SPINE WORKS INSTITUTE

Thank you for choosing us to be your healthcare provider

Name:_____ Date:_____

How did you hear about us?

1._____ Primary Care Dr._____
_____ Specialist Dr._____
_____ Chiropractor Dr._____

2._____Friend Who can we thank _____

3._____Website

4._____Internet

5._____Magazine Which one_____

6._____Radio

7._____Television

8._____Insurance

9._____Billboard

10._____Hospital Which one_____

11._____Other_____

SPINE WORKS INSTITUTE™
COMPREHENSIVE SPINE CARE

****IF YOUR INJURY IS A RESULT OF A WORK INJURY OR AUTO ACCIDENT PLEASE STOP AND SEE FRONT DESK****

Patient Information Sheet **DATE:** _____

NAME: LAST _____ FIRST _____ MI _____ **SSN** _____

STREET ADDRESS: _____ **DOB** _____

CITY: _____ _____ **STATE** _____ **ZIP** _____ **SEX:** [] MALE [] FEMALE

PRIMARY PHONE NUMBER :(____) _____ **SECONDARY PHONE NUMBER:** (_____) _____

EMAIL ADDRESS: _____ **PRIMARY CARE PHYSICIAN:** _____

MARITAL STATUS: [] SINGLE [] MARRIED [] DIVORCED [] WIDOWED [] PARTNER [] LEGALLY SEPERATED

RACE: [] AMERICAN INDIAN OR ALASKA NATIVE [] ASIAN [] NATIVE HAWAIIAN [] BLACK OR AFRICAN AMERICAN [] WHITE [] HISPANIC [] LATINO [] PACIFIC ISLANDER [] OTHER _____ [] UNREPORTED/REFUSED

EMERGENCY CONTACT: NAME: _____ **PHONE:** _____

PRIMARY INSURANCE: _____ **GUARANTOR NAME:** _____

GUARANTOR DOB: _____ **GUARANTOR SSN:** _____ **SEX:** [] M [] F

ADDRESS: _____

ID NUMBER: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE: _____ **GUARANTOR NAME:** _____

GUARANTOR DOB: _____ **GUARANTOR SSN:** _____ **SEX:** [] M [] F

ADDRESS: _____

ID NUMBER: _____ **GROUP NUMBER:** _____

I give my consent to Spine Works Institute to perform any and all examinations, tests, treatment, physical therapy, blood and urine specimen procurement, and any other reasonable measures we deem necessary to diagnose and treat my condition.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

FINANCIAL POLICY

This financial policy contains important information about billing and payment for our professional services. It outlines your responsibility as the patient and our responsibilities with regards to billing and payment for our services.

- Our practice participates with many health insurance companies. Our business office will submit the claim for any service rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our doctor is participating in their insurance plan at the time of service. The burden of proof is the patient responsibility and not the physician responsibility.
- Claims will be submitted to the Primary and Secondary insurance carriers only. If you have a Tertiary carrier it will be the patient's responsibility to submit the claim for any additional payment needed.
- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral the patient's visit may be rescheduled or the patient may be personally responsible for payment of services rendered.
- There will be a financial fee of $50 for each check returned for insufficient funds.
- There is a $50 administrative fee for completion of medical forms or copies of medical records.
- A $50 fee will be assessed for appointments not canceled 24 hour in advance, a $100 fee for procedures not cancelled 24 hours in advance, and $150 fee for MRI that is not canceled 24 hours in advance.
- Payment for professional services can be made with cash, check, credit or debit card.

Insurance & Insurance Collections

Your insurance policy is a contract between you and your insurance company. If your insurance has not paid your account in full within 60 days the balance of your account will be due. It is the patient's responsibility to make sure the insurance reimburses the physician for services rendered. Unresolved balances may be placed with an outside collection agency. In the unfortunate situation where accounts are sent to a collection agency or attorneys for non-payment, patients are responsible for collection fees, attorney fees, service charges, and accruing interest in addition to the unpaid balance. Once an account has been placed for collections, future appointments may not be made until you see or talk to a representative in our billing office, but emergency care will still be rendered.

Copays and Co-Insurance

Office visit copays are due at time of service. If your office visit is applied to your deductible or a co-insurance we will collect an estimated patient responsibility based on the current Insurance fee schedule. You may incur additional charges after your claim has been processed by your insurance company. If you are unable to pay your copayment or co-insurance your appointment will be rescheduled, no exceptions. Surgery deductibles and co-insurance must be paid prior to surgery.

Medicare

As a participating provider, we will bill your Medicare carrier. You are responsible for your 20% co-payment and we must collect at each visit.

Secondary Insurers

Having more than one insurance DOES NOT necessarily mean that your services are covered at 100%. Secondary insurances will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Interest

We reserve the right to charge interest in the amount of 12% as provided by state law for unpaid balances over 30 days. This monthly finance rate is subject to change without notice, but will not exceed rates allowed under applicable law.

No Warranty or Guarantee

I understand that no warranty or guarantee has been made to me as a result or cure.

Assignment of Benefits

I, the undersigned, certify that I (or my dependents) have insurance coverage with the above named insurance company and assign directly to Spine Works Institute all insurance 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 doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Patient Signature Date

Who to Contact
I hereby give permission to Spine Works Institute to disclose and discuss any information related to my medical conditions to/with the following:

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions

How to Contact
I wish to be contacted in the following manner:

Home Telephone:
_____ Okay to leave message with detailed information
_____ Leave message/voicemail with call back number only
Work Telephone:
_____ Okay to leave message with detailed information
_____ Leave message/voicemail with call back number only
Cell Phone:
_____ Okay to leave message with detailed information
_____ Leave message/voicemail with call back number only
Written Communication:
_____ Okay to leave message with detailed information
_____ Leave message/voicemail with call back number only

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that the request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information. **THIS IS NOT A REQUEST TO RELEASE MEDICAL RECORDS.**

_____ _____
Signature of Patient **Date**

PRIVACY NOTICE ACKNOWLEDGMENT

I have read a copy of the Notice of Privacy. I understand the Notice of Privacy provides me information about how Spine Works Institute handles my protected health information. I will be given a copy upon request.

Patient Name

Date

Patient/Guardian Signature

Date of Birth

Relationship to Patient

ATTENTION ALL PATIENT

In accordance with new regulations from the Federal Drug Administration (FDA) and the Drug Enforcement Administration (DEA), the changes detailed in this notification will take effect October 6, 2014-45 days from the date of ruling (August 22, 2014), requiring combination hydrocodone products, currently considered Schedule III drugs to be re classified as Schedule II because of their high risk for abuse due to a change in the Controlled Substance Act.

The rationale for this decision is the national epidemic of overdoses tied to opioids. The most commonly prescribed combination product affected by the ruling is hydrocodone plus acetaminophen (marketed as Vicodin, Lortab or Norco); however, **the Schedule II change will affect hydrocodone-containing products.**

Reclassifying hydrocodone-containing products to a Schedule II controlled substance means that there are more stringent government regulations for prescribing (quantity dispensed, refills, records) for these medications.

What does this mean to our Patient'? You will need to schedule an appointment to see your provider to get a refill on all C2 drugs. **You can no longer call the Pharmacy or the office to request a refill.**

These appointments will be made Monday-Thursday depending on your provider's schedule. No appointments AND/OR refills will be made on Fridays!! NO SAME DAY APPOINTMENTS WILL BE MADE SO PLAN AHEAD.

BY SIGNING THIS NOTICE YOU ACKNOWLEDGE THAT YOU UNDERSTAND THE NEW REGULATIONS AND OFFICE POLICIES.

Patient Signature Date

MEDICATION & TESTING POLICY AND CONSENT

Non C2 medications will be refilled during office hours only. These hours are 8:30 to 4:00 Monday thru Thursday. **NO MEDICATION VISITS OR NON C2 REFILLS WILL BE COMPLETED ON FRIDAY.**

If you need a refill on a Non C2 medication please call your pharmacy and have them fax us a request **AT LEAST TWO BUSINESS DAYS PRIOR TO NEEDING YOUR MEDICATION.** The office **WILL NOT** authorize refill requests on the day they are received.

YOU MUST SCHEDULE AN APPOINTMENT TO SEE YOUR PROVIDER TO GET A REFILL ON ALL C2 MEDICATIONS. YOU CAN NO LONGER CALL THE PHARMACY OR THE OFFICE TO REQUEST REFILLS.

UNDER NO CIRCUMSTANCES SHOULD YOU TAKE YOUR MEDICATION OTHER THAN HOW IT IS PRESCRIBED.

Safeguard your medications from loss, theft, diversion or use by others. Your prescriptions and medications are exactly like money. If either are lost or stolen, they **WILL NOT BE REPLACED. NO EXCEPTIONS.**

Medications will not be refilled at the surgery center. This must be done through the office.

If you call the office and are disrespectful in any way your phone conversation will be recorded.

Diagnostic Testing
If your physician orders a diagnostic test (e.g. MRI, CT Scan ect) you **MUST** schedule a follow up visit to receive your results. **PLEASE DO NOT CALL THE OFFICE FOR TEST RESULTS.**

I have read and had the above information explained to me.

I hereby grant permission to Spine Works Institute to view my prescription history from external sources

_____ _____

Patient/Guardian Signature Date

SPINE WORKS INSTITUTE

8801 N Tarrant Pkwy - NRH, TX 76182 – P - 817-616-0700 / F- 817-616-0708

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____

Phone/Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the use or disclosure of the above named individual's health information to medical office / facility / practice or provider described below for Spine Works Institutes information and continuation of care.

Name: _____

Address: _____

Phone & Fax #'s _____

City: _____ State: _____ Zip: _____

- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
  - _____ Complete health records
  - _____ Physical exam
  - _____ Immunization record
  - _____ Other (please specify: _____
  - _____ Lab results/X-ray reports
  - _____ Consultation reports

- I understand that 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.

- I understand that I have a right to 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 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 in sixty days. 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 copy 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 re-disclosure and the information may not be protected by federal confidentiality rules.

_____

Signature of patient or legal representative — Signature of witness

Date: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.

SPINE WORKS INSTITUTE
Please complete at each visit

Today's Date: _____

Name: _____ **Date of Birth:** _____
Height: _____ **Weight:** _____

1. What brings you to the clinic today? _____

2. Where is your pain located? Neck Mid Back Low Back Other: _____
   Arm(s) Leg(s): Right Left Bilateral

3. When did your pain begin? _____

4. Pain is a result of an: accident injury fall other: _____

5. Pain has: improved worsened remains unchanged
   Since: onset injection surgery last appointment

6. Pain level at this time: _____ Average over the past week: _____
   On a scale of 1 to 10 with 10 being the worst

7. Pain is: aching burning dull gnawing itching jabbing sharp sore stiff throbbing shooting cramping (circle all that apply)

8. Are you experiencing any numbness or tingling or weakness? Yes No
   If yes, where? _____

9. What makes your pain worse? bending coughing straining extension lifting sitting sleeping standing weather changes working walking physical activity

10. What makes your pain better? bending heat ice lifting sitting sleeping standing working medications rest exercise stretching nothing

11. Are you experiencing any problems with urination or having bowel movements? Yes No

12. Previous Treatments: (Please circle all treatments you have tried)

    X-Ray MRI CT Scan Physical Therapy Chiropractic Care Accupuncture

    Massage Traction Trigger Point Injection Epidural Injection Facet Injection

    Rhizotomy Home Exercise NSAIDS Pain Medication Other Medications Surgery

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Do you use tobacco products? Y N

Do you drink alcohol? Y N

Do you use illegal Drugs? Y N

Dominant Hand? Right Left

Marital Status: single married divorced widow other

Is your injury the result of an auto accident, work injury or third party claim? Y N

Have you traveled out of the United States within the past 30 days?

REVIEW OF SYSTEMS

Have you experienced any of the following in the past month? (circle all that apply)

ARE YOU ON BLOOD THINNERS: ___YES ___NO WHAT DR. PRESCRIBED _____

General: chills fever weight gain weight loss

Allergies: hives rash seasonal allergies

Eyes: vision changes blurred vision

ENT: difficulty swallowing nosebleed ringing in ears sore throat

Cardiovascular: chest pain/angina swelling irregular heartbeat heart murmur

Respiratory: cough blood in sputum shortness of breath wheezing

Gastrointestinal: abdominal pain constipation diarrhea nausea vomiting

Genitourinary: difficulty urinating painful urination frequent urination painful urination

Musculoskeletal: leg cramps muscle aches painful joints swollen joints weakness

Skin: hives itching rash frequent infections

Neurologic: fainting headache seizure tremors numbness tingling

Hematology: easy bruising prolonged bleeding recent transfusions clotting disorders

Patient Name: _____ DOB: _____

MEDICATION NAME & DOSAGE **DOCTOR THAT PRESCRIBED THE MEDICATION**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY INFORMATION

Name: _____

Phone: _____

Address: _____

	A	B	C	D	E	F	G
1	Personal Medical History						
2							
3	Condition	YES	NO				
4							
5	Alcoholism						
6	Alzheimer's Disease						
7	Anemia						
8	Anxiety						
9	Asthma						
10	Back Pain/Injury						
11	Bleeding Tendencies/Disorders						
12	Bowel Problems						
13	Cancer						
14	COPD						
15	Coronary Artery Disease						
16	De Quervain's Disease						
17	Depression						
18	Diabetes						
19	Diverticulitis						
20	Drug Addiction						
21	DVT/PE						
22	Emphysema						
23	Epilepsy						
24	Fibromyalgia						
25	GI Bleed						
26	Gout						
27	Hepatitis						
28	Heart Attack						
29	High Cholesterol						
30	HIV/AIDS						
31	Joint Pain						
32	Kidney Disease						
33	Liver Conditions						
34	Major Accidents						
35	Migraines						
36	Neck Pain						
37	Neuropathy						
38	Osteoporosis						
39	Psychiatric Disorders						
40	Rheumatoid Arthritis						
41	Sciatica						
42	Sleep Apnea						
43	Spinal Cord Injury						
44	Stroke						
45	Ulcer						
46							

	A	B	C	D	E	F	G
47	Surgical History				Allergies		
48							
49	Surgical Procedure	Yes	No		Allergy	Yes	No
50							
51	Cervical Fusion				Adhesive Tape		
52	Dorsal Column Stimulator				Codeine		
53	Heart Bypass				Glove Powder		
54	Heart Stents				Iodine		
55	Heart Surgery				Latex		
56	Lumbar Discectomy				Morphine		
57	Lumbar Fusion				NSAID's		
58	Lumbar Laminectomy				Penillin		
59	Organ Transplant				Sulfa Drugs		
60	Pacemaker				X-ray Dye		
61	Total Joint Replacement				Other		
62							
63							
64							
65	Family History						
66							
67	Disease	Yes	No		Relative		
68							
69	Bleeding Disorders						
70	Cancer						
71	Depression						
72	Diabetes						
73	DVT/PE						
74	Gout						
75	Heart Attack						
76	Hypertension						
77	Kidney Disease						
78	Liver Problems						
79	Lung Problems						
80	Migraines						
81	Rheumatoid Arthritis						
82	Stroke						

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1

SPINE WORKS INSTITUTE™
COMPREHENSIVE SPINE CARE

Date: _____ Patient Name: _____ DOB: _____

Clinic Policy Agreement for Controlled Substance Prescriptions

"Controlled Substance Agreement"

The purpose of this Clinic Policy and Agreement for Controlled Substance Prescriptions ("Agreement") is to prevent misunderstanding about controlled substances that you are or will be taking. This is to help both you and your physicians comply with the laws regarding controlled pharmaceuticals/substances. In addition, the following cautions should be understood:

- Overuse or over dosage of pain medication can result in lethal side effects, including decreased ability to breathe and death.
- If pregnant, narcotics should be continued only with the approval of the patient's obstetrician/gynecologist.
- Narcotics may impair one's ability to drive and operate heavy machinery.
- Daily use of narcotics can lead to tolerance and physiological dependence.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I will use the medication(s) exactly as directed by my physician. My physician will specify the amount and frequency of medication refills.

I agree that I will voluntarily submit to a blood or urine test when requested by your Spine Works Institute Provider to determine my compliance with my program of pain control medication and to determine medication levels. I understand that if I refuse to comply, I will not receive any prescriptions for controlled substances. I understand that if I test positive for illegal substances, treatment for chronic pain may be terminated.

I will not use any controlled medications, including opioids, narcotics, sedatives, stimulants, or anti-anxiety medications prescribed by or obtained from any other physician or source unless your Spine Works Institute Provider is fully informed of their use. In the event of an emergency that requires me to receive medications in the ER or hospital, I will inform my Spine Works Institute Provider of this.

I understand that my physician will periodically review my process, and if the medication(s) are not improving my quality of life/functioning or are causing adverse effects they may be discontinued. I understand that I must keep my appointments with my doctor or the medication(s) may be discontinued or I may be discharged from the practice.

I further understand that my physician may request that I meet with a Psychologist or Psychiatrist periodically as indicated while in treatment with My Spine Works Institute Provider.

I will not use any illegal controlled substances, including marijuana, cocaine, methamphetamine, ecstasy ECT.

I will safeguard my pain medication from loss, theft, diversion, or use by others. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED.

I agree that refill requests of my prescriptions for pain medicine will be made available only at the time of an office visit or during regular office hours. No refills will be available during evenings, weekends, holidays or when my Spine Works Institute Provider is not available. No prescriptions will be mailed to the patient or pharmacy.

I agree to use _____ Pharmacy, located at _____,

Telephone number _____, for filling prescriptions of all my pain medications.

I authorize my Spine Works Institute Provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my Spine Works Institute Provider to provide a copy of this Agreement to my pharmacy upon my request. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I understand that if I break or do not comply with this Agreement, my doctor may stop prescribing these controlled substances/pharmaceuticals, may taper of the medicine, as necessary, to minimize withdrawal symptoms, and/or may refer me for treatment through a drug dependence treatment program/specialist. I also understand that I may also be entirely discharged from my Spine Works Institute Provider's practice for breaking or failing to comply with this Agreement.

Authorization To Pick Up Medications
I authorize the following persons to pick up my medications in the event that I am unable to. I understand that my medications will not be released to anybody not listed on this form and that no exceptions will be made to this policy.

Person(s) Authorized to Pick Up Medications:

_____

_____

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this Agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin ECT.).
3. No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanation regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

A copy of this Agreement will be provided to me.

_____ _____

Patient's signature Spine Works Institute Provider Signature

_____ _____

Patient's printed name Witness/Date

_____

Date

PATIENT CONSENT FOR DRUG SCREENING

I understand that my Physician at Spine Works Institute does random drug testing and will request that I be tested to determine the level of drug or metabolite in my body.

Spine Works Institute does not discriminate due to age, sex, or race.

I further understand and agree that the testing will be performed in the physician's office and/or sent to an outside laboratory as needed, on a specimen of my urine that I provide for the purpose of this drug test.

I understand and agree that the outside laboratories used and my physician will maintain confidentiality of my urine drug test results.

I understand that the test results and interpretation will become part of my medical record. I understand that an insurance company may discover the results of this test by my informing them of this test or by obtaining a copy of my medical record from the physician.

I understand that any discrepancies between the results of the drug screening and the complete medication list I have provided may be considered a violation of my pain management agreement and result in actions by my physician.

I understand that I will be solely responsible for any financial balance to the outside laboratory and/or physician's office should the drug screening not be covered in part or full by my insurance company.

All of the above will be discussed and I will have the opportunity to have any questions answered that I have regarding the drug testing or my rights to privacy.

_____

Patient Name (print)

_____

Patient Signature Date

_____

Witness Date