THE ORTHOPAEDIC & SPINE INSTITUTE

PATIENT INFORMATION SHEET

PATIENT NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ALT. / CELL PHONE: _____ WORK PHONE: _____

SS#: _____ EMAIL: _____ WOULD YOU LIKE INFO ON NEW SERVICES VIA EMAIL? Y/N

DOB: _____ AGE: _____ MALE ( ) FEMALE ( ) MARITAL STATUS: M ( ) S ( ) D ( ) W ( )

SPOUSES INFORMAITON:

SPOUSES NAME: _____

ADDRESS: _____ PHONE#: _____ DOB: _____

EMPLOYER NAME: _____ PHONE#: _____

EMERGECNY CONTACT (OTHER THAN SPOUSE):

NAME: _____

RELATIONSHIP: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

******WERE YOU INJURED ON THE JOB? YES/ NO IS THIS A MOTOR VEHICLE ACCIDENT? YES/ NO**

EMPLOYER INFORMATION:

CURRENT EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE#: _____ OCCUPATION: _____

PRIMARY CARE/ REFERRING/ TREATING PHYSICIAN: (EVEN IF SENT FROM E.R.)

CLINIC NAME: _____ PHYSICAN NAME: _____

ADDRESS: _____

PHONE#: _____ FAX#: _____

INSURANCE: CIRCLE ONE: / PRIVATE / WORKER'S COMP / LEGAL

PRIMARY INSURANCE:

INS. NAME: _____ ID#: _____ GROUP#: _____

POLICY HOLDER'S NAME: _____ DOB: _____ SS#: _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE) SELF SPOUSE CHILD OTHER: _____

SECONDARY INSURANCE:

INS. NAME: _____ ID#: _____ GROUP#: _____

POLICY HOLDER'S NAME: _____ DOB: _____ SS#: _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE) SELF SPOUSE CHILD OTHER: _____

MEDICARE ASSIGNMENT FOR COVERAED SERVICES: I CERTIFY THAT THE INFORMATION ABOVE INCLUDING MY ID IS CORRECT AND HERBY REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT TO THE ORTHOPAEDIC & SPINE INSTITUE, LLC. (OSI) FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HERBY AUTHORIZE (OSI) TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I HAVE ALSO SIGNED AN ABN FOR MEDICAL SERVICES THAT MEDICARE WILL NOT COVER THAT WILL BE KEPT ON FILE. IF MY INSURANCE FAILS TO PAY (OSI) FOR ANY REASON, INCLUDING HMO CO-PAYS, DEDUCTIBLES, CO-INSURANCES, OR FAILURE TO REPORT CHANGES OF BENEFTIS, I AGREE TO PAY ALL UNPAID BALANCES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF KNOWLEDGE. I WILL NOTIFY THE ORTHOPAEDIC & SPINE INSTITUTE, LLC. OF ANY CHANGES IN PERSONAL INFORMATION, CO-PAY, OR TERMINATION OF BENEFITS.

SIGNATURE: _____ DATE: _____

THE ORTHOPAEDIC & SPINE INSTITUTE

CONSENT FOR SERVICES

Printed Name: _____ DOB: _____

CONSENT FOR TREATMENT: I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/ or therapy which my physician or his designees, determines to be necessary. By signing this consent, I also acknowledge that I may be sent by my physician or his designees to a facility in which the providers of the clinic have an ownership interest. I also acknowledge and agree that in rendering care for me, my physician and his designees may choose to use products in which they have an ownership interest. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment in this facility.

Additionally, I understand that OSI is and In-Network facility, however, some of OSI's contracted physicians have decided to remain Out of Network and have this right as Independent Contractors. Moreover, some of the facilities that OSI prefers to use may be Out of Network facilities. That said, I understand that the patient always has a choice in their healthcare and ultimately where they go to receive that care.

USE OF MEDICAL RECORDS IN RESEARCH: I authorize the use of my medical records for external medical or scientific research. By collecting information from medical records, researchers learn about new or better ways to diagnose and treat illnesses. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited in writing by me at any time. You may disagree with the use of my medical record for this purpose by crossing through this paragraph and initialing in the left margin.

CONSENT FOR PHOTOS: I consent to the taking of photographs for medical record documentation and to still or motion pictures or video tapes of patient care for educational purposes providing my identity is not disclosed.

CONSENT FOR RELEASE OF INFORMATION: I consent to the release of information about my medical condition to myself and to any health care provider or office personnel involved with my current treatment. I understand that I may be contacted by an office representative who is conducting a quality of care review or study, and that information from my medical record has been made available to that representative.

INSURANCE CONSENT: I request that payment of authorized benefits be made to The Spine & Orthopaedic Institute and to any affiliated physicians for any services furnished to me. I authorize this office to release to Medicare, and other accident or health insurers, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and studies. I understand that I may revoke this consent for release of information at any time by notifying the office in writing, but such revocation will not apply to information already released.

PRECERTIFICATION/ PRIOR AUTHORIZATION AGREEMENT: I understand that I am responsible to comply with the rules and regulations of my insurance company regarding precertification and prior authorization requirements.

GUARANTEE OF ACCOUNT: I agree to pay The Orthopaedic & Spine Institute for all charges for services not covered by any third party payer.

PATIENT OR LEGAL REPRESENTATIVE **LEGAL RELATIONSHIP** **DATE**

NOTE: This authorization must be signed by the patient, unless the patient is a minor child or is mentally or physically unable to sign.

REASON PATIENT UNALBE TO SIGN: _____

THE ORTHOPAEDIC & SPINE INSTITUTE

Cervical * Thoracic * Lumbar * Sacral Spine Specialist

SPINE CENTER

Steven J. Cyr, M.D., F.A.A.O.S.
Spine Surgeon
Board Certified Orthopaedic Surgeon

ORTHOPAEDIC PHYSICIAN ASSISTANTS

Paul Chen, PA-C
Board Certified Physician Assistant

Dustin W. Janzen, OPA-C, C-SFA
Orthopaedic Physician Assistant

PHYSICAL THERAPY

Marcus W. Trejo, PT
Licensed Physical Therapist

CHRONIC PAIN MANAGEMENT CENTER

Anjali Jain, M.D.
Michael McKee, M.D.

NEUROLOGY CENTER

John Sladky, M.D.

PATIENT FINANCIAL RESPONSIBILITY POLICY

In an ongoing effort to more efficiently serve you and to allow you to more effectively manage your healthcare costs, Orthopaedic & Spine Institute medical centers (OSI) has amended its patient financial responsibility policy effective October 1, 2013.

All co-insurance, deductibles and/or co-payments (patient financial responsibility) required under your group or individual policy of insurance are due and payable at the time service is rendered and will be collected by our front desk staff at the time you check in for your appointment.

If you are unsure of your patient financial responsibility, we advise you to review your insurance policy or speak to your employer's human resources representative to determine what, if any, patient financial responsibility is required under your policy.
For any patient seeing an OSI physician or medical service provider on an out-of-network basis you will be responsible for the balance of the charges that are not covered by your insurance company. OSI will make every effort to identify that amount prior to service being rendered.

Any unpaid balance will be due prior to service being rendered if it is known. If not, payment will be due immediately upon being invoiced by OSI's billing department. Any balance due must be paid prior to receiving service on your next appointment.

It is important to understand that payment of patient financial responsibility is a part of your insurance policy and allow OSI to participate with the managed care organizations.
In the event you are unable to meet your patient financial obligations at the time of service, we reserve the right to reschedule your appointment so as to allow you sufficient time to meet the financial obligation under your policy.

We value every patient relationship and the provision of medical services depends on providers, insurance companies and patients all meeting their obligations in a timely manner. We work diligently to collect all sums due from your insurance company whether you are in or out of network and we appreciate your prompt attention to any payments due from you under your policy.

Please contact our patient account specialist if you have any questions or concerns.
I have read and I understand and agree to the patient financial responsibility policy of Orthopaedic & Spine Institute medical centers.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient / Legal Guardian Date

THE ORTHOPAEDIC & SPINE INSTITUTE

PATIENT PRIVACY RIGHTS

Policy

It is the policy of ORTHOPAEDIC & SPINE INSTITUTE to implement the following policies and procedures that will ensure patient privacy rights in accordance with the Privacy Regulations promulgated under HIPAA:

1. **Availability of ORTHOPAEDIC & SPINE INSTITUTE'S Privacy Notice.** The patient has the right to receive our privacy notice in a timely manner. Upon request, the patient may at any time receive a paper copy of our privacy notice, even if he or she earlier agreed to receive the notice electronically. We must also post our privacy notice in a prominent location.

2. **Requesting restrictions on certain uses and disclosures.** The patient has the right to object to, and ask for restrictions on, how his or her health information is used or to whom the information is disclosed, even if the restriction affects the patient's treatment or our payment or health care operation activities. The patient may want to limit the health information that is included in patient directories, or provided to family or friends involved in his or her care or payment of medical bills. The patient may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to the patient's requested restriction.

3. **Receiving confidential communication of health information.** The patient has the right to ask that we communicate his or her health information to them in different ways or places. For example, the patient may wish to receive information about their health status in a special, private room or through a written letter sent to a private address. We must accommodate requests that are reasonable in terms of administrative burden. We may not require the patient to give a reason for the request.

4. **Access, inspection and copying of health information.** With a few exceptions, patients have the right to inspect and obtain a copy of their health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge the4 patient a reasonable fee for copies of their health information.

5. **Requesting amendments or corrections to health information.** If the patient believes their health information is incomplete or incorrect, they may ask us to correct the information. The patient may be asked to make such requests in writing and to give a reason as to why his or her health information should be changed. However, if we did not create the health information that the patient believes is incorrect, or if we disagree with the patient and believe his or her health information is correct, we may deny the request. We must act on the request within 60 days after we receive it, unless we inform the patient of our need for a one-time 30 day extension.

6. **Receiving an accounting of disclosures of health information.** In some limited instances, the patient has the right to ask for a list of the disclosures of their health information that we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must furnish the patient with a list within 60 days of the request, unless we inform the patient of our need for a one-time 30-day extension, and we may not charge the patient for the list, unless the patient requests such list more than once in a 12 month period. In addition, we will not include in the list disclosures made to the patient, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

7. **Complaints.** Patients have the right to file a complaint with us and with the Federal Department of Health and Human Services if they believe their privacy rights have been violated. We will not retaliate against the patient for filing such a complaint. To file a complaint with either entity, the patient should contact ORTHOPAEDIC & SPINE INSTITUTE'S Privacy Officer, who will provide the patient with the necessary assistance and paperwork.

Procedures

1. Should the law regarding patient privacy rights under HIPAA change, we will update our organization's policies and procedures regarding those rights, if applicable.

2. All new staff of ORTHOPAEDIC AND SPINE INSTITUTE shall receive a copy of this document at employee orientation and be directed at orientation as to how to access more detailed privacy policy and procedure documents.

3. All current staff of ORTHOPAEDIC AND SPINE INSTITUTE shall receive a copy of this document as part of our HIPAA compliance training session, and upon request

THE ORTHOPAEDIC & SPINE INSTITUTE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only

Patient Name: _____
Medical Record #:_____
Date of Admission: _____

By signing this form, you acknowledge that The Orthopaedic & Spine Institute has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this from on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

☐ I have received THE ORTHOPAEDIC & SPINE INSTITUTE Privacy Notice

☐ THE ORTHOPAEDIC & SPINE INSTITUTE has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____

Patient Signature Date

THE ORTHOPAEDIC & SPINE INSTITUTE'S staff should complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

☐ YES ☐ NO

Please explain why the patient was unable to sign an acknowledgement form and THE ORTHOPAEDIC & SPINE INSTITUTE'S efforts in trying to obtain the patient's signature:

_____

_____

THE ORTHOPAEDIC & SPINE INSTITUTE

8401 Datapoint Dr #700, San Antonio, TX 78229
PHONE: 210-487-7463 FAX: 210-487-7468

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Please print your name
Last Name

First Name MI

What is your age and date of birth?
Print numbers in the boxes.
Age Month Day Year

What is your sex? *Mark ONE circle*
Male Female

What is your height and weight?
Print numbers in the boxes.
Height: ft. in. Weight: lbs.

In the event you can't be reached, we need your permission to leave information on your voice mail system.

Yes, you can leave information pertaining to my medical care on my voice mail system.

No, you may not leave information pertaining to my medical care on my voice mail system.

How did you hear about our office?
Mark ONE circle.

ER	Physician	Friend
Internet	Newspaper	Radio
Phone book	Other—*Print other below.*	

Who is your family physician?
Print last name.

Who is the physician that referred you to our office?
Print last name.

HISTORY OF CURRENT PROBLEM

1. What is your primary orthopaedic problem today? *Mark ONE circle*

Pain	Tingling	Instability
Stiffness	Numbness	Weakness
Swelling	Other—*Print other below*	

2. Where is the location of your primary orthopaedic problem? *Mark ONE circle*
Right side Left side Both sides
a. If both sides, which side bothers you the greatest? Right Left

3. What body part is involved with your primary orthopaedic problem?
Mark all that apply

Neck	Upper Back	Shoulder
Arm	Elbow	Forearm
Wrist	Hand	Thumb
Index Finger	Middle Finger	Ring Finger
Pinky	Mid Back	Low Back
Pelvis	Hip	Buttocks
Thigh	Knee	Lower Leg
Calf	Ankle	Foot
Toe	Other—*Print other below*	

4. What is your dominant hand?
Right Left Ambidextrous

5. When was the onset of your current problem?
Unknown Gradually
Suddenly, without injury
Suddenly, after an injury or accident
a. Date of injury or accident.

Gradually after an injury or accident
a. Date of injury or accident.

6. If after an injury or accident, where did the injury or accident take place?
Mark ONE circle
Home School Sports
Motor Vehicle Accident (See 6a)
Work related (See 6b)
Other—*Print other below*

CONTINUE on page 2.

Continue question #6.

a. If your condition is due to a motor vehicle accident answer the questions below.
- Do you have an attorney representing you?
  No Yes
  If yes, name of the attorney representing you.

- Where were you when the accident happened? Driver
  Passenger Pedestrian
- If you were the passenger, where were you sitting?
  Front Seat Back Seat
- Were you wearing a seat belt?
  No Yes

b. If your condition is due to a work accident or injury answer the questions below.
- Name of the employer where the work injury or accident occurred.

- Date reported to your employer

- Not reported

7. How did the injury or accident occur?
Please write complete sentences in the space below.

8. Have you been treated for this problem in the Emergency Room? No Yes
a. If yes, which Emergency room or Hospital were you treated.

b. What treatment did you receive.

c. Were you admitted to the hospital.
No Yes

9. Have you been seen by another physician for this problem? No Yes
a. If yes, who was the treating physician?

10. Have you received Physical Therapy for this problem? No Yes

Continue question #10

a. If yes, where did you receive your Physical Therapy treatment?

b. How long did you receive Physical Therapy?
< 1 month 1 month
2 months 3-6 months
7-12 months Over 1 year

11. What medications are you taking for this problem?

Advil	Aleve	Arthrotec
Aspirin	Celebrex	Codeine
Daypro	Flexeril	Motrin
Naprosyn	Percocet	Skelaxin
Steroid Inj.	Tylenol	Vicodin
Voltaren	Other—*Print other below*	

12. In the space provided, list all other medications you are taking including non-prescription medications Do not include the medications you have previously listed. None

13. Indicate any past testing you've had done for this problem.

X-rays	MRI	Bone Scan
CAT Scan	Discogram	EMG
Ultrasound	Lab Tests	
Other—*Print other below*		

14. Have you had prior injuries of a similar nature? No Yes *If yes, explain below.*

15. Since the onset, what is the status of your symptoms?
Improved Worsening No change

CONTINUE on page 3.

16. How long have the symptoms been present?

Mark ONE circle.

	1	2	3	4	5	6	7	8	9	10	11	Not sure
Days												
Weeks												
Months												
Years												

17. On the scale below, mark the severity of your pain, 10 being the highest.

Mark ONE circle

	None		Mild			Moderate				Severe	
	0	1	2	3	4	5	6	7	8	9	10
Right											
Left											

18. How can the current problem be characterized?

Intermittent	Constant	Burning
Dull	Sharp	Stabbing
Throbbing	Aching	Cramping

19. What additional symptoms are you experiencing?

Chills	Fever	Numbness
Stiffness	Tingling	Weakness
Swelling	Instability	Fatigue
Loss of bowel control		Loss of feeling
Loss of bladder control		Sleep disturbance
Limit of motion		Difficulty walking
Radiation of pain		Headaches

20. Symptoms improve with:

Rest	Activity	Medication
Ice/cold	Heat	Walking

21. Symptoms feel worse with:

Rest	Activity	Sitting
Ice/cold	Heat	Walking
Climbing Stairs		

22. Are the symptoms worse during the day or night?

No difference Day Night

MEDICAL,PERSONAL,SOCIAL HISTORY

23. Do you have any allergies or reactions?

No known allergies.

Sulfa	Penicillin	Latex
Iodine dyes	Anesthesia	Codeine
Feathers	Eggs	Animals
Adhesive Tape	Environmental	

Other—*Print other below*

24. Have you had any surgeries?

No Yes

If yes, select from the list below.

Arthroscopy Knee	Arthroscopy Shoulder
Total Knee Replacement	Total Hip Replacement
Rotator Cuff Repair	Carpal Tunnel Release
Back Surgery	Neck Surgery
Appendectomy	Gall Bladder
Hysterectomy	Hernia
Malignancy	Bowel Surgery

Other—*Print other below*

25. Indicate past medical conditions.

No significant medical history

Anemia	Asthma
Bleeding Disorder	Blood Transfusions
BPH/Prostate dis.	Bronchitis
Cancer	COPD
Coronary Artery dis	Depression
Diabetes	Elev. Cholesterol
Angina/Arrhythmia	Fibromyalgia
GERD	Glaucoma
Gout	Hypertension
Intestinal Disease	Kidney/Renal Disease
Liver dis./Hepatitis	Obesity
Osteoarthritis	Osteoporosis
Osteomyelitis	Peripheral Vascular
Phlebitis	Rheumatoid Arthritis
Seizures	Stomach Ulcers
Stroke/TIA/CVA	Thyroid Disease

26. Indicate your father's medical conditions.

No medical conditions

Arthritis	Cancer	Diabetes
Gout	Heart Disease	Stroke
TB	Hereditary Defects	

High blood pressure

a. What is your father's health status?

Living Deceased Unknown

27. Indicate your mother's medical conditions.

No medical conditions

Arthritis	Cancer	Diabetes
Gout	Heart Disease	Stroke
TB	Hereditary Defects	

High blood pressure

a. What is your mother's health status?

Living Deceased Unknown

CONTINUE on page 4.

28. Indicate your sibling's medical conditions.

No medical conditions

Arthritis	Cancer	Diabetes
Gout	Heart Disease	Stroke
TB	Hereditary Defects	

High blood pressure

a. What is your sibling(s) health status?

All living All deceased

Some living/some deceased

Unknown

29. What is your marital status?

Mark ONE circle

Single	Married	Divorced
Separated	Widowed	

30. Do you live alone? No Yes

31. Are there stairs in your home?

No Yes

32. What is your level of Education/School?

N/A	Current Student
Less than 12th grade	High School
Trade/Vocational	College
Professional	

33. Do you drink caffeinated beverages?

Mark ONE circle No Yes

a. If yes, how many per day?

1-2 cups/cans 3-4 cups/cans

5+ cups/cans

34. Do you drink alcohol? *Mark ONE circle*

No Yes

a. If yes, how frequently do you drink?

Rarely Socially (2 to 3 per week)

Daily

35. Do you smoke tobacco?

Mark ONE circle No Yes

a. If yes, how many per day?

Less than one pack One pack

Two packs Three+ packs

b. How many years have you smoked?

1-5 years 6-10 years

11-20 years 20+ years

36. Do you have a history of recreational drug use? *Mark ONE circle*

No Yes Prior use

37. Select all problems you have had in the last 6 months?

Fevers	Sweats
Weight gain	Fatigue
Weight loss (unexpl.)	Hearing loss
Weight loss (planned)	Ringing in ears
Vision changes	Hoarseness
Trouble swallowing	Sore throat
Shortness of breath	Wheezing
Chronic cough	Leg cramps
High blood pressure	Palpitations
Irregular heartbeat	Chest pain
Diarrhea	Heartburn
Constipation	Nausea
Abdominal pain	Fracture
Vomiting	Bone pain
Other joint pain	Muscle spasms
Other muscle pain	Skin ulcers
Rashes	Hives
Loss of coordination	Weakness
Fainting	Numbness
Headaches/Migraine	Depression
Anxiety	Disoriented
Incontinence	Discharge
Burning urination	Freq urination
Difficulty urinating	Bleeding

Please sign and date this form

Signature Date

STOP *Please return your completed form to the front desk.*