Texas Spine Consultants, LLP.

Date: _____ Height: _____ Weight: _____

Name: _____ _____ _____
Last First M.I.

DOB: _____ Age: _____

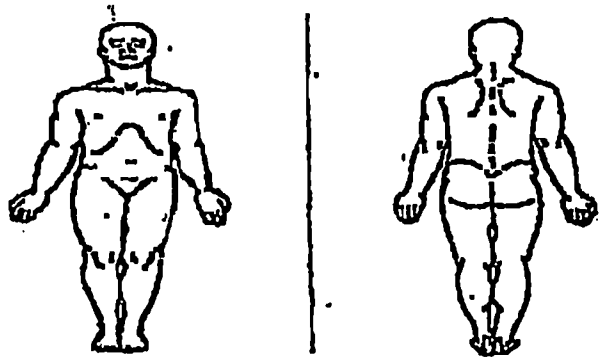
Dominant Hand: [ ] Right [ ] Left

Heidi Lee, M.D.

Please complete this form carefully. Your answers will help us better understand your presenting problem and design the best treatment program for you.

CHIEF COMPLAINT (Circle) Right / Left / Both — Upper / Mid / Low Back Neck — Legs / Buttock / Hip Arms / Wrist / Hands — Shoulder / Elbow Foot / Ankle

WHERE IS THE PAIN? Draw the location of your pain By shading on the diagram to the right: >>>>>>>>



Work related? ☐ Yes ☐ No
Legal Actions pending? ☐ Yes ☐ No
Workers Compensation? ☐ Yes ☐ No
Are you working now? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS:
How long have you noticed pain? _____Days _____Weeks _____Months _____Years

Was there any injury/event that caused your pain? ☐ No ☐ Yes (please describe):

_____

_____

The pain is described as: ☐ Constant ☐ Intermittent ☐ Unchanged ☐ Worse ☐ Better
Rate your USUAL pain: (circle)
NO PAIN 0 1 2 3 4 5 6 7 8 9 10 THE WORST PAIN IMAGINABLE

Describe your pain: Burning Sharp-shooting Tingling Numbness Pinprick Stabbing Deep-pressure Tightness Spasms other: _____

What makes pain worse? _____
What makes pain better? _____
How does the pain limit you? _____

Have you had any of the following: ☐ none
☐ weakness (where) _____ ☐ loss of bladder control _____
☐ numbness (where) _____ ☐ loss of bowel control _____

Have you had a recent neck/back MRI or CT scan? _____

Check treatment tried for pain and circle the best treatment to date: _____
☐ Physical Therapy ☐ TENS ☐ Heating pad ☐ Ice ☐ Injections ☐ Exercise ☐ Other pain coping
☐ Epidural steroids ☐ Surgery ☐ Massage ☐ Medications ☐ Acupuncture ☐ Chiropractor modalities (i.e. Meditation, Biofeedback, relaxation)

Please list all previous injections or surgeries for this pain

_____

Past SURGERIES:
☐
☐
☐

ALLERGIES: ☐ allergic to following: or [ ] no drug allergies
☐
☐
☐

Past/Current Pharmacologic Trials:

- ☐ Opiods: Type_____
- ☐ Nsaids: _____
- ☐ Muscle Relaxants: _____
- ☐ Anticonvulsants: _____
- ☐ Antidepressants: _____
- ☐ Topicals (ie: cream, patches): _____
- ☐ Steroids (Oral): _____

If female, are you pregnant? _____

Current Medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewing Physician Signature

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

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

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

Communication Consent

We respect your privacy and the privacy of your protected health information. Please help us by giving us guidelines as to how you would like to be contacted by our office. You may revoke or change this information at any time by completing a new form. We will ask you annually to update the information by completing a new form.

I authorize your office to contact me in the following manner:

Check all that apply

Home Phone # _____

- ☐ OK to leave message on voice mail or answering machine with **detailed message AND call back number**
- ☐ OK to leave message with **call back number only**
- ☐ OK to leave a message with **family member(s).** Please specify who:

_____

Cell Phone # _____

- ☐ OK to leave message on voice mail with **detailed message AND call back number**
- ☐ OK to leave message with **call back number only**
- ☐ OK to send a **text message appointment reminder**
- ☐ OK to send a **text message with a call back number only**

Work Phone # _____

- ☐ OK to leave message on voice mail with **detailed message AND call back number**
- ☐ OK to leave message with **call back number only**
- ☐ OK to leave a message with **co-worker(s).** Please specify who:

_____

I authorize the release of medical information to the following:

Name	Relationship

Printed Name of Patient _____

Signature of Patient or Parent or Guardian _____

Date Completed _____

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_____

5/19/2021

Telemedicine Informed Consent

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

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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THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association

PHYSICIAN FINANCIAL DISCLOSURE FORM

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

- Texas Health Surgery Center Addison

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