EMG Questionnaire

Today's Date:_____

Name: _____ MRN: _____
(office use only)

DOB: _____ Age: _____

Height: _____ Weight: _____ Hand preference: ❍ Right ❍ Left ❍ Both

Primary Care Physician: _____ Referring Physician: _____

HISTORY

Chief complaint: _____

How long have you had this pain?

❑ <3 months ❑ 3-12 months ❑ 1 – 2 years ❑ Other: _____

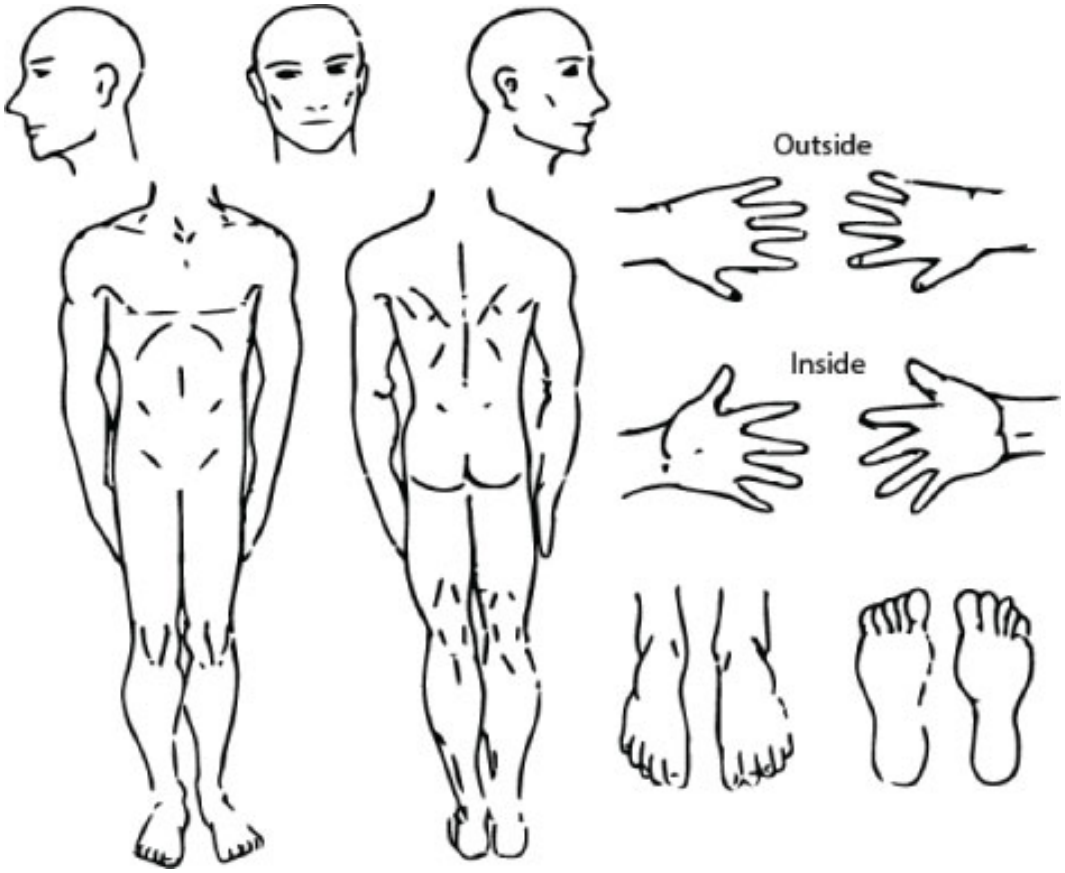
Where is your pain located?

❑ Neck ❑ Mid back ❑ Low back ❑ Other: _____

Please describe your pain (sharp, burning, pressure, etc.):

❑ Sharp ❑ Electric ❑ Burning ❑ Prickling ❑ Aching ❑ Stinging ❑ Throbbing
❑ Cramping ❑ Dull ❑ Spasm ❑ Stabbing ❑ Shooting ❑ Other: _____

Please mark the figure below with the location of your symptoms:



Key
Pain=XX
Numbness/Tingling=OO
Stabbing=//
Burning=++

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EMG Questionnaire

Patient Name: _____ DOB: _____ MRN: _____

How severe is your pain (mark below)?

0	1-2	3-4	5-6	7-8	9-10
Absent (No pain)	**Tolerable** (tolerate without medications)	**Bearable** (some activities restricted/ prevented, requires medication)	**Nearly intolerable** (sedentary, only able to watch TV, read, etc.)	**Intolerable** (Can't read, watch TV, use the phone, need to visit ER for pain killers)	**Devastating** (need hospitalization for pain control)

|----------|

0 10

(please draw a line through where you feel your pain is best represented)

MEDICATIONS

Please list all medications you are currently taking. *(Include any over the counter medications. Be sure to list if you are taking any form of aspirin.)* ❑ No medications

_____ _____

_____ _____

_____ _____

WORK HISTORY

Are you working? ❍ YES ❍ NO If yes: ❍ Full-time ❍ Part-time ❍ Restricted Duty

If restrictions, please describe: _____

If no, date last worked: _____ How long in position? _____

Occupation: _____ Employer: _____

PAST SURGICAL HISTORY

Please list any previous surgeries: ❑ No Surgeries

_____ Approximate Date: _____

_____ Approximate Date: _____

_____ Approximate Date: _____

_____ Approximate Date: _____

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EMG Questionnaire

Patient Name: _____ DOB: _____ MRN: _____

FAMILY HISTORY

Please list any medical illnesses that the following blood relatives have a history of:

Grandparents: _____ ❍ Living ❍ Deceased

Father: _____ ❍ Living ❍ Deceased

Mother: _____ ❍ Living ❍ Deceased

Siblings: _____ ❍ Living ❍ Deceased

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Patient Medical Questionnaire

Patient Name: _____ DOB: _____ MRN: _____

Illness/Condition	Is your PCP the treating physician?		If no, list treating physician's name	Is problem stable/ well controlled?		If no, please explain
Please check all that apply:	YES	NO		YES	NO	
❑ Alcoholism	☐	☐		☐	☐	
❑ Anemia	☐	☐		☐	☐	
❑ Anxiety	☐	☐		☐	☐	
❑ Arthritis	☐	☐		☐	☐	
❑ Asthma	☐	☐		☐	☐	
❑ Bleeding Disorder	☐	☐		☐	☐	
❑ Deep Vein Thrombosis	☐	☐		☐	☐	
❑ Depression	☐	☐		☐	☐	
❑ Diabetes	☐	☐		☐	☐	
❑ GERD	☐	☐		☐	☐	
❑ Gout	☐	☐		☐	☐	
❑ Heart Attack	☐	☐		☐	☐	
❑ Heart Disease	☐	☐		☐	☐	
❑ Heart Murmur	☐	☐		☐	☐	
❑ High Blood Pressure	☐	☐		☐	☐	
❑ High Cholesterol	☐	☐		☐	☐	
❑ History of Addiction	☐	☐		☐	☐	
❑ History of Substance Abuse	☐	☐		☐	☐	
❑ HIV/AIDS	☐	☐		☐	☐	
❑ Hyperthyroidism	☐	☐		☐	☐	
❑ Hypothyroidism	☐	☐		☐	☐	
❑ Kidney Disease	☐	☐		☐	☐	
❑ Liver Disease/Hepatitis	☐	☐		☐	☐	
❑ Lung Disease	☐	☐		☐	☐	
❑ Migraines	☐	☐		☐	☐	
❑ MRSA	☐	☐		☐	☐	
❑ Muscle Disease	☐	☐		☐	☐	
❑ Osteoporosis	☐	☐		☐	☐	
❑ Pneumonia	☐	☐		☐	☐	
❑ Psoriasis	☐	☐		☐	☐	
❑ Psychiatric Problem	☐	☐		☐	☐	
❑ Pulmonary Embolism	☐	☐		☐	☐	

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Patient Medical Questionnaire

Patient Name: _____ DOB: _____ MRN: _____

Illness/Condition continued	**Is your PCP the treating physician?**		**If no, list treating physician's name**	**Is problem stable/ well controlled?**		**If no, please explain**
❑ Rheumatic Fever	☐	☐		☐	☐	
❑ Rheumatoid Arthritis	☐	☐		☐	☐	
❑ Seizure Disorder	☐	☐		☐	☐	
❑ Sleep Apnea	☐	☐		☐	☐	
❑ Stroke	☐	☐		☐	☐	
❑ Thyroid Disorder	☐	☐		☐	☐	
❑ Tuberculosis	☐	☐		☐	☐	
❑ Ulcers	☐	☐		☐	☐	
❑ Other (Please explain)						

Cancer History	**Is your PCP the treating physician?**		**If no, list treating physician's name**	**Is problem stable/ well controlled?**		**If no, please explain**
Please check all that apply:	YES	NO		YES	NO	
❑ Leukemia	☐	☐		☐	☐	
❑ Breast Cancer	☐	☐		☐	☐	
❑ Cervical Cancer	☐	☐		☐	☐	
❑ Prostate Cancer	☐	☐		☐	☐	
❑ Ovarian Cancer	☐	☐		☐	☐	
❑ Throat Cancer	☐	☐		☐	☐	
❑ Bone Cancer	☐	☐		☐	☐	
❑ Skin Cancer	☐	☐		☐	☐	
❑ Lung Cancer	☐	☐		☐	☐	
❑ Cancer: other (please explain)						

SPINE TEAM TEXAS®

Consent for Treatment

Patient Name: _____ DOB: _____ MRN: _____

DISCLOSURE OF INFORMATION:

_____ (Initial) The undersigned agrees that all records concerning this patient's visit shall remain the property of Spine Team Texas. The undersigned understands that medical records and billing information generated or maintained by Spine Team Texas are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). THE INFORMATION MAY ALSO CONTAIN PSYCHIATRIC RECORDS.** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

_____ (Initial) **I GIVE PERMISSION** for Spine Team Texas to release any and all of my medical information to my Primary Care/Referring Physician by written or oral communication. I understand these records may contain psychiatric and/or infectious disease information.

_____ (Initial) **I AUTHORIZE** Representatives of Spine Team Texas PA to leave messages for me regarding appointments, prescriptions, or any other information pertinent to my medical care, on any phone number that I have provided. I also understand that I may revoke this agreement by sending a written, certified letter to Spine Team Texas PA, 1545 E. Southlake Blvd. #100 Southlake, Texas 76092, ATTENTION: Compliance Officer

_____ (Initial) **I GIVE PERMISSION** for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. ❑ **Yes** ❑ **No**

If yes, please list names below.

Name: _____

Name: _____

Name: _____

SPECIAL CONSENT FOR HIV TESTING:

_____ (Initial) The undersigned specifically consents to the testing of the patient's blood for human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

Consent for Treatment

Patient Name: _____ DOB: _____ MRN: _____

_____ (Initial)

CONSENT FOR DESTRUCTION OF FILMS

I understand that Spine Team Texas will **not** be responsible for the storage of my x-rays or any other radiological images. By signing this form, I understand and agree that I am responsible for my films and other radiological images that have been performed at a facility other than Spine Team Texas.

I further understand and agree that Spine Team Texas scans my images into their imaging system and retains those images on their scanning system. Spine Team Texas has the right to destroy my actual films if the films have been left at Spine Team Texas for 12 months or longer from today's date.

MEDICATION HISTORY:

_____ (Initial)

By initialing this paragraph and signing this form, I acknowledge and agree that in the event that I am given a prescription, I am granting permission for Spine Team Texas to obtain my medication history. This may be acquired through direct pharmacy contact.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS:

_____ (Initial)

I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the State notice and this facility policy statement regarding Patient's Rights.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

_____ (Initial)

A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below, you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

SPECIAL CONSENTS:

❑ Do
❑ Do Not

I (we) authorize Spine Team Texas PA and/or my physician to photograph/video or permit other persons to photograph/video for such purposes as may be deemed necessary.

❑ Do
❑ Do Not

I (we) consent to the presence of visiting physicians, students, residents or fellows, and vendors in the operating room to observe the procedure. I am aware that only the physician may grant this permission on my consent.

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONDITIONS OF ADMISSION AND TREATMENT" FORM.

PATIENT SIGNATURE: **X**_____ DATE:_____

PATIENT NAME PRINTED:_____

WITNESS SIGNATURE: **X**_____ DATE:_____

PATIENT IS UNABLE TO CONSENT BECAUSE: _____

RELATIVE / AUTHORIZED AGENT _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

Consent for Treatment

Patient Name: _____ DOB: _____ MRN: _____

FINANCIAL GUIDELINES FOR PATIENTS

_____ (Initial)

STT is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. We will assist you when we can, so that you receive all of the insurance benefits to which you are entitled.

To meet the needs of our patients, we participate in many insurance programs. Each insurance company has its own specific rule regarding the level of care and the amount of reimbursement. Insurance plans and benefits vary considerably, and we cannot guarantee what part of our service will or will not be covered by your particular insurance coverage.

We will gladly process your claim for you and when time permits we will also estimate your deductible, co-payment, co-insurance and charges for services rendered. Co-payment, co-insurance and deductibles are a contract responsibility between the patient and their employer and/or insurance carrier. These amounts are non-negotiable. That amount is due at the time of treatment and may be paid by cash, check or credit card. **Our estimates are subject to final approval by your insurance company and what actually takes place in the clinic visit and/or operative/procedure session; therefore, the amount due to our office could change.**

If you are scheduled for procedures or surgery, additional information will be available to you at the time of the scheduling. Please ask if you have any questions about our fees, financial policy or your responsibility.

ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT POLICY:

_____ (Initial)

I acknowledge the receipt of the payment policy by initialing and signing below. Spine Team Texas, PA is committed to serving you. As part of this commitment, we want you to understand your payment obligations. **Payment is expected at the time services are rendered. If you are unable to pay in full on date of service, payment arrangements must be made.**

_____ (Initial)

I ACKNOWLEDGE AND UNDERSTAND that Spine Team Texas PA and/or Spine Team Texas ASC LP may not participate with my insurance plan and that any payment due as a result will be discussed with me in detail before services are rendered. I also understand that as a courtesy, Spine Team Texas will review my payment options and evaluate them in detail before any services are rendered.

APPOINTMENT POLICY:

_____ (Initial)

I acknowledge and understand that Spine Team Texas has a No Show policy. I understand that if I no show for 3 or more appointments, or cancel with less than 24 hours' notice, I may be dismissed from the practice. I further acknowledge and understand that there is a $50.00 no show fee for EMGs that are no showed or cancelled with less than 24 hours' notice and Spine Team Texas also reserves the right to charge a $35.00 no show fee for office appointments that patients no show or cancel with less than 24 hours' notice. I understand the fees charged for no shows are not covered by my insurance and I will be liable for payment in full.

I acknowledge and understand that Spine Team Texas has a late arrival policy. I understand and acknowledge that if I arrive 15 minutes or more past my scheduled appointment, then I may have to be rescheduled.

Please indicate your receipt of this Notice by your signature below.

PATIENT SIGNATURE: **X**_____ DATE: _____

WITNESS SIGNATURE: **X**_____ DATE: _____

Notice to Patient

Patient Name: _____ DOB: _____ MRN: _____

NOTICE TO PATIENT OF FINANCIAL INTEREST (Allen)

As a patient of Spine Team Texas, (the "Practice"), some of your treatment or related procedures may be scheduled at Texas Health Spine Surgery Center Allen (the ASC). You are informed by this notice that certain practice physicians, including David Rothbart, MD; Anthony Berg MD; David Cooper, MD; Amit Darnule, MD; Michael Garcia, MD; David Garrigues, MD; Leonard Kibuule, MD; Cortland Miller, MD; Ryan Reeves, MD; and Andrew Carver Wilkins, MD hold financial interest in the Allen ASC. In addition, you may receive services at Texas Health Presbyterian Hospital, Allen. You are informed by this Notice that your physician may hold a financial interest in this entity. You have the option, at your discretion, to use an alternative health care facility.

Please indicate your receipt of this Notice by your signature below.

Date:_____ _____
Patient Signature

_____
Patient Printed Name

IMPORTANT INFORMATION FOR PATIENTS (Allen)

The "Texas Health Spine Surgery Center Allen" has entered into a name use agreement with Texas Health Resources (THR).

THR does not supervise any health care professionals at Texas Health Spine Surgery Center, nor does it provide any patient care services at Texas Health Spine Surgery Center.

It is important that you also understand that all ASC physicians who provide their services using ASC facilities are employed by Texas Health Back Care and are members of the Texas Health Spine Surgery Center Allen Medical Staff.

Date:_____ _____
Patient Signature

_____
Patient Printed Name

FAMILY AND FRIENDS REFERRAL PROGRAM

Spine Team Texas would like to thank our patients for referring their family and friends to us. Please let us know who referred you so that we can send them a thank you gift.

Today's Date: _____

❒ **Fellow/Former Patient**

Full Name: _____

Mailing Address (if known): _____

❒ **Family/Friend/Neighbor**

Full Name: _____

Mailing Address (if known): _____

Please select the location you are visiting today:

❒ **Southlake** ❒ **Bedford** ❒ **Alliance** ❒ **Rockwall** ❒ **Richardson** ❒ **Allen** ❒ **Prosper** ❒ **Dallas**

DON'T FORGET!

In addition to the new patient paperwork, please make sure you bring the following with you to your appointment:

- ❑ A picture ID
- ❑ Insurance cards
- ❑ Your co-pay (if required by your insurance)
- ❑ Your referral (if required by your insurance)
- ❑ Any report, film, or disc of radiology relating to your pain and treatment
- ❑ Any medical records relating to your pain and treatment
- ❑ A list of medications you are currently taking or their medication bottles

THANK YOU FOR CHOOSING SPINE TEAM TEXAS!