INTERVENTIONAL SPINE & PAIN

Dr. Mark LeDoux
Dr. John Michels
Dr. Nathan S. Walters

7115 Greenville Ave, Suite 230
Dallas, TX 75231

Office 214-888-3888
www.SpineDallas.com

Name: ______________________________ Date: _____________ Height: _____ Weight: _______

Social Security Number: ______________ Date of Birth: ______ Age: _______

Address: Street ______________________City: ___________ State: ________ Zip: ____________

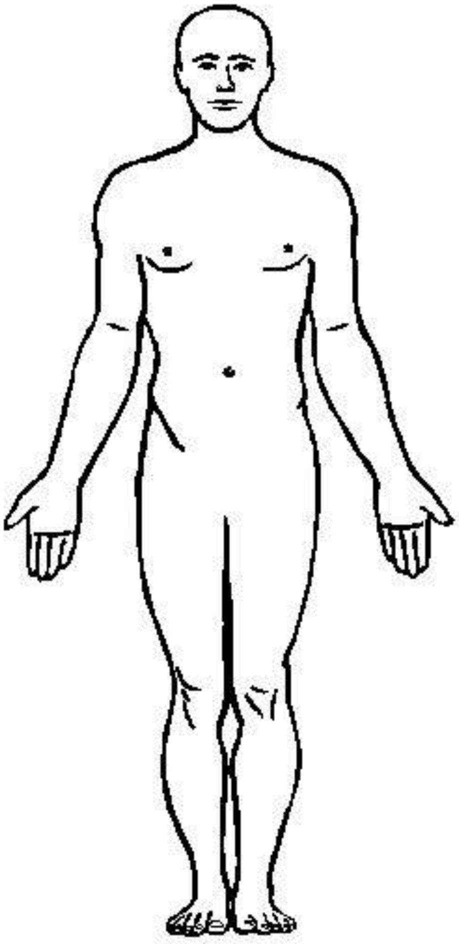
Home phone: _______________________ Cell: ___________________________

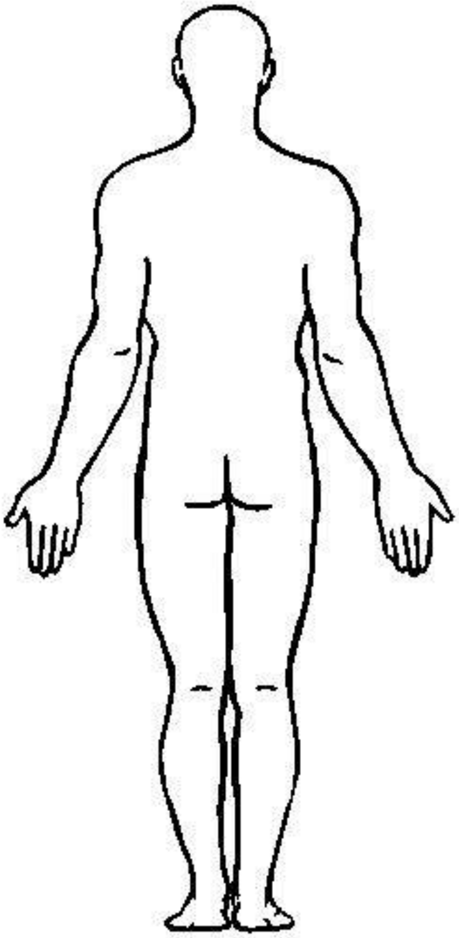
PAIN HISTORY

Referring Physician: ___________________________

Primary Care Physician: _______________________

Please use the diagram below to shade areas that are painful.





WHEN did your pain begin? ____

HOW did your pain begin? (e.g. "just started by itself", "car wreck", "accident at home/work")
____
____

Which activities (e.g. sitting, standing, walking, bending, etc.) **WORSEN** your pain?
____

Which positions (e.g. sitting, standing, lying down, etc.) **IMPROVE** your pain?
____

How does the pain affect your lifestyle? (What can you no longer do because of your pain?)
____

Which **TREATMENTS** have been used for your pain?
___ Pain killers
___ NSAIDS (ibuprofen, Motrin, Advil, Aleve, etc.)
___ Muscle relaxants
___ Physical therapy
___ Chiropractic
___ Massage
___ Ice/heat
___ Cortisone/steroid injections
___ Surgery (what kind and when? ____)

PAST MEDICAL & SURGICAL HISTORY

___ Angina/chest pain
___ Angioplasty or stent for heart
___ Anxiety/depression
___ Arrhythmia/atrial fibrillation
___ Asthma
___Bleeding disorder (hemophilia, ITP)
___ Cancer (type:_________________)
___ Congestive heart failure
___ DVT (clot in leg)
___ Diabetes
___ Drug or alcohol abuse/addiction
___ Emphysema
___ Fibromyalgia
___ Headache
___ Heart attack
___ Hepatitis (circle A / B / C)
___ High blood pressure
___ HIV or AIDS
___ Implantable defibrillator or pacemaker
___ Kidney failure/dialysis
___ Liver disease/ cirrhosis
___ Neuropathy
___ Pulmonary embolism (blood clot in lung)
___ Seizure or epilepsy
___ Sickle cell disease
___ Stomach ulcer
___ Stroke or TIA
___ Thyroid disease

Past Surgeries:
____
____

ALLERGIES to medications:
____
____

Are you allergic to Iodine contrast dye? (type of reaction: ___________________________)

CURRENT MEDICATIONS:

Pain medications:
____

Other medications:

_________________________________	__________________________________
_________________________________	__________________________________
_________________________________	__________________________________
_________________________________	__________________________________
_________________________________	__________________________________

Do you take aspirin or any blood thinners? ___ YES ___ NO

Do you currently smoke cigarettes? ___ YES ___ NO

WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE FOR YOUR PAIN RECENTLY:

___ X-rays
___ MRI
___ CT
___ Myelogram

___ Discogram
___ EMG/NCS (nerve test)
___ Bone scan

MEDICARE LIFETIME SIGNATURE ON FILE (<u>FOR MEDICARE PATIENTS ONLY</u>)

I request that payment of authorized Medicare benefits be made on my behalf to Interventional Spine & Pain, PA. for any services rendered to me by the physicians or medical staff of Interventional Spine & Pain, PA. I authorize any holder of medical information about me to release to the Healthcare Financing Administration (HCFA) and it's agents any information necessary to determine these benefits or benefits payable for related services. A photostatic copy of this agreement shall be considered effective and valid as the original.

____
Signature of patient or responsible party   Date

FINANCIAL UNDERSTANDING AND ASSIGNMENT OF BENEFITS

In consideration of the medical services to be rendered to me today and in the future, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF **Interventional Spine & Pain**, PA IN ACCORDANCE WITH THEIR REGULATIONS AND TERMS. I also hereby authorize direct payment to Interventional Spine & Pain, PA of any insurance benefits otherwise payable to me for said services, and I further authorize this office to release any medical information necessary to process my claims. I understand that I am responsible for any charges not covered by this assignment. Should my account be referred to an attorney or licensed collection agency for collection, I shall be responsible for attorney's fees or collection expenses. I understand that, as a courtesy, Interventional Spine & Pain, PA will file a claim with my insurance. If my insurance has not paid within 60 days of the filing date, I understand that I may be made responsible for the total balance of the account. A photocopy of this agreement shall be considered effective and valid as the original.

Regarding anesthesia services for pain procedures: most anesthesia is billed out of network by the company we use, HOWEVER, most plans honor a provision for the anesthesia claim to be processed in network, because the physician and facility is in network. This means that the claim will most likely apply to the in network benefits, and your out of pocket cost would be your in network deductible or co-insurance. You should call your carrier for specifics related to your specific plan prior to any procedures.

Moreover, Dr. Nathan S. Walters has personal investments in the Texas Institute for Surgery at Texas Health Presbyterian Dallas.

In addition, I will be financially responsible for appointments or procedures missed if I do not give 24 hours notice to the clinic. The fee billed is $50 for office visit and $150 for procedures.

____

Signature of patient of responsible party Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name ________________________________ SS# __________________________________
Address ______________________________ DOB __________________________________
City, State, Zip _________________________ Phone ______________________________

I hereby authorize:

Name: ____
Address: ____
City, State, Zip: ____
Fax: _____________________________________
Purpose for release: ____

To release my records to Interventional Spine & Pain

This authorization is given freely with the understanding that:
- Any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
- A photocopy of fax of this authorization is valid as the original
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period or sooner if noted below. The revocation must be in writing.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon obtaining this authorization.
- Information used of disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

________________________________ ________________________________
Patient printed name Expiration

________________________________ ________________________________
Patient signature Date

________________________________ ________________________________

Witness Date

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PATIENT AUTHORIZATION FOR CONTACT AND DISCLOSURE OF PROTECTED HEALTH INFO

Patient name: ______________________________________ Date of birth: ___________________

I authorize INTERVENTIONAL SPINE & PAIN DOCTORS AND STAFF to discuss my protected health information with the following individuals:
Name _____________________________ Name _____________________________ Name _____________________________ Name _____________________________

with the exception of the following health information (or n/a): ____

Expiration or termination of authorization: This authorization will remain in effect until written request to terminate by patient or legally authorized entity.

Patient of authorized representative signature: ____

Printed name: ____

Date: ____

INFORMED CONSENT AND TREATMENT AGREEMENT FOR CONTROLLED SUBSTANCES

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words “we” and “our” refer to the facility and the words “I,” “you,” “me,” or “my” refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician’s knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.
5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments for regular reevaluations. Please do not phone for prescriptions after hours or on weekends.
8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.
10. I understand that regular opiate use may lead to physical or psychological dependence.
11. I understand that taking more than prescribed can lead to overdose and possibly death.
12. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been made available to me.

____

Patient signature Date

____

Provider signature Date