Spine Vue
COMPREHENSIVE AND COMPASSIONATE

Patient Registration

Patient Name: _____
Last First Middle Maiden

Date of Birth: _____**Sex:** _____**Social Security #:** _____**Marital Status:** _____

Physical Address: _____ **City/State/Zip:** _____

Mailing Address: _____ City/State/Zip: _____

HOME PH: _____ **CELL:** _____ Phone: _____

Patient's Email: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City/State/Zip: _____

Per Government Mandate please complete the following: (If you wish to decline, please write "declined")

Language: _____ Race: _____ Ethnicity: _____

Consents and Emergency Contacts: Please indicate a person(s) with whom we may discuss your health/account. If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. NOTE: if the patient is a minor, parent(s) must be listed.

Name: _____ Relationship to Patient: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Name: _____ Relationship to Patient: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Primary Insurance: _____Policy ID #: _____

Group #: _____Policyholder: Last: _____ First: _____Middle: _____

Relationship to Pt: _____Social Security #: _____ Date of Birth: _____

Secondary Insurance: _____

Policy ID #: _____ Group #: _____

Worker's Comp Insurance: _____ **Date of Injury:** _____

Adjuster: _____ **Claim #:** _____ **Phone:** _____

Is this visit related to a Work Injury or Motor Vehicle Accident? (select one)_____

Date of Injury: _____ **Claim#:**_____

Adjuster Name:_____ **Adj Phone:** _____

Law Firm Name: _____

Lawyer Name: _____ **Lawyer Phone:** _____

Primary Care Physician Name: _____ **Phone:** _____

Pharmacy Name: _____ **Phone:** _____ **City:** _____

Were you referred by a physician? YES NO

Physician Name: _____ **Phone#:**_____

If not, how did you hear about Spine Vue?_____

CHIEF COMPLAINT: _____

_____

_____

PREVIOUS IMAGING STUDIES: Please note mo/yr of exam and location of body part

X-Rays: _____ MRI: _____

CT: _____ EMG: _____

PAST MEDICAL HISTORY Check all that apply: [ ] None Apply

[ ] Heart attack	[ ] Diabetes	[ ] Lung Disease	[ ] Liver Disease	[ ] Heart Failure (CHF)
[ ] Stroke	[ ] HIV	[ ] Hepatitis	[ ] High Blood Pressure	[ ] Seizures
[ ] AIDS	[ ] Thyroid trouble	[ ] Osteoarthritis	[ ] Mental Illness	[ ] Tuberculosis
[ ] Bleeding Disorders	[ ] Rheumatoid arthritis	[ ] Asthma	[ ] Anemia	[ ] Kidney disease
[ ] Ankylosing spondylitis	[ ] Kidney Failure	[ ] Serious injury	[ ] Gout	[ ] Blood clot in leg
[ ] Cancer	[ ] Blood clot in lung	[ ] Osteoporosis	[ ] Alcoholism	[ ] Stomach ulcers

PAST SURGICAL HISTORY Previous doctors seen for this problem: [ ] NONE

_____

_____

_____

Please list **ALL CURRENT MEDICATIONS** and doses: [ ] NONE

_____

_____

_____

ALLERGIES Please list any known allergies to food or medications and their reactions: [ ] NONE

_____

_____

FAMILY HISTORY Check all that apply: [ ] NONE apply

[ ] Stroke	[ ] Kidney trouble or stones	[ ] Seizures
[ ] Heart trouble	[ ] Diabetes	[ ] Gout
[ ] Mental illness	[ ] High Blood Pressure	[ ] Spine problems
[ ] Bleeding disorders	[ ] Arthritis	[ ] Alcoholism
[ ] Cancer	[ ] Other: _____	

SOCIAL HISTORY

Age: _____ Sex: ___ Height: _____ Weight: _____ Occupation: _____

Do you smoke? [ ] No [ ] Yes _____ packs/day for _____ years [ ] Former Smoker [ ] Never Smoker [ ] Quit How long?_____

Illicit drug use: _____ Alcohol Intake: None Occasional Moderate Heavy

Patient Name:_____ **Date:** _____ **DOB:**_____

Patient Waivers, Financial Responsibility Policies and Agreements

In order to reduce confusion and misunderstanding between our patients and practice (Spine Vue), we have adopted the following policies. If you have any questions regarding these policies, please feel free to ask the front desk staff to clarify the policies to you. We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. This agreement is between Spine Vue, and Patient.

Your Insurance

We require showing your insurance card at each visit, so we can verify the information that is in our system.

In-Network: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment and any additional percentage (co-insurance and/or deductibles) due. You could be billed for any remaining amount that insurance didn't pay after the services are rendered. **It is your responsibility for any amount not covered by insurance**.

If you are an HMO patient, we will work towards obtaining the appropriate referral from your primary care provider. If we are unable to obtain the appropriate referral before your appointment, then we can re-schedule your appointment or you can pay the self pay office visit charge of $300 for new patient or $250 for follow up patient. This payment is due at the time of service.

If you are a patient who purchased an Exchange insurance plan, and become terminated or ineligible for your insurance. It is your responsibility for all unpaid charges.

Out-of-Network: We do not contract with all insurance companies licensed to do business in Texas. In the event your insurance company is not contracted with us, we will honor your in network out of pocket amounts. It is critical to make sure your insurance has "Out Of Network" benefits (OON) under your policy. If you do not have OON benefits and you elect to receive care from Spine Vue, you may not receive ANY insurance reimbursements. If you have OON benefits, your claim will be processed using the prevailing "Usual-Customary and Reasonable" (UCR) rates for the services provided. We will not balance bill you for the remainder.

Payment & Collection Policies

It is our office policy to collect the co-payment/co-insurance/deductible when you arrive for your appointment. Unless other arrangements have been agreed upon in advance, full payment is due at the time of services provided. This also includes any other outstanding balances. Outstanding balances are due within 30 days, unless prior arrangements have been made in writing. You have 90 days from the date of notification (can be by phone, statement or email) to pay your balance before your account becomes delinquent. **If your account becomes delinquent and you have not established or made payment arrangements with our billing office, your account will be turned over to a collection agency and <u>we may ask you to seek your medical care from another medical office</u>**. We reserve the right to reschedule your appointment until such payments can be made. For your convenience, our office accepts cash and debit/credit cards.

Patient's Request for any type of paperwork that is to be completed by physician

In accordance with Federal Law, our office requires a written request (for available upon request) for the release of any type of forms. In some cases, we will need 15 business days (Monday through Friday) to process your request. According to the HIPAA privacy law, you may need to show identification that you have legal rights to this information. There is a fee of $25 per page for these form(s) and you may be required to see a physician.

Method(s) of Communicating with Patients

For your convenience, Spine Vue will call, text or email to remind you about your upcoming appointments based on the information you provide on your registration form.

Mid Level Practitioner and what it means

When you visit our offices, you will be seen by a Physician, a Nurse Practitioner (NP), a Physician Assistant (PA) or a Registered Nurse (RN), NPs and PAs are clinical professionals with advanced degrees (Master's Degree) who are licensed to practice medical care and who work in collaboration with physicians. NPs and PAs are collectively referred to as Mid Level Providers or Practitioners. They can diagnose, plan treatment, prescribe medications and therapies (physical therapy and/or occupational therapy). RNs are responsible for caring and educating patients and implementing orders written by physicians, NPs, or PAs. They are not licensed to make official diagnosis or to prescribe medication or therapies.

If a Nurse Practitioner or Physician Assistant is seeing you, they will evaluate and treat your spinal condition. If a surgical consultation is needed, your NP or PA will leave the room to discuss your concerns and their findings from the physical exam with the attending surgeon. Then both the surgeon and NP/PA will return to your exam room for further assessment and to discuss your treatment plan with you.

Medical Lifetime Authorization (MEDICARE PATIENTS ONLY)

I authorize any holder of medical or other information about me to release to the Social Security Administration and HealthCare Financial Administration or its intermediaries or carriers that have any information needed for this or any related Medicare claim(s). I permit a copy of this authorization to be used in lieu of the original and request payment of the medical insurances benefits to the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

Missed Appointments/ Untimely Cancellations

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment please give 24 hours notice to avoid being charged. There is a **$25 charge for missed or untimely canceled appointments**. **Excessive abuse of scheduled appointments may result in termination from the practice.** If you arrive later than 30 minutes after your scheduled appointment, you may be asked to reschedule at a later time and date.

Forms of Payment

We accept Cash and MasterCard and Visa only. We no longer accept checks as a form of payment. If there are any unpaid balances on your account, you will need to pay the unpaid balance in full prior to your next appointment. **Failure to pay will result in delayed treatment and/or termination from practice unless previous arrangement has been made in writing.**

Disability or Insurance Forms

There will be a **$25 per page** charge for completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms.

Estimates and Interests

An estimate of cost will be provided if requested by an uninsured patient, a patient not covered by a government program or an insured patient seeking out-of-network services. This practice does not charge interest for amounts past due and left unpaid by a third party payer.

Disclosures

I understand that Dr. Jones-Quaidoo has ownership and consults for medical facilities, medical device companies, intra-operative neurologic monitoring, peri-operative and procedural anesthesia services. I may be referred to have services provided at facilities or /and have medical devices(s) or / and per-operative services used for the benefit of my treatment. I have the option to choose another institution, medical device(s), or services that Dr. Jones-Quaidoo does not have any ownership or consulting interest in.

Imaging CDs/films

Imaging CDs/films will be kept in our files for a maximum of 6 months from date of service of the exam. Any CD or films older than 6 months will be destroyed unless picked up by the patient.

Facsimile or Reproduction Waiver

I understand that Spine Vue may transmit my medical information electronically. I authorize Spine Vue and any of its subsidiaries to send and/or receive the confidential electronic health care information as defined by Health Insurance Portability Accountability Act of 1996, 45CFR, Parts 160-164 (HIPAA) with full knowledge that it may be received in error by a third party. I absolve Spine Vue of any responsibility for issues that might arise from such error. I may revoke this authorization by giving Spine Vue 10 day written notice. This revocation will not pertain to information released prior to the date of the receipt of the revocation by Spine Vue.

Assignment of Benefits (required for filing insurance claims)

I hereby assign my interest and title to all medical benefits to which I am entitled to Spine Vue and any of its subsidiaries. I hereby authorize my insurance carrier to issue payments directly to Spine Vue for medical services rendered to myself regardless of my insurance benefits.

Authorization of Release of Information (required for filing insurance claims)*

I hereby authorize Spine Vue and any of its subsidiaries to:

1) Release any information necessary to insurance carriers, physicians, attorneys, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred for the treatment of services.

2) Process insurance claims generated in the course of examinations and treatments.

3) Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Spine Vue and any of its subsidiaries on my behalf and understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized.

I have read the Office and Financial policy and agree to its terms. I understand and agree that the term of this financial policy may be amended by the practice at any time without prior notification to me. I am aware that for my safety and protection, video and audio surveillance may be used on Spine Vue premises, in public areas only. I, the undersigned, as patient or on behalf of patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the physician on duty. I am also aware that my photograph may be taken for documentation of my patient chart. I understand that no guarantee or assurance has been made as to the results, which may be obtained. I understand that I have the right to revoke this consent, in writing, except where Spine Vue has already made disclosures in reliance on your prior consent. A photocopy of this signature is as valid as the original.

_____ _____

Patient Signature Date

Notice of Privacy Practices

To our Patients:

This notice describes how health information about you (as part of this practice may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces(including veterans) and if required by the appropriate officials.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions of law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issue in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Spine Vue, 7557 Rambler Road Suite 730, Dallas, TX 75231.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice. You may ask us to give you a copy of this notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or to the Secretary of the Department of Health and Human Services. To file a complaint with our practice, submit in writing your complaint to Spine Vue, 7557 Rambler Road, Suite 730, Dallas, TX 75231. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice of permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please notify us. I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices.

Signature: _____ Print Name: _____

Prescription Policy

A Spine Vue physician diagnoses and treats conditions of the spine. We may prescribe medications for you to help relieve the pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of medications. Spine Vue follows those laws.

Our policy:

1. Written prescriptions will not be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. In other words, do not change the frequency of the dose unless otherwise directed by a Spine Vue professional. If a change does occur, this will be noted in your chart.
3. Certain controlled substances such as Oxycontin, MS Contin and Percocet are written for a 30 day supply. It is necessary to make monthly follow up appointments in order to receive a refill. By law, controlled substance medications cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions cannot be refilled.
    - Sleep aids such as: Ambien
    - Anti-inflammatories such as: Vioxx, Bextra, Celebrex
    - Narcotics such as: Lortab, Vicodin, Darvocet, Hydrocodone
    - Muscle Relaxers such as: Soma, Robaxin, Flexeril
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will not be authorized at night, on weekends or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Spine Vue, please check your supply of medication. If you need a refill, please ask.
8. Refill requests for prescriptions not prescribed by a Spine Vue physician will not be authorized.
9. If you believe you may be pregnant, discover you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescription(s) refilled.

I authorize Spine Vue to obtain/have access to my medication history.

Patient Signature: _____

Date: _____

Surgical Assistants Assignment of Benefits

Surgical Assistants (SA's) are specially trained medical professionals who assist a surgeon during an operation. The surgeons of this practice commonly use SA's during surgery. The purpose of this notice is to provide you information regarding billing for this service.

The surgeons of this practice feel strongly that for many surgical procedures, SA's are a medical necessity. A surgical assistant works with the surgeon as a skilled second pair of hands to maximize safety and efficiency. Potential benefits of SA's include decreased exposure of the surgical site, decreased operative time, and decreased blood loss. Your treating surgeon has determined that the use of a SA is necessary for your upcoming surgery.

I understand **Dr. Sean M. Jones-Quaidoo** may require a Physician Assistant to assist in my surgery, and in consideration for receiving medical services provided pursuant to my health insurance policy, I assign payment of my insurance benefits directly to Rambler Surgical Care Associates, PLLC ("RSCA") or Anton Surgical Associates, PLLC ("ASA"). I understand that the charges for these services will be billed by RSCA or ASA to my insurance company. I understand my Surgeon participates in my health plan as an in-network provider and, therefore, I may be liable for applicable deductible and co-payments for covered services.

In the event that my health insurance plan refuses to pay for medically necessary surgical assist services, I assign all my appeal rights, either fully-funded or self-funded (*ERISA) rights, to a full and fair review process to RSCA or ASA for any and all paid, partially paid or denied surgical assist claims. In consideration for this assignment, RSCA or ASA agrees to potential non-payment and/or undertaking responsibility for the denial determination appeal process under the terms of my health care plan. I understand that if the surgical assistant prevails in any such payment dispute, I may be liable for applicable deductible and co-payment for the contested services.

I give consent to release medical and financial information contained in my insurance file to RSCA or ASA or its designated representative specifically for the purpose of the surgical services and treatment that were necessary for my care to my insurance company. I understand this information is privileged and confidential and will only be released as specific in this authorization, or as required or permitted by law.

Patient/Guardian printed name: _____

Patient/Guardian signature: _____

Date: _____

**ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed insurance claims according to ERISA regulations.*

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Injury/Accident Statement Form

Patient Name: _____ Today's Date:_____

How did the injury or pain occur, what were you doing?

_____

_____

_____

Have you seen another physician for this condition? _____ Doctor: _____

Injury at Work Date: _____ (required for insurance filing)

Did injury occur during work? Yes No

Were you clocked in? Yes No

Were you at Lunch? Yes No

Motor Vehicle Accident Date: _____ (required for insurance filing)

Were you the (circle one): front passenger back passenger driver pedestrian(not in car)

Who hit who?(circle one): You were struck by another car You struck the other car You struck stationary object

Where did you go immediately following the accident?(circle one)

Hospital-Name:_____ PCP This office Home Resume daily activities

Were there any imaging taken? MRI CT Xray

Is there a possible third party liability? Yes No

(Auto Insurance or Homeowner's Property, etc?)

If yes, a letter of subrogation should be provided before seeing the physician, Your health insurance will deny the claim if the letter is not obtained.

I certify that this information is true and accurate. I hereby authorize the release a copy of this statement as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury of condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the charges incurred.

_____ _____

Signature of Patient or Legal Guardian **Date**