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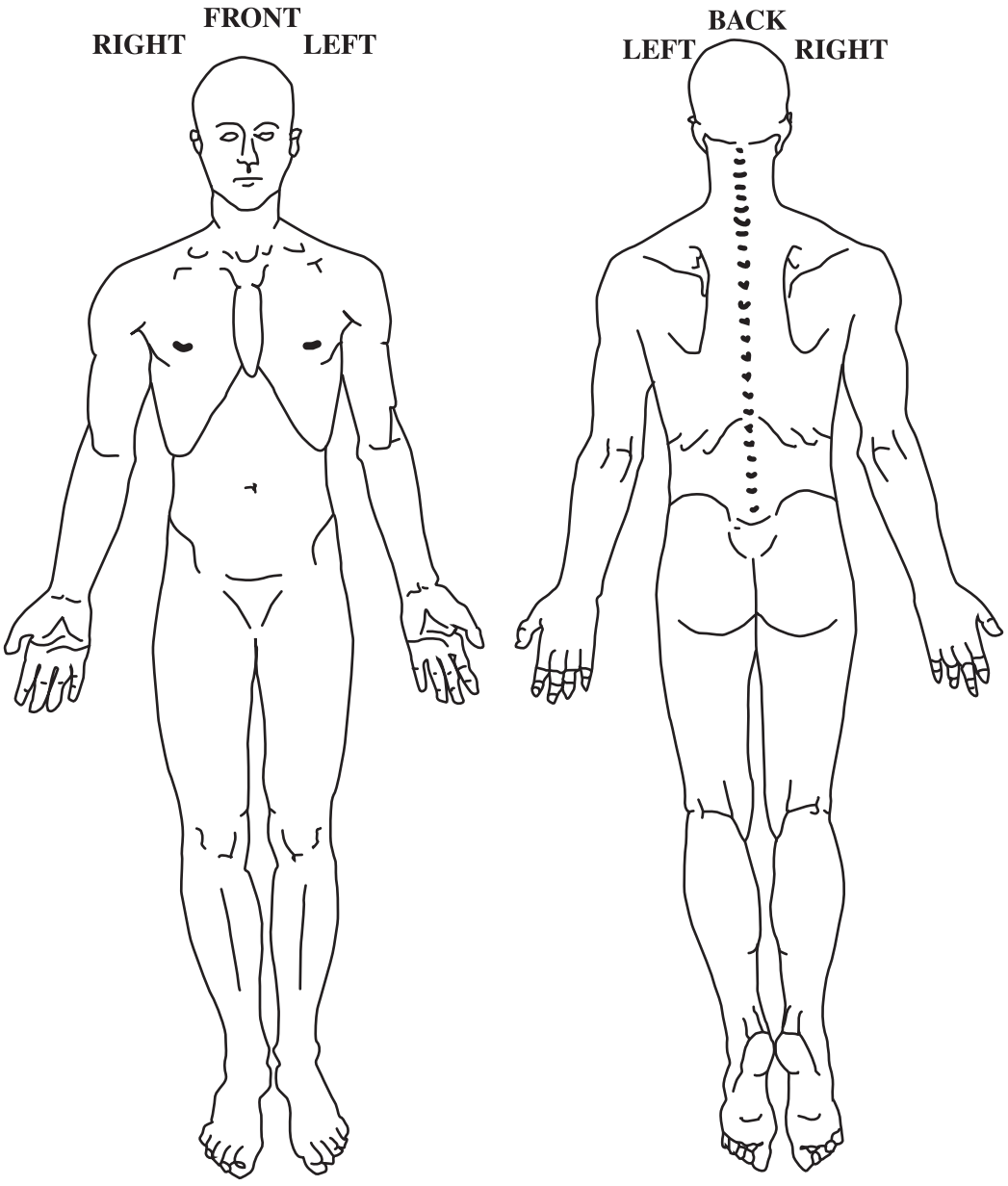
PAIN ILLUSTRATION

Mark the areas on your body where you feel the described sensations.
Use appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness = = = = = Pins & Needles ooooo Burning xxxxx
Stabbing ///// Chronic Ache zzzzz



ESTIMATE THE SEVERITY OF YOUR PAIN (CHOOSE ONE NUMBER)

0 No Pain 1 Mild Pain 2-3 Moderate Pain 4-5 Moderate to Severe Pain

6-7 Severe Pain 8-9 Intensely Severe Pain 10 Most Severe Pain

PATIENT PLEASE INITIAL _____ Date _____

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CURRENT SYMPTOM CHECKLIST

Please review the following and check any that currently apply. If this is a follow-up visit, please check only the **new** symptoms that have occurred since you were last seen.

Head & Neck
- ☐ Headahces
- ☐ Visual changes
- ☐ Eye pain or light sensitivity
- ☐ Ringing in the ears
- ☐ Ear pain or drainage
- ☐ Loss of smell or taste
- ☐ Sinus pain or nasal drainage
- ☐ Throat pain or infection

Chest:
- ☐ Painful breathing
- ☐ Shortness of breath
- ☐ Productive cough or infection

Cardiovascular:
- ☐ Chest Pain
- ☐ Irregular heart rhythm
- ☐ Fainting or light-headedness
- ☐ Swelling of the feet or hands
- ☐ Temperature or color change in hands or feet

Abdomen:
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Diarrhea
- ☐ Black/tarry stools
- ☐ Rectal bleeding
- ☐ Constipation

Urological:
- ☐ Painful urination
- ☐ Bloody urine
- ☐ Loss of bowel or bladder control
- ☐ Inability to void
- ☐ Loss of sexual ability

Musculoskeletal:
- ☐ Painful or swollen joints
- ☐ Muscle twitching
- ☐ Recent fractures
- ☐ Spine pain
- ☐ Muscle pain

Neurological:
- ☐ Seizure activity
- ☐ Confusion
- ☐ Numbness or tingling
- ☐ Balance or coordination loss
- ☐ Isolated weakness
- ☐ Paralysis
- ☐ Altered speaking ability
- ☐ Memory loss

Infection:
- ☐ Chronic Headaches
- ☐ Skin breakdown
- ☐ Unhealed wounds
- ☐ Drainage of pus
- ☐ Urinary or abdominal infections
- ☐ Dental infections or abscesses

Psychiatric:
- ☐ Depression
- ☐ Suicidal thoughts or intent
- ☐ Fatigue
- ☐ Loss of interest in pleasurable activities
- ☐ Abnormal anger or violent activities
- ☐ Hallucinations - visual or auditory
- ☐ Excessive daytime drowsiness

Endocrine:
- ☐ Cold or heat intolerance
- ☐ Excessive appetite or thirst
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Urinary frequency
- ☐ Abnormal hair growth or loss

Hematological/Oncology:
- ☐ Easy bleeding or bruising
- ☐ Notable or changing masses or lumps
- ☐ Multicolored or changing moles or markings
- ☐ Excessive weight loss without reason

Allergy/Immunology:
- ☐ Rashes
- ☐ Scaling
- ☐ Itching
- ☐ Wheezing

Skin:
- ☐ Skin discoloration
- ☐ Skin lesions

OB/GYN:
- ☐ Change in cycle
- ☐ Excessive bleeding during cycle
- ☐ Missed cycles
- ☐ Vaginal discharge

☐ **I have had no new symptom changes since my last evaluation.**

Signature: _____ Date: _____

Printed Name: _____

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Initial Medical Questionnaire - CONFIDENTIAL

PAST MEDICAL HISTORY: - Do you suffer from any of the following?

	YES	NO		YES	NO
Chronic Headaches	☐	☐	Urine / Stool Leakage (Incontinence)	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Heart Rhythm Disorders	☐	☐	Strokes	☐	☐
Heart Attacks	☐	☐	Muscular Dystrophy	☐	☐
Other Heart Disease	☐	☐	Recent Infections	☐	☐
Diabetes	☐	☐	Reactions to Anesthesia	☐	☐
Thyroid Problems	☐	☐	Sickle Cell Anemia	☐	☐
Asthma	☐	☐	Hemophilia / Easy Bleeding	☐	☐
Emphysema / COPD	☐	☐	Recent Weight Loss	☐	☐
Other Lung Disease	☐	☐	Depression	☐	☐
Heartburn or Ulcers	☐	☐	Suicidal Thoughts	☐	☐
Hepatitis	☐	☐	Cancer	☐	☐
Pancreatitis	☐	☐	Type: _____		
Kidney Stones	☐	☐	Other: _____		

PAST SURGICAL HISTORY:

	YES	NO		YES	NO
Spine (Neck or Back)	☐	☐	Tubal Ligation	☐	☐
Tonsillectomy	☐	☐	Bladder / Kidney	☐	☐
Appendectomy	☐	☐	Bowel / Colon / Ulcer	☐	☐
Gallbladder	☐	☐	Shoulder / Knee / Hip / Joint	☐	☐
Lung	☐	☐	Other: _____		
Heart	☐	☐	_____		
Hysterectomy	☐	☐			

FAMILY HISTORY: - Do your parents, brothers, sisters, etc., suffer from any of the following?

	YES	NO		YES	NO
Heart Disease	☐	☐	Migraines	☐	☐
Hemophilia / Bleeding Disorder	☐	☐	Anesthetic Reactions	☐	☐
Sickle Cell Anemia	☐	☐	Muscular Disorders	☐	☐
Cancer	☐	☐	Other: _____		

SOCIAL HISTORY: - Do you, or have you ever used the following?

	YES	NO		YES	NO
Smoking / Tobacco	☐	☐	Cocaine	☐	☐
Alcohol	☐	☐	Other Street Drugs: _____		
Marijuana	☐	☐	Other: _____		

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Disabled
Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed
Lawsuits Pending: ☐ Yes ☐ No ☐ Settled

MEDICATIONS:

ALLERGIES: _____ IODINE: ☐ Yes ☐ No

ALL CURRENT MEDICATION YOU ARE TAKING (NAME, SIZE AND FREQUENCY)

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Name (sign please): _____ **Date:** _____

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PAIN MEDICATION AGREEMENT

I WILL NOT

I will not see any other "Pain Management" type physician for my pain management while under the care of this group. All my medication from this clinic cannot be obtained from any other source. In the event of an acute case (dental work or surgical procedure), I must notify my physician in advance.

I will not use alcohol or illegal controlled substances (cocaine, marijuana, etc.). I have been made aware of the dangerous side effects of narcotic and tranquilizer use alone or in combination with other substances. Thus, I absolve the physicians and staff of any willful negligence.

I will not share, sell or trade my medication(s) or prescription(s) with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors unless approved by my physician in advance.

I WILL

I will provide the physician and staff with all my medical records pertaining to my past pain treatment. I understand that failure to provide such information gives the clinic the right to refuse to treat me.

I will be responsible for my pain medicine, keeping it safe from loss or theft. Lost medications will NOT be replaced. Stolen medication will not be considered for refill until a police report is filed and sent to the doctors' attention.

I will use my medicines at the rate they are prescribed. If I use my medicines at a greater rate, it will result in my being without medication for a period of time. Physicians will NOT authorize any early refills under any circumstance.

I will use only one pharmacy to fill all my prescriptions. I agree to use _____

Pharmacy, located at _____ .

telephone number: _____ for filling prescriptions for all my pain medications.

I will agree that no refills will be available during evenings or weekends.

I will agree to authorize the doctor and the pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse or sale etc. of my pain medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.

I will submit to a blood or urine test if requested by my doctor.

I understand all the policies above and my signature below states my agreement to comply. I am aware that if I breach this agreement, then *Doctor, McCann & Arthur, L.L.P.* holds the absolute right to discharge me as a patient.

Signature: _____ **Date:** _____

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PATIENT GUIDELINES

GOALS

Our physicians work specifically with cases involving spinal injury or spine-generated pain. Our goal is to identify the source of your pain so that realistic treatment options can be given. We will help to develop a care plan for you to follow and provide treatment or referral as indicated.

OFFICE HOURS

Office hours are from 9:00 AM to 5:00 PM Monday through Friday. The office personnel will answer all calls during these hours. Calls outside of these hours will be received by an answering service that will refer to on call physicians in emergency situations.

PROCEDURE PRECERTIFICATION

Verifying the type and extent of your personal insurance coverage usually requires 1-3 days for commercial and Medicare insurance. Preauthorization through Workers' Compensation insurance may involve a process that could take 1-2 weeks. All desired treatments must be precertified prior to scheduling. We always strive to finish the process as soon as possible to make the treatments available to you at the earliest time possible. Once precertification is obtained, you will be contacted to schedule the procedure. Please contact us if scheduling has not contacted you within a reasonable time period.

PROCEDURES

Prior to the procedure, all risks, benefits and questions will be addressed. Once a procedure is precertified, contact our billing manager concerning any questions about physician's fees. If you develop symptoms of any additional illnesses (fever, infections or the flu for example) prior to your procedure, contact us as soon as possible. It is in your best interest to reschedule, thus saving you the inconvenience and expense of a wasted trip to the facility. Rescheduled procedures generally do not need additional insurance verification.

I have read the above, had any questions answered, and understand these guidelines.

Signature: _____ **Date:** _____

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COST OF TREATMENT

Commercial Insurance

Your portion of the total charges is to be paid when you arrive for your appointment and you are responsible for all charges until your deductible has been met. Insurance claims will be filed by our billing office and questions regarding your statement should be first directed to their office at (281) 540-7246.

Workers' Compensation

If you are covered by Workers' Compensation Insurance, our office personnel must obtain preauthorization prior to any treatment or evaluation. Depending on your carrier and the treatments requested, preauthorization can take from one to two weeks on average. If you feel there has been an inordinate delay in obtaining your preauthorization, please contact your adjuster. Costs of treatment are covered by your Workers' Compensation Insurance according to their fee schedule.

Medicare

The physicians and non-physician practitioners of *Doctor, McCann & Arthur, L.L.P.* are currently Medicare providers, and thus you will be responsible solely for the portion of your charges not covered by Medicare, or your secondary insurance provider, according to the Medicare fee schedule.

Payments

You are responsible for payments at the time of service rendered, unless prior arrangements have been made. Payments can be made with cash, personal check, VISA, MasterCard, American Express or Discover Card.

If you have any questions regarding exact fees, please ask prior to your evaluation or treatment to speak directly with our business staff for an estimate of charges.

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____
(Printed Name)

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OBTAIN MEDICAL DOCUMENTATION

Patient's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

DOCUMENTATION INCLUDED

This document allows *Doctor, McCann & Arthur, L.L.P.* to obtain your (or your dependent's) medical records from other healthcare providers who have treated or are treating you (or your dependent minor).

This authorization applies to any and all of my (or my dependent's - if guardian of minor) medical records including, but not limited to, progress notes, laboratory reports, radiological / nuclear medicine reports, history and physical examinations, consultation reports, electrophysiological studies and any other medical documentation pertaining to my (or my dependent's) care.

_____ (Initials)

I understand that my express consent is required to release any of my health care information pertaining to testing, diagnosis, and/or treatment for AIDS (HIV), sexually transmitted diseases, psychiatric / psychological / mental health disorders, drug or alcohol abuse. I hereby authorize the person(s) below to release to *Doctor, McCann & Arthur, L.L.P.*, or their representatives, all information pertaining to such diagnoses.

Exclusions: _____ ☐ **None** _____
(Patient's Initials)

By signing below, I agree to all the terms and conditions of this document and certify that I have read and understand the above information and its implications. This authorization is valid indefinitely or until I revoke it in writing. I have made any and all exclusions specially known as noted in writing above. A Photostat copy of this authorization is valid as the original.

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____ Date: _____
(Witness Signature)

FOR OFFICE USE ONLY

This document shall authorize the person(s) or entity listed below to release to *Doctor, McCann & Arthur, L.L.P.* any and all of the above patient's records as per the above release.

Name: _____

REASON FOR REQUEST:

☐ Coordination of treatment ☐ Obtain information regarding previous treatment(s)

☐ Other: _____

Provider: ☐ Dr. McCann ☐ Dr. Doctor

Fax or send information to: 7505 S. Main St., # 150, Houston, TX 77030 **Fax:** (713) 790-1525
Questions, please call: (713) 790-1500 **Phone:** (713) 790-1500

Provider: ☐ Dr. Arthur

Fax or send information to: 18955 Memorial N., Ste. 420, Humble, TX 77338 **Fax:** (281) 540-0080
Questions, please call: (281) 540-7246 **Phone:** (281) 540-7246

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information.

Use and Disclosure of your Health Information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including Veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information.

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except otherwise required by law; in emergencies, or when the information is necessary to you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Medical Records, *Doctor, McCann & Arthur, L.L.P.*, 7505 S. Main, # 150, Houston, TX 77030.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Medical Records, *Doctor, McCann & Arthur, L.L.P.*, 7505 S. Main, # 150, Houston, TX 77030. You must also provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, please contact our front desk personnel.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact M. Williams, c/o *Doctor, McCann & Arthur, L.L.P.*, 7505 S. Main, # 150, Houston, TX 77030. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact K. Frey, c/o *Doctor, McCann & Arthur, L.L.P.*, 7505 S. Main, # 150, Houston, TX 77030; telephone number: (713) 790-1500.

I hereby acknowledge that I have been presented with a copy of *Doctor, McCann & Arthur, L.L.P.*'s Notice of Privacy Practice.

Signature: _____ Date: _____

Printed Name: _____

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RELEASE OF MEDICAL DOCUMENTATION

Patient's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

DOCUMENTATION INCLUDED

This document allows *Doctor, McCann & Arthur, L.L.P.* to release your medical records to other healthcare providers who have treated or are treating you (or your dependent minor) or payors who request these records as allowed by law.

This authorization applies to any and all of my (or my dependent's - if guardian of minor) medical records including, but not limited to, progress notes, laboratory reports, radiological / nuclear medicine reports, history and physical examinations, consultation reports, electrophysiological studies and any other medical documentation pertaining to my (or my dependent's) care.

_____ (Initials)

I understand that my express consent is required to release any of my health care information pertaining to testing, diagnosis, and/or treatment for AIDS (HIV), sexually transmitted diseases, psychiatric / psychological / mental health disorders, drug or alcohol abuse. I hereby authorize *Doctor, McCann & Arthur, L.L.P.* to release all information pertaining to such diagnoses.

Exclusions: _____ ☐ None _____ (Patient's Initials)

By signing below, I agree to all the terms and conditions of this document and certify that I have read and understand the above information and its implications. I have made any and all exclusions specially known to *Doctor, McCann & Arthur, L.L.P.* as noted in writing above. This authorization is valid indefinitely or until I revoke it in writing. A Photostat copy of this authorization is valid as the original.

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____ Date: _____
(Witness Signature)

☐ ADDITIONAL RELEASE TO:

This document shall authorize *Doctor, McCann & Arthur, L.L.P.* to release any and all of my medical records as understood above to:

Name: _____

Address: _____

REASON FOR RELEASE:

☐ Coordination of treatment
☐ Disability application
☐ Provide information regarding previous treatment(s)
☐ Provide information for legal matters

☐ Other: _____

_____ Date: _____
(Patient/Guardian/Guarantor Signature)

_____ Date: _____
(Witness Signature)

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No Show Appointments

Due to the rising number of patients who do not cancel their appointments when circumstances arise, it has become necessary to charge for a missed appointment.

Effective immediately, Spine Care Consultants, will charge A $25 “No Show” fee.

We understand that there are occasions when an appointment cannot be kept and for these instances we request 24 hour prior cancellation notice. After two missed appointments, it may be necessary to find another medical provider.

We regret these policies; however, we must protect the rights of other patients who want to be scheduled.

Signature: _____ Date: _____

Printed Name: _____