OmniSpine Pain Management
Registration Form

Patient Information

Patient's Last Name: **First:** **Middle:**

Legal Name *(if different)*: **Preferred Name** *(if different)*:

Cell #: **Home #:**

Street address: **City:** **State:** **Zip Code:**

Occupation: **Employer:** **Employer Number:**

Social Security Number:

Preferred language: **Race:** **Ethnicity:**

Insurance Information

(please give your insurance card to the receptionist)

Person responsible for bill: **Birth date:** / / **Address:** *(if different)*

Is this person a patient here? ☐ Yes ☐ No **Occupation:** **Employer:**

Name of primary insurance: **Member ID:** **Group number:** **Relation to subscriber:**

Subscriber's social security number:

In Case Of Emergency

Name of local friend or relative (not living at same address):

Relationship to patient: **Mobile: ( ) -** **Alternate Number: ( ) -**

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 or my insurance company to release any information required to process my claims.

Patient/Guardian Signature ***Date***

OmniSpine Pain Management Financial Policy and Authorizations

We are happy that you selected OmniSpine Pain Management 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.

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

OmniSpine Pain Management

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
- 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
4500 Hillcrest Road, Suite 185, Frisco, TX 75035
(p)214-705-1200 (f) 214-705-1201
www.omnipainrelief.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 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 any information obtained in the adjudication of any claim for services furnished to me by OmniSpine Pain Management.
- I acknowledge that OmniSpine Pain Management 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:_____

OmniSpine Pain Management
(p)214-705-1200 (f) 214-705-1201
www.omnipainrelief.com

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize OmniSpine Pain Management to (check all that apply):

☐ All The Following Below:
☐ Leave a detailed voicemail messages
☐ Send text messages to my personal **cell number** ( )
☐ Transmit and Receive messages through Patient Portal (E Clinical Works or Other) including secure email
☐ Send to **Email Address :** @
☐ None of the above

I authorized OmniSpine Pain Managment, PLLC and affiliated organizations to send text messages and /or emails for appointment reminders and other healthcare communication/information to me on my provided cell phone number and email address. By accepting these terms, I am expressing understanding that text communication is not always secure. Text messages can be intercepted. Unencrypted email is not a secure from of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email maybe misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information in any communication. I understand that the request to receive emails and text messages will apply to all future appointment reminders/feedback/health. OmniSpine Pain Management and its affiliate do not charge for this service, but standard text messaging rates may apply as provided in your wireless plan(contact your carrier for pricing plans and details).

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at leas-t 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.

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

I understand that once OmniSpine Pain Management discloses my health information to the recipient, OmniSpine Pain Management 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 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; except, however, if my treatment at OmniSpine Pain Management is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case OmniSpine Pain Management 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. Privacy Office at the address listed below. The revocation will be effective immediately upon OmniSpine Pain Management receipt of my written notice, except that the revocation will not have any effect on any action taken by OmniSpine Pain Management in reliance on this Authorization before it received my written notice of revocation.

I may contact OmniSpine Pain Management about Privacy by email at scheduling@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 **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

OmniSpine Pain Management
New Patient Medical History

DOB: / /

NAME :

REVIEW OF SYMPTOMS *(please circle)*

Appetite Change	Nausea	Insomnia
Fever	Constipation	Rash
Change in Bladder	Prolonged Bleeding	Fatigue
Weakness	Depression	Anxiety
Chest Pain	Shortness of Breath	Seizures
Dizziness	Suicidal Thoughts	

What is your main pain complaint? _____

_____

How long has it been present? Years: Months:

If the pain is located in the neck or back does it radiate into your **arms** or **legs**? *(please circle)*

Yes No

Weakness: _____ Where: _____

Numbness or Tingling _____ Where: _____

Is the pain associated with any other symptoms?

- ☐ None
- ☐ Less back pain when bending forward
- ☐ Sexual Dysfunction
- ☐ Difficulty Sleeping
- ☐ Difficulty Walking
- ☐ Other: _____

What words best describes how the pain feels? *(please circle)*

Sharp	Burning	Shooting	Deep	Tender
Stabbing	Throbing	Aching	Pressure	Shocking
Dull	Tingling	Sore	Other _____	

How often is the pain present?

- ☐ Constant
- ☐ Occasional (serval times per hour)
- ☐ Sporadic (serval times per day)
- ☐ Frequent (serval times per hour)

What makes your pain worse? *(please circle)*

Walking	Cold	Sitting
Coughing/Sneezing	Bending	Standing
Other: _____	Stress	Lying

What makes your pain better? *(please circle)*

Rest	Cold	Heat
Other: _____	Medication	Exercise

How did you hear about us:

- ☐ Doctor Refered, Who _____
- ☐ Online, Where _____
- ☐ Friend _____

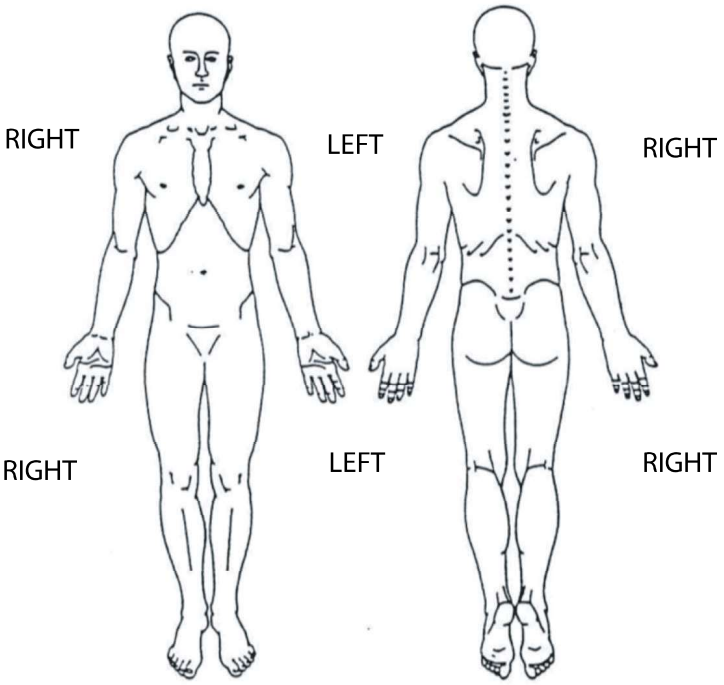
Name of Primary Care Physician:

Preferred Pharmacy:

Phone: ( ) -

Address:

Please shade the areas where you are experiencing pain,numbness/pins & needles.



O= PAIN
X=NUMBNESS, PINS & NEEDLES

For the scales below, circle a number to indicate your level of pain.

0 = no pain, 10 = most extreme/severe.

Please indicate your current pain

0 1 2 3 4 5 6 7 8 9 10

Your worst pain in the last week:

0 1 2 3 4 5 6 7 8 9 10

Your least pain in the last week:

0 1 2 3 4 5 6 7 8 9 10

OmniSpine Pain Management

Patient Name:

PAIN HISTORY

How did your main pain complaint begin? *(please give details)*

_____

_____

_____

_____

Work-Related Injury Date: _____

Motor Vehicle Accident Date: _____

Fall or Other Trauma Date: _____

Following Surgery Date: _____

Following Illness Date: _____

Unknown Reason Date: _____

Other: _____

TREATMENT HISTORY

What diagnosis, if any, have you been given for your current pain?

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? *(please circle)*	
		Yes	No
		Yes	No

Have you had surgery intended to treat your current pain complaint? ☐ Yes ☐ No

Name of Surgeon	Date	Procedure Name

Have you seen any other specialists related to your main pain complaint? ☐ Yes ☐ No

Name of Specialist	Date Seen	Specialty

Have you had an Electromyography or EMG test to evaluate nerve function? ☐ Yes ☐ No

Physician Performing Test	Date	Performed on arms/legs/both?

Have you had Radiologic Imaging for your current pain complaint? ☐ Yes ☐ No

Study Type	Body Part Imaged	Date of Study	Where Study Performed
X-Ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

OMNISPINE PAIN MANAGEMENT

Patient Name: _____ **PAST MEDICAL HISTORY**

Have you been diagnosed with any of the following conditions at any point in your life? *(please circle)*

AIDS/HIV	Congestive Heart Failure	Gastric Reflux	Migraine Headaches	Rheumatoid Arthritis
Alcoholism	COPD	Gout	Multiple Sclerosis	Scoliosis
Alzheimers	Coronary Artery Disease	Hepatitis	Heart Attack	Seizure Disorder
Anemia	Crohn's Disease	High Cholesterol	Obesity	Sleep Apnea
Angina	Degenerative Joint Disease	High Bloos Pressure	Osteoarthritis	SLE/Lupus
Arthritis	Depression	Inflammatory Bowel Disease	Osteoporosis	Spinal Stenosis
Asthma	Diabetes	Kidney Disease	Parkinson Disease	Thyroid Disease
Atrial Fibrillation	Drug Abuse	Liver Disease	Peptic Ulcer Disease	Heart Disease
Enlarge Prostate	Blood Clot	Lyme Disease	Psoriasis	Bipolar Disorder
Cancer	Fibromyalgia	CRPS/RSD	Vascular Disease	Stroke

Other:_____

PAST SURGICAL HISTORY *(please circle)*

ACL Surgery	Wrist Surgery	LASIK	Broken Bone Surgery	Hysterectomy
Heart Stent	Shoulder Surgery	Disectomy	Knee Surgery	Gender Specific
Low Back Surgery	Gastric Bypass	Muscle Biopsy	Gallbladder Removal	Appendectomy
Heart Surgery	Hernia Repair	Ankle Surgery	Hip Replacement	Thoracic Back Surgery
Pacemaker	Cataract Extraction	Carpal Tunnel Release	Thyroid Removal	Tonsillectomy
Hip Surgery	Bowel Surgery	Neck Surgery		

Other:

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 ☐

DO YOU HAVE ANY KNOWN ALLERGIES?
If yes please list your allergies below:
☐ Yes *(please list)* ☐ No

Are you allergic to shellfish?	☐ Yes	☐ No
Are you allergic to IV contrast dye?	☐ Yes	☐ No
Are you allergic to local anesthetics?	☐ Yes	☐ No
Are you allergic to latex?	☐ Yes	☐ No

OmniSpine Pain Management

Patient Name: **SOCIAL HISTORY**

Are you currently working? ☐ Yes ☐ No ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired

If working what is your present work status? ☐ Full-Time ☐ Part-Time ☐ Disability ☐ Unemployed

If not working what was your last job? How long have you been out of work?

Did you stop working due to your pain? ☐ Yes ☐ No Is one of your goals to return to work? ☐ Yes ☐ No

What is your marital status? *(please circle)* Single Married Divorced Widowed

Do you have children? ☐ Yes ☐ No How many? What age?

What is your highest level of education? *(please circle)* Did Not Graduate High School High School

GED Vocational Degree Some College College Degree Graduate Degree

Do you use tobacco? *(please circle)* ☐ Never ☐ Occasional ☐ Smokeless ☐ Cigarettes, _____ packs/day

Do you use alcohol? *(please circle)* ☐ Never ☐ Rarely ☐ Socially ☐ Regularly, _____ drinks/day

Yes	No	Have you used recreational (street)drugs in the past 5 years? *If so please list* _____
Yes	No	Do you have a history of recreational or street drug addiction?
Yes	No	Do you have a history of alcohol dependence or alcoholism?
Yes	No	Have you ever been enrolled in a drug and alcohol treatment program?
Yes	No	Do you have a history of prescription drug abuse?
Yes	No	Do you have a history of physical or sexual abuse?
Yes	No	Are you receiving workers compensation?
Yes	No	Are you receiving disability payment?
Yes	No	Have you applied or plan to apply for workers compensation or disability?
Yes	No	Have you ever been incarcenated?

CURRENT MEDICATIONS

Medication Name	Dosage	Medication Name	Dosage

OMNISPINE
PAIN MANAGEMENT

Andrew Morchower, MD, MPH

Financial Agreement including
Credit Card Authorization and No Show Policy

Client Name: _____ Client Date of Birth: _____/_____/_____

At OmniSpine Pain Management , we require a credit or debit card on file as a convenient method of payment for the portion of services for which you are liable. Your credit card information is kept confidential and secure.

Please read and initial each below, directing questions to the clinicians or office staff:

_____ I understand payment is due at the time of service and the appointment will be rescheduled if this obligation cannot be fulfilled.

_____ I understand if I no-show an appointment or cancel without at least *24 hour notice*, for any reason I will be charged $25 *per appointment* .

_____ I understand if I no Show or cancel a procedure without at least 72 hour notice, for any reason I will be charged $100 per missed procedure.

_____ I understand that if there is a balance on my account, OmniSpine Pain Managemement will charge the credit card on file after I have been notified. This may include balances due for services rendered the insurance company did not cover. ***Payment plans are available upon request.***

_____ I acknowledge I am encouraged by this office to review the Explanation of Benefits (EOB) provided to me by my insurance to ensure proper claim processing. Should my insurance overpay for services rendered, I am encouraged to contact OmniSpine Pain Management to request a refund.

Cardholder Signature: _____ **Date:**_____/_____/_____