SPRINTZ CENTER

NEW PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ MI: _____

Address:_____ City/State:_____ Zip Code:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Male _____ Female ____

Employer: _____Occupation: _____E-Mail_____

Emergency Contact:_____Relationship:_____Phone:_____

Referring Physician_____ Primary Care Physician:_____

Marital Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐

Spouse's Name:_____ Date of Birth:_____

Spouse Employer:_____ Employer Phone:_____

_____ _____

Primary Insurance Carrier — Subscriber Name/DOB/SSN

_____ _____

Secondary Insurance Carrier — Subscriber Name/DOB/SSN

NOTE: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will be transferred to patient responsibility.

Are **any** of your pain conditions related to a work injury? ☐Yes ☐No Date of Injury: _____
Are you currently involved in an open Workman's Comp case for that injury? ☐ Yes ☐ No
Are **any** of your pain conditions the result of a car or other accident? ☐Yes ☐No Date of Injury: _____
Are you currently involved in a lawsuit for this or any pain related issue? ☐ Yes ☐ No
Name of the lawyer/Law firm representing you:_____ Lawyer Phone_____

My signature below indicates that I have been given the chance to read and review the foll**owing and understand and agree to their terms:**

**Patient Acknowledgement Form (see page 2)*

**Financial Policy, Consent for Treatment, and Release of Medical Information Form* (see page 3)

**Notice of Privacy Practices* at my discretion (located at front desk).

I agree that the above information is true and I authorize **Sprintz Center** to use this information to obtain financial reimbursement. Additionally, I authorize **Sprintz Center** to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to **Sprintz Center.** In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient's Signature: _____ Date: _____ _____

Reviewed by: _____ Date: _____

SPRINTZ CENTER

MEDICAL HISTORY FORM

Your Name: _____ **Today's Date** _____

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ☐ TV ☐ Radio ☐ Insurance Company ☐ Family ☐ Friend ☐ PCP

☐ www.sprintzcenter.com ☐ Facebook ☐ Twitter ☐ YouTube ☐ Other Website _____

Pain Description ☞☞☞ DON'T HAVE ANY PAIN PROBLEMS? Check this box and skip to page 4

❑ No chronic pain issues

Where is your **worst** area of pain located? _____

Does this pain radiate? ☐ Yes ☐ No; If so, where? _____

Please list any additional areas of pain: _____

Approximately when did this pain begin? _____

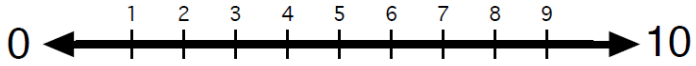
What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



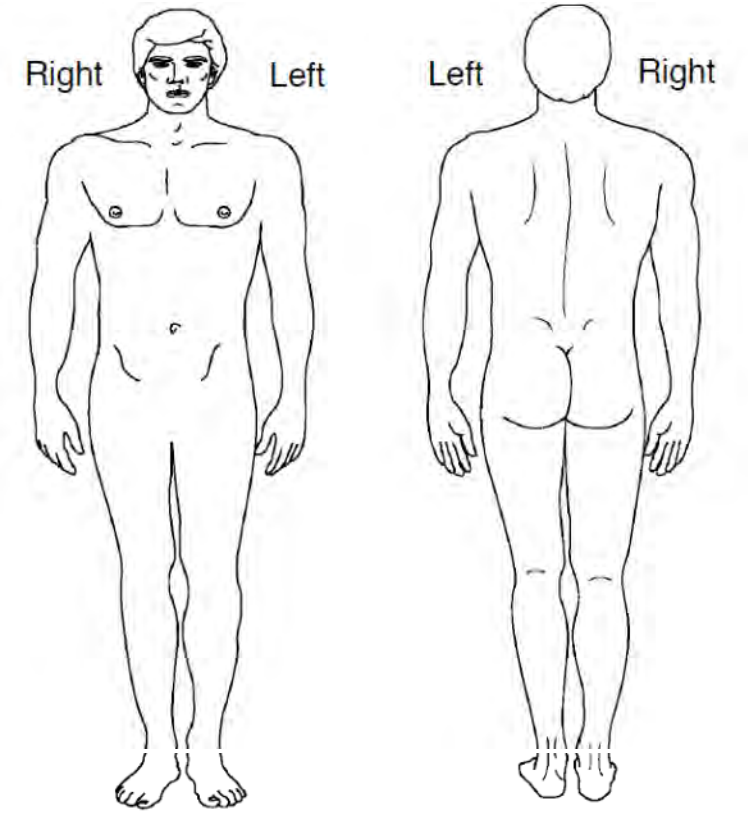
What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **average pain over the last month**? _____

Use this diagram to indicate the location of your pain and check all of the following that describe your pain.



- ☐ Aching
- ☐ Cramping
- ☐ Dull
- ☐ Hot/Burning
- ☐ Numbness
- ☐ Shock-like
- ☐ Shooting
- ☐ Spasming
- ☐ Squeezing
- ☐ Stabbing/Sharp
- ☐ Throbbing
- ☐ Tingling/Pins & Needles
- ☐ Tiring/Exhausting

Pain Frequency

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life	☐ Normal Work	☐ Sleep
☐ General Activity	☐ Recreational Activities	☐ Walking
☐ Mood	☐ Relationships with People	☐ Other: _____

☐ My goal is to resume normal activities

In the past three months have you developed any new:

☐ Balance Problems	☐ Bladder incontinence	☐ Bowel incontinence	☐ Chills
☐ Difficulty Walking	☐ Fevers	☐ Nausea	☐ Vomiting

☐ Numbness/Tingling – Where?_____ ☐ Weakness – Where? _____

☐ **I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

Diagnostic Tests and Imaging

List the most recent test(s) you have had that are related to your current pain complaints:

☐ MRI of the _____ Date: _____ Facility: _____

☐ X-ray of the _____ Date: _____ Facility: _____

☐ CT scan of the _____ Date: _____ Facility: _____

☐ EMG/NCV study of the _____ Date: _____ Facility: _____

☐ Ultrasound of the _____ Date: _____ Facility: _____

☐ Other diagnostic testing: _____

☐ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Physical Therapy ☐ Psychological Therapy ☐ Podiatrist Treatment

☐ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Nerve Blocks – Area/Nerve(s) _____

☐ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

☐ Spine Surgery

☐ Trigger Point Injection – Where? _____

☐ Vertebroplasty / Kyphoplasty – Level(s) _____

☐ Other: _____

☐ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐ No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐ No

Which type of anesthesia did you react adversely to? Please check all that apply.

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

☐ Local anesthesia ☐ Epidural ☐ General anesthesia ☐ IV Sedation

resume here if you skipped pain section

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type _____
- ☐ Diabetes – Type _____
- ☐ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Migraines

Cardiovascular / Hematologic
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker/Defibrillator
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Stroke

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema / COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Exposure to Mold
- ☐ Obstructive Sleep Apnea (OSA)
- ☐ CPAP Use
- ☐ Home Oxygen Use

Gastrointestinal
- ☐ Bowel Incontinence
- ☐ Acid Reflux (GERD)
- ☐ Gastrointestinal Bleeding
- ☐ Constipation

Musculoskeletal
- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Chronic Neck Pain
- ☐ Chronic Joint Pain
- ☐ Fibromyalgia
- ☐ Joint Injury
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid Arthritis
- ☐ Tennis/Golfer's Elbow
- ☐ Vertebral Compression Fracture

Genitourinary/Nephrology
- ☐ Bladder Infection(s)
- ☐ Dialysis
- ☐ Kidney Infection(s)
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hepatic
- ☐ Hepatitis A (active / inactive / unsure)
- ☐ Hepatitis B (active / inactive / unsure)
- ☐ Hepatitis C (active / inactive / unsure)

Neuropsychological
- ☐ Alcohol Abuse
- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Prescription Drug Abuse
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Complex Regional Pain Syndrome (CRPS) / RSD
- ☐ History physical/sexual/ other abuse

☐ Other Diagnosed Conditions

_____

_____

_____

_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

- ☐ Gallbladder removal _____
- ☐ Appendectomy _____
- ☐ Other _____

Female Surgeries

- ☐ Caesarean section _____
- ☐ Hysterectomy _____
- ☐ Laparoscopy _____
- ☐ Ovarian _____
- ☐ Other _____

Heart Surgery

- ☐ Valve replacement _____
- ☐ Aneurysm repair _____
- ☐ Stent placement _____
- ☐ Other _____

Joint Surgery

- ☐ Shoulder _____
- ☐ Hip _____
- ☐ Knee _____

Spine / Back Surgery

- ☐ Discectomy (levels)_____
- ☐ Laminectomy _____
- ☐ Spinal fusion (levels) _____

Other Common Surgeries

- ☐ Hemorrhoid surgery _____
- ☐ Hernia repair _____
- ☐ Thyroidectomy _____
- ☐ Tonsillectomy _____
- ☐ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):_____

_____

☐ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Alcohol Problems	Cancer	Diabetes	Drug Problems	Gambling Problems	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Liver Disease	Rheumatoid Arthritis/Lupus	Smoking	Stroke
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other medical problems: _____

☐ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ☐ **I AM ADOPTED (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No *If so*, are you currently pregnant? ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar school ☐ High School ☐ College ☐ Post-graduate

What is/was your occupation?_____; Are You Currently Working? ☐ Yes ☐ No

Alcohol Use: ☐ Current Alcoholism ☐ History of Alcoholism ☐ Social Alcohol Use ☐ Never Drinks Alcohol
☐ Daily Limited Alcohol Use

Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Never Used Tobacco

Illicit Drug Use: ☐ Denies Any Illicit Drug Use ☐ Currently Using Illicit Drugs; Which: _____
☐ Currently Uses Marijuana ☐ Currently Using Someone Else's Prescription Medications
☐ Formerly Used Illegal Drugs (not currently using); *If So*, Which? _____

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No; *If So*, Which?_____

Are you in recovery from drugs, alcohol, or any addiction? ☐ Yes ☐ No ☐ Not applicable

Medications

Please indicate which (if any) of the following **blood-thinners** you are taking:

☐ Aggrenox ☐ Coumadin ☐ Effient ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pletal ☐ Pradaxa

☐ Ticlid ☐ Warfarin ☐ Xarelto ☐ Other _____

Please list **ALL** medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name **Allergic Reaction Type (What Happens?)**

_____

_____

_____

Please check if you are allergic to ☐ Iodine or ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Review of Systems

Mark the following symptoms that you **currently** suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional: ☐Weakness ☐Fatigue ☐Weight Gain ☐Weight Loss ☐Fever ☐Chills ☐Night Sweats

Eyes: ☐Recent Visual Changes ☐Eye Glasses/Contact Lenses ☐Double Vision

Ears/Nose/Throat: ☐Dental Problems ☐Earaches ☐Hearing Problems ☐Nosebleeds
☐Recurrent Sore Throats ☐Ringing in the Ears ☐Sinus Problems

Cardiovascular: ☐Chest Pain ☐Irregular Heartbeat ☐Murmur ☐ Rapid Heartbeat ☐Blood Clots
☐Swollen Extremities ☐Palpitations ☐Fainting

Respiratory: ☐Cough ☐Shortness of Breath on Exertion/Effort ☐Wheezing ☐Shortness of Breath at Rest

Gastrointestinal: ☐Acid Reflux ☐Abdominal Cramps ☐Constipation ☐Diarrhea ☐Vomiting
☐Coffee Ground Appearance in Vomit ☐Dark and Tarry Stools

Genitourinary/Nephrology: ☐Blood in Urine ☐Decreased Urine Flow/Frequency/Volume ☐Flank Pain
☐Erectile Dysfunction ☐Painful Urination ☐Incontinence

Integumentary/Skin: ☐Change in Skin Color ☐Rashes ☐Puritis ☐Dry Skin

Musculoskeletal ☐Joint Swelling ☐Back Pain ☐Muscle Spasms ☐Joint Pain ☐Neck Pain
☐Pelvic Pain ☐Joint Stiffness

Psychiatric: ☐Depressed Mood ☐Anxiety ☐Stress ☐Suicidal Thoughts

Endocrine: ☐Heat Intolerance ☐Cold Intolerance ☐Hair Changes ☐Excessive Thirst

Neurological: ☐Dizziness ☐Seizures ☐Headaches ☐Numbness/Tingling ☐Memory Loss
☐Difficulty with speech ☐Incoordination ☐Difficulty Walking

Hematologic/Lymphatic: ☐Ease of Bruising ☐Ease of Bleeding ☐Impaired Wound Healing
☐Lymphadenopathy

Allergic/Immunologic: ☐Recurrent Infection ☐Hives ☐Swelling ☐Itching eyes or nose

SPRINTZ CENTER

HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

I understand that the patient's health information is private and confidential. I understand that Sprintz Center works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. Sprintz Center displays a copy of their "NOTICE OF PRIVACY PRACTICES" in every office location.

I understand that Sprintz Center may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Sprintz Center is required by federal, state, or local law to release this information without my permission. One example would be in response to a warrant, summons, court order, subpoena or similar legal process.

Sprintz Center has a detailed document called the "NOTICE OF PRIVACY PRACTICES". It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. One example would be disclosure of health information for research purposes. I understand that I have the right to read the "NOTICE OF PRIVACY PRACTICES" before signing this Acknowledgment.

Sprintz Center may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Sprintz Center will provide me with the most current "Notice of Privacy Practices". Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Sprintz Center has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Sprintz Center by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Patient's Name: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for choosing Sprintz Center as your health care provider

PLEASE READ CAREFULLY

You and your insurance carrier are responsible for your bill.
Knowing your insurance plan benefits is your responsibility.

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Insurance information must be presented/updated at the time of making your appointment not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Provider prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals you will not be seen and your appointment will be rescheduled.

- **Payment in Full for non-insurance services is expected at the time of service. Co-payments for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.**

- If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

- Sprintz Center is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

- Sprintz Center is not contracted with Texas Traditional Medicaid. You will be responsible for your 20% Medicare coinsurance. This does not apply if you have Texas Medicaid QMB.

Page 2
Financial Policy, Consent for Treatment, Release of Medical Information

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

- For services that are not covered by insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

- **Insured individuals electing to be self-pay**. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. Sprintz Center will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

- **If you do not have insurance coverage for the service, are self-pay**, **or have insurance that Sprintz Center does not participate in or accept**, payment is expected at the time of service. Sprintz Center has established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service.

  No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law.

  If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and your visit will be rescheduled.

- Out of Network Insurance – Some insurance plans require you to pay different out-of-pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self pay. You may also apply for financial hardship review if the "Out of Network" patient liability exceeds your ability to pay.

Page 3
Financial Policy, Consent for Treatment, Release of Medical Information

- Insurance information provided after the services have been provided will be billed or not billed at the discretion of Sprintz Center. Due to the insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If Sprintz Center agrees to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

- Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

- In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00

- Please note that our office charges $50.00 for missed appointments and $100.00 for missed procedures. Please contact our office 24 hours in advance to reschedule your appointment in order to avoid this fee.

- You will be charged a $25 fee per call for excessive phone calls (3 or more) within a 24-hour period. If we do not answer, please leave a message on the proper voicemail when prompted.

- In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

- Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 24 hours) cancelling of appointment or not showing up for their appointments will be subject to review for dismissal from our practice.

- **We do not complete disability/FMLA paperwork or provide parking placards.**

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize Sprintz Center to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Sprintz Center. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to Sprintz Center. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give Sprintz Center permission to appeal any denials by my insurance for services rendered on my behalf. I will assist Sprintz Center with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

Page 4
Financial Policy, Consent for Treatment, Release of Medical Information

I have read the Sprintz Center Financial Policy, Consent for Treatment, Release of Medical Information, and understand and agree to each document's terms. This authorization is to remain in full force unless I revoke the same in writing.

_____	_____
(Patient/Responsible Party) Signature	(Patient/Responsible Party) Printed Name
_____	_____
(Date)	(Date)

SPRINTZ CENTER

Patient Contract for Pain Management and Medication Agreement

[Not Required If Patient is being treated with Injection Procedures Only, No Pain Medications]

This agreement between _____(the patient) and Sprintz Center (the physician) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive pain management and/or pain medications. This may include the care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, biofeedback), alternative therapies, physical therapy, weight management and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. Pain medication may not completely eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:
**** Your initials are required next to each statement in the space provided**

_____1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioids.

_____2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medication prescribed to me. Prescriptions and bottles of medications must be safeguarded from loss and out of reach of children.

_____3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

_____4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids and withdrawal can be life threatening for a baby. If a female of child bearing age, I certify that I am not pregnant, and I will use appropriate contraceptive measures during the course of treatment, with medications. Many medications could harm the fetus or cause birth defects.

_____5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

_____6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.

_____7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.

_____8. I agree that continued treatment and/or refill of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

_____9. I am responsible for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. **Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances, as determined by and at the Physician's discretion and will only be bridged until the next available appointment.**

A. Refill requests for medication requiring a written prescription must be called to the office 48 business hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.
B. Refills will not be made after hours, at night or on weekends. This policy will be strictly adhered to.
C. **Refill will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if someone else has taken some of my prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.**
D. Refills will not be made as an "emergency". I will call my pharmacy at least 4-5 days prior to needing my prescription(s) **(for medications that do not require a written prescription).**

_____10. I agree that I will use my medication at a rate no greater that the prescribed rate unless it is discussed directly with my physician. I understand, I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).

_____11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.

_____12. I will not share, sell, or trade my medication or exchange medication for money, goods, or services.

_____13. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.

_____14. I understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regards to infraction involving prescription medications.

_____15. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

_____16. I agree that I will submit to random urine, blood, saliva toxicology test if requested to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

a. I understand that I will be financially responsible for the charges for any urine, blood, or saliva test. If you have insurance coverage it will be billed but you will be responsible for all patient liability.
b. I understand that I will be financially responsible for the charges for any urine, blood, or saliva test that has to be sent out to an outside lab for testing or confirmation.
c. Presence of unauthorized substances or the lack of prescribed medications may necessitate a referral to an addiction specialist, as well as dismissal from this practice.

_____17. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office.

_____18. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

_____19. I will keep all scheduled follow up appointments as outlined in my treatment plan.

_____20. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.

_____21. I understand with respect to the prescribing of my pain medications the doctors, my pharmacy, and insurers will cooperate fully with any city, state, or federal agency in the investigation of any possible misuse, sale, or other diversion of my pain medication as required by law, state and federal regulations.

Page 3 Patient Contract for Pain Management and Medication Agreement

_____22. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

_____23. I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology and/or psychological and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your physician in no way invalidates any other provisions of this agreement.

If at any time you are concerned about your medication or side effects of your medication, you may call the office at 713-714-1399.

I agree to use _____ Pharmacy, located at _____

telephone number _____for all my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this _____ day of _____ 20_____.

_____ _____

Patient Signature Witness

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care and satisfaction. Providers may include primary care practitioners, specialists, and/or subspecialists. The information provided during a telemedicine visit may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

Expected benefits of telemedicine health services may include the following:

- Improved access to medical care by enabling the patient to communicate with the physician or other practitioner at a distance.
- More efficient medical evaluation and management of health conditions.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any health care service, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor image resolution) to allow for appropriate medical decision-making by the physician or other practitioner, which may necessitate an in-person medical evaluation.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. In the event of an equipment failure, the physician or other practitioner will make a determination as to whether or not the visit can be continued via telephone. If it is determined that a telephone call is insufficient, the physician or other practitioner may determine that the appointment should be rescheduled.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand:

1. The laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other health care entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My physician has explained the alternatives to my satisfaction. My physician may require that I schedule an in-person medical evaluation to follow up in certain circumstances.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
6. It is my duty to inform my physician of electronic interactions regarding my care that I may have with other health care practitioners.
7. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Notice Concerning Complaints

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information, please visit the Texas Medical Board website at www.tmb.state.tx.us.

Patient Consent to Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize the performing provider to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Patient/Representative Name Relationship to Patient

_____ _____

Patient/Representative Signature Date

SPRINTZ CENTER
FOR PAIN AND RECOVERY

PATIENT NOTICES

COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE

PLEASE NOTE THAT WE DO CHARGE THE FOLLOWING FOR ANY CANCELLED AND NO-SHOW APPOINTMENTS THAT ARE NOT CANCELLED WITHIN A 24-HOUR PERIOD.

- $50.00 – OFFICE VISITS & CONSULTS
- $100.00 – SURGICAL PROCEDURES

NOTICE TO PATIENTS REGARDING DRUG TESTING

Our clinic will do its best to send your Urine, Blood, and Toxicology samples **to a facility that is in-network with your insurance plan**. Please note that the Sprintz Center has NO FINANCIAL INTEREST with any of the following:

- Tribal Diagnostics
- FirsTox Laboratories
- LabCorp Services
- Sagis
- North Lakes Pain Consultants
- Quest Diagnostics

All questions regarding your invoice should be directed directly to the Testing Facility.

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

Thank you for the opportunity to provide your interventional pain, medication management, behavioral health and wellness needs. We are committed to assuring your complete satisfaction.

The purpose of the disclosure[1,2] notice is to inform you that we, the physicians at The Sprintz Center, have financial interests in the following facilities in Texas – **North Pines Surgery Center & Essential Imaging**.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate medical facility, monitoring or implant company. You will not be treated differently by your physician if you choose to obtain health care services at another facility, or to utilize another monitoring or implant company, if applicable. We welcome you as a patient and value our relationship with you.

By signing this *Disclosure*, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has a financial interest in the listed facilities and acknowledge the above stated fees & services.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Type or Print Name of Patient	Type or Print Name of Parent or Guardian

Dated: _____

[1] Texas Administrative Code § 190.8(2)(H)
[2] American Medical Association E-8.03

SPRINTZ CENTER

MEDICAL RECORDS RELEASE

I, _____

hereby authorize _____

to disclose the following protected health information:

_____

_____

_____

The protected health information may be disclosed to:

_____SPRINTZ CENTER_____

This protected health information is being used or disclosed for the following purpose(s):

_____EVALUATION AND TREATMENT_____

_____

This authorization shall be in force and effect until: _____

I understand that, as set forth in the Pain Addiction Consultants' Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Sprintz Center, PLLC
111 Vision Park Blvd, Suite 100
Shenandoah, Texas 77384

SEE PRIVACY NOTICE CONCERNING ADDITIONAL DISCLOSURE INFORMATION

I understand that I have a right to:

1. Inspect or copy my protected health information to be used or disclosed as permitted under fereal/state law.
2. Refuse to sign this authorization.

Date of birth: _____ SSN: _____

Full Name: _____

Signature: _____ Date: _____

** If a Personal Representative's signature appears above, please describe Personal Representative's relationship to the Patient:

_____

SPRINTZ CENTER

Authorization to Discuss or Disclose Health Information

I authorize Sprintz Center to discuss and/or disclose my health information with the following person(s) listed below:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that this information may include any and all: treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and evaluations, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should not be released:

_____

_____

_____

_____

_____

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

Patient's Signature: _____

Date Signed: _____

Witness Signature: _____

Date Signed: _____

This form is valid for one year from patient signature date.