SASPINE

PATIENT INFORMATION SHEET

DATE: _____

PATIENT NAME: _____

MAIDEN NAME, IF APPLICABLE: _____ NICKNAME: _____

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

STREET/SECONDARY ADDRESS IF PO BOX USED: _____

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

SS#: _____ EMAIL: _____ MALE ❒ FEMALE ❒

DOB: _____ AGE: _____ MARITAL STATUS: M ❒ S ❒ D ❒ W ❒

RACE: _____ ETHNICITY: _____ PRIMARY/SECONDARY LANGUAGE: _____

WHAT IS YOUR DOMINANT HAND? ❒ RIGHT ❒ LEFT ❒ AMBIDEXTROUS SEXUAL ORIENTATION: _____

WOULD YOU LIKE INFO ON NEW SERVICES VIA EMAIL? ❒ YES ❒ NO

SPOUSE'S INFORMAITON:

SPOUSE'S NAME: _____

ADDRESS: _____ PHONE #: _____ DOB: _____

EMPLOYER NAME: _____ PHONE #: _____

EMERGENCY 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 Date of injury: _____**

***IS AN ATTORNEY/LEGAL INVOLVED IN ANY ASPECT RELATED TO THIS VISIT OR INJURY? 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: ❒ PRIVATE ❒ WORKERS' COMP ❒ ATTORNEY/LEGAL ❒ OTHER: _____

PRIMARY INSURANCE:

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

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

RELATIONSHIP TO PATIENT: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER: _____

SECONDARY INSURANCE:

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

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

RELATIONSHIP TO PATIENT: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER: _____

…continued on next page

PATIENT NAME: _____ DOB: _____

PHARMACY NAME, ADDRESS, PHONE: _____

BY SIGNING HERE, I'M PROVIDING CONSENT FOR THE RELEASE OF MY E-MED HISTORY TO YOU: _____
(This helps to assure safe drug interactions, etc.)

PATIENT PRIVACY INFORMATION:

❒ YES, YOU MAY LEAVE A MESSAGE FOR ME ON MY PHONE ❒ NO, YOU MAY NOT LEAVE A MESSAGE ON MY PHONE

❒ YES, YOU MAY EMAIL MESSAGES FOR ME ❒ NO, YOU MAY NOT EMAIL MESSAGES FOR ME

I AUTHORIZE THE FOLLOWING PEOPLE ACCESS TO MY MEDICAL INFORMATION, INCLUDING VERBAL CONVERSATIONS, APPOINTMENT INFORMATION, PRESCRIPTIONS, ETC.:

NAME 1: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

EXCEPTIONS: DON'T RELEASE (I.E., PRESCRIPTIONS, PLAN OF TREATMENT, ETC.) _____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: _____

NAME 2: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

EXCEPTIONS: DON'T RELEASE (I.E., PRESCRIPTIONS, PLAN OF TREATMENT, ETC.) _____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: _____

NAME 3: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

EXCEPTIONS: DON'T RELEASE (I.E., PRESCRIPTIONS, PLAN OF TREATMENT, ETC.) _____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ❒ INTERNET ❒ PHYSICIAN REFERRAL ❒ FRIEND/ASSOCIATE ❒ MAGAZINE

❒ OTHER: _____

ASSIGNMENT FOR COVERED SERVICES: I CERTIFY THAT THE INFORMATION ABOVE, INCLUDING MY ID, IS CORRECT AND HEREBY REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT TO SASPINE, LLC, FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE SASPINE TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. IF MY INSURANCE FAILS TO PAY SASPINE FOR ANY REASON, INCLUDING COPAYS, DEDUCTIBLES, COINSURANCES, OR MY FAILURE TO REPORT CHANGES OF BENEFITS, I AGREE TO PAY ALL UNPAID BALANCES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY SASPINE, OF ANY CHANGES IN PERSONAL INFORMATION, OR CHANGES OF BENEFITS/TERMINATION, ETC.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

Fax for all locations: 210.487.7468

❒ 8401 Datapoint Drive, Suite 700, San Antonio, TX 78229

Phone for all Houston area: 832.919.7990

❒ Memorial Clinic, 11777 S. Kay Freeway, Suite 260S, Houston, TX 77079
❒ Orange Clinic, 610 Strickland Drive, Suite 290, Orange, TX 77630
❒ Woodlands/Spring Clinic, 25440 I-45 North, Suite 300, The Woodlands, TX 77386
❒ Richmond Clinic, 21155 Southwest Freeway, Richmond, TX 77469

Follow Up Visit - Clinical Intake Form

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

Patient printed name: _____ Date: _____

DOB: _____ Age: _____ ID #: _____

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Have you been diagnosed with any of the following conditions:

❒ Anemia
❒ Bleeding disorder
❒ BPH/Prostate disease
❒ Cancer
❒ Coronary artery disease
❒ Diabetes
❒ Angina/arrhythmia
❒ GERD
❒ Other _____

❒ Gout
❒ Intestinal disease
❒ Liver disease/hepatitis
❒ Osteoarthritis
❒ Osteomyelitis
❒ Phlebitis
❒ Seizures
❒ Stroke/TIA/CVA

❒ Asthma
❒ Blood transfusions
❒ Bronchitis
❒ COPD
❒ Depression
❒ Elevated cholesterol
❒ Fibromyalgia
❒ Glaucoma
❒ **HIV/AIDS *** (complete separate form)

❒ Hypertension
❒ Kidney/renal disease
❒ Obesity
❒ Osteoporosis
❒ Peripheral vascular
❒ Rheumatoid arthritis
❒ Stomach ulcer
❒ Thyroid disease
❒ **Alcohol/substance abuse*** (complete separate form)

* = restricted file

Do you have any allergies or reactions? ❒ No known allergies ❒ Sulfa ❒ Penicillin ❒ Latex

❒ Iodine dyes ❒ Anesthesia ❒ Codeine ❒ Feathers ❒ Eggs

❒ Animals ❒ Adhesive tape ❒ Environmental Other: _____

Select all problems you have had in the last 6 months:

❒ Fever
❒ Weight gain
❒ Weight loss (unexplained)
❒ Weight loss (planned)
❒ Vision changes
❒ Sweats
❒ Fatigue
❒ Hearing loss
❒ Ringing in ears
❒ Hoarseness
❒ Trouble swallowing
❒ Shortness of breath

❒ Chronic cough
❒ High blood pressure
❒ Irregular heartbeat
❒ Diarrhea
❒ Constipation
❒ Abdominal pain
❒ Vomiting
❒ Other joint pain
❒ Other muscle pain
❒ Rashes
❒ Loss of coordination
❒ Fainting

❒ Headaches/migraines
❒ Anxiety
❒ Incontinence
❒ Burning urination
❒ Difficulty urinating
❒ Sore throat
❒ Wheezing
❒ Leg cramps
❒ Palpitations
❒ Chest pain
❒ Heartburn
❒ Nausea

❒ Fracture
❒ Bone pain
❒ Muscle spasms
❒ Skin ulcers
❒ Hives
❒ Weakness
❒ Numbness
❒ Depression
❒ Disoriented
❒ Discharge
❒ Frequent urination
❒ Bleeding

Patient name: _____ DOB: _____

What medications are you taking?

❒ Advil ❒ Steroid injections ❒ Flexeril ❒ Codeine
❒ Aspirin ❒ Voltaren ❒ Percocet ❒ Motrin
❒ Daypro ❒ Aleve ❒ Tylenol ❒ Skelaxin
❒ Naprosyn ❒ Celebrex ❒ Arthrotec ❒ Vicodin
❒ Herbal/homeopathic products _____
❒ Vitamin/mineral supplements _____
Other: _____

Have you had any surgeries? ❒ Yes ❒ No If yes, select from the list below:

❒ Arthroscopy knee ❒ Back surgery ❒ For malignancy ❒ Neck surgery
❒ Total knee replacement ❒ Appendectomy ❒ Total hip replacement ❒ Gall bladder
❒ Rotator cuff repair ❒ Hysterectomy ❒ Carpal tunnel release ❒ Hernia
❒ Bowel surgery Other: _____

Is this a result of an injury or accident? ❒ Yes ❒ No If yes, where did the injury/accident take place?

❒ Home ❒ School ❒ Sports ❒ Motor vehicle accident ❒ Work related (see below & separate form) ❒ Other (see below)

***If Other*,** please explain: _____

If work related: Were you injured on the job? ❒ Yes ❒ No If yes, date of injury: _____

Date the injury was reported to employer: _____

Describe the circumstances of how the injury occurred: _____

_____

Name of employer: _____

Has a Workers' Compensation claim been filed? If so, what is the claim number? _____

Do you have an attorney involved in your Workers' Compensation case? ❒ Yes ❒ No

If yes, what is the attorney's name? _____

Are you seeing a physician already for this specific problem? ❒ Yes ❒ No

If yes, what is the name of the physician/provider? _____

Indicate your father's medical conditions: ❒ No medical conditions ❒ Arthritis ❒ Cancer ❒ TB

❒ Heart disease ❒ Gout ❒ High blood pressure ❒ Diabetes ❒ Stroke
❒ Hereditary defects What is your father's health status: ❒ Unknown ❒ Living ❒ Deceased

Indicate your mother's medical conditions: ❒ No medical conditions ❒ Arthritis ❒ Cancer ❒ TB

❒ Heart disease ❒ Gout ❒ High blood pressure ❒ Diabetes ❒ Stroke
❒ Hereditary defects What is your mother's health status: ❒ Unknown ❒ Living ❒ Deceased

Patient name: _____ DOB: _____

Indicate your sibling(s) medical conditions: ❒ No medical conditions ❒ Arthritis ❒ Cancer ❒ TB

❒ Heart disease ❒ Gout ❒ High blood pressure ❒ Diabetes ❒ Stroke ❒ Hereditary defects

What is your sibling(s) health status: ❒ Unknown ❒ All living ❒ All deceased ❒ Some living/some deceased

What is your marital status? ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

Do you live alone? ❒ Yes ❒ No

Are there stairs in your home? ❒ Yes ❒ No

Do you drink caffeinated beverages? ❒ No ❒ Yes If yes, how many cups/cans per day? ❒ 1-2 ❒ 3-4 ❒ 5+

Do you drink alcohol? ❒ No ❒ Yes If yes, how frequently do you drink? ❒ Rarely ❒ Daily ❒ Socially (2-3 per week)

Do you use tobacco products? ❒ No ❒ Yes ❒ Never smoked ❒ Previously smoked

If yes, how many per day: ❒ Less than 1 pack ❒ 1 pack ❒ 2 packs ❒ 3+ packs

How many years have you smoked? ❒ 1-5 years ❒ 6-10 ❒ 11-20 ❒ 20+ years

Do you use smokeless nicotine products? ❒ E-cigarettes ❒ Vape ❒ Chewing tobacco

Do you have a history of recreational drug use? ❒ No ❒ Yes ❒ Prior use

Additional comments you would like to make regarding your health circumstances:

_____

_____

Patient signature: _____ Date: _____

Processed with patient by _____ Date _____

Entered in EMR by _____ Date _____

Vital signs:

HT: _____ WT: _____ BP: _____ P: _____ T: _____ R: _____

Pain level: 0 1 2 3 4 5 6 7 8 9 10

RESTRICTED/CONFIDENTIAL RECORD

Alcohol/Substance Abuse Formal Treatment

Patient printed name: _____ Date: _____

DOB: _____ Age: _____ ID #: _____

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Providers currently/previously seen for treatment:

_____ _____
Provider's name Date(s) of treatment

_____ _____
Address Phone

_____ _____
Provider's name Date(s) of treatment

_____ _____
Address Phone

Medications, if applicable: _____

_____

Have you been hospitalized for treatment? If so, when: _____

Are you receiving any type of counseling? ❒ No ❒ Yes _____

Additional comments: _____

_____

_____ _____
Patient's signature Date

5-3-19

RESTRICTED/CONFIDENTIAL RECORD

HIV/AIDS Diagnosis/Treatment

Patient printed name: _____ Date: _____

DOB: _____ Age: _____ ID #: _____

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Date diagnosed as infected HIV _____ or date confirmed with AIDS _____

Current symptoms as a result of diagnosis: _____

_____

Providers currently/previously seen for treatment:

_____ _____
Provider's name Date(s) of treatment

_____ _____
Address Phone

_____ _____
Provider's name Date(s) of treatment

_____ _____
Address Phone

Medications, if applicable: _____

_____

Have you been hospitalized for treatment? If so, when: _____

Are you receiving any type of counseling? ❒ No ❒ Yes _____

Additional comments: _____

_____

_____ _____
Patient's signature Date

PATIENT PRIVACY RIGHTS

Policy
It is the policy of SASpine to implement the following policies and procedures that will ensure patient privacy rights in accordance with the Privacy Regulations promulgated under HIPAA. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Availability of SASpine'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.

Requesting restrictions on certain uses and disclosures: There are circumstances not requiring prior patient authorization to release information, i.e., related to treatment, payment, emergency situations, public health entity requests, etc. 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.

Our practice provides information to our patients via multi-media services, i.e., appointment reminders via phone, voicemail, email communication, etc., and patients have the right to place restrictions on these services.

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.

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 the patient a reasonable fee for copies of their health information.

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.

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 of 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.

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 SASpine's Privacy Officer, who will provide the patient with the necessary assistance and paperwork.

Procedures:
Should the law regarding patient privacy rights under HIPAA change, we will update our organization's policies and procedures regarding those rights, if applicable. All new staff of SASpine 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. All current staff of SASpine shall receive a copy of this document as part of our HIPAA compliance training session, and upon request.

AMENDMENT TO TEXAS HB 300

NOTICE OF ELECTRONIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

If we obtain or create information about your health, we are required by law to protect the privacy of your information. Protected health information (PHI) includes any information that relates to:

- Your past, present, or future physical or mental health or condition;
- Health care provided to you; and
- Past, present, or future payment for your health care.

We may not disclose your PHI electronically without your authorization unless allowed by law. For example, we may share your PHI through approved, secure electronic methods for the purpose of treatment, payment for health care services, or health care operations such as case management or care coordination. We may also need to share your PHI electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts. For a complete list of reasons that we are allowed by law to share your PHI, please refer to our Notice of Privacy Practices.

If you believe that we have violated the obligations described in this notice, you have the right to file a complaint to the Privacy Officer at:

SASpine
8401 Datapoint Drive, Suite 700
San Antonio, TX 78229-5907

Fax for all locations: 210.487.7468

❒ 8401 Datapoint Drive, Suite 700, San Antonio, TX 78229

Phone for all Houston area: 832.919.7990

❒ Memorial Clinic, 11777 S. Kay Freeway, Suite 260S, Houston, TX 77079
❒ Orange Clinic, 610 Strickland Drive, Suite 290, Orange, TX 77630
❒ Woodlands/Spring Clinic, 25440 I-45 North, Suite 300, The Woodlands, TX 77386
❒ Richmond Clinic, 21155 Southwest Freeway, Richmond, TX 77469

Acknowledgement of Receipt of Privacy Notice

By signing this form, you acknowledge that SASpine 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 form 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 SASpine's Privacy Notice.

❒ SASpine has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____

Patient's signature Date

_____ _____

Patient's printed name Date of birth

Staff at SASpine should complete if this 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 this acknowledgement form and SASpine's efforts to obtain the patient's signature:

_____

_____

SASPINE

Change of Patient Privacy Information

(This form replaces my original requests)

Today's date: _____ Effective date of change: _____

Patient name: _____

Address: _____

Phone & alternate number if applicable: _____

Email address: _____

❒ Yes, you may leave a message for me at the following number: Phone: _____

❒ No, I do not want a message left for me on my phone.

❒ Yes, you may email me at the following email address: _____

❒ No, I do not want email messages sent to me.

I AUTHORIZE THE FOLLOWING PEOPLE ACCESS TO MY MEDICAL INFORMATION, INCLUDING VERBAL CONVERSATIONS, APPOINTMENT INFORMATION, PRESCRIPTIONS, ETC.:

NAME 1: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

EXCEPTIONS: DON'T RELEASE (I.E., PRESCRIPTIONS, PLAN OF TREATMENT, ETC.) _____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: _____

NAME 2: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

EXCEPTIONS: DON'T RELEASE (I.E., PRESCRIPTIONS, PLAN OF TREATMENT, ETC.) _____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: _____

NAME 3: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

EXCEPTIONS: DON'T RELEASE (I.E., PRESCRIPTIONS, PLAN OF TREATMENT, ETC.) _____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: _____

Patient signature _____

Printed name _____

Office locations in San Antonio and Houston, Texas

CONSENT FOR SERVICES

Patient 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 may (or may not) have an ownership interest by SASpine and/or contracted physicians, which may include but not limited to, PPI, BHT or Oracle. Although SASpine has preferred vendors, a patient always has the right to choose a different entity for care. 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 the facility.

Additionally, I understand that SASpine is an in-network facility, however, some of SASpine's contracted providers may be considered out of network with insurance carriers such as UHC, Aetna, etc., and have this right as independent contractors. Consequently, patients may be balance billed for some services. Moreover, some of the facilities that SASpine 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 videos 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 healthcare 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 SASpine and to any affiliated providers for any services furnished to me. I authorize this office to release to health plans, 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 SASpine for all charges for services not covered by any third party payer.

_____

Patient signature / legal guardian, 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 unable to sign:

_____

Signature: _____ Date: _____

Fax for all locations: 210.487.7468

❒ 8401 Datapoint Drive, Suite 700, San Antonio, TX 78229 P: 210.487.7463

Phone for all Houston area: 832.919.7990

❒ Memorial Clinic, 11777 S. Kay Freeway, Suite 260S, Houston, TX 77079
❒ Orange Clinic, 610 Strickland Drive, Suite 290, Orange, TX 77630
❒ Woodlands/Spring Clinic, 25440 I-45 North, Suite 300, The Woodlands, TX 77386
❒ Richmond Clinic, 21155 Southwest Freeway, Richmond, TX 77469

Patient Financial Responsibility Policy

All coinsurance, deductibles and/or copayments (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 a SASpine provider 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. SASpine 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 SASpine'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 SASpine 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 SASpine.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient / Legal Guardian (if guardian, note relationship) Date

10-11-19

Fax for all locations: 210.487.746

❒ 8401 Datapoint Drive, Suite 700, San Antonio, TX 78229

Phone for all Houston area: 832.919.7990

❒ Memorial Clinic, 11777 S. Kay Freeway, Suite 260S, Houston, TX 77079
❒ Orange Clinic, 610 Strickland Drive, Suite 290, Orange, TX 77630
❒ Woodlands/Spring Clinic, 25440 I-45 North, Suite 300, The Woodlands, TX 77386
❒ Richmond Clinic, 21155 Southwest Freeway, Richmond, TX 77469

Financial Policy Agreement

The financial policy of SASpine is designed to allow us to provide quality care to our valued patients. We are always happy to clarify or answer any questions you may have regarding your account. The financial responsibility for services rendered rests with you, the patient, or the party held responsible as guarantor regardless of your agreement with your insurance company.

After three (3) statements are sent to the patient of any delinquent accounts with no payment, our billing system will automatically turn over the patient balance to our collections agency. If our billing statement is returned "address unknown" the account will immediately be turned over to collections as it is the patient's responsibility to notify us of any changes.

After the account has been placed with a collector or a patient has filed for bankruptcy relief, the patient will be seen on a cash only basis at the time of service. As a service to you, we do allow you to put any patient balance on a Payment Plan Agreement. This form must be signed after an agreement has been made for clearing out the incurred balance. On this basis, and only this basis, will we consider calling the collections agency and removing you, based on terms that we have internally agreed that you will fulfill your agreement to pay the total balance.

There will be a $35 service charge for all returned checks. If returned checks are not picked up and redeemed by cash or money order within 10 working days of notification, the account will be turned over to the collections agency.

There is a "No Show Policy". If you have a copay, for any missed appointments without a 24 hour cancellation notice, you will be billed your copay amount. If you do not have a copay, for any missed appointments without a 24 hour cancellation notice, you will be billed a $35 charge.

After three (3) No-Show appointments, you will be dismissed from the practice. We have this policy in place and strictly enforce it for the benefit of our patients. If we have enough cancellation notifications from one patient, it allows us to fit in another patient who may be waiting to see the same provider.

Received and acknowledged:

_____ _____

Patient signature Date of birth

_____ _____

Patient's printed name Date signed

Completion of FMLA, Disability, Social Security Administration Forms

We understand how important it is for you to receive your expected payments and we want to work with you closely to make sure that happens.

To be sure all documents are submitted and as required, please give us the full packet of information that you have received.

Please complete any sections that require your personal information, documentation and signature, etc., and ask to speak with Mary Jane, if she is available.

You may also email your packet to MedicalRecords@saspine.com.

It is very important that you immediately give the forms to us when you receive them so we can submit them as quickly as possible for you.

To be sure there isn't any delay, we ask that you complete our medical records release form in case we must provide information from your file.

In most cases, there is a $40 fee to complete this process and payment should be submitted to us with the forms. Payment does need to be made prior to the submission of the paperwork to the appropriate organization.

Thank you!

3-25-19

HIPAA AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH OR PERSONAL INFORMATION FOR MARKETING, PUBLIC RELATIONS AND EXTERNAL COMMUNICATIONS

I, _____, authorize SASpine, LLC, to use and/or disclose health
(Printed Name)
information / or personal/photo information about me for marketing, promotional, educational and informational purposes to local, state and national government officials; reporters for local, state and national media publications, including news-papers, magazines and online social media; and to reporters for local, state and national television broadcast stations, or as otherwise specifically described below:

Instagram, Facebook, YouTube, internet and social media, lectures, written and digital print, video

Other _____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health and/or personal information:

_____ Appearance/interview by media on camera; still photos or video footage for use in publications (print or electronic), web sites, audio, video, television commercial, advertising or film.

_____ Surgical or other medical procedure: _____

_____ Other health information to be used or disclosed: _____

_____

I understand that:
1. I understand that this consent is strictly voluntary and I have the right to refuse.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation. Further details may be found in the SASpine Notice of Privacy Practices.
4. If the receiver is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form.
6. I may have an executed copy of this form.

This authorization will expire one year after the date signed at bottom of form, or sooner by my choice, in which case this consent will expire on _____.
(Date)

SIGNATURES	
I have read, I understand and I agree to the above and authorize the disclosure of the protected health information as stated.	
Signature of Individual or Patient/Guardian/Patient Representative:	Date:
Print Name of Individual or Patient's Representative:	Relationship to Individual or Patient: