SPINE ASSOCIATES

RICHARD R.M. FRANCIS, MD, MBA, FRCS Ed., FRCS Ed. (Tr & Orth)
Orthopaedic Surgeon
Surgery of the Spine

Today's Date:

Patient Name:	SSN DOB	Age	Sex Male ☐ Female☐	Marital Status Single Divorced Married Widowed

If Patient Is A Minor (under 18) Parent or Guardians Name	Relationship:

Home Address:	City	State	Zip

Home Phone:	Cell Phone:	Email:

Employer:	Work Phone: Ext:

Business Address:	City	State	Zip

Referring Physician	Phone
Primary Care Physician	Phone
Pharmacy	Phone

Primary Insurance Information		Secondary Insurance Information	
Do you have Medicare? ☐ Yes ☐ No Do you have Texan Plus (Medicare HMO)? ☐ Yes ☐ No		Name of Insurance:	
Name of Insurance:		Name of Insured:	DOB
Name of Insured:	DOB	Social Security number	
Social Security #:	Relationship to patient: ☐ self ☐ spouse ☐ child ☐ other	Relationship to patient: ☐ self ☐ spouse ☐ child ☐ other	
Employer	Bus. Phone	Employer	Bus. Phone
Business address		Business address	
Insurance ID#		Insurance ID #	
Group/Plan#		Group/Plan #	
Insurance Phone #:		Insurance Phone #:	

Emergency Contact Information

Name:	**Relationship:**	**Emergency contact#**

Reason for Appointment / Chief Complaint:

PAIN ILLUSTRATION

Mark the areas on your body where you feel the described sensations. Use appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness = = = = = Pins & Needles ooooo Burning xxxxx
Stabbing ///// Chronic Ache zzzzz

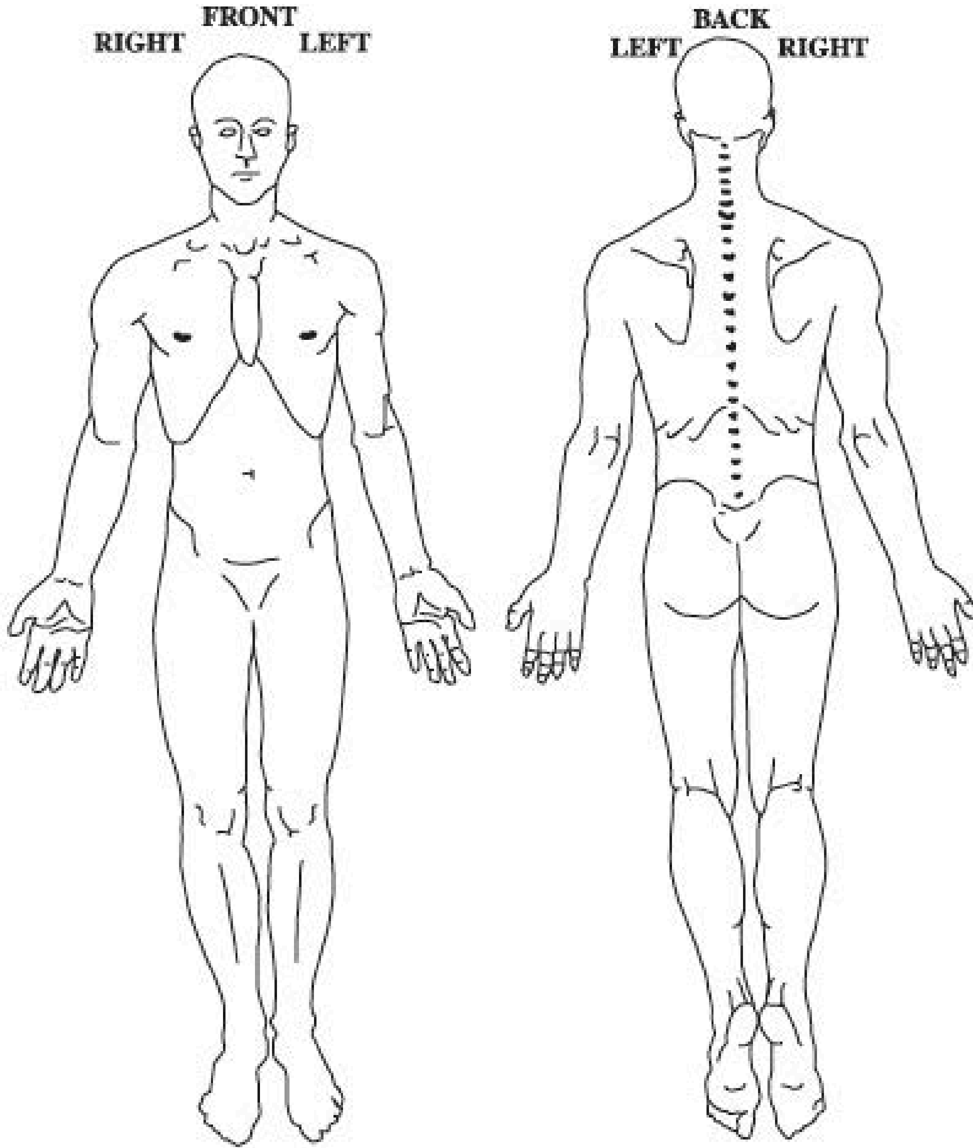
Patient Name:___________________________

Date: ___________________________________

Gender: ☐ Male ☐ Female **Handedness:** ☐ R ☐ L

Date of Birth: _________ **Current Age:** ______

Height:__________ **Weight:**__________



How bad is your pain? Circle the number on each of the lines below to indicate your pain.

How bad is your **neck** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **arm** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **middle back** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **low back** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **leg** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

Please identify which ONE of the following best describes your spine (back or neck) vs extremity (arm or leg) pain:

☐ 100% Spine pain to 0% Extremity pain
☐ 90% Spine pain to 10% Extremity pain
☐ 80% Spine pain to 20% Extremity pain
☐ 70% Spine pain to 30% Extremity pain
☐ 60% Spine pain to 40% Extremity pain
☐ 50% Spine pain to 50% Extremity pain
☐ 40% Spine pain to 60% Extremity pain
☐ 30% Spine pain to 70% Extremity pain
☐ 20% Spine pain to 80% Extremity pain
☐ 10% Spine pain to 90% Extremity pain
☐ 0% Spine pain to 100% Extremity pain

Patient Initials________ Date___________

FACTORS OF COMPLAINT

What would you like to happen as a result of this visit?

____

____

____

____

How / when did your problem begin? (please mark all that apply to your neck / back pain)

- ☐ I don't know how it began
- ☐ It comes and goes
- ☐ I've had it a long time (______ years)
- ☐ Injury (date of injury_______) on the job? ☐ yes ☐ no
  Please explain how injury happened
  ____

Are you currently in litigation with regards to your back pain?
☐ yes ☐ no

Have you been laid off from your job? ☐ yes ☐ no ☐ N/A

Is your pain worse at night? ☐ yes ☐ no
Does your pain awaken you from sleep? ☐ yes ☐ no
Does coughing affect your pain? ☐ yes ☐ no
Do your legs tire / hurt if you walk too far? ☐ yes ☐ no
If YES, how far can you walk?
☐ less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks
Is this relieved by resting your legs? ☐ yes ☐ no
Is this relieved by bending forward? ☐ yes ☐ no

Bladder Control (urine):
- ☐ No problem
- ☐ Can't empty bladder
- ☐ Loss of urine (accidents)

Bowel Control:
- ☐ No problem
- ☐ Constipation
- ☐ Loss of control (accidents)

How does each of the following affect your pain? (check all that apply)

Sitting	☐ Better	☐ Worse	☐ No change	
Standing	☐ Better	☐ Worse	☐ No change	
Walking	☐ Better	☐ Worse	☐ No change	
Lying down	☐ Better	☐ Worse	☐ No change	
Rising from a chair	☐ Better	☐ Worse	☐ No change	
Physical activity	☐ Better	☐ Worse	☐ No change	
Heat	☐ Better	☐ Worse	☐ No change	☐ Don't know
Cold	☐ Better	☐ Worse	☐ No change	☐ Don't know
Massage	☐ Better	☐ Worse	☐ No change	☐ Don't know

Have you ever had surgery ON YOUR NECK or BACK?

☐ Yes ☐ No **If YES, complete the following:**

1) Type of surgery: ______________________________

Date_______________ Surgeon_______________

Did it make your pain ☐ better ☐ worse ☐ no change?

2) Type of surgery: ______________________________

Date_______________ Surgeon_______________

Did it make your pain ☐ better ☐ worse ☐ no change?

Please mark the timeframe for any tests that were performed for this CURRENT back/neck pain

	<6 months	6-12 months
X-ray	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
Discogram	☐	☐
EMG/NCV (nerve test)	☐	☐

Previous treatments for this CURRENT back/neck pain

Chiropractic care	☐better	☐worse	☐no change
Physical Therapy	☐better	☐worse	☐no change
Injections	☐better	☐worse	☐no change
Psychiatric Consultation	☐better	☐worse	☐no change
Other:_______________	☐better	☐worse	☐no change

Patient Initials________ Date____________

GENERAL MEDICAL HISTORY

Check all the conditions below that you currently have or have had in the past. If NONE check ☐

☐ Heart attack	☐ Colon problems	☐ Gout	☐ Enlarged prostate
☐ Heart murmur	☐ Diabetes	☐ Anxiety	☐ Menstrual problems
☐ Angina	☐ Hepatitis	☐ Depression	☐ Caner: Type _______________
☐ High blood pressure	☐ Cirrhosis	☐ Emphysema	☐ Osteoporosis
☐ Stroke	☐ Kidney Stones	☐ Tuberculosis	Have you used:
☐ Varicose Veins	☐ Kidney infection	☐ Chronic bronchitis	☐ Immunosuppression
☐ Stomach ulcers	☐ Degenerative arthritis	☐ Frequent pneumonia	☐ Corticosteroids
☐ Duodenal problems	☐ Rheumatoid arthritis	☐ Asthma	☐ Other: ___________________
☐ Anemia	☐ Bleeding tendency	☐ Sexual difficulty	

REVIEW OF SYSTEMS

Have you seen a primary care physician within the past year? ☐ yes ☐ no

Do you have any of the following?

General:

Recent weight loss of more than 10 lbs?	☐ yes ☐ no
Recent weight gain of more than 10 lbs?	☐ yes ☐ no
Fever?	☐ yes ☐ no
Chills?	☐ yes ☐ no
Night sweats?	☐ yes ☐ no

Cardiovascular:

Chest pain	☐ yes ☐ no
Shortness of breath	☐ yes ☐ no

Respiratory:

Wheezing	☐ yes ☐ no
Pneumonia	☐ yes ☐ no
Chronic cough	☐ yes ☐ no

Gastrointestinal:

Abdominal pain	☐ yes ☐ no
Nausea	☐ yes ☐ no
Vomiting	☐ yes ☐ no
Diarrhea	☐ yes ☐ no
Liver problems	☐ yes ☐ no

Skin:

Open sores	☐ yes ☐ no
New moles	☐ yes ☐ no
Poor healing	☐ yes ☐ no
Skin infection	☐ yes ☐ no

Endocrine:

Thyroid problems	☐ yes ☐ no

Genitourinary:

Abnormal kidney function	☐ yes ☐ no
Pain with urination	☐ yes ☐ no
Frequent urinary infections	☐ yes ☐ no

Mental health:

Sleep disturbances	☐ yes ☐ no
Feeling of hopelessness	☐ yes ☐ no

Nervous system:

Headaches	☐ yes ☐ no
Tremors	☐ yes ☐ no
Poor speech	☐ yes ☐ no
Changes in vision	☐ yes ☐ no

Bones/Joints:

Shoulder pain	☐ yes ☐ no
Wrist/hand pain	☐ yes ☐ no
Hip pain	☐ yes ☐ no
Knee pain	☐ yes ☐ no
Lupus	☐ yes ☐ no
Muscle weakness	☐ yes ☐ no
Fibromyalgia	☐ yes ☐ no

Hematologic/Oncologic:

Easy bruising	☐ yes ☐ no
Blood thinning medications	☐ yes ☐ no
Blood transfusions	☐ yes ☐ no
Organ transplant	☐ yes ☐ no

Are you allergic to any medications? ☐ yes ☐ no
If YES, please list:

____
____
____
____

Patient Initials________ Date_____________

FAMILY MEDICAL HISTORY

☐ I do not know the medical history of my biological parents or other family members. (Go on to next section)	**Mother:** ☐ Alive age:______ ☐ Deceased at age:______ Due to __________________	**Father:** ☐ Alive age:______ ☐ Deceased at age:______ Due to __________________	Number of living brothers/sisters:______ Number of deceased brothers/sisters:______ cause(s):____________

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:
Check all that apply

☐ Heart Trouble
☐ Kyphosis
☐ Stroke
☐ Back Problems
☐ Arthritis
☐ Diabetes
☐ Cancer
☐ None of these
☐ Lung Disease
☐ Osteoporosis
☐ Don't know
☐ High Blood Pressure
☐ Scoliosis
☐ Other:___________________

SOCIAL HISTORY

Smoking
☐ Current every day smoker (see A below)
☐ Current some day smoker (see A below)
☐ Former smoker (see B below)
☐ Never smoked

A)
Year Started: _____________
Cigarettes ______ packs / day
Cigars ______ # per week
Smokeless / chewing ______ amount / day

B)
I quit smoking in / around the year ________ ,

But I smoked ______ packs/day for _____ years.

Alcohol
Do you drink:
☐ Beer? ☐ yes ☐ no ____ #/day
☐ Wine? ☐ yes ☐ no ____ #/day
☐ Hard liquor? ☐ yes ☐ no ____ #/day

Frequency of drinking:
☐ never
☐ rarely
☐ socially (# per week _____)
☐ daily (# per day ________)

Do you have a history of heavy drinking?
☐ yes ☐ no

Effect of your neck/back pain on your lifestyle

I describe my home setting as supportive of me during this time ☐ yes ☐ no
I describe my work setting as supportive of me during this time ☐ yes ☐ no
My pain has affected my interaction with my family and friends ☐ yes ☐ no
The changes in my lifestyle due to my problem have been difficult for me ☐ yes ☐ no

Ability to enjoy life:
☐ Excellent
☐ Good
☐ Fair
☐ Poor

Please indicate your <u>current work status</u>
☐ Working full time
☐ Working part time
☐ Seeking employment
☐ Not working by choice (retired, homemaker, student, etc.)
☐ Physically unable to work **due to** neck/back pain
☐ Physically unable to work **not due to** neck/back pain

<u>Before</u> having neck/back pain, did you normally work:
☐ full time ☐ part time ☐ neither
What is your usual occupation?

____

Do you like your work situation?
☐ yes ☐ no ☐ N/A

Patient Initials________ Date_______

S P I N E A S S O C I A T E S

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Surgery of the Spine

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY ACT OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

This Notice ofPrivacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) which went into effect April 14, 2003. ThisNotice describes how we may use and disclose health information about you for treatment, payment, healthcare operations, or for other purposes that are permitted or required by law. It also describes your rights to access and control your health information in some cases. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Use and Disclosure of Information by Your Healthcare Provider

The provider may use your health information for purposes of providing treatment, obtaining payment for treatment, and conducting healthcare operations. Your health information may be used or disclosed only for these purposes unless the Provider has obtained authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, employee review activities, education, training programs, accreditation, certification, licensing or credentialing activities, as well as compliance reviews, me dical reviews, and business management and general administrative activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We will disclose your health information to you, as described in the Patient Rights section of this Notice. With your permission, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: W may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will no use your health information of marketing communications without your written authorization.

Required by Law: We may use or disclose your health information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, official having lawful custody of health information or inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters.)

Worker's Compensation: The provider may release your health information to comply with worker's compensation laws or similar programs.

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of the Notice.

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Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

Our Promise to You: We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to health information, and to abide by the terms of their notice of privacy practices in effect.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us in the contact information listed at the end of the Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

5420 WEST LOOP SOUTH, STE 2500, BELLAIRE, TX 77401 • OFFICE: (713) 383-7100 • FAX: (713) 383-7500
3820 POINTE PARKWAY, BEAUMONT, TX 77701 • OFFICE: (409) 767-8221 • FAX: (409) 785-4200
www.myspineassociates.com

SPINE ASSOCIATES

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Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ _______________________

Patient, Personal Representative or Guardian Date

If Personal Representative or Guardian signature appears above, please describe the relationship to the patient: ____

SPINE ASSOCIATES

ATTN: Privacy Officer
5420 W. Loop South Suite 2500
Bellaire, TX 77401

The Privacy Officer can be contacted by telephone at 713-383-7100

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Financial Policy Statement

It is the policy of Spine Associates to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time services are rendered. If your insurance carrier does not permit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Spine Associates, you recognize your obligation to promptly remit payment to Spine Associates.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised that as a Worker's Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Spine Associates, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.
The above information has been explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

____ ____________________

Patient or Responsible Party Date

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RELEASE OF MEDICAL DOCUMENTATION
HIPPA RELEASE FORM

Patient's Name: ______________________________ Date: ______________

Social Security Number: ____________________ Date of Birth: ______________

DOCUMENTATION INCLUDED

This document allows *Spine Associates* to release your medical records to other healthcare providers who have treated or are treating you (or your dependent minor) or payors who request these records as allowed by law.

This authorization applies to any and all of my (or my dependent's - if guardian of minor) medical records including, but not limited to, progress notes, laboratory reports, radiological / nuclear medicine reports, history and physical examinations, consultation reports, electrophysiological studies and any other medical documentation pertaining to my (or my dependent's) care.

_______ (Initials)

I understand that my express consent is required to release any of my health care information pertaining to testing, diagnosis, and/or treatment for AIDS (HIV), sexually transmitted diseases, psychiatric / psychological / mental health disorders, drug or alcohol abuse. I hereby authorize *Spine Associates*. to release all information pertaining to such diagnoses.

Exclusions: ______________________________ ☐ None ______________
(Patient's Initials)

By signing below, I agree to all the terms and conditions of this document and certify that I have read and understand the above information and its implications. I have made any and all exclusions specially known to *Spine Associates* as noted in writing above. This authorization is valid indefinitely or until I revoke it in writing. A Photostat copy of this authorization is valid as the original.

______________________________ Date: ______________
(Patient/Guardian/Guarantor Signature)

______________________________ Date: ______________
(Witness Signature)

☐ ADDITIONAL RELEASE TO:

This document shall authorize *Spine Associates* to release any and all of my medical records as understood above to:

Name: ______________________________

Address: ______________________________

REASON FOR RELEASE:

☐ Coordination of treatment
☐ Disability application
☐ Provide information regarding previous treatment(s)
☐ Provide information for legal matters

☐ Other: ______________________________

______________________________ Date: ______________
(Patient/Guardian/Guarantor Signature)

______________________________ Date: ______________
(Witness Signature)

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CONSENT FOR MEDICAL TREATMENT

Knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital.
This form has been fully explained to me and I certify that I understand its contents.

______________________________________ ________________
Patient's Signature **Date**

____
Witness

Patient is:______a minor__________unable to consent because__________________

____

I hereby consent on his/her behalf and in his/her stead on ______________________
Date

Signature of Person Responsible for Patient or Patient's Legal Guardian

______________________________________ __________________
Signed **Print Name**

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