

OmniSpine Pain Management of North Texas

REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:	City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						
Preferred Language:		Race:		Ethnicity:		

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:		Employer:	Employer address:		Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare (Please provide coupon)	<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize OmniSpine Pain Management of North Texas or insurance company to release any information required to process my claims.			
Patient/Guardian signature		Date	

OmniSpine Pain Management of North Texas Financial Policy and Authorizations

We are happy that you selected OmniSpine Pain Management of North Texas for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

Patient or Parent/Guardian if Minor

Date

2-23-2007; Rev 2-13-15; Rev 9-1-15

OmniSpine Pain Management of North Texas

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt-out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

*Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

OmniSpine Pain Management of North Texas
4500 Hillcrest Road, Suite 185, Frisco, TX 75035
(p)214-705-1200 (f) 214-705-1201
www.NorthTexasPain.com

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the “Notice of Privacy Practices” (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize [OmniSpine Pain Management of North Texas](#) to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to [OmniSpine Pain Management of North Texas](#) any information obtained in the adjudication of any claim for services furnished to me by [OmniSpine Pain Management of North Texas](#).
- I acknowledge that [OmniSpine Pain Management of North Texas](#) the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____ Date: _____

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PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize [Omnispine Pain Management of North Texas](#) to (check all that apply):

- Leave a detailed message on voice mail/machine
- Call my workplace phone number and leave a message
- Call my workplace phone number and speak only to me
- Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email
- None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ Date: _____

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress/Physician Notes | <input type="checkbox"/> X-Ray Report | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> EKG/EMG/EEG Report | <input type="checkbox"/> Consult Report |
| <input type="checkbox"/> Emergency Report | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Other _____ | | | |

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about mental health or mental retardation services
- Psychotherapy Notes created by a mental health professional
- Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexually transmitted diseases
- Information about alcohol or drug abuse treatment program services
- Information about sexual assault
- Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom [OmniSpine Pain Management of North Texas](#) may disclose my health information: _____

Address of the recipient or where my health information should be delivered: _____

TERM: This Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20____.
- Until [OmniSpine Pain Management of North Texas](#) fulfills this request.
- Until the following event occurs: _____
- Other: _____

PURPOSE: I authorize [OmniSpine Pain Management of North Texas](#) to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once [OmniSpine Pain Management of North Texas](#) discloses my health information to the recipient, [OmniSpine Pain Management of North Texas](#) cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that [OmniSpine Pain Management of North Texas](#) may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at [OmniSpine Pain Management of North Texas](#) ; except, however, if my treatment at [OmniSpine Pain Management of North Texas](#) is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case [OmniSpine Pain Management of North Texas](#) may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to [OmniSpine Pain Management of North Texas](#) Privacy Office at the address listed below. The revocation will be effective immediately upon [OmniSpine Pain Management of North Texas](#) receipt of my written notice, except that the revocation will not have any effect on any action taken by [OmniSpine Pain Management of North Texas](#) in reliance on this Authorization before it received my written notice of revocation.

I may contact [OmniSpine Pain Management of North Texas](#) about Privacy by email at czapata@omnipainrelief.com

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize [OmniSpine Pain Management of North Texas](#) to use or disclose my health information in the manner described above.

Signature of Patient

Date

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized
Personal Representative

Relationship to
Patient

Date

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Standard EC.PS.02.01

OmniSpine Pain Management of North Texas

Pain History	Patient Name
Work related injury Date: _____ Motor vehicle accident Date: _____ Fall or other trauma Date: _____ Following Surgery Date: _____ Following illness Date: _____ Unknown reason Date: _____ Other _____	How did your main pain complaint begin? (Please give details) _____ _____ _____ _____ _____ _____
No diagnosis has been given	What diagnosis, if any, have you been given for your current pain?

Treatment History

Have you ever been treated by another pain management physician or clinic? **YES** **NO**

Name of physician/clinic	Location	Dates of treatment	Reason for leaving

Have you been evaluated by a surgeon for your main pain complaint? **YES** **NO**

Name of Surgeon	Date	Was surgery recommended?	YES	NO

Have you had surgery intended to treat your current pain complaint? **YES** **NO**

Surgery #1	Procedure name:	Date	Surgeon

Have you seen any other specialists related to your main pain complaint? **YES** **NO**

Name of specialist	Specialty	Date seen

Have you had an Electromyography or EMG test to evaluate nerve function? **YES** **NO**

Performed on arms/legs/both?	Physician performing test	Date

Have you had Radiologic Imaging for your current pain complaint? **YES** **NO**

(Please Bring accrual films or CD containing the images to your initial appointment)

Study type	Body Part Imaged	Date of study	Where study was performed
X-Ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

Past Medical History	Patient Name:
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Have you been diagnosed with any of the following conditions at any point in your life? (Please circle)

AIDS/HIV	Congestive heart failure	GERD	Migraine headaches	Renal disease
Alcoholism	COPD	Gout	Multiple sclerosis	Rheumatoid arthritis
Alzheimers	Coronary artery disease	Hepatitis	Myocardial infarction	Scoliosis
Anemia	Crohn's disease	Hyperlipidemia	Obesity	Seizure disorder
Angina	Degenerative joint disease	Hypertension	Osteoarthritis	Sleep apnea
Arthritis	Depression	Inflammatory bowel disease	Osteoporosis	SLE/Lupus
Asthma	Diabetes	Juvenile rheumatoid arthritis	Parkinson disease	Spinal stenosis
Atrial fibrillation	Drug abuse	Kidney disease	Peptic ulcer disease	Spondyloarthopathy
Benign Prostatic hypertrophy	DVT	Liver disease	Psoriasis	Thyroid disease
Cancer	Fibromyalgia	Lyme disease	Vascular Disease	Valvular disease
Cerebrovascular accident	Gallbladder disease	Other	Reflex Sympathetic Dystrophy	Bipolar disorder

Past Surgical History. Please circle and date your surgeries

ACL surgery	Arthroscopy wrist	Colostomy:	LASIK	Gender Specific:
Angioplasty:	Arthroscopy shoulder:	Discectomy:	Meniscus surgery:	Neck Surgery:
Angio w/stent:	Back surgery:	Gastric bypass:	Muscle biopsy:	Other:
Appendectomy:	CABG:	Hernia repair:	ORIF:	O o
Arthroscopy ankle:	Cardiac valve replacement:	Hip arthroplasty:	Pacemaker:	
Arthroscopy elbow:	Carpal tunnel release:	Hip replacement:	Small bowel resection:	
Arthroscopy hip:	Cataract extraction:	Knee replacement:	Thyroidectomy:	
Arthroscopy knee:	Cholecystectomy:	Laminectomy:	Tonsillectomy:	

Family History (please list medical problems of your immediate family such as diabetes, high blood pressure, heart disease, etc.)

Relation	Medical Condition	Relation	Medical Condition

Please check here if you are adopted

Allergies

Do you have any known allergies? YES NO	Are you allergic to shellfish?	YES	NO
If yes please list your allergies below	Are you allergic to IV contrast dye?	YES	NO
	Are you allergic to local anesthetics?	YES	NO
	Are you allergic to latex?	YES	NO

