PATIENT RECORD OF DISCLOSURE

THe HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

Patient/Parent Signature ______________________ Date ______________

Print Name ______________________ Date of Birth (M/D/Y) ______________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

The following names listed are those that I give Seton Family of Doctors, the authorization to give health information:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Acknowledgment:

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices (Version Effective 3/03).

Signature of Patient / Legal Guardian: ______________________ Date: ______________

(To be completed if patient refuses to sign acknowledgement)

Date: ______________ Name of person providing notice ______________________

Reviewed ______________________ Date ______________

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PERSONAL INFORMATION

1 Patient information

Last Name ______ First Name ______ MI ______

Address ______

City ______ State ______ Zip ______

Mobile Phone # ______ Work Phone # ______

Home Phone # ______

Email Address ______

Social Security # ______ Medicare # ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (M/D/Y) ______ Age ______ Sex (M/F) ______

Occupation (If retired, list prior occupation) ______

Employer's Address ______

City ______ State ______ Zip ______

Emergency Contact ______ Telephone # ______

Name of Personal Doctor ______

City ______ State ______

Primary Language ______

Ethnicity (i.e. Hispanic, White European) ______

Race (i.e. Asian American, African American) ______

How would you like to receive reminders? ☐ Phone ☐ Email ☐ Text

If phone, please select the preferred phone # below.

☐ Mobile ☐ Work ☐ Home

2 Person responsible for payment

(Leave blank if same as patient)

Last Name ______ First Name ______ MI ______

Address ______

City ______ State ______ Zip ______

Personal Phone # ______ Work Phone # ______

Email Address ______

Social Security # ______

Date of Birth (M/D/Y) ______ Age ______ Sex (M/F) ______

Occupation (If retired, list prior occupation) ______

______

Employer's Address ______

City ______ State ______ Zip ______

3 How did you hear of us?

☐ Friend/Relative ☐ Newspaper/Magazine ☐ Yellow pages ☐ Internet

☐ Insurance directory ☐ Referral - Dr. name ______

4 Insurance information

Primary Insurance ______

Policy # ______ Group # ______

Claims Address ______

City ______ State ______ Zip ______

Insurance Telephone # ______

Name of Policy Holder ______

Social Security # ______ Date of Birth (M/D/Y) ______

Secondary Insurance ______

Policy # ______ Group # ______

Claims Address ______

City ______ State ______ Zip ______

Insurance Telephone # ______

Name of Policy Holder ______

Social Security # ______ Date of Birth (M/D/Y) ______

Reviewed ______ Date ______

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1 Patient information

Chart # ____

Today's Date ____

Referring Doctor ____

Last Name ____ First Name ____ MI ____

Date of Birth (M/D/Y) ____ Age ____

Sex (M/F) ____ Height ____ Weight ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere? ____

How long have you had these symptoms?

☐ ≤ 6 weeks ☐ ≥ 7 - 12 weeks ☐ 4 months or more

Do you have pain radiating past your knee or elbow? ☐ Yes ☐ No

Does your leg or arm ever go numb? ☐ Yes ☐ No

The pain is: ☐ Constant ☐ It comes & goes

Does your pain wake you up at night? ☐ Yes ☐ No

What things makes the pain better? (rest, ice, heat, pills) ____

What makes the pain worse? (sitting, standing, lifting) ____

Do you have pain that radiates into the arm or leg? ☐ Yes ☐ No

(If yes, describe) ____

Lost any control over bowel or bladder functions? ☐ Yes ☐ No

(If yes, describe) ____

Any weakness in an arm or leg? ☐ Yes ☐ No

(If yes, describe) ____

How long can you: ____ Sit ____ Stand ____ Walk

Is your pain the result of a: ☐ Fall ☐ Auto accident ☐ Other (list) ____

3 Current status

Is there a law suit pending on problem? ☐ Yes ☐ No

Which of the following describes you currently?

☐ Working; if yes: ☐ Full duties ☐ Limited

☐ Not working because of back or neck problem

☐ Not working because of another health problem

☐ Homemaker, retired or unemployed

How long have you been at that job? ____

Does your job require lifting, standing, sitting? ☐ Yes ☐ No

Employer at time of injury ____

4 Your pain

Draw your pain on the diagram below, using the corresponding symbols to show the type of pain you feel.

R L

Stabbing pain ////
Burning pain 000
Aching pain XXX
Pins and needles VVV
Numbness ===

What percentage of your pain resides in the following areas? **(Must add up to equal 100%)**

BACK ____ %
BUTTOCK/LEG ____ %
NECK ____ %
SHOULDER/ARM ____ %
TOTAL 100 %

Circle current pain level.

0 10 20 30 40 50 60 70 80 90 100

For Office Use Only. Date: ____ VAS ____% ODI ____

Reviewed ____ Date ____

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5 Previous treatments & tests

Name of the doctor that treated you FIRST for this problem and the city. ______

What treatments did you have? ______

What tests have you had? ☐ CT scan ☐ MRI ☐ X-ray ☐ EMG
☐ Other (list) ______

Did you have any injections for your problem? ☐ Yes ☐ No
(If yes, describe) ______

Did these injections help? ☐ Yes ☐ No
(If yes, describe) ______

Did you have previous back or neck surgery? ☐ Yes ☐ No
(If yes, describe) ______

List any other PREVIOUS SURGERIES you had, and dates: ______

Have you ever had a blood transfusion? ☐ Yes ☐ No
(If yes, describe) ______

Did you have physical therapy before for your problem? ☐ Yes ☐ No
(If yes, describe) ______

Did this therapy help? ☐ Yes ☐ No
(If yes, describe) ______

Do you do any special exercises for your back or neck? ☐ Yes ☐ No
(If yes, describe) ______

Please list PRESCRIPTIONS and over the counter MEDICATIONS you take below.

Name of Medication:	Dose (total milligrams):	How many times daily:

What other medications have you tried? ______

What do you hope we can accomplish today? ______

What other concerns do you have? ______

6 Your health

List any ALLERGIES you have to medications, foods, etc. ______

Do you have any adverse reactions to anesthesia? ☐ Yes ☐ No
(If yes, describe) ______

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?) ______

Do you drink alcohol? ☐ Yes ☐ No (If yes, how many days a week?) ______

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Recently, have you had...	
Heart problems	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No
Migraines/headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Muscle diseases	☐ Yes ☐ No	Worse pain at night	☐ Yes ☐ No
Swollen ankles	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No

Other problems: ______

7 Your family history

Do any family members have a history of:

Back/neck problems	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Migraines/headaches	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Muscle diseases	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No

Other problems? ______

Reviewed ______ Date ______

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Seton
Spine & Scoliosis
Center

Oswestry Disability Index

Patient Name ______________________________________ **Today's Date** __________________

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by circling one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please circle only the number that indicates the statement **which most clearly describes your problem.**

Section 1. Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment

Section 2. Personal Care (e.g. washing, dressing)

0. I can look after myself normally without causing extra pain
1. I can look after myself normally but it causes extra pain
2. It is painful to look after myself and I am slow and careful
3. I need some help but can manage most of my personal care
4. I need help every day in most aspects of self-care
5. I do not get dressed, wash with difficulty and stay in bed

Section 3. Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives me extra pain
2. Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently place e.g. on a table
3. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
4. I can only lift very light weights
5. I cannot lift or carry anything

Section 4. Walking Section

0. Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than ¼ mile
4. I can only walk using a stick or crutches
5. I am in bed most of the time

Section 5. Sitting

0. I can sit in any chair as long as I like
1. I can only sit in my favorite
2. Pain prevents me sitting more than one hour
3. Pain prevents me sitting more than 30 minutes
4. Pain prevents me sitting more than 10 minutes
5. Pain prevents me sitting at all

Section 6. Standing

0. I can stand as long as I want without extra pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing for more than 1 hour
3. Pain prevents me from standing for more than 30 minutes
4. Pain prevents me from standing for more than 15 minutes
5. Pain prevents me from standing at all

Section 7. Sleeping

0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I have less than 6 hours sleep
3. Because of pain I have less than 4 hours sleep
4. Because of pain I have less than 2 hours sleep
5. Pain prevents me from sleeping at all

Section 8. Employment / Homemaking

0. My normal homemaking / job activities do not cause pain
1. My normal homemaking / job activities increase my pain but I can still perform all that is required of me
2. I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful duties
3. Pain prevents me from doing anything but light duties
4. Pain prevents me from doing even light duties
5. Pain prevents me from doing any job or homemaking duties

Section 9. Social Life

0. My social life is normal and gives me no extra pain
1. My social life is normal but increases the degree of pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
3. Pain has restricted my social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have no social life because of pain

Section 10. Traveling

0. I can travel anywhere without pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over two hours
3. Pain restricts me to journeys of less than one hour
4. Pain restricts me to short necessary journeys under 30 minutes
5. Pain prevents me from traveling except to receive treatment

Reviewed ______________________________ Date ________________________

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Injury Report Form

1 Universal injury or accident statement

Last Name ______ First Name ______ MI ______ Today's Date ______

Please complete the following statement. Most insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.

Dateofinjury ______

Place where injury occurred (work, home, parking lot, car, friend's house, etc.) ______

2 Please describe how the injury or accident occurred

______

______

______

3 Work related injury

Was the injury work related? ☐ Yes ☐ No (If yes, complete this section)

Name of Employer ______

Telephone # ______

Employer's Address ______

City ______ State ______ Zip ______

Please be advised that Seton Spine & Scoliosis Center does not accept Workers Compensation.

4 Third party liability settlement

Is there a possible third party liability settlement? (e.g., auto, homeowners, property)

☐ Yes ☐ No (If yes, complete this section)

Name of Insurance ______

Telephone # ______

Adjuster's Name (if known) ______

Telephone # ______

5 Authorization

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient Name (or signature of responsible party) ______ Today's Date ______

Reviewed ______ Date ______

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PRIVACY NOTICE | YOUR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have that right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed): ______________________ Signature: ______________________ Date: __________

Reviewed ______________________ Date __________

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OUR PAIN MEDICATION POLICY

In the course of your treatment, you may receive pain medications. However, all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics.

Consequently, all patients need to make arrangements to obtain any necessary prescription refills prior to the weekend. We will not provide pain prescriptions or pain prescription refills during the weekend which begins each Friday at noon and ends the following Monday at 8:30 a.m.

The goal of our spine center is to help patients become less dependent on pain medications. Consequently, our policy is to NOT provide prescription refills by phone. So you may need to see the physician or the physician assistant to make these arrangements. Please call at least two days prior to your last dose. This will assure the most prompt response to your request. Do not wait until the day your medication runs out. Our clinical staff needs sufficient time to review your request for refill.

USE ONE PHARMACY

Using the same pharmacy helps assure that the pharmacy will stock your medication for refills and that the pharmacy will know that you have a legitimate need for pain medication. Consequently, it is in your best interest to use only ONE pharmacy for refills of your pain medication.

PROTECT YOUR MEDICATION FROM LOSS

You are personally responsible for the safekeeping of your medication. Please do not sell, trade or give it away. If your medication is damaged, stolen or lost you must notify us right away.

Please do not seek pain medication from any other doctor unless approved by our clinical staff. Let us know if at any time another doctor prescribes medication for you.

The above restrictions apply a variety of prescription drugs, including, but not limited to:

1. Narcotics. (Example include, Vicodin, Percocet, Oxycontin & Codeine)
2. Non-Steroidal Anti-Inflammatory drugs, "NSAIDS". (Example include, Motrin, Celebrexx & Naprosyn)
3. Non-narcotic and other Pain Medicine. (Example include, Ultram or Darvocet)
4. Muscle Relaxants. (Example include, Flexeril or Soma)

Reviewed ______________________ Date __________

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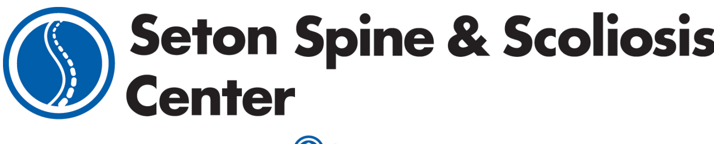

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee. I understand that Seton Spine and Scoliosis includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to the Seton Spine and Scoliosis until revoked by me in writing.

2. Consent to Release Information

I acknowledge that Seton Spine and Scoliosis may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Seton Spine and Scoliosis.

I acknowledge and consent to allow Seton Spine and Scoliosis to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Seton Spine and Scoliosis all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Seton Spine and Scoliosis are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Seton Spine and Scoliosis on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Seton Spine and Scoliosis or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of Privacy Practice

I acknowledge receipt of the “Notice of Privacy Practices” from Seton Spine and Scoliosis.

_________________________________ _______________
Patient Printed Name Patient Date of Birth

_________________________________ _______________
Patient/Responsible Party Signature Date

_________________________________ _______________
Witness Date