The Spine Institute of Southeast Texas

10907 Memorial Hermann Dr. Suite 320
Pearland, Tx 77584
P:713-987-7760 F:832-288-5837

Today's Date: [Date]	PCP:

PATIENT INFORMATION

Last name: First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address: (Street, city, state and zip)

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer: Phone Number:	Personal Email:

How/who referred you to our office? ◯ [Doctor's name]

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Spine Institute of Southeast Texas or insurance company to release any information required to process my claims.

Patient/Guardian signature: Date

The Spine Institute of Southeast Texas

Thomas L. Jones, MD

NEW PATIENT Name:_____ Date of visit: _____

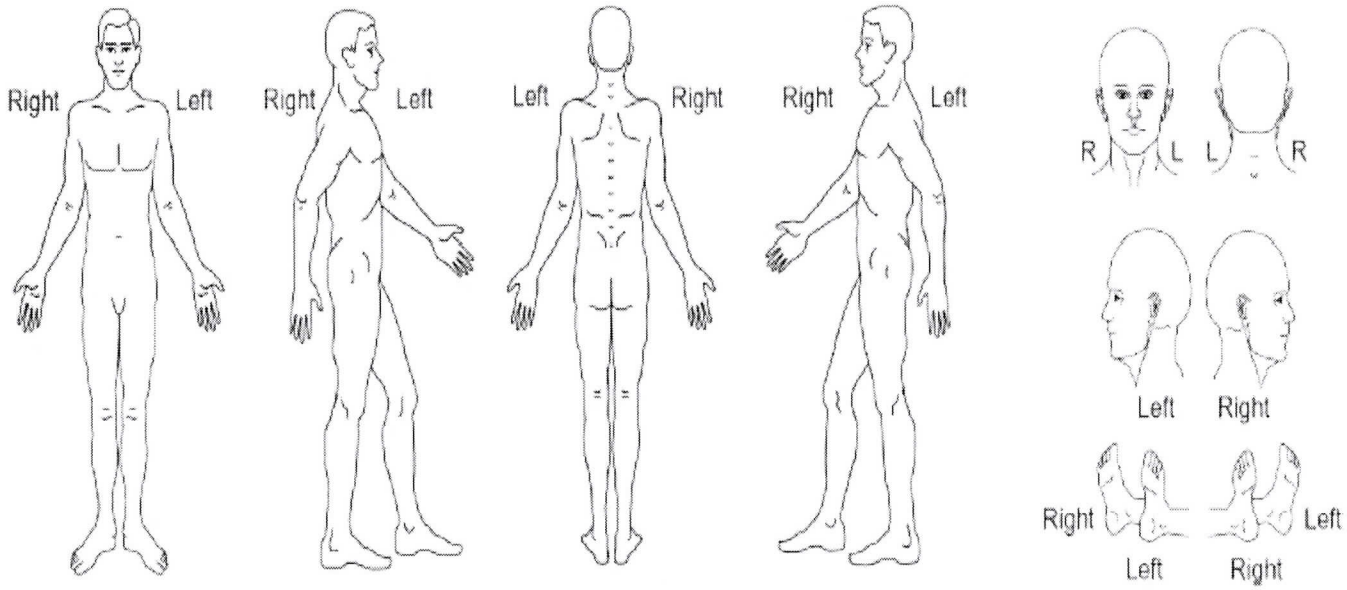
Pain/Chief Complaint: _____

How long have you had this pain? _____

Has the pain recently changed in intensity and/or character? **YES or NO** If YES, please describe:

_____

Where is it located? (Please mark spot of pain with an X)



PAIN SCALE

Over the last week, rate: (please circle answer)

	None										Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office Use Only:

Vital Signs

Temp: _____ BP: _____SP:____

Weight: _____Height:_____

Pulse: _____

Resp: _____

Taken by: _____

What makes the pain better? (Circle all that apply)

Heat Cold Walking Sitting Standing Massage Resting in bed Medications Other: _____

What makes the pain worse? (Circle all that apply)

Heat Cold Walking Sitting Standing Bending down Coughing Other: _____

The Spine Institute of Southeast Texas

How would you describe your pain? (Circle all that apply)
Aching Penetrating Stabbing Tender Miserable Twisting Tiring Shooting Numb Sharp Burning Pressure Throbbing Nagging Gnawing Unbearable Dull Tingling Shocking Other: _____

What other symptoms do you have: (Circle all that apply)
Fatigue Nausea Depression Anxiety Drowsiness Difficulty Thinking Shortness of Breath Insomnia Poor Appetite Feeling of Well-Being

How would you describe the cause of your symptoms? (Circle all that apply)
Increasing Worsening Gradually Worsening Rapidly Worsening
Decreasing Gradually Improving Without Change

Pharmacy Name: _____ **Phone:** _____

CURRENT MEDICATIONS:

Medications	Dose	Frequency

ALLERGY: _____
Reaction: _____

<u>Other Pain Treatments:</u> (Circle all that apply)
Physical Therapy Nerve Blocks Back Brace
Other: _____

How much pain relief have pain treatments and medicines (in total) provided for you in this past week?
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Past Medical History: (Circle all that apply) Diabetes High Blood Pressure Seizure Stroke Heart Attacks Kidney Problems Liver Problems Bleeding Problems Cancer Infections
Other: _____

Past Surgery History: (Past surgeries with dates) _____
_____
_____

Family History of Cancer or Painful Conditions: _____
_____

Marital Status: Married Single Separated Divorced
Children (#): _____ **Occupation:** _____

Smoking: YES or NO or Quit **Pack per day:** _____ **How long have you smoked?** _____

Alcohol Use: Never Occasionally Frequently **Drinks per day:**

_____

History of Drug Abuse: YES or NO If yes, please elaborate: _____

Is there anything specifically that we can help you with today?

_____

_____

PREVIOUS TREAMENT

We need to know about the treatments you have may have already received for your current back/neck pain. If you have had a treatment below, did it make your condition better or worse?

Chiropractic Care	☐ Better	☐ Worse
Physical Therapy	☐ Better	☐ Worse
Injections	☐ Better	☐ Worse
Psychological Consultation	☐ Better	☐ Worse
Other _____		

For your current back/neck pain, please mark the boxes for the timeframe in which any tests were done.

	< 6 months	**< 12 months**
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelograms	☐	☐
Discogram	☐	☐
EMG/NCV (nerve test)	☐	☐

Have you ever had surgery on your back or neck? **YES** **NO**

IF YES, please complete the following:

1) Type of Surgery_____ Surgeon_____
   Did it make your pain: ☐BETTER ☐WORSE
2) Type of Surgery_____ Surgeon_____
   Did it make your pain: ☐BETTER ☐WORSE
3) Type of Surgery_____ Surgeon_____
   Did it make your pain: ☐BETTER ☐WORSE

Do you have any of the following problems?

Is your pain worse at night?	☐ YES	☐ NO
Does your pain awaken you from sleep?	☐ YES	☐ NO
Does coughing affect your pain?	☐ YES	☐ NO
Do your legs tire or hurt if you walk too far?	☐ YES	☐ NO
If YES, how far can you walk? _____		
Is this relieved by resting your legs?	☐ YES	☐ NO
Is this relieved by bending forward?	☐ YES	☐ NO

Bladder Control: ☐ No Problem ☐ Can't Empty Bladder ☐ Loss of Control (Accidents)

Bowel Control: ☐ No Problem ☐ Constipation ☐ Loss of Control (Accidents)

The Spine Institute of Southeast Texas

Payment Policy and Patient Responsibility
Consent Form

Thank you for choosing The Spine Institute of Southeast Texas. We are committed to providing you quality and affordable health care. Please read the following policies and sign below in the space provided. A copy will be provided to you upon your request.

1) **INSURANCE** Knowing your insurance billing information and benefits is your responsibility. Please contact your insurance company with any questions you may have regarding eligibility and covered services.
2) **CO-PAYMENTS** All co-payments are patient responsibility and must be paid at the time of service. This arrangement is part of the contract between you and your insurance company.
3) **DEDUCTIBLES & CO-INSURANCE** All deductibles and co-insurance amounts are patient responsibility. This arrangement is part of the contract between you and your insurance company.
4) **NON-COVERED SERVICES** Please be aware that some or all of the services provided to you during your visit may not be covered by your insurance company. Any non-covered charges are patient responsibility. Please call your insurance carrier to appeal any non-covered charges.
5) **PROOF OF INSURANCE** All patients must complete the patient registration form before receiving any services through our facility. We also require a copy of a valid photo ID, such as state license, and a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim in full.
6) **CLAIMS SUBMISSION** Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims to both primary and secondary insurance. Some insurance companies require patients to submit information directly, and if so, this is your responsibility. Please be aware that the balance of the claim is your responsibility if your insurance company does not pay.
7) **COVERAGE CHANGES** It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failing to do so may result in unpaid claims and you may be responsible for the balance of the claim in full.
8) **UNINSURED/SELF-PAY PATIENTS** If you are seeking medical services at our facility and do not have insurance, a minimum deposit is required for each visit - **$300.00 for new patient appointments and $200.00for established patient appointments**.
9) **MOTOR VEHICLE ACCIDENT (MVA)** If you are receiving treatment as a result of an MVA, it is your responsibility to provide us the claim information which will then be verified with the insurance company prior to your visit. If we are unable to verify the claim information and you do not have regular medical insurance, you will be responsible for paying as an uninsured/self-pay patient until verification is made. If your claim in denied, we will bill your regular medical insurance, if any, and you will be required to pay all amounts not covered by your medical insurance.
10) **WORKERS COMPENSATION (WC)** If you are receiving treatment for a work related injury, it is your responsibility to provide us the claim information, which will be verified prior to your appointment with the insurance company, and accurately complete an 827 form which we will provide. If we are unable to verify the claim information or do not receive the completed 827 form and you do not have regular medical insurance, you will be responsible for paying as an uninsured/self-pay patient until verification is made. If your claim is denied, we will bill your regular medical insurance carrier, if any, pursuant to ORS 656.313and you will be required to pay all amounts not covered by your medical insurance.

11) **PRESCRIPTION REFILLS** If you are in need of a prescription refill, you must call your pharmacy at least 48 hours prior to running out of your medication. If you have no refills remaining, your pharmacy will contact us directly to request additional refills. Please note, our on-call providers may not be able to refill medications during evening and weekend hours.

12) **STATEMENTS** Patient statements are mailed monthly and payment is required upon receipt of your statement. If your account is over 30-days past due and arrangements for payment have not been made, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will be accepted after satisfactory arrangements have been made with our billing department. If balances remain unpaid, we may refer your account to a collection agency. Accounts with small balances under $10.00 will not have statements sent and will be collected at the patient's next visit.

13) **RETURNED CHECKS** If you pay with a check and your check is returned, your account will be charged a $30.00 fee which you will be responsible for along with the amount of the payment.

14) **MISSED, CANCELLED, & RESCHEDULED APPOINTMENTS** We require a 24-hour notice on all appointments cancellations and reschedules. Our policy is to charge a $25.00 fee billed directly to the patient or responsible guardian for missed appointments and failure to cancel or reschedule more than 24 hours in advance. The $25.00 fee must then be paid prior to receiving additional services through our facility. If you fail to keep an appointment due to unforeseen circumstances, please discuss this with our clinic manager or billing department. After two missed appointments or cancellations/reschedules without 24 hour advance notice, your account will be reviewed for possible discharged from our facility.

15) ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with and assign directly to Thomas Jones II, M.D. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submissions.

16) **TREATMENT AUTHORIZATION** I authorize Thomas Jones II, M.D. to give me reasonable and proper medical care by today's standards.

17) **APPOINTMENT & VOICEMAIL AUTHORIZATION** I acknowledge that I have today received the Notice of Privacy Practices from this practice. I understand that routine protocol in the office includes: confirmation messages may be left on answering machines, voice mail, or with another individual. I understand that I will be charged a $25.00 missed appointment fee if my appointment is not cancelled or rescheduled within 24 hours of my scheduled appointment time.

18) **MEDICARE AUTHORIZATION** I request that payment of authorized Medicare benefits be made on my behalf to Thomas Jones II, M.D. for any services furnished me by physicians of this group. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. The physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

19) PHOTOGRAPHY CONSENT FORM/ RELEASE I, (print name) _____, hereby grant permission to The Spine Institute of Southeast Texas representatives, to take and use: photographs and/or digital images of me for use in news releases and/or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of The Spine Institute of Southeast Texas.

"I acknowledge that I have read, understand, and will follow all policies and responsibilities stated above. I acknowledge that I am financially responsible for all charges for services rendered. If it becomes necessary to effect collections of any amount owned on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I also hereby authorize The Spine Institute of Southeast Texas to release information necessary to secure payment."

_____

Patient Name (Print)

_____ _____

Patient or Legally Authorized Representative Signature Date

_____ _____

Legally Authorized Representative(Print) Relationship to Patient

FORM OF PHYSICIAN DISCLOSURE

NOTICE TO PATIENTS

As required by Section I 02.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

National Neuromonitoring Services
Alliance MRI
Houston Physicians Hospital
Altus Houston
USPI Medical Center

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

_____

Patient Name /Date:

The Spine Institute of Southeast Texas

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

D 2 years prior from last date seen
D Dates Other: _____
D Specific Information Requested:
_____

The purpose of disclosure is:

D Change of Insurance or Physician
D Continuation of Care (e.g., VA Med Ctr)
D Referral
D Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Dr.Thomas Jones

Address: 10907 Memorial Hermann Dr. #320

City, State, Zip: Pearland, Texas 77584

Fax: 832-288-5837 **Phone: 713-987-7760**

D **Please mail records.**
D **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**_____.
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.**I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

X_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative Relationship / Capacity to patient

_____
Address and telephone number of authorized representative