Patient Registration Form

12332 Bear Plaza Suite 100
Burleson, TX 76028

Phone: 817-615-8840 Fax: 682-285-2468

Patient Information (confidential):

Name: ____ Date: ____________________

(First) (Middle) (Last)

Address: ____ City __________ State ____ Zip ________

Phone: Home (___) ______________ Work (__ _) ________________ Cell (____) ______________

Birth Date: ______________ SS# ____ - ____ - ______ E-Mail : ______________________________

Employer (if Minor, Parent's Employer) ____

Employer Address: ______________________________ City ____________ State ____ Zip ________

Spouse Name (if Minor, Parent's Name) __________________________ Phone: (___) __________

Primary Care Physician : ____________________________________ Phone: (___) __________

Emergency Contact: ______________________________________ Phone: ( ) __________

Relationship to patient: __________________________

How did you hear about our practice? __________________________ Phone: (___) __________

Responsible person if different from above.

Do you have medical insurance coverage: ☐ Yes ☐ No

Name of Person on account : ________________________________ Phone : ______________

Relationship to Patient: __________________ SSN - ____- Birth Date: ______________

Insurance Company: ____________ ______________ Policy No: ________ Group Number: __________

Phone Number of insurance company: ________ ______

Do you have addition al insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Insured: __________________________ Relationship to patient: ____________________

SSN: ____________ DOB: ________ ____

Insurance Company: ____________ ______________ Policy No: ________ Group N mber: __________

If you are covered und er worker's compensation or motor vehicle insurance, enter info below:

Name of Worker's Co p or Motor Vehicle Accident Insurance Carrier: ________________________

Employer: ______________________________ Claim No .: ______________________________

Date of Injury: ____________________ Adjuster/Case Manager: __________________________

Adjuster/Case Manager Phone No.: ______________________________

Carrier Address: ____

Patient Initial: ____________________

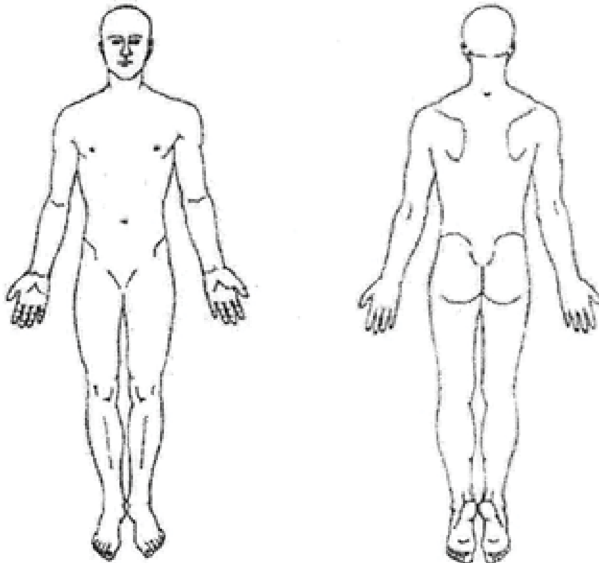
INTERVENTIONAL PAIN & SPINE

NEW PATIENT FORM

Patient Name :		DOB:		Age :		☐ M ☐ F
Name of Referring Physician :			Name of PCP :			
Reason for Visit:						
How long have you had this pain?		Average Pain Level (1 (no pain) to 10 (worst)) :		-		

Height:______ Weight:______

On the diagram below, mark the area where you have pain.



Describe the pain

☐ Aching	☐ Mild	☐ Moderate
☐ Burning	☐ Throbbing	☐ Severe
☐ Pins/needles	☐ Constant	☐ Sharp/stabbing
☐ Numbness	☐ Intermittent	

What makes your pain Worse:

What makes your pain Better:

Do you have WEAKNESS in your : ☐ Arms ☐ R ☐ L
☐ Legs ☐ R ☐ L

Do you have NUMBNESS in your : ☐ Arms ☐ R ☐ L
☐ Legs ☐ R ☐ L

TREATMENT HISTORY

For your current symptoms, please mark the boxes for the following imaging/studies that have been performed

☐ X-Ray ☐ MRI ☐ CT scan ☐ Discogram ☐ EMG/NCV (nerve test) ☐ CT myelogram

Where was this imaging/study done?

____

Please mark the type of treatment(s) that you have had in the past and how well they worked, OTHERWISE LEAVE BLANK:

Injections: ☐ Better ☐ Worse ☐ No Change
Type: ______________________________

____

Spine Surgery: ☐ Better ☐ Worse ☐ No Change
Type of surgery and year?

____

____

TENS unit: ☐ Better ☐ Worse ☐ No Change

Chiropractor: ☐ Better ☐ Worse ☐ No Change

Massage: ☐ Better ☐ Worse ☐ No Change

Physical Therapy: ☐ Better ☐ Worse ☐ No Change
How recently? ______________________________

Bracing: ☐ Better ☐ Worse ☐ No Change
Type:

____

____

Heat / Ice: ☐ Better ☐ Worse ☐ No Change

Acupuncture: ☐ Better ☐ Worse ☐ No Change

Psychology: ☐ Better ☐ Worse ☐ No Change

PAST MEDICATIONS

Please indicate which medications you have used in the past for your current pain condition (OTHERWISE DO NOT CHECK):

ANTI-INFLAMMATORY	Helped? Yes	No
Naproxen (aleve)	☐	☐
Ibuprofen (advil, motrin)	☐	☐
Diclofenac (voltaren)	☐	☐
Tylenol (acetaminophen)	☐	☐
Flector patch	☐	☐

MUSCLE RELAXANTS	Helped? Yes	No
Carisoprodol (soma)	☐	☐
Cyclobenzaprine (flexeril)	☐	☐
Skelaxin (Metaxolone)	☐	☐
Methocarbamol (robaxin)	☐	☐
Tizanidine (zanaflex)	☐	☐

NARCOTICS / OPIOIDS	Helped? Yes	No
Tramadol	☐	☐
Tylenol with codeine	☐	☐
Hydrocodone (Vicodin)	☐	☐
Oxycodone (Percocet)	☐	☐
Morphine, MS Contin	☐	☐
Hydromorphone	☐	☐
Nucynta (tapentadol)	☐	☐
Fentanyl patch	☐	☐
Methadone	☐	☐
Opana	☐	☐
Suboxone	☐	☐

NERVE MEDICATIONS	Helped? Yes	No
Gabapentin (Neurontin)	☐	☐
Lyrica	☐	☐
Amitriptyline (Elavil)	☐	☐
Nortriptyline	☐	☐
Cymbalta	☐	☐
Effexor	☐	☐
Savella	☐	☐
Lidoderm patch	☐	☐

PAST MEDICAL HISTORY

Please document all medical history below , including any of the following medical conditions :

☐ **Anxiety Disorder**	☐ **Depression**	☐ **High Blood Pressure**	☐ **Obsessive Compulsive d/o**
☐ **Bipolar Disorder**	☐ **Diabetes**	☐ **Heart attack/disease**	☐ **Abuse during childhood**
☐ **Schizophrenia**	☐ **Cancer**	☐ **Attention deficit d/o**	☐ **Kidney/Liver disease**
☐ **Osteoporosis**	☐ **Gout**	☐ **Attention deficit d/o**	☐ **Rheumatoid arthritis**
☐ **HIV or AIDs**	☐ **Stroke**	☐ **Hepatitis (A , B, C)**	☐ **Peptic Ulcer Disease**

Other past medical history:

ALLERGIES TO MEDICATIONS

Iodine Allergy	☐ **Yes** ☐ **No**
Shellfish Allergy	☐ **Yes** ☐ **No**

PAST SURGERIES

FAMILY HISTORY

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

☐ **Coumadin/Warfarin** ☐ **Plavix** ☐ **Xarelto** ☐ **Pradaxa** ☐ **Eliquis** ☐ **Brilinta**

Other Blood Thinners

NAME OF MEDICATION	DOSE and # of pills/day

SOCIAL HISTORY

Occupation :

Are you currently working? ☐ Yes ☐ No ☐ Part-time ☐ Full-time

Education : ☐ Elementary ☐ High School ☐ College ☐ Graduate school

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant Other

Children : ☐ Yes ☐ No **If Yes, how many?** ____________

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No **Worker's Comp?** ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No **# of packs / day** ________ **How many years?** ___________

Do you use alcohol? ☐ Yes ☐ No **# of drinks / day** ________ **How many years?** ___________

Do you use illicit substances? ☐ Yes ☐ No

If Yes, describe ____

REVIEW OF SYSTEMS:

Are you CURRENTLY experiencing any of the following symptoms? If so, check mark Yes. Otherwise, check no (blank also implies no)

GENERAL:	Yes	No	ENDOCRINE:	Yes	No	EARS/NOSE/THROAT:	Yes	No
Loss of appetite ……	☐	☐	Thyroid disease………	☐	☐	Hoarseness………………	☐	☐
Recent weight loss	☐	☐	Heat/Cold intolerance	☐	☐	Trouble swallowing……	☐	☐
Fever or chills ………	☐	☐				Hearing loss………………	☐	☐
RESPIRATORY:	**Yes**	**No**	**CARDIOVASCULAR:**	**Yes**	**No**	**PSYCHIATRIC:**	**Yes**	**No**
Shortness of breath	☐	☐	Chest pain………………	☐	☐	Depression………………	☐	☐
Chronic cough ………	☐	☐	Palpitations………………	☐	☐	Drug/Alcohol addiction	☐	☐
						Suicidal Thoughts………	☐	☐
KIDNEY/BLADDER:	**Yes**	**No**	**EYES:**	**Yes**	**No**	**NEUROLOGICAL**	**Yes**	**No**
Painful urination……	☐	☐	Blurred vision…………..	☐	☐	Headaches………………	☐	☐
Blood in urine…………	☐	☐	Double vision…………..	☐	☐	Seizures…………………	☐	☐
Kidney problems ……	☐	☐	Loss of vision…………..	☐	☐	Dizziness………………..	☐	☐
GASTROINTEST	**Yes**	**No**	**HEMATOLOGIC:**	**Yes**	**No**	**SKIN:**	**Yes**	**No**
Nausea/vomiting	☐	☐	Easy bruising…………..	☐	☐	Frequent Rashes	☐	☐
Blood in stool……	☐	☐	Easy bleeding…………..	☐	☐	Skin ulcers………	☐	☐
Heartburn…………	☐	☐				Lumps………………	☐	☐
Constipation……	☐	☐						

Patient/Representative Name (print) ____

Signature__________________________

Date _______________

Financial Policy and Consent to Proceed

BY PROVIDING US WITH ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY

1. We need copies of your insurance card(s) for our files. Proper member and group number(s) of all insurances and Social Security numbers are required with the name of the person who carries the insurance. If retired, please list under employer "retired from" (list name of company) Without the information completed you will be considered a personal pay account. **The responsibly party is the person signing this form**.
2. We expect you to know and understand your insurance policy. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various service, it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer) **For uninsured patients, all payments must be paid in full at time of appointment**. (special arrangements can be made for large accounts but not guaranteed)
3. As a courtesy we will file through your insurance (if you choose to file with your own insurance, you will need to pay for all your services at the time of visit) We do not accept what your insurance pays as payment in full. It is your responsibility to ensure that the services provided are covered and authorized by your insurance plan. If authorization is required, as a **COURTESY** Interventional Pain and Spine will attempt to get authorization on your behalf. However, the patient is responsible for making sure we have an authorization on file, and it is valid.
4. If your insurance company denies any claims and/or only pays a portion to Interventional Pain and Spine, the balance will become the patient's responsibility. All balances are due in full within 30 days of receiving a statement in mail and/or in person.
5. It is your responsibility to inform us of any insurance changes and/or cancellation of your policy. It is also your responsibly to inform us of any name, phone number, and address changes.
6. If your insurance requires a special claim form, we must have it within two working days, or the billing department will be processed and sent without it.
7. If your visit is related to a work injury, you must report it to the receptionist. We will need the case number and diagnosis code(s). If the patient does not file on their work-related injury, it must be done by this office. Patients will continue to receive statements of their record until we are satisfied by the insurance.
8. Workman's Compensation: In the event it is determined by the workman's compensation board that the illness or injury is not a result of a compensated workman's compensation case, I hereby agree to pay usual and customary fees for services rendered.
9. In accordance with the FEDRAL TRUTH IN LENDING ACT, all doctors are required to give to their patient's complete information in connection with the extension of credit. The patient is responsible for all medical bills in our office. Our staff will help with the completion of insurance forms as accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and negotiate with your your insurance company over any disputed claims.
10. Rejected Claims: If your insurance company rejects your claim, IPS policy requires you to pay the balance in full 30 days within receiving statement through mail and/or in person. If you cannot pay in full, please contact our billing department.
11. Delinquent Accounts: If your account is over 90 days, they are turned over to our collection department. If the bill remains unpaid and satisfactory arrangements for payments are not made, the billing department will review the account with the doctor to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and to add attorney fees and/or court costs. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and cost of collection.
12. **We do not accept checks, money orders, care credit or cash (unless a special arrangement has been made with our billing department).**
13. **You will be charged a no-show fee of $35 if a clinic appointment is missed or not cancelled 24 hours prior to your scheduled appointment time. If you are more than 15 minutes late to your appointment, you will be rescheduled and charged a $35 no show fee. The same applies for procedures, however the no-show/cancelation charge will be $125 for in office and $250 at any surgical center. Patients be dismissed from our practice for three (3) no-showed appointments in a year**.
14. **Co-pays and outstanding balances must be made at the time of your appointment. Otherwise, your appointment may be rescheduled.**
15. Monthly statements: You will receive a monthly statement until your bill is paid in full whether you have insurance or not. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has been paid, you are responsible for the unpaid balance. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum of .50 cents per month.

I have read and agree with the Financial Policy of this office.

Patient: ________________________ Date: __________________ Witness: _______________________

AGREEMENT FOR CHRONIC PAIN MEDICATION

PLEASE INITIAL ALL SECTIONS BELOW

_________ I understand the purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled medications.

_________ I understand that if I break the agreement, we will stop prescribing pain medications to you.

_________ I will not use any illegal controlled substances. I will not increase or decrease the dosage without informing my doctor. If I feel that adjustments in the medication dosage is required, I agree to contact the prescribing doctor.

_________ I will not share my medications with anyone, nor will I take another person's medication.

_________ I will not receive any pain medications from any other doctor, including ER doctors. All patients will be monitored for this via The State of Texas pharmacy monitoring program at each visit and any violations of the rule may lead to discharge from the practice.

_________ I understand that it is my responsibility to safeguard my medication. They will not, **UNDER NO CIRCUMSTANCE,** be filled early if they are lost, stolen, destroyed or used up early.

_________ I understand that there may be risks that associate with the use of pain medication, including risk of death, respiratory depression, bowel and bladder dysfunction, sexual dysfunction, change of appetite with possible weight gain or loss, change of coordination (which may interfere with driving, operating machinery and fine motor movement) and others.

_________ Additionally, the continuous use of pain medication may result in dependence, addiction, change in personality and sleep changes. I also understand that I will not mix alcohol with pain medication, and I will report any changes in my mental state as well as possible side effects.

_________ I agree to submit to frequent urine drug testing on an as needed basis to monitor for medication complications and compliance with recommended treatment.

_________ I understand the risks and benefits of taking pain medications. I understand that opioids can impair my judgement and motor skills and for this reason I will not take part in activities that will endanger myself and/or others while using these medica tions.

_________ I understand that sudden stopping of pain medications can lead to rebound pain, withdrawal symptoms, seizures and other symptoms. I have been informed not to stop any pain medications suddenly unless decided jointly by myself and my pain doctor.

_________ I agree to allow my pain doctor to review any of my past medical or psychological records

_________ I agree that when I have any contact with the doctors, Nurses/MAs or any other team members will not be rude, aggressive, swear and or disruptive. This can lead to being discharged from the practice.

_________ **I have read and understand the above information. I agree and understand that non-compliance with the above will result in formal discharge with notification to my Primary Care Physician and other treating physicians.**

Patients Name: _________________________________ **Signature:** __________________________ **Date:** ________________

Physician/Witness Signature: _______________________ **Date:** ________________

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I understand that Recipient may redisclose the Records and that the Records may no longer be protected by the Federal privacy regulation.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV-related diseases and communicable disease-related information. With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me, pursuant to a separate written authorization, or is otherwise permitted by applicable law.

By signing below, I authorize Interventional Pain & Spine, its agents and employees ("Provider"), to use and/or disclose any and all of my Protected Health Information ("Records") on my behalf, of any kind and description, to the following ("Recipient"):

Recipient Name:	Relationship:

I also allow my provider to release my protected health information to my insurance, primary care provider(s), referring provider(s), hospitals, diagnostic centers and/or laboratories that may require this information for continued care and authorize Provider to transmit this information through electronic means.

Organized Health Care Arrangement/Data Exchange:

Interventional Pain and Spine participates in an organized health care arrangement consisting of greater Dallas/Fort Worth metropolitan area hospitals, as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment, or the health care operations of this organized health care arrangement.

Patient Printed Name or Legal Representative: ____________________________ Date of Birth:____________________

Patient or Legal Representative Signature: ________________________________ Date: __________________________

PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Dr. Jay Vyas, he may refer you to various facilities in the event you require General Anesthesia for your procedure. These facilities may include Baylor Surgical Hospital – Fort Worth, Texas Health Huguley ASC, or Medical City Southlake ASC.

In connection with any referral to these facilities, you are hereby advised that Dr. Vyas has an investment interest in these three facilities.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Baylor Surgical Hospital – Fort Worth, Texas Health Huguley, or Medical City Southlake. You will not be treated differently by your physician or these facilities if you choose to use a different facility. If desired, your physician can provide information about alternative providers and/or facilities.

By signing below you acknowledge that should you be referred to the Hospital or Surgery Centers, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility. Lastly, you further acknowledge by signing below that you signed Physician Ownership Disclosure Form prior to Dr. Vyas's referral of you to these facilities.

Date: ______________________

Signature of Patient: ____

Printed Name of Patient: ____