



## 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](mailto: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 \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Telephone Number \_\_\_\_\_

### 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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### Initial Consultation-Patient Questionnaire

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

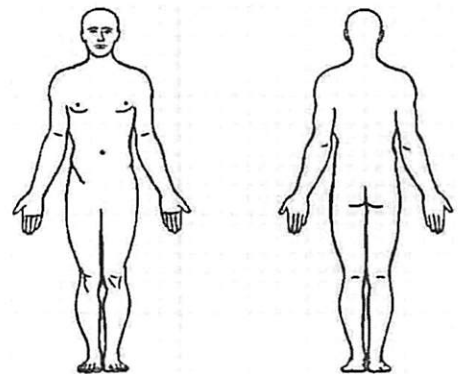
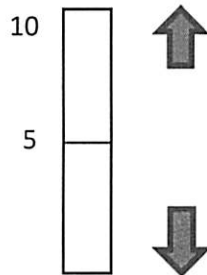
Location of Visit: \_\_\_\_\_

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): \_\_\_\_\_

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): \_\_\_\_\_

Myelogram:                        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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## 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 \_\_\_\_\_  
Person(s)/organizations authorized to use/disclose  
information (from) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_  
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 \_\_\_\_\_

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- 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 assess 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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## **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 \$ 50.00 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.**

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**Patient or Patient Representative Signature**

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**Date**



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## **NOTICE OF PRIVACY ACT**

### **HIPPA POLICY**

I understand that I have certain rights to privacy regarding my protected health information. This information can be used for treatment and follow up to a referring physician or obtaining insurance payment.

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Signature

## Spine Care of San Antonio

Office Hours: Mon-Fri 8:00 am-5:00 pm  
Closed for Lunch 12:00 pm -1:00 pm

Phone (210) 545-0087  
Fax (210) 545-3455

1. **Prescription Refills:** We do not do any refill of medications over the phone or fax, if you need a refill/change medication you will need to schedule an appointment.
  2. **Referrals:** We will not backdate referrals. Referrals to see Dr. McKee must be requested 3 days prior to your appointment. Without a valid referral, you may be responsible for any incurred charges at the office. Any delay in getting the information within 72 hours could cause you to have to reschedule your appointment.
  3. **Lab & Imaging Results:** Please allow 5 business days for results of lab or imaging. These results will only be discussed during a follow up visit with the Doctor. You are responsible for setting up a visit to discuss the results.
  4. **Regarding your appointment...** We understand your time is valuable, and we do our best to run on schedule. There are many ways you can assist us in staying on time:
    - Arriving 10-15 minutes prior to your appointment time.
    - Ensuring your insurance information is up to date prior to your scheduled appointment time. If current insurance is not on file prior, be prepared to reschedule your appointment.
    - Appointment times are allotted for one patient only. Inform the reception if you require more time.
  5. **Cancellations, No Shows and Late arrivals:** For the courtesy of other patients, we require that all cancellations be made 24 hours in advance of appointment. We will call the day before as a courtesy, provided we have the correct contact information; however you are responsible for keeping your appointment. Spine Care will charge \$30 for missed/cancelled appointments received less than 24 hours prior to your appointment time. Our office has the right to discharge any patient that has missed or has been late to three or more appointments. If you believe you are going to be greater than 15 minutes late for your appointment, you will be required to reschedule to a later date or time.
  6. **Co-Pays, Co-Insurance, & Deductibles:** As a part of our contract with your insurance company, we are required to collect any copays, coinsurance, and deductible at the time of service. Full payment is expected at the time of service.
  7. **Medical Records:** Your medical records are strictly confidential. If you wish to personally request your records, there will be a \$25 charge. If you authorize another physician's office to request records, there will be no charge.
  8. **Hospital:** When patients require care at the hospital, they will be cared for by the hospitalist. The hospitalist will manage all hospital care and patients will be referred back to the clinic for follow up care.
  9. **Forms:** Appointments are required for any Forms/Paperwork that needs to be filled out for Disability, FMLA, and detailed insurance forms.
- Thank you in advance for your cooperation with following these policies.**

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Patient Signature

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Date