FORT WORTH BRAIN & SPINE INSTITUTE, LLP

Patient's Full Name

First Name Last Name

Email

example@example.com

Primary Phone Number

Area Code Phone Number

Patient Home Address

Street Address

Apt

City

State / Province

Postal / Zip Code

Date of Birth

Month

Day

Year

What is your primary language?

Social Security Number

What is your preferred location?

Do you have a preferred FWBSI physician?

Referring Physician

Primary Care Physician

Emergency Contact

Insurance Information

Please fill out as shown on the insurance card.

Primary Insurance Company Name

Primary Insurance ID# / Group Number

Secondary Insurance Company Name

Secondary Insurance Company ID# / Group Number

Patient Medical Information

Please answer the following questions to the best of your ability.

Sex

Hold old are?

How much do you weigh? (in pounds)

What is your dominant hand?

Please provide the results of your most recent neurosurgeon visitation (if applicable)

What is your height?

On a scale of 1-10 how much pain are you currently experiencing?

Have you previously seen a neurosurgeon for this issue?

- ◯ YES
- ◯ NO

How far are you able to walk unassisted?

What brings you in today?

Have you experienced any of these Diziness, Fainting, Nausea, Vomiting, Seizures, Stroke, Loss of Vision, Loss of Hearing, TIAs, LOC

- ◯ YES
- ◯ NO

What seems to aggravate your symptoms?

- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Walking
- ☐

Neurological History

Please provide the date and type of back surgeries you've had (if applicable)

Please provide the date and type of neck surgeries you've had (if applicable)

What treatment have you had for your back/neck problems?

	No Relief	Some Relief	Good Relief
Bed Rest	○	○	○
Physical Therapy	○	○	○
Traction	○	○	○
TENS Unit	○	○	○
Spinal or Muscle Injectons	○	○	○
Chiropractic Treatment	○	○	○
Soft Collar	○	○	○
Lumbar Corset or Brace	○	○	○
Application of Heat or Ice	○	○	○
Medication	○	○	○

Have you had any medical tests for your back/neck problems?

	Facility	Date
CT Scan		
Myelogram		
MRI		
X-Ray		
Discogram		
EMG or NCV		
Bone Scan		

Please list all significant illnesses

Prior hospitalizations

Preferred Pharmacy for Prescriptions

Prior surgeries

Known allergies

Check all of the following that you take as treatment

- ☐ Echinacea
- ☐ Garlic
- ☐ Ginger
- ☐ Ginko Bilboa
- ☐ Ginseng
- ☐ St. Johns Wort
- ☐ Metabolife
- ☐ Kava Kava
- ☐ Feverfew
- ☐ Ephedra

Please list all medications you take

Do you have an active DNR agreement (Do not resuscitate wishes for your family)?

- ◯ YES
- ◯ NO

Please select any of the following illnesses which "run in your family"

- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Mental Disease
- ☐ Stroke
- ☐ _____

Please check all of the Cardiovascular symptoms you've experienced

- ☐ Angina
- ☐ Chest pain
- ☐ Blocked arteries
- ☐ Palpitations
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart failure
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ _____

Please check all of the Respiratory symptoms you've experienced

- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ COPD
- ☐ _____

Please check all of the Genitourinary symptoms you've experienced

- ☐ Blood in urine
- ☐ Albumin in urine
- ☐ Trouble getting your stream of water started
- ☐ Surgery on your prostate gland
- ☐ Venereal or sexually transmitted disease
- ☐ Impotence/sexval dysfunction
- ☐ Urinary incontinence
- ☐ Bowel or bladder problems
- ☐ _____

Please check all of the HEENT symptoms you've experienced

- ☐ 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
- ☐ _____

Please check all of the Gastrointestinal symptoms you've experienced

- ☐ Ulcer
- ☐ Change in bowel habits
- ☐ Bloody stools
- ☐ Jaundice
- ☐ _____

Please check all of the Breasts symptoms you've experienced

- ☐ Breast cancer
- ☐ Discharge from your nipples
- ☐ Soreness
- ☐ Lumps
- ☐ Biopsies
- ☐ _____

Please check all of the Musculoskeletal symptoms you've experienced

- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ _____

Please check all of the Endocrine symptoms you've experienced

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ _____

Please check all of the Hematological symptoms or Cancers you've experienced

- ☐ Cancer
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Neoplasms
- ☐ _____

Please check all of the Psychiatric symptoms you've experienced

- ☐ Depression
- ☐ Schizophrenia
- ☐ Manic-depressive disorder
- ☐ Bipolar disorder
- ☐ Learning disorder
- ☐ _____

Do you have any children?

- ○ YES
- ○ NO

Have you ever been pregnant?

- ○ YES
- ○ NO

Information about pregnancies (if applicable)

What is your marital status?

What type of work do you (or did do if retired)?

How much Tobacco/Nicotine do you consume?

How much alcohol do you consume?

How much caffeine do you consume?

Do you use drugs recreationally? If so, what?

Communication and Restriction of Private Health Information (PHI)

The following people are able to receive and access any of my health information

May we contact you via email address provided above?

- ○ YES
- ○ NO

Please select how we may deliver Protected Health Information (PHI) to you?

- ☐ Phone
- ☐ Email
- ☐

May we leave a message with patient information?

- ○ YES
- ○ NO

May we leave a callback number?

- ○ YES
- ○ NO

Who holds the patient's Medical Power of Attorney (if applicable)?

First Name Last Name

You ("the patient") have requested confidential communication and/or restrictions of the use and disclosure of the patient's PHI. Please sign below to authorize.
This authorization is valid for one year from date of signature.

Patient Signature

Consent to Treat Policies

I, the undersigned, have third-party insurance coverage and assign directly to Fort Worth Brain and Spine Institute, LLP, 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 and Spine Institute, LLP to release all information necessary to secure the payment of benefits. I authorize the use of the below signature on all my insurance submissions.

Medicare Authorization (Only applicable to Medicare-enrolled Patients)

If covered by Medicare, I request the payment of authorized Medicare benefits be made to or on my behalf to Fort Worth Brain and Spine Institute,LLP, 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 below 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 non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Fort Worth Brain and Spine Institute, LLP’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 upon request.

Consent for Treatment

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 be 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 physician 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.

By signing below you accept the Assignment of Benefits

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Patient Signature

Office Policies

APPOINTMENT DETAILS: For initial office visits, all items listed below must be received by our office prior to being seen, Patients should arrive at least 30 minutes before their appointment time in order to complete the registration process. The appointment may be rescheduled if we do not have them.

- All new patient paperwork
- Insurance card(s)
- Driver license or government issued photo ID
- CD's of all imaging & the accompanying reports
- EMG & other tests related to diagnosis

For follow-up office visits, all items listed below must be received by our office prior to being seen. Patients should arrive at least 10 minutes before their appointment time to complete the check-in process. If X-rays are being done in office prior to being seen, the patient should arrive at least 30 minutes before their appointment time. Due to physicians' patient load, arrival more than 10 minutes late for your appointment, may result in being rescheduled.

APPOINTMENT RESCHEDULING AND CANCELLATIONS: Please notify our office as soon as possible in the event an appointmentneeds to be rescheduled or cancelled. Failure to notify our office of the cancellation at least 24 hours prior to your appointment, may result in a missed appointment fee. Our office hours are 8:00 am to 5-00 pin, Monday through Friday. **PHYSICIAN EMERGENCY SURGERY SCHEDULE CHANGES:** Please he aware that our physicians are on-call surgeons for some of the busiest hospitals in the area. Should a physician be called away for an emergency surgery. He/she may run late seeing patients. Occasionally, an emergency may necessitate cancelling office appointments on short notice, These types of emergencies could also affect your scheduled surgery date/time. Every effort will be made to contact you in the event this does occur. Please be sure all contact information remains current so our office can contact you in a timely manner. **WORKERS' COMPENSATION:** It is the patient's responsibility to notify their Workers' Compensation case manager of any change in appointment date and/or time. If a case manager accompanies you to the appointment, there is a $250 charge he/she must pay at the time of check-in for a team conference. **FINANCIAL RESPONSIBILITY:** All co-pays, cO-insurance, and/or deductibles are due at the time of service. If the patient does not have health insurance or if their health insurance plan is not one with which our physicians participate, full payment for services is due at the time of service. Please note that additional services provided in the office, such as but not limited to x-rays, reprogramming, and injections are not included in the office visit charge. Post-operative visits are included in the insurance carrier's global period frame surgery, however, x-rays are not. MEDICARE PATIENTS ONLY: Unless the patient has supplemental or secondary insurance coverage, you are responsible for your twenty percent co-insurance at the time of your visit. If your visit is the result of an injury due to a Motor Vehicle Accident which led to a liability claim, your office visit here and any surgery will be on a cash only basis. Any surgery must be paid in full prior to the day of surgery. We do nat accept letters of protection from attorneys, There is a $25 fee for any returned checks due to insufficient funds. **NETWORK PARTICIPATION AND REFERRALS:** Our office will make every effort to verify your insurance prior to your visit, but it is ultimately the patient's responsibility to ensure we are participating in the plan prior to your appointment. If your insurance requires a referral to see our physicians, please check with your primary care physician to see that a referral has been completed, If the referral is not received in the office prior to your appointment, the appointment may have to be rescheduled. **DISABILITY/FMLA & OTHER FORMS:**We will gladly complete forms for disability/FMLA/ or other requests. There is a $35 fee per form each time it is completed and is payable at the time of request. Please allow 7-10 business days for completion. **PRESCRIPTION REFILLS:** Requests for prescription refills must be called in at least 24 hours in advance, No refills will be called in over the weekend or holidays. Refill requests submitted on Friday may be called into the pharmacy on Monday. Refills are given under the direction of the physician who reserves the right to refuse a refill at any time.

By signing below you accept the Office Policies

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Patient Signature

Physician Disclosure Agreement

Dear Patient:

The Physicians at Fort Worth Brain & Spine Institute, LLP are independent, private practice physicians. This means our Physicians are not employed by any corporate or outside health care entity. And this means we work for YOU, not for a hospital, an administrator, or any other corporate or outside health care entity. In order to assure the highest quality and efficient delivery of your health care, the Physicians of Fort Worth Brain & Spine' Institute, LLP may maintain financial interests in other health care facilities and providers. Our commitment to providing the highest quality care for our patients is paramount. Having financial interests in certain health care facilities and/or providers enables your Physician to have additional control on the quality of care provided to you as opposed to having little control or' input with corporate health care entities. A simple example would be having an imaging study done in a specific fashion tailored to the patient's individual condition, rather than having to accept a "cookie-cutter" study that is done the same way for every patient, regardless of the condition being investigated. Decisions regarding your care are always based on your best individual medical treatment plan developed by you and your Physician. Patients of Fort Worth Brain & Spine Institute, LLP always have the option of utilizing alternate health care facilities or providers, and at times, this may actually be dictated by their individual health insurance plan. Regardless, your Physician and you will develop the best treatment regimen available for your specific condition, using evidence-based "best practices." Please feel free to discuss your options or any questions you may have with your Physician or our staff during your visit. We welcome any questions regarding this aspect of your patient care. The following list includes the facilities and providers for which our Physicians maintain any form of ownership interest. As a Patient of Fort Worth Brain & Spine Institute, LLP, you may receive care or services from any of these facilities or providers. Your Physician may receive some form of financial benefit related to the care or services rendered by these facilities and providers, depending on the legal ownership structure of each individual facility or entity.

- Methodist Southlake Hospital, Southlake, TX 76092
- Baylor Surgical Hospital, Fort Worth, TX 76110
- Parkway Surgical Hospital, Fort Worth, TX 76177
- Page Medical, Grapevine, TX 76051
- Vaquero Medical, Grapevine, TX 76051
- Polestar Medical Solutions, Southlake, TX 76092
- Trinity LOM, Fort Worth, TX 76104
- 117 Surgical Assistants, Fort Worth, TX 76104
- Squire Surgical Services, Southlake, TX 76092
- Fort Worth Ranch Assist, Fort Worth, TX 76109
- Myeuverse IOM, Fort Worth, TX 76102
- FW CSN Monitoring, Fort Worth, TX 76102
- Lone Star Monitoring, Irving, TX 75063
- Lone Star Neurosurgical Assistants, Westlake, TX 76262
- Select Pain Procedure Center, Fort Worth, TX 76102
- Brain Assist, Keller, TX 76248
- IONM, Keller, TX 76248

Patient Acknowledgement

I acknowledge that my attending Physician(s) has disclosed to me, at the time of initial contact and at the time of referral (A) his/her affiliation if any, with the facilities or providers for whom, I, the patient am being referred, and (B) that he/she may receive financial benefit related the care rendered by the facility or provider based on the individual legal ownership structure of the facility or provider. I understand that I, the Patient, have the right to choose the providers of my health care services.

Please sign below to acknowledge the receipt of this disclosure and to indicate that you do not have any objections to using the facilities or providers listed above.

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Patient Signature