WELCOME TO OUR OFFICE

Name: _____ Date of Birth: _____ Sex: M/F
Address: _____City: _____ State: _____ Zip: _____
Email: _____ Social Security Number: _____
Driver's License: _____ Marital Status (circle one) M S W D
Employer Address: _____ Occupation: _____
Date of Injury: _____ Work Phone Number: _____
Emergency Contact Name and Phone Number:
_____

INSURANCE INFORMATION
Policy Holder's Name: _____ Relationship to Patient: _____
Address: _____ Phone Number: _____
Social Security Number: _____ Date of Birth: _____
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 Spine Care of San Antonio, for medical services. I represent that I have insurance coverage and do hereby authorize, Spine Care of San Antonio, to release and obtain all information necessary to secure payment of said benefits. If my insurance fails to pay, Spine Care of San Antonio, 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.

I acknowledge that the Notice of Privacy Practices has been made available to me in the lobby. I understand the payment is expected at the time of office services rendered.

Patient Signature: _____ Date: _____

SpineCare OF SAN ANTONIO

INITIAL CONSULTATION-PATIENT QUESTIONNAIRE

Patient's Name: _____ **Date of Birth:** _____ **Today's Date:** _____

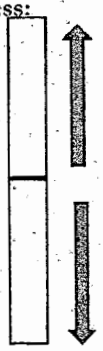
Location of Visit: _____

Referring Physician: _____

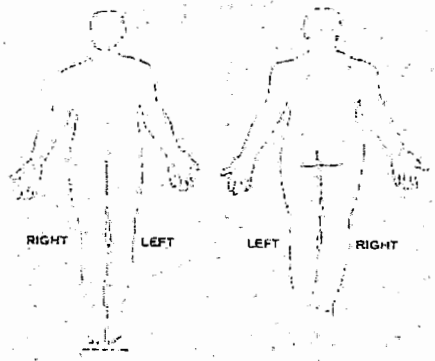
Family Doctor: _____

Main Complaint(s): _____

History of Present Illness:



PAIN BODY DIAGRAM



Patient's Age: _____ Height: _____ Weight: _____
Date of Injury (if applicable): ___/___/___ How long have you had this pain? _____
HISTORY OR PAIN
Intensity of Pain: 0 1 2 3 4 5 6 7 8 9 10
Nature of the pain: Sharp Shooting Burning Intermittent Constant 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
Decreases Pain: Lying down Medication Heat Ice other(explain):
Sleep: _____ hours per night
Are you currently working? _____ Receiving disability benefits? _____
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: _____ H: ___ Physical Therapy? Chiropractic Care? Acupuncture?
T: _____ K: ___ L: ___

SpineCare OF SAN ANTONIO

Initial Consultation (continued)

Doctor who prescribes to you: _____

Previous pain medication: _____ Allergies: _____

Past Pain Procedures: _____ Other interventional measures: _____

Social History: _____ Smoke: _____

Alcohol consumption: _____ Drug Abuse: _____

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):

CT 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 treatment of your condition:

_____

_____

_____

_____

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OF SAN ANTONIO

PRESCRIPTION OF NARCOTIC MEDICATION AND OTHER CONTROLLED SUBSTANCES AGREEMENT

Patient's Name: _____ Date of Birth _____

1. Medication is being prescribed to me as a part of my treatment plan on a temporary basis, with the goal being an eventual reduction of pain medications.
2. 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.
3. 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 results in death.
4. I agree that I will not consume alcohol or other illicit drugs in conjunction with the medications prescribed by my Physician.
5. Any deviation of use, including, but not limited to, sharing prescribed medications with other, obtaining undisclosed prescriptions from other Physicians, running out of prescribed medication prior to the next scheduled visit, including unexplainable loss and or misplacement, will results in my discharge from Spine Care of San Antonio.
6. In the event I am discharged from Spine Care of San Antonio for any reason, it is up to my Physician's discretion to provide one month of medication while I find another Physician to take on my case.
7. My Physician reserves the right to discharge me from his care if any of the forementioned prescription medication misuse is suspected.
8. In the even of my losing control of narcotic or other controlled drug use, I may be referred to a detoxification center, at my Physician's discretion.
9. 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 dependency and withdrawal potential.
10. Aggressive behavior toward my Physician or any of the office staff will not be tolerated and will be ground for immediate discharge from Spine Care of San Antonio.
11. Refusing a random drug test will also be grounds for discharge from Spine Care of San Antonio

Patient Signature: _____ Date: _____

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 of your insurance reimbursement. If your insurance carriers refuse 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.

Canceled Appointment

Spine Care of San Antonio requires you to call no less than 48 hours before your appointment if you need to cancel. If you do not cancel giving a 48 hour notice a $50 fee for office visits and $100 for procedures. This fee will be incurred to your account. This does need to be paid prior to scheduling another appointment.

NSF Check Fee

If your check is returned for any reason, there will be a $30 fee assessed to your account and you will no longer be able to write checks as a form of payment.

Failure to Pay Your Balance

Failure to pay your account balance may result in your account being placed with an 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 the Financial Policy at Spine Care of San Antonio and that you are responsible to pay any balance due after insurance review.

_____ Date: _____

Patient or Patient Representative Signature

SpineCare OF SAN ANTONIO

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 all records, whether written, oral or in electronic format are confidential and cannot be without 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: _____

_____

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

_____

_____

Information that may be used/disclosed:

___ Record of Visit(s)
___ Discharge Summary
___ History/Physical
___ Consultation report
___ Problem List
___ Progress Notes
___ Immunization Record(s)
___ Medication Record(s)
___ Laboratory Report(s)
___ Xray, MRI, CT
___ Echo, Stress Tests, Holters
___ Mental Health/Alcohol/Drug abuse treatment
___ AIDS or HIV information
___ Hepatitis information
___ Entire Medical Record
___ Statement of Charge/Payments

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

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

___ Continued patient care
___ Disability Determination
___ Personal Use
___ Attorney/Legal
___ Insurance Claim
___ Other _____

1. Will the healthcare 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 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.

- 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.
- 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 _____ Date _____

SpineCare OF SAN ANTONIO

SPINE CARE OF SAN ANTONIO

Office Hours: Monday – Friday 8:00 am – 5:00 pm

Closed for lunch from 12:00 pm – 1:00 pm

Phone: 210-545-0087

Fax: 210-545-3455

1. **Prescription Refills**: We do not accept refill requests over the phone or by fax. If you need a refill/change in medication you will need to schedule an appointment.
2. **Referrals**: We will not back date referrals. Referrals to see a provider with Spine Care of San Antonio 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 and Imaging Results**: Please allow 5 business days for results of lab or imaging. These results will only be discussed during a follow up with your Provider. You are responsible for setting up a visit to discuss 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.
    a. Arriving 10-15 minutes prior to your appointment time.
    b. Ensuring your insurance information is up to date prior to your scheduled appointment time. If appropriate insurance requires a referral, you will be scheduled.
    c. 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 48 hours in advance of the appointment time. Spine Care of San Antonio will charge $50 no show/cancelation fee if less than 48 hours' notice is given. If you arrive more than 15 minutes late to an appointment you will be required to reschedule and you will be charged a $50 cancelation/late fee. There is a $100 cancelation/no show fee for procedures that are not canceled with 48-hour notice.
6. **Co-pays, Co-Insurance, Deductibles**: As part of our contract with your insurance company, we are required to collect any copays, coinsurance, and deductibles at the time of service. Full payment is expected at the time of service.
7. **Medical Records**: Your medical records is strictly confidential. If you wish to personally request your records, there will be a $40 charge. If you authorize another Physician's office to request records this fee will be waived.
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 to the clinic for follow up.
9. **Forms**: Appointments are required for any Forms/Paperwork that needs to be filled out to include Disability, FMLA, and detailed insurance forms. There is a $50 charge for completion of these forms.

Patient Signature: _____ **Date:** _____

SpineCare
OF SAN ANTONIO

Notice of Privacy Act

HIPAA

(Health Insurance Portability and Accountability Act)

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.

If you would like a copy of the Privacy act, please inform the front desk and one will be printed for you.

I decline a copy of the Privacy Act _____
(Initials)

Signature of acknowledgement _____ Date: _____