SPINE TEAM TEXAS
A TEAM APPROACH TO BACK & NECK PAIN

HISTORY AND PHYSICAL

Today's Date:_____

Name: _____ Age: _____ DOB: _____

Height: _____ Weight: _____ Are you (please circle): Right handed Left handed

Referring Physician: _____ Primary Care Physician: _____

HISTORY

Chief complaint: _____

How long have you had this pain? _____

Where is your pain located? _____

Does this pain radiate into arms, legs, buttocks, etc.? _____

Did anything specific happen to cause the pain? _____

Do you feel any weakness, tingling, Numbness or stiffness? _____

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

Any other symptoms with the pain (i.e. headaches, loss of bowel or bladder, etc.)? _____

What makes the pain better? _____

What makes the pain worse? _____

How severe is your pain (circle below)?

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

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

0 10

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

(please circle)

Have you been treated by other clinicians for this problem? YES NO

If yes, please list name, date seen, and treatment given: _____

Have you had any physical therapy (PT)? YES NO

How many sessions? _____ Has PT helped? YES NO

Have you had epidural or facet injections? YES NO

How many? _____ Did they help? YES NO

Have you had a previous back or neck surgery? YES NO

Have you had diagnostic tests performed? (CT, MRI, EMG, etc.) YES NO

If yes, please list: _____

Are you having difficulty with sleep because of your pain? _____

How long can you: Sit _____ Stand _____ Walk _____

Have you lost any control over bowel or bladder functions? YES NO

Is your pain related to a specific injury? YES NO

If yes, please describe: _____

Is the injury or pain the result of a work-related injury? YES NO

If yes, what is the date of injury? _____

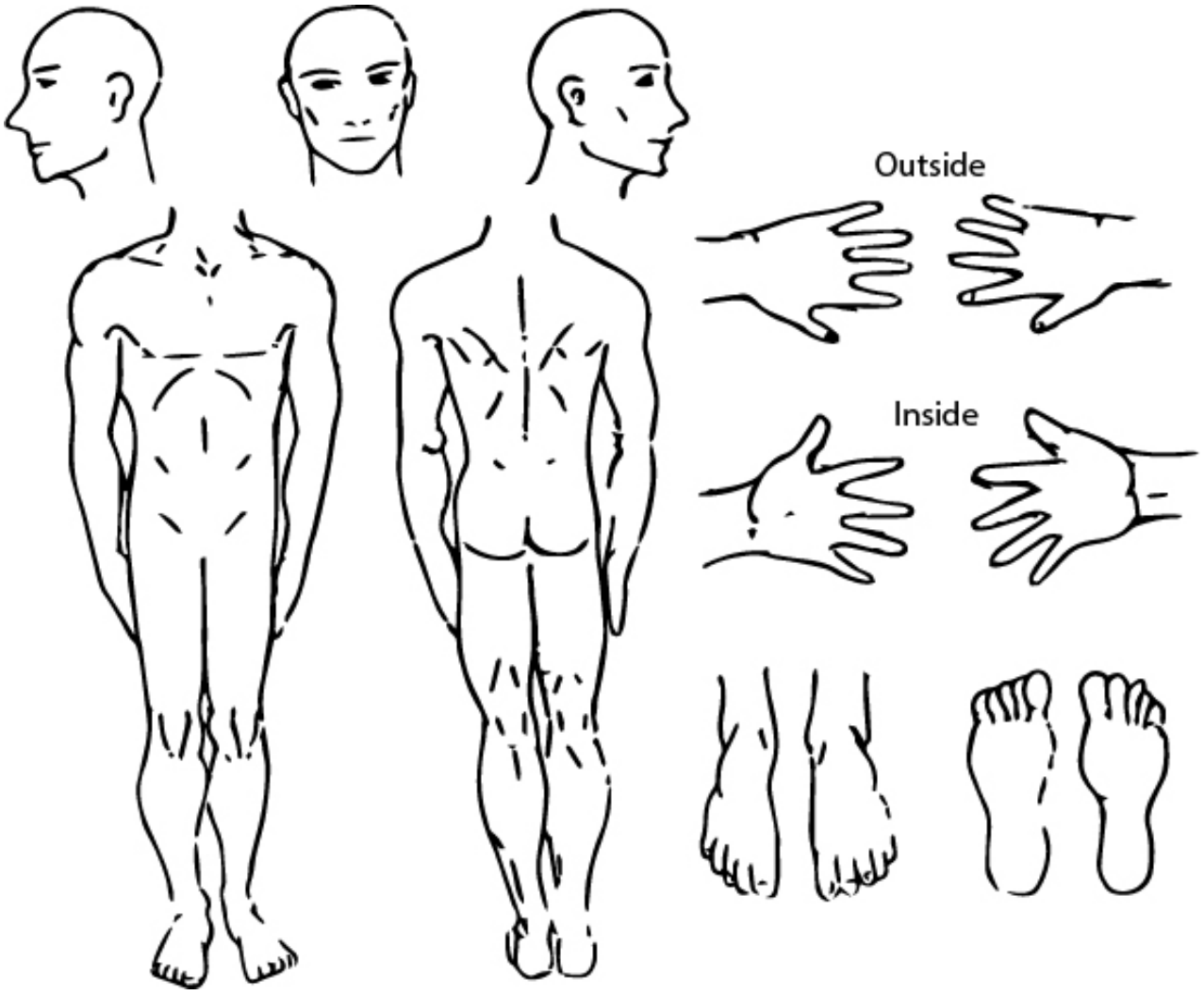
Have your reported it to your employer? YES NO

Is the injury or pain motor vehicle related? YES NO

If yes, what was the date of your accident? _____

Is there a lawsuit (pending or considered)? YES NO

Please mark the figure below with the location of your symptoms: **Pain=XX** **Numbness/Tingling=OO**



What do you hope to accomplish today? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Illness/Condition			**Is your Primary Care Doctor 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		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								
Rheumatic Fever								
Rheumatoid Arthritis								
Seizure Disorder								
Sleep Apnea								
Stroke								
Thyroid Disorder								
Tuberculosis								
Ulcers								
Other (Please explain)								

Cancer History			Is your Primary Care Doctor 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		Yes	No	
Leukemia								
Breast Cancer								
Cervical Cancer								
Prostate Cancer								
Ovarian Cancer								
Throat Cancer								
Bone Cancer								
Skin Cancer								
Lung Cancer								
Cancer: other (please explain)								

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.)*

_____ _____

_____ _____

_____ _____

List medications that you have taken in the past and if they did or did not help:

_____ Did the medication help? YES NO

_____ Did the medication help? YES NO

_____ Did the medication help? YES NO

Medication allergies? YES NO Please list: _____

Do you have any other known allergies? YES NO Please list: _____

Please list the name, address, and phone number of the pharmacy you use: _____

_____

PAST SURGICAL HISTORY

Please list any previous surgeries:

_____ Approximate Date: _____

_____ Approximate Date: _____

_____ Approximate Date: _____

_____ Approximate Date: _____

FAMILY HISTORY

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

(please circle)

Grandparents: _____ Living Deceased

Father: _____ Living Deceased

Mother: _____ Living Deceased

Siblings: _____ Living Deceased

SOCIAL HISTORY

Marital Status (please circle): Single Married Divorced Separated Widow

Number of children: _____ Ages: _____

Do you smoke? YES NO How much? _____ For how long? _____

Previous Smoker? YES NO When did you quit? _____

Do you drink alcohol? YES NO How many drinks per day? _____

Do you use recreational drugs? YES NO If yes, what type: _____

WORK HISTORY

Are you working? YES NO If yes (please circle): Full-time Part-time Restricted Duty

If restrictions, please describe: _____

If no, date last worked: _____

Occupation: _____ Employer: _____

How long in position? _____

REVIEW OF SYMPTOMS

Please mark an "X" for Yes or mark "I have none of the symptoms."

CONSTITUTIONAL

I have none of the symptoms listed below: _____

Fever _____ Chills _____

Fatigue _____ Night Sweats _____

Unexplained weight Gain/Loss _____

SKIN

I have none of the symptoms listed below: _____

Rashes _____ Nail changes _____

Easy Bruising _____ Color changes _____

Jaundice _____ Infections _____

EYES/EARS/NOSE/THROAT

I have none of the symptoms listed below: _____

Vision changes _____ Hearing Loss _____

Hoarseness _____ Ringing in the ear _____

Dizziness/ Vertigo _____ Difficulty Swallowing _____

Discharge/ Drainage _____

RESPIRATORY

I have none of the symptoms listed below: _____

Cough _____ Wheezing _____

Coughing up blood _____ Shortness of Breath _____

Sputum Production _____ Recent Infection _____

CARDIOVASCULAR

I have none of the symptoms listed below: _____

Chest Pain _____ Palpitations _____

_____ Leg Swelling _____

MUSCULOSKELETAL

I have none of the symptoms listed below: _____

Joint swelling _____ Stiffness _____

Cramping _____ Infection _____

GASTROINTESTINAL

I have none of the symptoms listed below: _____

Abdominal pain _____ Nausea _____

Constipation _____ Blood in stool _____

Diarrhea _____ Vomiting w/wo blood _____

_____

GENITOURINARY

I have none of the symptoms listed below: _____

Painful urination _____ Blood in urine _____

Venereal Disease _____ Difficult urination _____

Sexual problems _____ Menstrual Problems _____

Pregnant _____ Menopausal _____

ENDOCRINE

I have none of the symptoms listed below: _____

Changes in urination _____ Changes in heat or cold intolerance _____

Changes in appetite/thirst/ sweating _____

PSYCHIATRIC

I have none of the symptoms listed below: _____

Depression _____ Anxiety _____

Suicidal Thoughts _____ Mood Changes _____

PATIENT SIGNATURE_____ Date:_____

PHYSICIAN SIGNATURE_____ Date:_____

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Consent for Treatment

Disclosure of Information: 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 PSYCIATRIC 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.

Special Consent for HIV Testing: 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.

☐ **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.

_____**(Initial) Acknowledgement of Receipt of Payment Policy:** 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) Patient Rights:** 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.

_____**(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 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: _____

_____**(Initial) Acknowledgement of Notice of Privacy Practices:** 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.

_____**(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

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_____**(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.

_____**(Initial)** 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 re-scheduled.

_____**(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.

_____**(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.

_____**(Initial)** I agree that Spine Team Texas can leave a detailed message for me regarding prescriptions, appointments, or other medical care on the phone numbers I have provided.

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: **X**_____ Date:_____

Patient is unable to consent because: _____

Relative / Authorized Agent _____

Relationship to patient: _____Date: _____

Spine Team Texas, P.A.
Financial Guidelines For Patients

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.

Thank you again for choosing Spine Team Texas.

_____ _____

(Patient Signature) (Date)

_____ _____

(Witness Signature) (Date)

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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.

_____ _____
(Patient Signature) (Date)

_____ _____
(Witness Signature) (Date)

NOTICE TO PATIENT
OF FINANCIAL INTEREST

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 Southlake (the ASC). You are informed by this notice that certain practice physicians, including David Rothbart, MD; Ryan Reeves, MD: Michael Garcia, MD; Heather Blackburn, MD; Amit Darnule, MD; Leonard Kibuule, MD; and Jennifer Donnelly-Straach, MD hold financial interest in the Southlake ASC. In addition, you may receive services at Texas Health Harris Methodist Hospital, Southlake. 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

The THR/STT SOUTHLAKE ASC, LLC (ASC) doing business under the name Texas Health Spine Surgery Center Southlake 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 Southlake Medical Staff.

Date:_____ _____

Patient Signature

_____

Patient Printed Name

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HOW DID YOU HEAR ABOUT SPINE TEAM TEXAS?

Name: _____ **Zip Code:** _____ **Today's Date:** _____

Please check ALL the information sources below if they apply. You may check more than one:

REFERRALS

- ❒ **Physician/PA/NP**. Please provide their name so that we may thank them _____
- ❒ **Chiropractor**. Please provide their name so that we may thank them _____
- ❒ **Nurse**. Please provide their name so that we may thank them: _____
- ❒ **Hospital.** Please provide their name so that we may thank them: _____
- ❒ **Fellow.** Patient Please provide their name so that we may thank them: _____
- ❒ **Family/Friend/Neighbor.** Please provide their name so that we may thank them: _____
- ❒ **Drive by Location.** Please identify the address of the location: _____
- ❒ **Insurance Company.** Please provide their name: _____

MEDIA

- ❒ **Radio.** Please identify the station on which you heard about us: _____
- ❒ **TV.** Please identify the channel on which you remember seeing us: _____
- ❒ **Newspaper.** Please identify the newspaper in which read about us: _____
- ❒ **Magazine.** Please identify the magazine in which you read about us: _____
- ❒ **Billboard.** Please identify the location in which you noticed the billboard: _____
- ❒ **Online Search/Website.** Please identify the search engine or web site on which you saw us: _____
- ❒ **Social Media.** Please identify the social media platform in which you found us: _____
- ❒ **Direct Mail.** Please identify when you remember reading about us: _____

EVENTS

- ❒ **Community.** Please tell us the event at which you heard about us: _____
- ❒ **Health Fair.** Please identify the health fair at which you saw us: _____
- ❒ **Local Seminar.** Please identify when you remember participating: _____

OTHER: Please briefly explain how you heard about us: _____

Thank you for your time!