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.

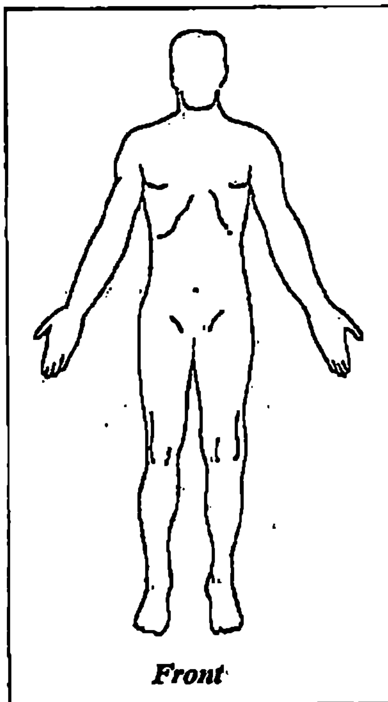
Chief Complaint/Main Problem: ______________________________________

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: ///



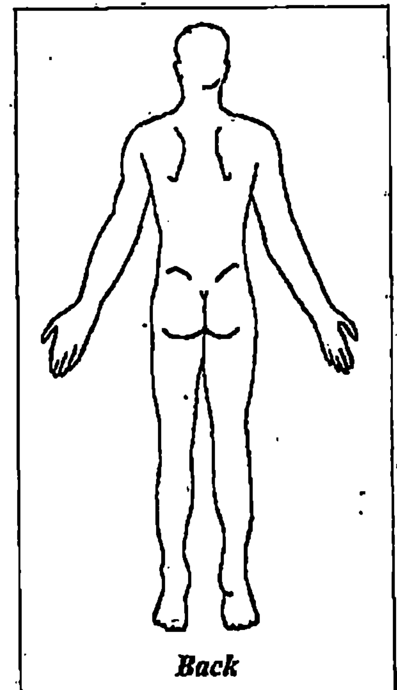
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

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) **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

PHYSICIAN FINANCIAL DISCLOSURE FORM

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

- Methodist Hospital for Surgery
- Methodist Office Building
- National Neuromonitoring
- Neuro Pro, LLC
- New Era Orthopaedics
- Safe Guidance LLC
- TSC Anesthesia
- Ultra Management, LLC

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)

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: ______________________________

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Texas Spine Consultants, LLP at 214-370-3535.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

______________________________	______________________________
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
______________________________	______________________________
Witness Signature	Date

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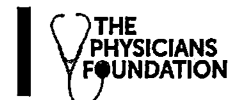

NOTICE: This information is provided as a commentary on legal issues and is not intended to provide advice on any specific legal matter. This information should NOT be considered legal advice and receipt of it does not create an attorney-client relationship. **This is not a substitute for the advice of an attorney.** The Office of the General Counsel of the Texas Medical Association provides this information with the express understanding that (1) no attorney-client relationship exists, (2) neither TMA nor its attorneys are engaged in providing legal advice, and (3) the information is of a general character. Although TMA has attempted to present materials that are accurate and useful, some material may be outdated and TMA shall not be liable to anyone for any inaccuracy, error or omission, regardless of cause, or for any damages resulting therefrom. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.

RELEASED: March 2020, Texas Medical Association

Texas Spine Consultants
Prescription Policy

Texas Spine Consultants diagnoses and treats conditions of the spine. We may prescribe medications for you to help relieve the pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of medications. Texas Spine Consultants follows those laws.

Our policy:

1. Written prescriptions will not be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. In other words, do not change the frequency of the dose unless otherwise directed by a Texas Spine Consultants professional. If a change does occur, this will be noted in your chart.
3. Certain controlled substances such as Oxycontin, MS Contin and Percocet are written for a 30 day supply. It is necessary to make monthly follow up appointments in order to receive a refill. *By law, controlled substance medications cannot be refilled over the phone.*
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office, prescriptions cannot be refilled.

   - Sleep aids such as: Ambien
   - Anti-inflammatories such as: Vioxx, Bextra, Celebrex
   - Narcotics such as: Hydrocodone, Percocet
   - Muscle Relaxers such as: Soma, Robaxin, Flexeril

5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will not be authorized at night, on weekends or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Texas Spine Consultants, please check your supply of medication. If you need a refill, please ask.
8. Refill requests for prescriptions not prescribed by a Texas Spine Consultants physician will not be authorized.
9. If you believe you may be pregnant, discover you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately.
10. Urinary drug screens will occur prior to any narcotic regimen and approximately every three months following.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescription(s) refilled.

Signature__________________________________Date________________

Michael Hennessy, M.D.
Chester Donnally, M.D.
Andrew Park, M.D.
Robert Viere, M.D.
Heidi Lee, M.D.

Comprehensive Care of Neck and Back Disorders
Phone: 214.370.3535/ Fax: 214.370.0004
www.TSCspine.com

DISCLOSURE AUTHORIZATION FORM

PATIENT NAME:		
DATE OF BIRTH:	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*):

____

This authorization will be in full force and effect for two years unless otherwise indicated below.

☐ Expiration Date:____________________

☐ Occurrence of the following expiration event:________________________________

☐ Upon conclusion of the research study

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 redisclosure 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)