Michael S. McKee, M.D.

Interventional Pain Management/*Spine Care of San Antonio*
Board Certified: American Board of Pain Medicine & American Board of Anesthesiology
Phone 210.545.0087 Fax 210.545.3455 Email *spinecaretx@yahoo.com*
20079 Stone Oak Parkway, Suite 1245, San Antonio, TX 78258

WELCOME TO OUR OFFICE

Name_____ Date of Birth_____ Sex: M F

Address _____ City_____ State_____ Zip_____

Telephone Number_____ Social Security Number_____

Driver's License Number_____ Marital Status (circle one) M S W D

Patient's Employer_____ Occupation_____

Employer Address_____ Work Phone Number_____

Date of Injury_____

INSURANCE INFORMATION

Policy Holder's Name_____ Relationship to Patient_____

Address _____ Phone Number_____

Social Security Number_____ Date of Birth_____

Primary Insurance_____ Group #_____ ID #_____

Secondary Insurance_____ Group #_____ ID#_____

Medicare #_____ Medicaid #_____

Referring Doctor_____ Phone Number_____

MEDICARE ASSIGNMENT FOR COVERED SERVICES

I certify the information given in applying for payment is correct and request payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Michael S. McKee, M.D. for medical services. I represent that I have insurance coverage and do hereby authorize Michael S. McKee, M.D. to release and obtain all information necessary to secure payment of said benefits. If my insurance fails to pay Michael S. McKee, M.D. for any reason, I agree to pay all unpaid balances.

I have read and understand the Medical Services Disclosure, Medicare Assignment, and Assignment of Insurance Benefits and agree to all terms stated.

I acknowledge that the Notice of Privacy Practices has been made available to me in the lobby.

I understand that payment is expected at the time office services are rendered.

Patient Signature_____ Date_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name _____ **Date of Birth** _____

Person(s)/organizations authorized to use/disclose information (from) _____

_____

_____

Person(s)/organizations authorized to receive the information: _____

_____

_____

Information that may be used/disclosed:
(Include date where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- ❑ Record of Visits (all) _____
- ❑ Record of Visit(s) (Specific) _____
- ❑ Discharge Summary _____
- ❑ History/Physical _____
- ❑ Consultation Report(s) _____
- ❑ Operative Report(s) _____
- ❑ Problem List _____
- ❑ Progress Notes _____
- ❑ Immunization Record(s) _____
- ❑ Medication Record(s) _____
- ❑ Laboratory Report(s) _____
- ❑ X-Ray, MRI, CT _____
- ❑ Echo, Stress Tests, Holters _____
- ❑ EKG Report _____
- ❑ Mental Health/Alcohol/Drug Abuse Treatment _____
- ❑ AIDS or HIV Information _____
- ❑ Hepatitis Information _____
- ❑ Entire Medical Record _____
- ❑ Statement of Charges/Payments _____
- ❑ Other _____

SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

a. The information will be used/disclosed for the following purposes:

- ❑ Continued Patient Care
- ❑ Disability Determination
- ❑ Personal Use
- ❑ Attorney/Legal
- ❑ Insurance Claim
- ❑ Other _____

b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No _____

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department, in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. The authorization expires _____
(Insert applicable date or event that triggers expiration)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the Federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Printed name of Patient's Representative (if applicable) Relationship to Patient

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PRESCRIPTION OF NARCOTIC MEDICATION AND OTHER CONTROLLED SUBSTANCES AGREEMENT

Patient's Name _____
Date of Birth _____ **MRN#** _____ **Date** _____

- Medication is being prescribed to me as part of my treatment plan on a temporary basis, with the goal being an eventual reduction of pain medications.
- Narcotics and other controlled substances have the potential to be habit forming, therefore, dosage amounts and frequency of prescribed medications will be closely monitored by my physician.
- It is my responsibility to keep my prescription medications out of the hands of others, especially children, as an accidental overdose can be harmful and possible result in death.
- I agree that I will not consume alcohol or other illicit drugs in conjunction with the medications prescribed by my physician.
- Any deviation of use, including, but not limited to, sharing prescribed medications with others, obtaining undisclosed prescriptions from other physicians, running out of prescriptions medications before the next scheduled visit, including unexplainable loss and/or misplacement of medications, will result in my discharge from my physician's care.
- My physician reserves the right to discharge me from his care if any of the aforementioned prescription medication misuse is suspected.
- In the event I am discharged from my physician's care for any reason, it is up to my physician's discretion to refer me to another physician and/or to prescribe any further medication.
- If there is high suspicion and/or evidence of illicit drug use and/or misuse of prescription medications, my physician reserves the right to contact the proper authorities, as well as any of my (the patient's) other physicians to inform them of said misconduct.
- In the event of my losing control of narcotic or other controlled drug use, I may be referred to a detoxification center, at my physician's discretion.
- At any point and time my physician may require me to have a "medication holiday" in order to decrease narcotic or controlled substance tolerance or to asses coping behavior and/or drug dependence and withdrawal potential.
- Aggressive behavior toward my physician or any of the office staff will not be tolerated and will be grounds for immediate discharge from physician's care.

The goal of this medical office is to maintain a friendly, positive environment that is conducive to increasing the health and quality of life of our patients. Strict adherence to this contract will allow for a healthy physician-patient relationship and help us achieve our goal.

I have read the above contract and understand and agree to all terms stated.

_____ _____
Patient Signature **Date**

_____ _____
Michael S. McKee, M.D. **Date**

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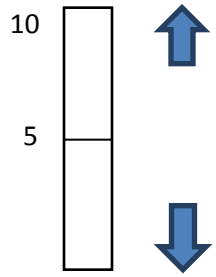
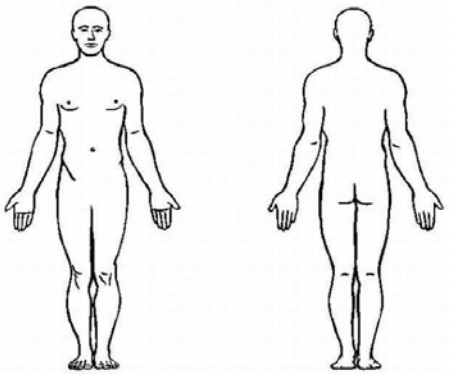
Initial Consultation-Patient Questionnaire

Patient's Name: _____ **Date of Birth:** ___/____/_____ **Today's Date:**___/___/___
Location of Visit: _____
Referring Physician:_____
Family Doctor:_____

Main Complaint(s):_____
History of present illness:





Patient's Age:_____ **Height:**_____ **Weight:**_____
Date of Injury (if applicable):___/___/_____ **How long have you had this pain?:**_____

History of the pain:
Intensity of pain: 0 1 2 3 4 5 6 7 8 9 10
Nature of pain: sharp shooting burning intermittent continuous
(circle all that apply) throbbing aching hot cold tingling
Numbness: yes no
Weakness: yes no
Pain during the day: Morning Afternoon Evening
Increases pain: sitting standing bending sitting to standing lifting
other (explain):_____
Decreases pain: lying down medication heat ice other (explain):_____
Sleep: _____hours per night
Are you currently: working? receiving disability payments?
Are there currently disability claims or lawsuits pending related to your pain?: yes no
Medical conditions: Hypertension Diabetes Mellitus Heart Disease Thyroid Stroke
Depression Other (explain):_____

- ○ Physical Therapy
- ○ Acupuncture
- ○ Chiropractor
- ○ Other

Past surgeries: _____
Current Medications: _____
Pain Medications: _____

MRI Findings
C: _____
T: _____
L: _____
S: _____
H: _____
K: _____

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Initial Consultation (continued)

Doctor who prescribes to you: _____

Previous pain medications: _____

Allergies: _____

Past pain procedures: _____

Other interventional measures: _____

Social History: **Smoke** **Alcohol Consumption** **Drug Abuse**

Physical Exam:

Please circle and provide dates for any of the following diagnostic tests you have undergone for your pain:

X-rays: **Date(s):** _____

EMG: **Date(s):** _____

Myleogram: **Date(s):** _____

CAT Scan: **Date(s):** _____

Nerve Conduction Study: **Date(s):** _____

Discogram: **Date(s):** _____

MRI: **Date(s):** _____

Other: **Date(s):** _____

Please add any additional comments that you feel would aide in the treating of your condition:

_____

_____

_____

_____

_____

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Financial Policy

EFFECTIVE 04/13/2012

Health Insurance

Health Insurance is a contract between you and your insurance company only. Spine Care of San Antonio is not a party to your contract and can in no way guarantee any level of insurance reimbursement. If your insurance carrier refuses payment, for any reason, the patient remains responsible for the balance. Spine Care of San Antonio withdraws itself from involvement in insurance disputes, but will provide you, or your insurance company, with any information that we are capable to release. We will do our best at helping you get the best reimbursement possible.

Cancelled Appointment

Spine Care of San Antonio requires you to call not later than 24 hours before your appointment if you need to cancel. If you do not call within 24 hours your account will be assessed a $50. fee that must be paid prior to your next appointment.

NSF Check Fee

If your check is returned for any reason there will be a $25. dollar fee assessed to your account.

Failure to Pay Your Balance

Failure to pay your account balance may result in your account being placed with our outside collection agency. If this occurs you are responsible for any collection agency fees that may result from this action.

By Signing below you are stating that you are fully aware of Spine Care of San Antonio's Financial Policy and that you are responsible to pay any balance due after Insurance review.

_____ _____

Patient or Patient Representative Signature **Date**