FORT WORTH
BRAIN & SPINE
INSTITUTE, LLP

Brent T. Alford, M.D., F.A.C.S.
Alok Chaudhari, M.D., F.A.C.S.
Thomas S. Ellis, M.D., F.A.C.S.
Atif Haque, M.D.
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Diplomates, American Board of Neurological Surgery

TO OUR PATIENTS

WELCOME TO FORT WORTH BRAIN & SPINE INSTITUTE, LLP

You have been scheduled for an appointment with one of our physicians. Please complete the enclosed forms and bring them with you to your appointment. You must have your completed packet, insurance card(s) and driver's license with you at the time of your appointment. **If you do not have this information with you, your appointment may have to be rescheduled.** You should plan to arrive 30 minutes before your appointment in order to complete the registration process.

IF YOU ARE SEEING OUR PHYSICIAN FOR AN INITIAL CONSULTATION, YOU MUST BRING ALL ACTUAL X-RAY FILMS AND X-RAY REPORTS, EMG AND ANY OTHER TESTS THAT HAVE BEEN PERFORMED AS A RESULT OF YOUR PROBLEM. Please make every effort to have all films and reports with you in order to avoid rescheduling.

IF THE FACILITY WHERE YOUR TEST WAS PERFORMED ISSUES YOU A CD, PLEASE CONTACT THIS OFFICE AT 817-878-5333, PRIOR TO YOUR APPOINTMENT TO VERIFY IF THE PHYSICIAN YOU ARE SCHEDULED TO SEE WILL ACCEPT THE CD, AS SOME OF THE PHYSICIANS IN THE PRACTICE REQUIRE ACTUAL FILMS.

If you are unable to make your appointment, please call our office as soon as possible to notify us of the cancellation. Failure to notify our office of your cancellation, no later than 24 hours prior to your appointment, may result in a missed appointment fee. Our office hours are 8:00 am to 5:00 pm, Monday through Friday. Please be aware that because our doctors are on call for emergencies, they sometimes run late seeing patients. Occasionally an emergency may necessitate canceling office appointments on short notice. In which case, we will make every effort to contact you.

Our office visits range from $180.00 to $440.00. **All co-pays and/or co-insurance are due at the time of service.** If you are not a part of a PPO or HMO with which we participate, full payment for your consultation is due at the time of your appointment. It is your responsibility to verify with your insurance company prior to your appointment that our doctors are on your plan. **If your insurance requires a referral to see our physicians, please check with your primary physician to see that a referral has been made. If the referral is not received in the office prior to your appointment, your appointment may have to be rescheduled.**

Our doctors participate with Medicare. You will be responsible for your deductible and twenty percent co-pay at the time of your visit unless you have supplemental insurance coverage.

If your injury is due to a liability claim, your visit here and any surgery will be on a cash only basis. Any surgery must be paid in full prior to entering the hospital. We do not accept letters of protection from attorneys.

Requests for prescription refills must be called in at least 24 hours prior to needing them refilled. No refills will be made over the weekend or holidays. Refills called on Friday will be called in to the pharmacy on Monday. Refills are given under the direction of the physician who reserves the right to refuse a refill at any time.

FORT WORTH
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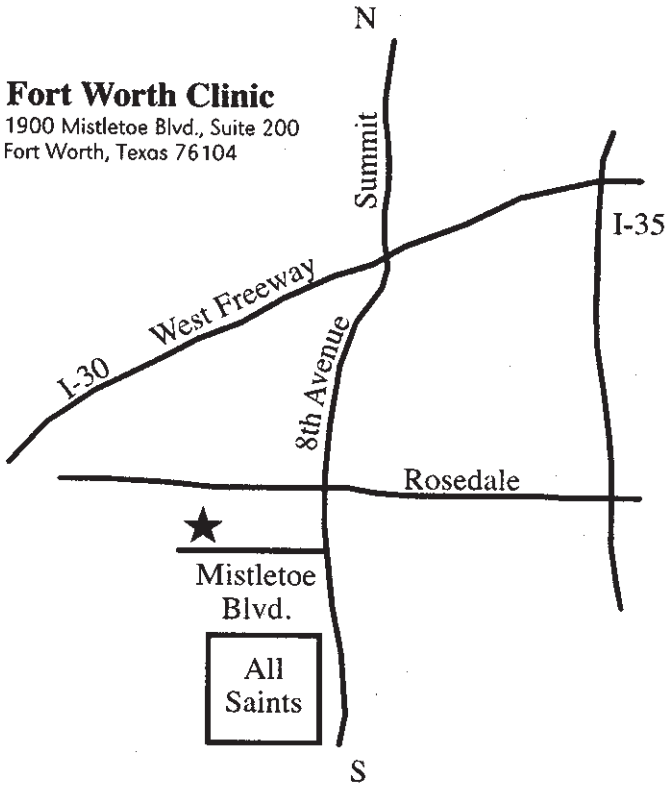
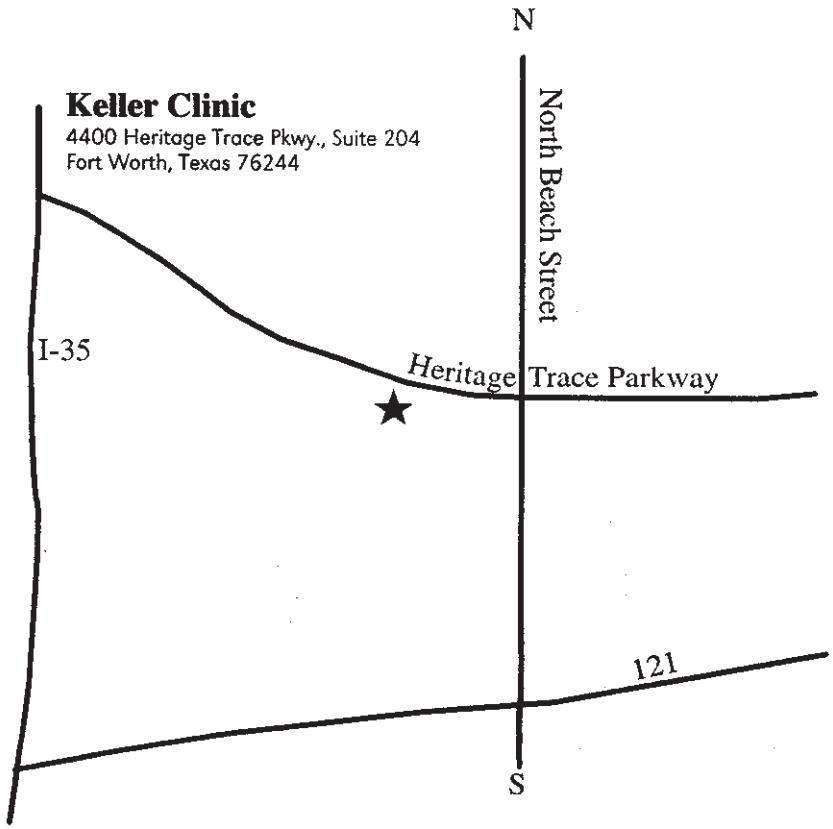
Fort Worth Clinic

1900 Mistletoe Blvd., Suite 200
Fort Worth, Texas 76104



Keller Clinic

4400 Heritage Trace Pkwy., Suite 204
Fort Worth, Texas 76244



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PATIENT REGISTRATION SHEET

Date: _____

Patient Name: _____
Last First MI

Address: _____
Street Address City State Zip

Date of Birth: _____ Social Security Number: _____
Age: _____ Marital Status: _____ Sex: _____
Home Phone #: _____ Cell Phone #: _____
Email: _____
Employer: _____ Work Phone #: _____
Address: _____
Spouse: _____ Phone #: _____

Who can we contact in case of emergency or if we need to change an appointment and are unable to reach you?
Name: _____ Relationship: _____
Address: _____ Phone #: _____

INSURANCE INFORMATION:

Primary Insurance Company:
Name: _____
Group #: _____ ID #: _____
Subscriber Name: _____ SSN: _____
Relationship: _____ Date of Birth _____

Secondary Insurance Company
Name: _____
Group #: _____ ID #: _____
Subscriber Name: _____ SSN: _____
Relationship: _____ Date of Birth _____

Worker's Comp Carrier:
Name: _____
Adjuster: _____
Phone #: _____
Claim #: _____

Are your current complaints the result of an accident? _____ Work related? _____
Auto Accident? _____ Date of accident _____
Do you have an Attorney? _____ Name: _____
Phone #: _____ Address: _____

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NAME: _____ SS#: _____ Age_____ Race: _____ Male or Female

Height:_____ Weight: _____ Handedness R L

WE NEED COMPLETE NAME AND ADDRESS OF YOUR TREATING PHYSICIAN AND THE REFERRING PHYSICIAN IN ORDER TO FORWARD OUR REPORT TO THEM.

Medical Doctor or Primary Care Physician	Referring Physician
Name: _____ MD/DO	Name: _____ MD/DO
Street: _____	Street: _____
City_____ **State**_____	**City**_____ **State**_____
Phone # ( ) -	Phone # ( ) -

Do you have an active DNR agreement? (Do not resuscitate wishes for your family) **YES** **NO**

What brings you here today/What is your most important complaint?

_____

_____

When did this start?_____

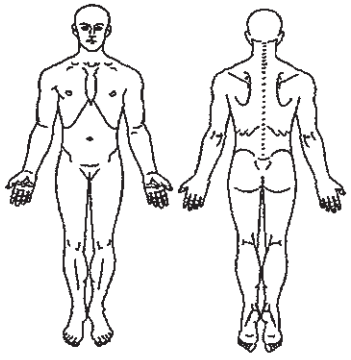
Back/Neck

Do you have Back pain?_____ Neck Pain?_____ How long?_____
Do you have Leg pain?_____ R L B Arm Pain?_____ R L B How long?_____
Do you have Hip pain?_____ R L B How Long: _____
Do you have Bowel or Urinary Incontinence?_____ How long? _____
Are you Improving?_____ or Worsening?_____ or Same: _____

1. On a **PAIN SCALE** of 1-10 (1 being slight pain and 10 being severe pain) what number would you consider yourself **1 2 3 4 5 6 7 8 9 10**
2. Do you have numbness____, tingling____ or burning____? Arms R L B: Legs R L B
3. Do you experience any weakness? Arms - R L B Legs - R L B

Head

1. Where is your pain: Front, Back, Lt side, Rt side, eyes
2. How long does the pain last?_____
3. How often does it occur?_____
4. Do you have problems with: Vision, hearing, fainting, dizziness, nausea, vomiting, loss of balance, LOC, Stroke, TIAs or seizures.



X = Pain
B = Burning
T = Tingling
W = Weakness

Please place the appropriate letter as noted above in the areas of the body where you experience pain, burning, tingling and/or numbness on the drawing.

Official Use (only)

1. What seems to aggravate your symptoms? **Sitting, Standing, Lying down, Walking**
2. How far are you able to walk? _____

NEUROLOGICAL HISTORY

Have you ever had:

1. Previous neck injury or Surgery Yes____ No____ If yes, when _____.
2. Previous back injury or Surgery Yes____ No____ If yes, when _____.
3. Previous head injury or Surgery Yes____ No____ If yes, when _____.

What treatment have you had for your back/neck problems? Indicate your response to the treatment:

Treatment	No Relief	Some Relief	Good Relief
Bed Rest			
Physical Therapy			
Traction			
TENS Unit			
Spinal or Muscle Injections			
Chiropractic Treatment			
Soft Collar			
Lumbar Corset or Brace			
Application of Heat? or Ice?			
Medications			
Other			

Have you had any TESTS for your back/neck problems (Please Check those that apply?

☐	CT Scan	☐	Discogram
☐	Myelogram	☐	EMG or NCV
☐	MRI	☐	Bone Scan
☐	X-rays	☐	Other

PAST MEDICAL HISTORY

Medical History: Please list all illnesses: (Examples: High blood pressure, diabetes, cancer, heart, lung, liver, or kidney problem)

_____

_____

_____

Prior **SURGERIES** and dates: _____

_____

_____

Hospitalizations (dates): _____

List all **ALLERGIES** to medications?

Have you had an allergic reaction to food, seafood, or iodine?

PHARMACY

Name_____

Location_____

Phone_____

List **ALL MEDICATIONS** being taken now, including over-the-counter medications

Medication Name	Dose and Frequency	Ordering Doctor

PLEASE CIRCLE IF YOU ARE TAKING ANY OF THE FOLLOWING:

ECHINACEA, GARLIC, GINGER, GINKO BILOBA, GINSENG, ST. JOHN'S WORT, METABOLIFE, KAVA KAVA, FEVERFEW, EPHEDRA

Patient Name:_____

FAMILY HISTORY

	Age	Living or Deceased	Health Problems/or cause of death
Mother		Living or Deceased	
Father		Living or Deceased	
Brother(s)		Living or Deceased	
Sister(s)		Living or Deceased	
Children		Living or Deceased	

Please circle any disease that "runs in the family": Tuberculosis, Diabetes, Cancer, Heart Disease, Kidney Disease, Mental Disease, Stroke.

SOCIAL HISTORY

Marital Status? Married Single Widowed Divorced
Tobacco use? How much?_____How often?_____ For how long?_____
Alcohol use? How much: _____How often?_____ For how long?_____
Caffeine (How much? How often?)_____
Drug Use? Yes_____No_____
What type of work do you do?_____
If retired, what type of work did you do?_____
How long have you worked at your present job?_____

REVIEW OF SYSTEMS: (PAST AND PRESENT)

Circle/Indicate if you have had:

HEENT: Failing vision, blurring of vision, watering of eyes, itching of eyes, trouble with sinus, frequent colds, nose bleeds, false teeth, bleeding gums, hoarseness, headaches, dizziness, previous head injury, stroke.

RESPIRATORY SYSTEM: Asthma, Emphysema, Bronchitis, COPD

CARDIOVASCULAR SYSTEM: Angina, chest pain, blocked arteries, palpitations, heart attack, high blood pressure, heart failure, irregular heartbeat, pacemaker, defibrillator.

GASTROINTESTINAL SYSTEM: Ulcer, change in bowel habits, bloody stools, jaundice.

GENITOURINARY: Blood in urine, albumin in your urine, trouble getting your stream of water started, surgery on your prostate gland, venereal or sexually transmitted disease, impotence/sexual dysfunction, urinary incontinence, bowel or bladder problems.

OBSTETRICAL HISTORY: How many pregnancies?_____. Miscarriages?_____. Abortions?_____. Full- term deliveries?_____. How many children?_____. Ages of children living and deceased. _____.

BREASTS: Breast cancer, discharge from your nipples, soreness, lumps, biopsies.

MUSCULOSKELETAL: Rheumatoid arthritis, gout, osteoarthritis, osteoporosis, other _____.

ENDOCRINE: Diabetes, thyroid disease.

PSYCHIATRIC: Depression, Schizophrenia, Manic-depressive disorder, Bipolar disorder, Learning disorder.

HEMATOLOGICAL/ONC: Cancer, Anemia, Sickle cell disease, Neoplasms, Other _____.

Patient's Signature _____ Date:_____

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4400 Heritage Trace Pkwy • Suite 204 • Fort Worth • Texas • 76244
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Communication and Restrictions of Private Health Information (PHI)

Patient Name (please print) _____ Date of Birth _____ Social Security # _____

The above named patient has requested confidential communication and/or restrictions of the use and disclosure of his/her PHI. This authorization is valid for one year from date of signature.
The following persons are able to receive and access any of my private health information (PHI):

Relationship

Name:_____ Phone:_____ _____

Name:_____ Phone:_____ _____

Name:_____ Phone:_____ _____

Oral communications are limited to: Call: Home_____ Work_____ Cell _____
Other:_____
May we leave a message? ___Y ___N
May we leave a number to call back? ___Y ___N
May we leave appointment reminder? ___Y ___N
How may we send appointment reminders? (Please check all which apply.)
Phone___Text ___Email___ Mail___

Written Communications are limited to:
This address at ____Home ____Work ____Other

_____

_____

_____

Send appointment reminder to this address? _____Y _____N

Person who holds (Medical) Power of Attorney (if you have one): _____
(Please Print)

_____ _____
Signature of Patient or Guardian Date

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Fort Worth Brain & Spine Institute, L.L.P's 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.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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ASSIGNMENT OF BENEFITS

I, the undersigned, have insurance coverage with _____ and assign directly to Fort Worth Brain & Spine Institute, L.L.P., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Fort Worth Brain & Spine Institute, L.L.P., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to or on my behalf to Fort Worth Brain & Spine Institute, L.L.P., for any services furnished me by one of their physicians. I authorize any holder of information about me to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

Consent for Treatment and Notice:

The undersigned patient ("Patient"), or legally-authorized representative of the Patient, desires a physical evaluation and/or treatment at Fort Worth Brain and Spine Institute, LLP. The undersigned voluntarily consents to such care, which may include (but is not limited to) routine diagnostic procedures, physical examinations (including but not limited to x-rays, blood draws, laboratory tests), administration of medication and to medical or surgical treatment by physicians and staff members of Fort Worth Brain and Spine Institute, LLP, as well as any other health care providers who may by called upon to consult or assist in the Patient's care as judged necessary by Patient's treating physicians. The undersigned acknowledges that the practice of medicine is not an exact science and further acknowledges that no guaranties have been made as to the results of Patient's examination or treatment at Fort Worth Brain and Spine Institute, LLP. The undersigned acknowledges that treatment at Fort Worth Brain and Spine Institute, LLP is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment, the undersigned accepts responsibility to follow the advice of the Patient's treating physician including compliance with medications, discharge instructions and follow up with all needed physicians. The undersigned agrees that Patient shall return to the clinic or seek care in an emergency department of a hospital if Patient's condition substantially changes. The undersigned further agrees to hold harmless the physicians and staff of Fort Worth Brain and Spine Institute, LLP should the undersigned fail to comply with the above conditions. Patients at Fort Worth Brain and Spine Institute, LLP will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, Fort Worth Brain and Spine Institute, LLP reserves the right to refuse care to any individual for any reason at the discretion of the physician on duty.

The undersigned further acknowledges that he/she has been notified that Drs. Alford, Chaudhari, Ellis, Haque, Lapsiwala, Lee, and Siadati have an ownership interest in Baylor Surgical Hospital of Fort Worth, Preferred Imaging Forest Park Medical Center at Fort Worth and Select Pain Management. The undersigned acknowledges that he/she has received notice of the above-described ownership interests a sufficient enough time in advance of any procedure or surgery to make a meaningful decision regarding Patient's receipt of care. The undersigned acknowledges that he/she has the option of requesting additional information for other options for care. This consent shall remain in force until such time as it is specifically revoked in writing.

Patient Name: _____

Signature of patient or patient's legally authorized representative: _____

(Representative signature required if the patient is a minor or unable to consent)

Representative's relationship to patient: _____

Patient is unable to consent because: _____

Witness: _____