Spine Physicians Institute
SPI
Where the Patient's Interest, Is the Only Interest

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS# (optional): _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Spouse's Name: _____ Spouse's Date of Birth: _____/_____/_____

Main Contact#: _____ Alternate#: _____

Emergency Contact:_____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____Please Specify)

Primary Insurance:_____ Policy/ID# _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Secondary Insurance: _____ Policy/ID#: _____

Name of Policy Holder:_____ DOB: _____/_____/_____ Group/Acct #:_____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work #: _____

Father's/Guardian Name: _____ Relationship: _____

Mother's/Guardian Name: _____ Relationship: _____

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GENERAL CONSENT FORM

Patient Name: _____ **Date of Birth:** _____/_____/_____

Assignment of Benefits. I authorize Spine Physicians Institute (SPI) to submit claims on my behalf directly to my private health insurance carrier. This means that Spine Physicians Institute will collect payment for supplies and services provided. **I understand that I am financially responsible** to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and or treatment in order to process claims. This assignment will remain in effect until revoked by me in writing.
Patient Initials: _____

Consent for Treatment. I consent for Spine Physicians Institute to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, Spine Physicians Institute may have such BBF tested for human immunodeficiency (HIV/AIDS) at SPI's expense. **Patient Initials:** _____

Mail/Email/Phone Calls. I certify that I understand the privacy risks of the mail, phone calls and email. I hereby authorize a SPI representative or my physician to mail, call and or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Spine Physicians Institute to that effect in writing. **Patient Initials:** _____

Lab/X-Ray/Diagnostic Services: I understand that I may receive a separate bill if my medical care should include lab, x-ray and or other services, such as other diagnostic or anesthesia services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by insurance for whatever reason. **Patient Initials:** _____

Involvement of Others in Care. I authorize Spine Physicians Institute to discuss my/the patient's care and medical needs with the following person.

Name	Date of Birth	Relationship	Phone

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone#: _____
◯ Leave message with contact number only
◯ Leave message with detailed information
◯ Do not leave message

Secondary Phone#: _____
◯ Leave message with contact number only
◯ Leave message with detailed information
◯ Do not leave message

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GENERAL CONSENT FORM

Patient Financial Policy
I acknowledge receipt of the "Patient Financial Policy" **Patient Initials:**_____

Notice of Privacy Practice
I acknowledge receipt of the "Notice of Privacy Practice" **Patient Initials:** _____

Prescription Policy
I acknowledge receipt of the "Prescription Policy" **Patient Initials:** _____

Cancellation/No Show Policy
I acknowledge receipt of the "Cancellation/No Show Policy" **Patient Initials:** _____

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative Date

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PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing staff or billing company. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- We have made prior arrangements with many insurers and health plans (HMO & PPO) to accept assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

- Private Pay/Self Pay patients are required to pay in full at the time of check-in.

- Unless other arrangements have been made in advance by you and or your health insurance carrier, full payment for office services are due at the time that services are rendered. For your convenience we accept Visa, MasterCard, Discover and American Express. Please be advised that there is a $35 service charge on all returned checks.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay within a reasonable period, will with assign all "balance due" to the patient for payment.

- You will be financially responsible for all services "not covered" by your health insurance. Payment for these services will be due at the time that the services are rendered.

- Fees for fracture care are often billed as "global" and include fracture care and office visits for a specified time period. X-rays, supplies, cast application fees, etc. are charged separately. Fracture care codes are listed under the insurance code section for surgery even though no "surgery" may have been performed.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our offices.

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I agree that I will not withhold or delay payment if my insurance company denies payment on any of the services rendered and or not covered. In the event it should become necessary to place for collection, any unpaid balance due to SPI, I/we agree to pay interest, collection fees and any/all legal fees, should legal action be filed.

SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information as outlined below. Patient agrees to notify provider in the future immediately of any additions, changes or deletions in primary or secondary insurance coverage. Initial/complete as applicable.

_____ **I have no secondary insurance coverage.**

_____ **I have secondary insurance coverage as described on the attached Patient Demographic form.**

If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered and or dismissal from the practice.

Failure to keep your account balance current may require us to cancel/reschedule your appointment and or you may be subject to dismissal from the practice.

SPINE PHYSICIANS INSTITUTE, firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please discuss with the Practice Manager.

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PRESCRIPTION POLICY

In order to provide outstanding quality care, Spine Physicians Institute, adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our physician, as this allows you to the update the physician on any changes in your medication or advise him of any new or ongoing symptoms. We understand, however, that sometimes this is not possible and in those situations it will be necessary to follow our refill policy.

Please call your pharmacy for all prescription refills. Most pharmacies will contact our physician office regarding renewal of medications. Should your pharmacy decline renewal; your pharmacist will instruct you regarding the next steps to take.

When it is necessary to call in for a refill, please call the Medical Assistant of your physician.

The following guidelines will be followed when processing your refill request:

- There will be no refills given afterhours, weekends or Holidays
- A process time of 3 days minimum will be needed for all refill requests
- There will be **NO early refills**, patient must follow prescriptive directions
- Prescription phone-in/pick-up must be done **Mon-Fri 9am – 3:30pm**
- Non-controlled/non-narcotic prescriptions will require a follow up appointment every **3 months**
- Controlled/Narcotic prescriptions will require a follow up appointment every **30 days**
- New symptoms and/or change in pain levels or new injury will require clinic appointment
- No refills will be given for prescriptions NOT originally prescribed by SPI physician
- Signed "Prescription Refill Policy" is required if using narcotic/controlled medications

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PHARMACY INFORMATION

Today's Date: _____

Patient Name: _____

Patient DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

_____

Patient Signature **Date**

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Cancellation Policy/No Show Policy
For Doctor Appointments and Procedures

1. Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **Excessive late cancellations/No Show can result in dismissal from the practice.**

If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty five ($35) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however, we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

We require our patients to authorize a credit card to be left on file for the $35 no show/late cancellation fee. $35 fee will ONLY be charged if there is a violation to the Cancellation/No Show Policy. The fee will be charged to the credit card on the same day as the missed appointment.

CC Type (please circle one) AMEX VISA MC

Credit Card No. _____

Exp Date. _____ **CV2** _____ **Billing Zip Code** _____

Name on Card: _____

Authorized Signature: _____

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Research Release Form

The Physicians and staff at the Spine Physicians Institute (SPI) are dedicated to providing evidence medicine. In order to ensure that you the patient are receiving such care, it is necessary to utilize our patient's medical history along with their treatment plans as a source of study and information.

By signing this form, you are giving the physicians and staff of SPI permission to utilize your medical records for the purposes of research, lectures and patient education videos. Your medical records, for these purposes are defined as your diagnostic images and your medical history. At no time will your name, date of birth or social security number be disclosed to anyone.

Please indicate below whether or not you will allow SPI to use your medical information for the purpose of research.

[ ] **Do not release any of my medical information for any reason**

[ ] **I give permission for SPI to use my medical information for the purposes outlined above.**

_____ _____

Patient Signature Date

From time to time we have patients that have questions regarding their upcoming surgery and request to get in touch with a past surgical patient. If you have had surgery by Dr. Venkat Sethuraman and would be interested in participating in a patient education program to mentor future surgical patients, please sign below. Your signature gives SPI permission to disclose your name and number ONLY to another patient for the sole purpose of gaining insight regarding their treatment plan. At no time will any medical history be disclosed.

_____ _____

Patient Signature Date

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NEW PATIENT QUESTIONNAIRE

Today's Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Who referred you to our office: _____

When did your problem start: _____

**** Only complete sections A-F below that apply to you. There will be a General Medical section that will need to be completed in full. ****

INJURY OR TRAUMA (SECTION A)

Did a particular accident or injury cause your problem? ◯ **NO** (please skip to Section) ◯ **YES** (continue this section)

Check only one:

◯ **I have never had back/neck problems in this area of my spine prior to this injury**

◯ **I had back/neck problems in this area of my spine before, and this injury made it worse**

Check all that apply:

◯ **This injury occurred at work**

◯ **I have filed a claim through worker's compensation**

In your own words, please explain how this injury occurred: _____

_____

_____

_____

_____

_____

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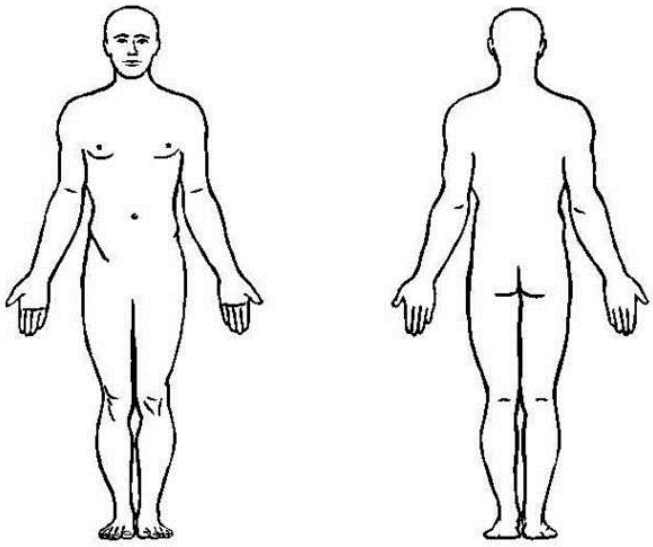
PAIN AND DISABILITY: (SECTION B)

This section pertains to pain only. You will have an opportunity to answer questions about numbness and tingling in Section C.

Does your neck or back problems cause pain? ◯**NO** (please skip to Section) ◯ **YES** (continue this section)

Please mark on the figure below to show where you feel pain.



Pain Scale 0-10 (0= No pain, 10= pain severe enough to pass out)

What number would you give your pain today: _____
What number would you give your pain on average: _____
What number would you give your pain at its worst: _____

Please check all that describe your pain:

□ **Burning** □ **Sharp/Stabbing** □ **Tingling** □ **Aching** □ **Throbbing**

□ **Shooting** □ **Pulling/Tearing** □ **Cramping** □ **Other _____**

Please check all of the appropriate responses in each category to complete the phrase "My Pain……"

□ **Began suddenly** □ **Began gradually** □ **interrupts my sleep** □ **is constant** □ **comes and goes**

My pain is worse….. □ **all day** □ **at night** □ **in the morning** □ **in the afternoon**

My pain is worse when….. □ **Walking** □ **Running** □ **Standing** □ **Sitting** □ **Bending** □ **Lifting** □ **Driving**

□ **applying heat** □ **applying ice** □ **exercising** □ **frequently changing positions**

□ **Lying down** □ **Sports _____** □ **Overhead lifting**

□ **Nothing makes my pain worse**

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My pain is better while…… □ Walking □ Running □ Standing □ Sitting □ Bending □ Lifting □ Driving

□ applying heat □ applying ice □ exercising □ frequently changing positions

□ Overhead activity □ Lying on back □ Lying on side □ Lying on stomach

□ Recliner □ Sports _____ □ Nothing makes my pain better

Overall, which single word of phrase would you use to describe your pain the majority of the time?

□ Trivial/Minimal □ Annoying □ Limiting □ Disabling □ Unbearable

Because of my pain, I am unable to…….. □ Walk over _____ miles □ Run over _____miles

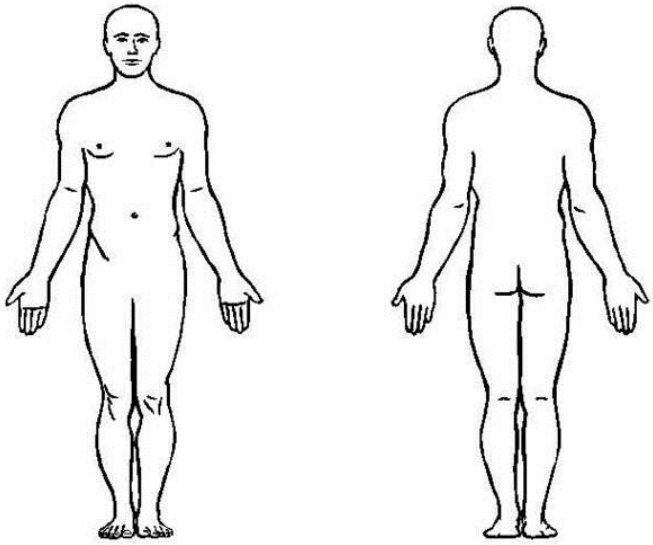
□ Sit longer than _____min/hours □ Stand longer than _____ min/hours

□ Lift over _____ pounds

NUMBNESS/TINGLING (SECTION C)

Do you feel numbness or tingling? ◯**NO** (skip to Section D) ◯ **YES** (continue this section)

Please mark on the figure below to show where you feel numbness (loss of feeling) or tingling (pins and needles)



My numbness and tingling is made worse while…. □ Walking □ Running □ Standing □ Sitting □ Bending

□ Lifting □ Driving □ Heat □ Ice □ Exercising

□ Frequently change of position □ Sports
□ Nothing makes numbness and tingling worse

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My numbness and tingling is made better while….. □ **Walking** □ **Running** □ **Standing** □ **Sitting** □ **Bending**

□ **Lifting** □ **Driving** □ **Heat** □ **Ice** □ **Exercising**

□ **Frequently change of position** □ **Sports**
□ **Nothing makes numbness and tingling better**

SPINAL DEFORMITY/TUMOR (SECTION D)

Do you have a curve, lump or mass near or on your spine? ◯**NO** (skip to Section E)

◯ **YES** (continue this section) **PLEASE CHECK ALL THAT APPLY TO YOUR SITUATION**

□□ **I have a spinal curvature or deformity (scoliosis or kyphosis) that was present at birth**

□□ **I have a spinal curvature or deformity (scoliosis or kyphosis) that developed in childhood and was not present or obvious at birth**

□□ **I have a spinal curvature or deformity (scoliosis or kyphosis) that developed as an adult and was not present in childhood**

□□ **I wore a brace when I was younger to help my scoliosis or kyphosis**

□□ **I am wearing a brace now** □□ **I have noticed my spinal curvature getting worse**

□□ **My clothes no longer fit or hang properly** □ **I have a lump or mass on my spine that is getting larger**

□□ **I have a lump or mass on my spine that is not getting larger**

□□ **The mass is painful** □ **The mass is NOT painful**

ASSOCIATED PROBLEMS (SECTION E)

Please check all that apply to you

□□ **Clumsiness in hands**

□ **Frequent falling or stumbling**

□ **Leakage of bowel contents or staining underwear**

□ **Unable to completely empty bladder**

□ **Unable to look forward without bending knees**

□□ **Must look at feet in order to walk**

□□ **Unable to stand up straight**

□□ **Leakage of urine or staining of underwear**

□□ **Impotence**

□□ **I HAVE NONE OF THESE PROBLEMS**

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TESTING AND TREATMENT (SECTION F)

Which of the following tests have you had in the last year for your spine problem? (check all that apply)

□□ X-Ray □ Blood Test □ Myelogram □ MRI □ CT (CAT Scan) □ Discogram

□□ Bone Density Scan □ Nuclear Bone Scan □ Nerve Study (EMG/NCV)

□□ Other _____ □ I HAVE HAD NO TESTS TO EVALUATE MY PROBLEM

Your treatment history (check all that apply)

		Complete Relief	Improved	Unchanged	Worse
	Physical Therapy				
	Home Exercises				
	Chiropractic Care				
	Epidural Steroid Injection (performed in hospital)				
	Facet Injection (performed in hospital				
	Local or Trigger Point Injection (performed in office)				
	Massage				
	Brace, Corset or other support				
	Acupuncture				
	Other				
	I HAVE NOT STARTED OR COMPLETED ANY OF THE ABOVE TREATMENTS				

Please list all of the physicians that you have seen in the past 2 years

Physician Name	Issue or Problem

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GENERAL MEDICAL SECTION

(Complete all areas below)

MEDICAL HISTORY

Please check any and all medical problems that you currently have or have experienced in the past

	Diabetes		**Seizures**		**Hypertension (high blood pressure)**
	Stroke		**Heart Disease**		**Emphysema**
	Brain Aneurysm		**COPD**		**Hepatitis**
	Anemia		**Blood Clotting Problems**		**Asthma**
	HIV/AIDS		**Osteoporosis/Osteopenia**		**Valley Fever (coccidiomycosis)**
	Kidney problems (renal failure, stones, infection)		**Cancer (type)**		**Tuberculosis**
	Thyroid		**Stomach Ulcers**		**Other Joint Pain**
	Rheumatoid Arthritis		**Reflux disease**		**Depression**
	Hiatal Hernia		**Psychiatric illness (type)**		**Other**
	No Medical Problems				

PRIOR SPINE SURGERY

Have you ever had surgery on your spine? (This includes Fusions, decompressions, or any disc procedures)

◯ **YES (complete this section)** ◯ **NO (please skip to medical history)**

Date	**Procedure**	**Rate the outcome of surgery. Poor. Good or Excellent (See legend below)**

Legend:

Poor = the surgery had no change or made me worse
Good = the surgery improved my symptoms
Excellent = Dramatically improved or resolved my symptoms

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Please list all non-spine related surgeries:

Procedure	Date (month/year)

MEDICATION HISTORY

Please list all medical/supplements you have tried or are currently taking in treating your spinal disorder(s). Please include last date, dose, number of pills per day and if medication helped. (examples = Naproxen, Voltaren, Ibuprofen, Feldine, Orudis, Indocin, Vicodin, Percocet, Oxycontin, Darvocet, Morphine, Soma, Flexeril, Robaxin, Skelaxin, Baclofen, Celebrex, Mobic, Neurontin, Lyrica, Elavil, Cymbalta, Ultram, Trazadone, etc.)

When last used?	Medication	Dose	# of Pills per day	Did medication help?
mm/yy	Example: motrin	800mg	4	Very

Other Medications (not related to your spine)

Medication	Dose	Condition for which you are taking medication for

Medication Allergies

◯ **I am not allergic to any medications**
◯ **I am allergic to the following medications**

Medication	Reaction

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FAMILY HISTORY

Please check next to any medical problem that runs in your family

	Diabetes		Hypertension (blood		Seizures
	Stroke or Aneurysm		Heart Disease		Emphysema (COPD)
	Hepatitis		Kidney/Bladder problems		Asthma
	Tuberculosis		Valley Fever		Stomach Ulcer or reflux disease (peptic ulcer, hiatal hernia)
	Osteoarthritis (degenerative)		Rheumatoid Arthritis		Cancer (type)
	Depression		Spinal Disorder		Psychiatric illness
	NO FAMILY MEDICAL HISTORY		OTHER:		

SOCIAL HISTORY

What is your current occupation: _____
How long have you been in this line of work? _____

Please check all that apply to your work or school status:

□□ **I have missed no time from work/school due to my spinal problem**

□□ **I am currently working full time** □□ **I am a full-time student**

□□ **I have missed a total of _____ days from work/school due to spinal problem**

□□ **I am working _____ Part-time _____ Full-time**

□□ **I am unable to work due to my spinal problems**

□□ **I am unable to work due to another problem unrelated to my spine reason?**
_____

□□ **The last date worked was: _____**

□□**I have been receiving worker's compensation since**
_____

□□ **I have been on disability since _____ Short Term _____ Long Term _____**

Marital Status (circle one) Single Married Separated Divorced Widowed

Living Situation (circle one) Homeless With children With Spouse With Relatives Alone

List any sports or recreation that you participate in with frequency and duration

_____

_____

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SOCIAL HISTORY (CONT'D)

Please check all that apply to you:

☐☐ **I do not smoke cigarettes**

☐☐ **I quit smoking _____ years/months ago**

☐☐ **I smoke _____ packs of cigarettes per day and have smoked for _____ years/months**

☐☐ **I chew tobacco** ☐☐ **I use other tobacco products _____**

☐☐ **I never drink alcohol**

☐☐ **I drink alcohol (circle one) Very often Daily Weekly Monthly Rarely**

☐☐ **I am recovering from alcohol addiction**

☐☐ **Recreational drug use _____ how often _____**

☐☐ **I have not, nor do I plan to take legal action related to this injury**

☐☐ **I am considering or have taken legal action as a result of this injury**
Attorney name: _____

☐☐ **Legal action related to this injury is closed or settled Date of closure/settlement**
_____

REVIEW OF SYSTEMS

Please check all problems that apply to you

	Shortness of Breath		**Nausea & Vomiting**		**Fever**
	Chest Pain		**Fainting**		**Chills**
	Memory Problems		**Loss of Consciousness**		**Night Sweats**
	Anxiety or Nervousness		**Dizziness**		**Bowel Incontinence**
	Chronic Fatigue		**Convulsions**		**Unable to Urinate**
	Frequent Headaches		**Unexplained Weight Loss**		**Loss of appetite**