared to the back: _____ worse _____ same _____ less

Using the key below, please mark the drawing to describe your symptoms:

Ache/Sore: >>>> Dull: DDDD Sharp: SSSS Throbbing: TTTT Numb: NNNN Cramping: CCCC
Pressure: PPPP Tingling: xxxx Pins/Needles: oooo Stabbing: //// Burning: BBBB Shooting: ++++



Front



Back

Name of Medication	Dosage	Directions

Patient Date

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, 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.

Texas Spine Consultants, LLP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Texas Spine Consultants Privacy Officer at (214) 370-3535.

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") is a federal statute that requires that all protected health information used or disclosed by Texas Spine Consultants, L.L.P. ("**Practice**") in any form, whether electronically, on paper, or orally, are kept confidential. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services ("**PHI**"). As required by HIPAA, this Notice of Privacy Practices ("**Notice**") describes how the Practice is required to maintain the privacy of your PHI and how it may use and disclose PHI. It also describes your rights to access and control your PHI.

Use and Disclosures of PHI

Your PHI is subject to use or disclosure by the Practice's physicians, office staff, employees or other third parties that are involved in your care and treatment, including electronic disclosures. It is the Practice's responsibility to ensure that all uses or disclosures are made in accordance with HIPAA and as further detailed below in this Notice.

Required Disclosures: The Practice is required to disclose PHI to you directly when requested in accordance with your rights described below or the Department of Health and Human Services when investigating or determining the Practice's compliance with HIPAA. **Family Members:** The Practice may disclose relevant PHI with family members involved in your health care if you do not object to sharing of the information (i.e. appointment reminders).

No Authorization Required

Treatment: The Practice will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party, consultation between physicians relating to your care, or your referral for health care to another physician. For example, the Practice may share results of diagnostic imaging in consultation with its staff or other healthcare professionals to develop a treatment plan.

Payment: The Practice will use and disclose your PHI, as needed, as it relates to payment for your health care services. This may include obtaining reimbursement information for the health care services you are receiving, confirming coverage or co-pay amounts under your health plan, billing and collecting from you, an insurance company, or a third party for your health care services, or obtaining precertification or preauthorization for specific health care services. For example, the Practice may send a claim for payment to your insurance company and that claim may contain PHI such as a code describing your diagnosis or medical treatment.

Health care Operations: The Practice will use and disclose your PHI, as needed, in order to support the business operations of the Practice. These activities include, but are not limited to, quality assessment and improvement activities, auditing functions, cost-management analysis, or training. For example, the Practice may disclose your PHI to medical school students that see patients at the office. In addition, the Practice may use a sign-in sheet at the registration desk where you will be asked to sign your name. The Practice may also call you by name in the waiting room when your physician is ready to see you. The Practice may use or disclose your PHI, as necessary, to contact you to remind you of your appointment (including to family members).

Business Associates: The Practice will use and disclose your PHI, as needed, to business associates. There are some services provided in the Practice through contracts with business associates (i.e., the Practice may disclose PHI to a company who bills insurance companies on the Practice's behalf to enable that company to assist in obtaining payment for the healthcare services provided). To protect your PHI the Practice will require its business associates to appropriately safeguard the information.

Other Uses or Disclosures: The Practice may also disclose your PHI for the following additional purposes without your authorization: when required by law (statute, law enforcement, judicial or administrative order); for public health activities (to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc., as required by law); when there is a belief you are a victim of abuse, neglect, or domestic violence; for health oversight activities (to public agencies or legal authorities charged with overseeing the health care system, government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights); for judicial or administrative proceedings (pursuant to court order or subpoena if assurances are received); for law enforcement purposes; to funeral directors, coroners, or organ procurement organizations; for research; if there is a belief of a serious threat to health and safety; for certain essential government functions (national security, military, etc.); disaster relief efforts; to comply with workers' compensation; and as part of a limited data set pursuant to a data use agreement for research, public health or health care operations.

Authorization Required

Any uses or disclosures outside the scope described above will be made only with your written authorization. Most uses or disclosures of psychotherapy notes, and of PHI for marketing purposes and the sale of PHI require an authorization. You may revoke such authorization in writing at any time and the Practice is required to honor and abide by that revocation, except to the extent that it has already taken actions relying on your authorization.

Your Rights for PHI

You have the right to obtain a paper copy of this Notice and you may exercise any of the rights described below by contacting the Practice and requesting to speak with the Privacy Officer.

You have the right to make reasonable requests to receive confidential communications of your PHI from the Practice by alternative means or at alternative locations.

You have the right to request restrictions on uses and disclosures of PHI for treatment, payment or healthcare operations, or disclosures to family members, other relatives, close personal friends, or any other person identified by you. Generally, the Practice is not legally required to agree to a requested restriction. However, if the request is made to restrict disclosure to a health plan for purposes of carrying out Payment or Health Care Operations and the PHI pertains solely to a health care item or service for which you have paid out of pocket in full, the Practice is legally required to agree to the requested restriction.

You have the right to read or obtain a copy of your PHI or choose to get a summary of your PHI in lieu of a copy. There are some reasons why the Practice may deny such a request which will be delivered to you in writing stating the reason. If a summary or a copy of your PHI is provided, you may have to pay a reasonable fee.

You have the right to request the Practice to amend or correct your PHI to the extent legally and ethically permissible. If the Practice denies the request, it will do so in writing and you will have the ability to file a statement of disagreement.

You have the right to receive an accounting of the disclosures of PHI by the Practice in the last six years but it will not include certain disclosures including those made for treatment, payment, healthcare operations or where you specifically authorized a use or disclosure.

Complaints

You have recourse if you feel that the privacy of your PHI has been violated. If you feel there has been a violation, you have the right to file a complaint by submitting your complaint in writing by mail to the address above or by fax at the number above. You may also contact the Practice directly by telephone. For all complaints, please ask for or direct attention to the Privacy Officer. There will be no retaliation for filing a complaint. You may also file a complaint with or contact the Department of Health and Human Services, Office for Civil Rights at: Office of Civil Rights, DHHS, Region VI – Dallas by mail at 1301 Young Street, Suite 1169, Dallas, Texas 75202, by telephone at (214) 767-4056 or (214) 767-8940 (TDD), or by facsimile at (214) 767-0432.

Effective Date

The Practice is required by law to maintain the privacy of your PHI, to provide you with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. This Notice is effective as of February 7,2019 The Practice reserves the right to change the terms of this Notice and to make any such changes or amendments effective for all PHI that it maintains. The Practice will periodically post from time to time, and you may request a written copy of, any updated versions of this Notice.

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. Cameron Carmody has financial/consulting agreements with the following entities:

- 4 Web Medical
- Baylor Scott & White, Frisco
- Globus Medical (Royalties)
- Methodist Hospital for Surgery
- Neuro Pro, LLC
- Safe Guidance Neuromonitoring
- Simplify Artificial Disc

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