



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):

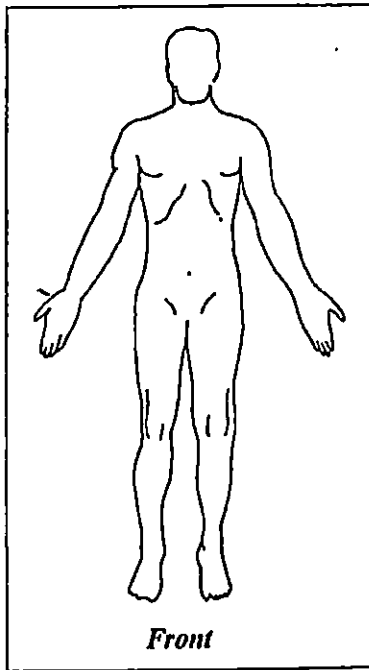
ache/sore: >>>
cramping: ccc

dull: DDD
pressure: ppp
burning: BBB

sharp: sss
tingling: xxx
shooting: +++

throbbing: TTT
pins/needles: ooo

numb: nnn
stabbing: ///



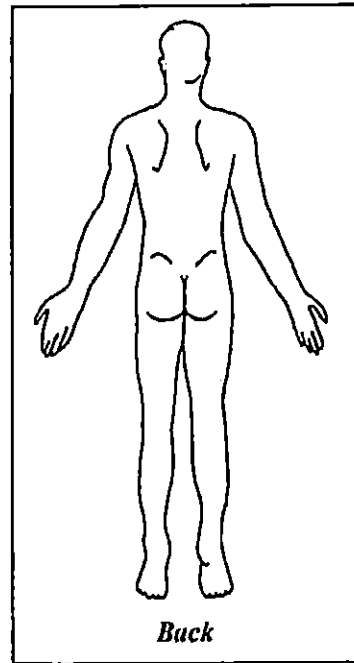
Neck Pain: Circle Severity Level
 0 1 2 3 4 5 6 7 8 9 10
 minor moderate severe

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

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)
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 sitting		Lying on stomach	Lying on side	Rising from
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: 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	<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: 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:

- 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, within 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: _____



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: _____



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

- 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.

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)