AMARILLO
SPINE
INSTITUTE

COMPREHENSIVE SPINE TREATMENT

Welcome to Amarillo Spine Institute

Thank you for entrusting us with your healthcare needs.
Enclosed you will find patient information forms that need to be completed.
If you have any questions, please do not hesitate to contact our office.

6826 Plum Creed Dr. Amarillo, TX 79124 P: 806-322-3000 F: 806-322-3006

PATIENT INFORMATION

Patient Name (Last, First, Middle) | Social Security Number

Date of Birth | Age | Sex | Marital Status

Race: □American Indian □ Asian □Black/African American □Other Pacific Islander □Caucasian □Hispanic

Ethnicity: □Hispanic/ Latino □Non-Hispanic or Latino

Mailing Address **(City, State and Zip)** | Phone Number

Residing Address (If Different) | Cell Phone Number

Email Address

Employer

Employer's Address (City, State and Zip) | Employer's Phone Number

Guarantor/Responsible Party | Social Security Number | Relationship

Guarantor/Responsible Party's Mailing Address | Phone Number

Guarantor/Responsible Party's Employer

Guarantor/Responsible Party's Employers Address (City, State and Zip) | Employer's Phone Number

Person to Contact in an Emergency (Who Does Not Live with You)

Address (City, State and Zip) | Phone Number

INSURANCE INFORMATION

Primary Insurance Carrier | Policy Owner/s Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Group Name

Mailing Address (City, State and Zip)

Secondary Insurance Carrier | Policy Owner's Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Social Security Number | Date of Birth

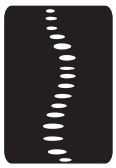
Mailing Address (City, State and Zip)

IS THIS A WORK-RELATED INJURY? □YES □NO If "YES", Please Provide the Information Below.

Date of Injury | Date Reported to Employer | Supervisors Name

Employer | Employer Address | Telephone Number

Employer's Workers Compensation Insurance Company | File/Claim Number



AMARILLO
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Medical History

Name: _____ Date of Birth: _____ SS#: _____ - _____ - _____
Height: _____ Weight: _____ Drug Allergies: _____
Food Allergies: _____ Location of Pain: _____

Are you working now? ☐ Yes ☐ No ☐ Retired ☐ Disabled
Is today's visit a result of some type of injury? ☐ Yes ☐ No
Did your injury happen on the job? ☐ Yes ☐ No
Are you here related to a Worker's compensation Claim? ☐ Yes ☐ No

If yes, on what date did the injury occur? _____
Name of employer at the time of the injury: _____
Claim Number: _____
Name of Workers Compensation Adjuster: _____
Phone Number: (____) _____ - _____

Are you here related to a motor vehicle accident? ☐ Yes ☐ No
Are you currently taking Aspirin? ☐ Yes ☐ No
Are you currently taking Fish Oil? ☐ Yes ☐ No

MEDICATIONS: (Please list all the medications you take including supplements, vitamins, and over the counter medications)

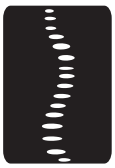
Name	Dose (Strength)	Schedule Taken

Past History: (Please circle any prior major illnesses and/or injuries)

Asthma	COPD	Heart Murmur	Hypothyroidism
Autoimmune Disease	Coronary Artery Disease	Hepatitis	Myocardial infarction
Bleeding Disorder	Depression	Hyperlipidemia	
Cancer	Diabetes Mellitus	Hypertension	
Congestive Heart Failure	GERD	Hyperthyroidism	

Other: _____

Surgeries/Hospitalizations	Year	Complications



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INSTITUTE

COMPREHENSIVE SPINE TREATMENT

Have you ever had problems with Anesthesia or Sedation? ☐ Yes ☐ No
Allergies/Reactions to Medications, Anesthetics or Materials:

_____

_____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of Children: _____ Occupation: _____
Do you live... ☐ Nursing Home ☐ Senior Facility ☐ Long-term Care Facility ☐ Assisted Living
Illicit Drug use? ☐ Yes ☐ No
Doy you drink alcohol? ☐ Yes ☐ No
If yes, how often? ☐ Daily ☐ 1 or more times a week ☐ 1 or more times a month
Do you smoke? ☐ Yes ☐ No

- ☐ If yes, _____packs of cigarettes per day for _____ years.
- ☐ Yes, I smoke cigars or a pipe.
- ☐ No, I have never smoked.
- ☐ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____years.

Family History

Do you have a family history of trouble with anesthesia? ☐ Yes ☐ No
Do you have a family history of easy bleeding?
Other family history:
Father: _____
Mother: _____
Sister: _____
Brother: _____
Maternal Grandmother/Father: _____
Paternal Grandmother/Father: _____

Review of Physicians

Do you currently, or have you ever seen any of the following

Neurologist ☐ Yes ☐ No

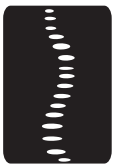
Name of Physician: _____ Phone Number: _____

Pain Management ☐ Yes ☐ No

Name of Physician: _____ Phone Number: _____

Cardiologist: ☐ Yes ☐ No

Name of Physician: _____ Phone Number: _____



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INSTITUTE

COMPREHENSIVE SPINE TREATMENT

Review of Systems

Are you currently, or have you had problems with:

Circle one

Constitutional		
Weight gains	YES	NO
Weight loss	YES	NO
Night sweats	YES	NO
Insomnia	YES	NO
Eyes		
Double Vision	YES	NO
Visual Loss	YES	NO
Ear, Nose, Throat and Mouth		
Hearing loss	YES	NO
Noise/ringing in ears	YES	NO
Nasal congestion	YES	NO
Nasal drainage	YES	NO
Sore throat	YES	NO
Trouble swallowing	YES	NO
Hoarseness	YES	NO
Cardiovascular		
Chest pain or angina	YES	NO
Heart trouble	YES	NO
Rheumatic fever	YES	NO
Heart murmur	YES	NO
High blood pressure	YES	NO
Neurological		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO
Psychiatric		
Depression	YES	NO
Allergic/ Immunologic		
Sneezing	YES	NO
Itchy eyes/nose	YES	NO
Itchy throat	YES	NO
Skin rash	YES	NO
HIV	YES	NO

Respiratory		
Asthma	YES	NO
Cough up blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble Breathing	YES	NO
Snoring	YES	NO
Gastrointestinal		
Indigestion	YES	NO
Heartburn	YES	NO
Ulcer	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood in stool	YES	NO
Black, tarry stools	YES	NO
Genitourinary		
Bladder trouble	YES	NO
Prostate disease	YES	NO
Kidney disease	YES	NO
Musculoskeletal		
Arthritis	YES	NO
Endocrine		
Diabetes	YES	NO
Thyroid disease	YES	NO
Hematologic		
Bleeding disorder	YES	NO
Easy bleeding	YES	NO

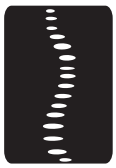
The above information is accurate to the best of my knowledge.

_____

Patient Signature

_____

Date



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SPINE
INSTITUTE

COMPREHENSIVE SPINE TREATMENT

HIPAA (Health Information Portability & Accountability Act)

I understand that at any time I may contact ASI to obtain a current copy of the Notice of Privacy Practices as it pertains to my treatment with ASI & its physicians & midlevels.

1) I authorize my doctor and his clinic staff to release my private medical information to: (Example: Family members, attorney, friends, or social security administration.)

Name Relationship

_____

_____

_____

_____

2) I authorize my doctor and his clinic staff & third party entities contracted with ASI to leave messages with myself or others on recording devices at the following numbers.

YOUR Primary Phone Number: _____

YOUR Secondary Phone Number: _____

I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, third party entities contracted with ASI or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

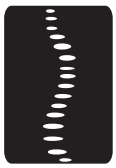
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of ASI. ASI is required to agree to any restrictions that I may request. If, however, ASI agrees to any restriction requested by me, such restriction shall be binding on ASI and it's physicians and midlevels. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that ASI and it's physicians and midlevels has taken action in reliance on this consent.

☐ I consent to the terms of this agreement.

☐ I do not consent to the terms of this agreement.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____



AMARILLO
SPINE
INSTITUTE

COMPREHENSIVE SPINE TREATMENT

Patient Pain Management Contract

Name_____ **Date of Birth** _____

The treatment of pain, the need for stimulant and sedative types of medications are a necessary and important part of caring for patients. We are committed to making sure we address your needs while providing you with alternatives designed to minimize the addictive potential of the treatments we use. In this regard, we have a Medication Management process related to pain mediations, stimulants, and sedatives to insure you know about and have access to the best, safest treatments available. If your medication (pain, stimulant, sedative) requires ongoing prescriptions for these controlled substances that have significant addiction potential, we will be requesting you to see a specialist as applicable. Controlled substances are often addictive and must be taken exactly as prescribed. To clarify our expectations in giving you this medication and to emphasize the risk of taking these substances we are requesting you to read and sign this agreement.

I have discussed my diagnosis, the treatment options and alternatives with my physician, the anticipated results, side effects, potential impairment, and my questions have been answered. I understand that I am part of the pain management team and accept responsibility for following the below restrictions.

This is agreement between_____(patient name) and ASI, it's physicians & mid-levels concerning the use of opioid analgesics (narcotic pain- killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve quality of life. **Failure to comply to any of the below listed restrictions may result in being dismissed as a patient and being reported to the police.**

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have serious withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may

occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
5. Since the medication may cause drowsiness, sedations, dizziness and short term memory problems, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
6. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
7. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
8. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy, and give my physician permission to discuss my treatment with my pharmacist. I agree to not take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with my ASI Dr. I give permission for the doctor to verify that I am not seeing other doctors for opioid medications or going to other pharmacies.
9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
10. I agree not to sell, lend, or in any way give my medication to another person.
11. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a laboratory test/urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drug levels.
12. I authorize my provider to communicate with all physicians I have seen.
13. I understand that it is illegal to share this medication.
14. I agree to keep my medication locked in order to prevent loss or theft.
15. I understand that I will be taken off this medication if there is evidence of addiction and/or abuse.
16. I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.
17. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that if I fail to attend my scheduled appointments it will be grounds for dismissal.

18. I understand that there is a risk that opioid addiction could occur. This means that I might become physiologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the physician may discontinue this form of treatment.

Patient Signature Date and time

Physician Signature Date and time

Patient Financial Contract

I, _____ (Patient's Name) agree to the terms fo this financial contract. I agree that if I do not meet the payment guidelines ASI can refer me with or without notice to the collection bureau of is choice. By signing below I am acknowleging receipt of this document and therefore giving my permission to send my account to collections if I do not adhere to the payment guidelines.

Payment guidelines are as follows:

1. I will be responsible for any and all balances left to patient responsibility by my insurance company.
2. I will be responsible for any patient balances due to deductible, co-insurance, co-pay, termed insurance or non-covered services.
3. I will agree to pay 25% of the entire balance monthly, or $250 a mont, whichever is greater.
4. I agree that my account may be sent to collections if I do not make monthly payment when owed.
5. This applies to any and all balances incurred with ASI, LLP.

This is a financial contract between ASI and the patient. By violating this agreement the patient agrees to be sent to collections and can be dismissed from ASI.

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ASI and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of a default, I agree to pay all cost of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Name:_____

Patient Signature: _____ Date: _____

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REFERRAL WAIVER
NOTICE OF FINANCIAL RESPONSIBILITY

- **FIRSTCARE**
- **BLUE CROSS/HMO**
- **MEDICARE**
- **MEDICAID**
- **MANAGED CARE**
- **OTHER**
- **COMMERCIAL**

Member's Name _____ **ID No.**_____

The above mentioned insurance company will not pay for services by specialist physicians and certain providers when those services are not property referred by the primary care physician or do not have prior authorization from the above mentioned insurance company when applicable.

Your insurance company (listed above) Is likely to deny payment for health services because:

- You do not have a referral from your primary care physician
- This visit will exceed the number of visits previously authorized and your PCP has not approved additional visits
- Your insurance company has not properly authorized the services you are requesting.
- The services you are requesting typically are not covered by your Insurance plan.
- Your insurance premium has not been paid.

MEMBER AGREEMENT

I have been notified by my physician/provider that he believes my insurance (listed above) is likely to deny payment for my healthcare services for the reason(s) stated above. If my Insurance company denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Member's Signature Date

_____ _____

Witness Date

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Consent for Purposes of Treatment and Consent by Mid-Level Practitioner

Consent to Treatment: I recognize that I need medical services. I consent to care at ASI, by its providers and/or physician assistants or nurse practitioners (a healthcare professional licensed by the Texas State Board of Medical Examiners.) I understand that the practice of medicine is not an exact science and that any treatment and/or prescribed medication may involve risk and side effects. I understand that I will be informed about the availability of alternate modes of treatement or procedures and their benefits and risks, including no treatement at all, except in emergencies.

A Physician's Assistant (PAC) and/or Nurse Practitioner (NP) is incorporated by ASI to provide an additional level of access to high quality patient care. I understand that I may change this decision at any time by requesting to see a physician, at which time the clinic staff will assist me in scheduling my care, If you would like additional information about mid-level practitioner services and training, please ask the receptionist.

Print Name: _____

Signature: _____

Date: _____

Leagal Guardian (If Necessary): _____

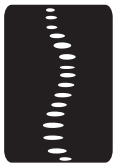
Due to a Federal Government mandate,we are now required to send you an e-mail offering you the opportunity to communicate with us via an online patient portal.

Please note: you will only receive one e-mail from us inviting you to join this portal. Once you get this email, you can either elect to join or decline the offer.

Thank you in advance for helping us comply with this federal mandate by suppling us with your email address.

Name: _____

Email: _____



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Office Policies *(Please retain a copy far your reference and records)*
OFFICE HOURS: Monday-Thursday 8am to 4pm & Friday 8am to 12 Noon.
LUNCH: 12pm-1:15pm

OFFICE APPOINTMENTS:
New patients appointments are scheduled for 30 minutes and follow up appointments for 15 minutes. New patient information packets will be given to patients the day of the appointment or mailed if requested and it time permits. You can also find the paper work on website www.lubbockspineinstitute.com. These will need to be completed prior to scheduled office visit. Excessive cancellations and rescheduling are not acceptable.

Patients are responsible for bringing their imaging and films (MRI and/or CT Scan) and their radiology reports from the aforementioned imaging.

Co-pays are expected at the time of service. Deductibles are due in full amount or can be billed with.
an agreement to our billing personnel.

If a referral is required, the patient is responsible to obtain and maintain a current referral from their primary care physician. Patient may inquire which insurance companies this practice is contracted with at any time.

A current insurance card, Medicare, supplemental insurance or current Workman's Compensation information is required at time of each office visit.

The patient will be responsible to pay any expenses incurred that are not covered by their insurance. If the balance is not paid in a timely manner, the balance will be subjected to collections.

PRESCRIPTIONS:
Amarillo Spine's prescription line is 806-322-3000. Ask to be transferred to the prescription line and follow the voice prompts. The patient will be responsible for leaving a detailed message with medication refill requested,the pharmacy name, address and phone number that needs to be called. The medication line will be checked at the **END OF THE DAY** and medications will be refilled with **48 HOURS**.

Triplicate prescriptions will be filled **ONLY** Monday-Thursday 8am-4pm. Triplicate prescriptions MUST be picked up **IN THE OFFICE**. They can not be called into a pharmacy. These prescriptions are heavily scrutinized and regulated, and Federal Law prohibits these medications from being called into a pharmacy.

MEDICAL RECORDS:
If you need a copy of your medical records, you will need to come to our office to fill out a release of records. Letters of Medical Necessity can be typed at the patients request. Please allow **2 WEEKS** for these records and/or letters to be completed.