



SPINE ASSOCIATES

Today's Date:

Patient Name:		SSN	Age	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status Single Divorced Married Widowed
		DOB			
Last Name: If Patient Is A Minor (under 18) Parent or Guardians Name First Name:				Relationship:	
Home Address:		City	State	Zip	
Home Phone:			Cell Phone:		
Employer:		Work Phone:		Ext:	
Business Address:		City	State	Zip	
Referring Physician			Phone		
Office address		City	State	Zip	
Pharmacy			Phone		
Primary Insurance Information			Secondary Insurance Information		
Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name of Insurance:		
Do you have Texan Plus (Medicare HMO)? <input type="checkbox"/> Yes <input type="checkbox"/> No					Birthdate
Name of Insurance:			Name of Insured:		
Name of Insured:		Birthdate	Social Security number		
Social Security number:		Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other	Relationship to patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		
Employer		Bus Telephone	Employer		Bus Telephone
Business address			Business address		
Insurance ID#			Insurance ID#		
Insurance group/plan#			Insurance group/plan#		
Insurance Telephone#:			Insurance Telephone#:		
Emergency Contact Information					
Name:		Relationship:		Emergency contact#	
Reason for appointment/chief complaint:					

Spine Associates

5420 West Loop South, Ste 2500, Bellaire, Texas 77401
Office (713) 383-7100 * Fax (713) 383-7500
3129 College Street, Ste 300, Beaumont, Texas 77001
Office (409) 767-8221 * Fax (409) 785-4200
Richard R.M. Francis, MD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY ACT OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) which went into effect April 14, 2003. This Notice describes how we may use and disclose health information about you for treatment, payment, healthcare operations, or for other purposes that are permitted or required by law. It also describes your rights to access and control your health information in some cases. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Use and Disclosure of Information by Your Healthcare Provider

The provider may use your health information for purposes of providing treatment, obtaining payment for treatment, and conducting healthcare operations. Your health information may be used or disclosed only for these purposes unless the Provider has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, employee review activities, education, training programs, accreditation, certification, licensing or credentialing activities, as well as compliance reviews, medical reviews, and business management and general administrative activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an

authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We will disclose your health information to you, as described in the Patient Rights section of this Notice. With your permission, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information of marketing communications without your written authorization.

Required by Law: We may use or disclose your health information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal officials health information required for lawful intelligence, official having lawful custody of health information or inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters.)

Worker's Compensation: The provider may release your health information to comply with worker's compensation laws or similar programs.

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of the Notice.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

Our Promise to You: We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to health information, and to abide by the terms of their notice of privacy practices in effect.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us in the contact information listed at the end of the Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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Richard R.M. Francis, MD

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient or Personal Representative

Date

If Personal Representatives signature appears above, please describe Personal Representatives relationship to the patient: _____

SPINE ASSOCIATES

Attn: Privacy Officer

5420 West Loop South

Bellaire, TX 77401

The Privacy Officer can be contacted by telephone at (713) 383-7100

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Financial Policy Statement

It is the policy of Spine Associates to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not permit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Spine Associates, you recognize an obligation to promptly remit same to Spine Associates.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised as a Worker's Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Spine Associates, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient or Responsible Party

Date

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CONSENT FOR MEDICAL TREATMENT

**Knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital.
This form has been fully explained to me and I certify that I understand its contents.**

Patient's Signature

Date

Witness

Patient is: _____ a minor _____ unable to consent because _____

I hereby consent on his/her behalf and in his/her stead on _____
Date

Signature of Person Responsible for Patient or Patient's Legal Guardian

Signed

Print Name

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RELEASE OF MEDICAL INFORMATION

Date: _____

I, _____ allow

Patient Name

_____ to release

(Medical Institution) or (Legal Representative)

Medical Records to _____

(Medical Institution) or (Legal Representative)

Please release the following:

_____ Clinical Notes

_____ Diagnostics (CT's, MRI's, X-rays, etc....)

_____ Surgical Procedures

Requestor's DOB: _____

Requestor's Social Security #: _____

Signature

Address

City/State/Zip

Telephone

Witness



SPINE ASSOCIATES

RICHARD R.M. FRANCIS, M.D., MBA, FRCS Ed. (Tr. & Orth.)
Orthopaedic Surgeon
Surgery of Spine

Pregnancy Release

Name: _____

Date: _____

I do hereby state and assure that there is absolutely no possibility that I am or might be pregnant at this time. I understand that this facility will take every precaution to safeguard my well being and that no pregnancy exists. My signature below, therefore, releases the above doctor and employees of this facility, and/or heirs from any further responsibility or liability regarding this manner.

Patient Signature

Guardian Signature for Minor

Witness



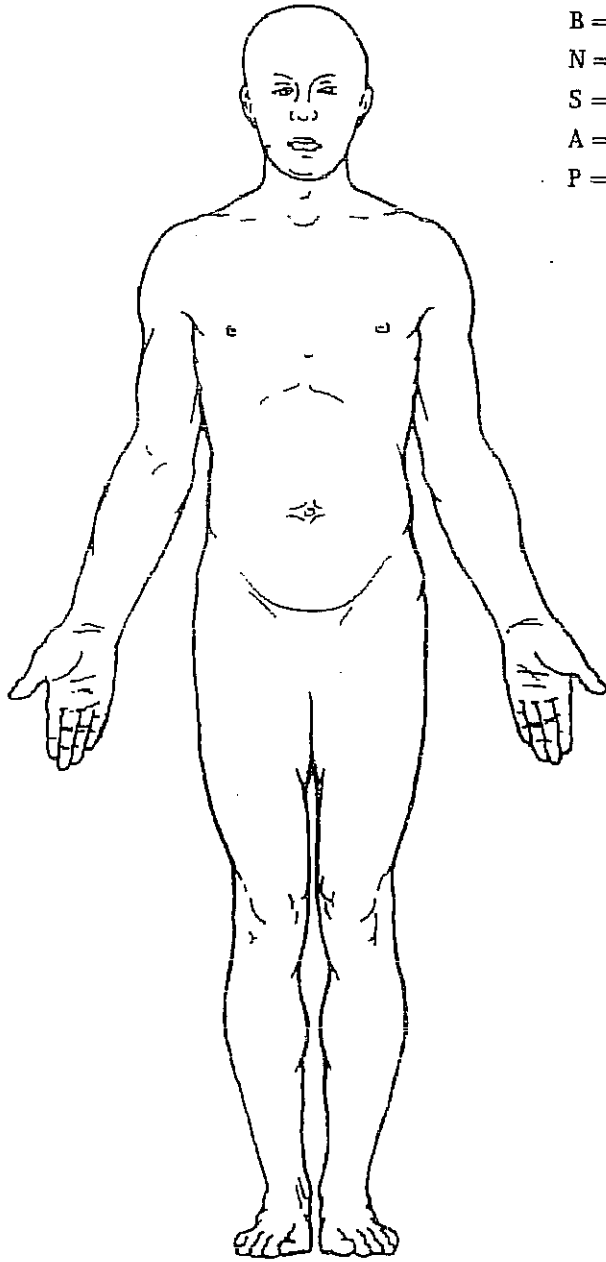
SPINE ASSOCIATES

RICHARD R.M. FRANCIS, M.D., MBA, FRCS Ed. (Tr. & Orth.)

Orthopaedic Surgeon

Surgery of the Spine

Front



Types of Pain

B = Burning

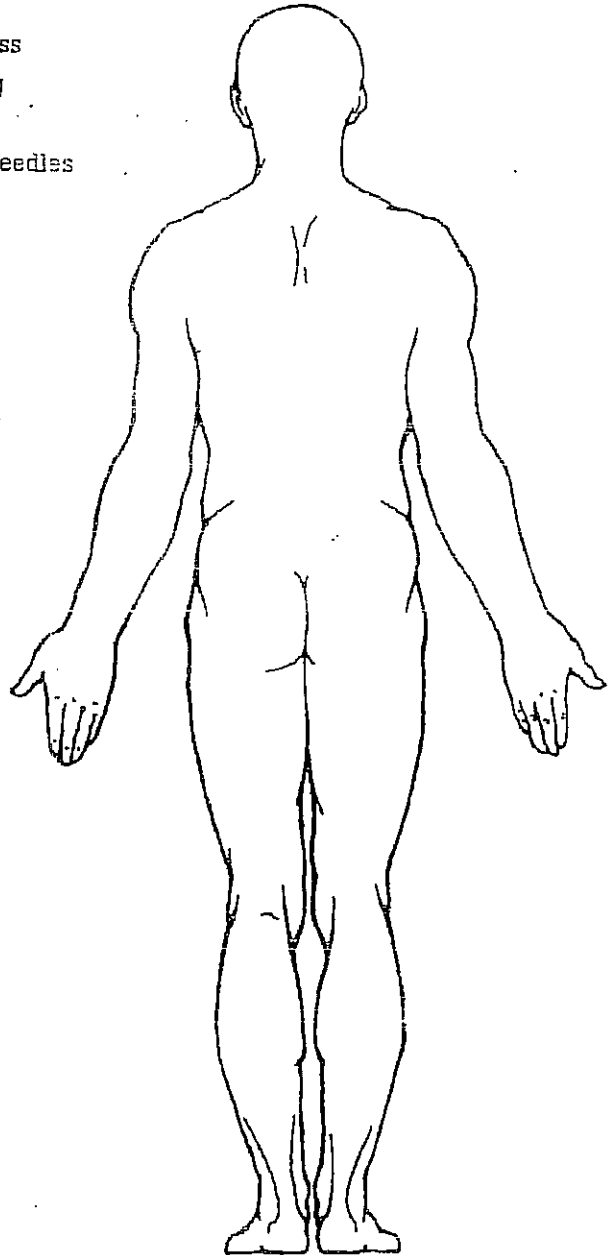
N = Numbness

S = Stabbing

A = Aching

P = Pins & Needles

Back



PLEASE COMPLETE THIS SECTION.

Your name _____ SS# _____ Today's date _____

Height _____ Weight _____ Birth date _____ Age _____

Claim# _____

Chief complaint _____

5420 WEST LOOP SOUTH, SUITE 2500, BELLAIRE, TEXAS 77401 • OFFICE: (713) 383-7100 • FAX: (713) 383-7500

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www.spineassociatesofhouston.com

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Dr. Richard R.M. Francis, MD

PATIENT NAME: _____

BIRTHDATE: _____ AGE _____ HEIGHT: _____ FT: _____ IN: _____ WEIGHT: _____

EXPLAIN HOW YOUR PAIN BEGAN:

Injury Yes or No Sports On the Job Motor vehicle accident

I don't know how it began

Date of Injury _____

Explain How it happened _____

RATE YOUR PAIN: (Mark X on the Line)

1. How bad is your Low Back Pain Now:

0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10
Worse Possible

2. How bad is your Leg Pain Now?

0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10
Worse Possible

3. How Bad is your Neck or Upper Back Pain Now?

0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10
Worse Possible

4. How Bad is your Arm Pain now?

0 _____ 2 _____ 4 _____ 5 _____ 6 _____ 8 _____ 10
Worse Possible

Have you had Back/Neck Pain before this episode? Yes or No

If yes when _____ For how long _____

WHAT MAKES YOUR DISCOMFORT WORSE: (PLEASE CHECK ALL THAT APPLY)

NECK

Activity Bending Neck Forward Bending Neck Backward

Bending neck to the left Bending Neck to the Right

Other _____

BACK

Activity Bending Forward Bending Backward Sitting Standing

Walking Sneeze/Cough/Straining going to bathroom/bearing down

Other _____

WHAT MAKES YOUR DISCOMFORT BETTER: (PLEASE CHECK ALL THAT APPLY)

NECK

Bed Rest Massage Stretching "Popping" Neck Heat Ice

Other _____ Nothing Helps

BACK

- Bed Rest Decrease Activities Bending Forward Bending Backward
- Other _____ Nothing Helps

I ALSO HAVE THE FOLLOWING PROBLEMS:

- Specific Weakness in my arms or hands
- Generalized weakness of arms or hands due to pain or discomfort
- Numbness TINGLING OF: Arms Hands Legs Feet Torso
- Specific Weakness of legs
- Generalized weakness of legs due to pain and discomfort
- My legs fatigue or hurt when I walk too far This is relieved by resting my legs
- I can walk: Less than a block 1-2 Blocks More than 3 blocks
- Trouble with my bladder (Urine) control
- Can't empty bladder
- Loss of urine (accidents)
- Trouble with bowels
- Constipation
- Loss of bowel (accidents)
- My pain is worse at night
- My pain awakens me from sleep

OCCUPATION:

Employed Yes or No Date last worked _____ Retired _____
Employer _____

MY JOB REQUIREMENTS ARE:

- Heavy: Lifting over 60 Lbs. and Frequent bending and stooping
- Medium: Lifting 30 – 50 Lbs.
- Light: Lifting 10 – 20 Lbs.
- Sedentary: Sit most of the time and very little lifting

GENERAL MEDICAL HISTORY

YEAR ILLNESS

- _____ Heart Trouble Angina Heart Attack Heart Failure Heart Murmur
- _____ Valve Disease Other _____
- _____ High Blood Pressure
- _____ Stroke
- _____ Ulcer: Stomach Duodenal Colon
- _____ Diabetes (High Blood Sugar)
- _____ Liver Disease: Hepatitis Type A Type B Other
- _____ Cirrhosis Other _____
- _____ Kidney Disease: Stones Infections Other _____
- _____ Lung Disease: Emphysema TB Chronic Brochitis Cancer Asthma
- _____ Frequent Pneumonia Other _____
- _____ Blood Disorders: Anemia Leukemia Bleeding Tendency Other
- _____ Eye Disease Glaucoma Other _____
- _____ Arthritis Degenerative Rheumatoid Gout Other
- _____ Cancer Type and Sites: _____
- _____ HIV Positive Aides _____
- _____ Psychological Difficulties: Depression Psychosis Other _____
- _____ No Major Illnesses

MAJOR INJURIES:

- Auto or Cycle accidents, etc. (Describe) _____
- Other Major Injuries: _____

HOSPITALIZATION: (Explain) _____

LADIES MENSTRUAL HISTORY: Pregnant Yes or No

- Menopausal hormone treatment

MEN: Problems with Sexual Function

FAMILY MEDICAL HISTORY:

Members of my family (brothers, sisters, grandparents, aunts and uncles) suffer with the following:

- Stroke High Blood Pressure Cancer-type _____
- Diabetes Heart Attack Lung Disease
- Arthritis Other: _____ I Don't Know

SOCIAL HISTORY:

I live with my children or other relatives.

Explain: _____

I drink Yes or No If yes beer Wine "Hard" Drinks None Daily Socially

I honestly consider myself to drink too much I don't think I drink too much

I smoke Yes or No If yes Cigarettes Pipe Cigars _____ Parts/Day for _____ Years

My Recreational activities includes: Jogging Bicycling Sports – List _____

REVIEW OF SYSTEMS:

Do you have problems other than Neck or Back: _____

Eyes Ears Nose Throat Explain: _____

Skin, Moles, Spots, or Sores that are unusual Explain: _____

Unusual Humps or Bump under skin, such as enlarged lymph nodes Explain: _____

Trouble breathing Short of Breath Cough Pain w/Breathing Other

Chest Pain Discomfort Sharp Aching Arm Discomfort along with Chest Discomfort

With Activity After Meals When under stress Other _____

Trouble with Stomach or Bowels Nausea / Vomiting Stomach Pain Diarrhea

Constipation

Bleeding in Bowel Black / Tarry Stools Other _____

Trouble with Legs Fatigue with walking/Relieved by rest

Other _____

Trouble with Nerves Anxious / Fearful Down/Depressed

ALLERGIES:

REACTION: Itching Nausea Hospitalized

Penicillin _____

Sulfer _____

Keflex _____

Codeine _____

Other _____

None

CURRENT/PREVIOUS TREATMENT: (For Back or Neck)

None

Physician's Name: _____

He Prescribed Medications (Give Names): _____

Anti-Inflammatories: _____

Muscle Relaxers: _____

Pain Meds: _____

List other medications: _____

Physical Therapy Yes or No If Yes When _____

Traction

Exercises

Manipulations (Osteopath) _____

Heat Ice

Chiropractor's Name: _____

Physical therapy facility: _____

Injections Yes or No If yes when _____

Physician's name: _____

Type of injections: _____

Surgery Yes or No

Please list surgeries:

Type of Surgery _____

Date: _____ Where: _____ Doctor: _____

Described: _____

Infections: _____ Treatment: _____

Type of Surgery _____

Date: _____ Where: _____ Doctor: _____

Described: _____

Infections: _____ Treatment: _____

Type of Surgery _____

Date: _____ Where: _____ Doctor: _____

Described: _____

Infections: _____ Treatment: _____

I HAVE HAD THE FOLLOWING TESTS: (PLEASE CHECK ALL THAT APPLY)

Regular X Rays CT scan MRI Myelogram Discogram Bone scan

EMG/Nerve Conduction Studies

I have seen other doctors for my condition. List types of doctors and who they are:

