International Center for Neuroscience PLLC www.ICNSpine.com
Correspondence address:
3431 Rayford Rd, Suite 200-563, Spring, TX 77386
Tel: 832-932-9300
Fax: 1-888-847-6562

REGISTRATION

Patient First Name_____Last Name_____
Cell/Home Phone:_____ Work Phone_____ Email_____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security #_____ Driver's License #_____
Insured Name_____ Pharmacy Number _____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City _____ State _____ Zip_____Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____Phone_____ Occupation_____ City_____ State _____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Injury date:_____** Primary Care Physician Name:_____ Phone:_____ Person to contact in emergency (Name and Phone #)_____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. **X**_____ _____ Signature of Insured / Guardian Date

Once completed in its entirety (i e. all 5 pages) and signed, you may either:
1. Bring this form with you on your appointment date to our office.
2. Mail this form 2 weeks in advance to our correspondence address: 3431 Rayford Rd. #200-563, Spring TX 77386
3. E-mail this form to Appointment@ICNSpine.com. Please note that E-mail is not a secure method of communication. By emailing this form, you acknowledge and accept the associated risks.

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birthdate:_____

Height: _____ Weight: _____

Reason for Office Visit (briefly explain):_____

_____

_____

_____

☐ Injury/Date of Injury _____

☐ Illness/Date Illness Began_____

☐ Symptoms/Date symptoms began _____

☐ Second Opinion/IME _____

1. Pain is:

☐ in the neck ☐in the shoulder ☐in the arm/hand

☐in the back ☐in the hip ☐in the leg/foot

☐ other_____

2. Pain occurs with the following frequency:

☐ occasionally ☐ on and off ☐ all the time

☐ throughout the day ☐ at night ☐ no difference

3. Each episode of pain usually lasts: _____

☐ seconds ☐ minutes ☐ hours ☐ days ☐ weeks

4. Are you: Right Handed_____ Left Handed _____
Use both Equally_____

5. Pain feels like:

☐a dull aching ☐sharp ☐stabbing ☐burning ☐cramping

Pain location: ☐ Neck ☐ middle of low back
☐ to Left ☐ to Right
☐ across buttock / back
☐ across shoulders

7. Intensity of pain (scale of 1-10: 1 –2 –3 –4 –5 –6 –7 – 8 – 9 – 10)

☐no pain (0) ☐mild pain (1-2)

☐moderate pain (3-4) ☐severe pain (5-6)

☐very severe pain (7-8) ☐worst possible pain (9-10)

8. Pain in the neck compared with arm is:

☐ worse in the neck ☐same ☐less in the neck

Pain in the back compared with leg is :

☐ worse in the back ☐ same ☐less in the back

9. Mark the body position and /or activities that make pain better or worse:

a.	Sitting	☐ better	☐ worse
b.	Standing	☐ better	☐ worse
c.	Walking	☐ better	☐ worse
d.	Laying Down	☐ better	☐ worse
e.	At night, pain is	☐ better	☐ worse
f.	Coughing, Sneezing	☐ better	☐ worse
g.	Straining only	☐ better	☐ worse
h.	Movement	☐ better	☐ worse
i.	During the day pain is	☐ better	☐ worse
j.	No activity	☐ better	☐ worse

10. Any urinary or fecal incontinence? ☐ NO ☐ YES

11. Do you have foot drop or paralysis? ☐ NO ☐ YES

12. Previous tests done: Where/ when ?

☐MRI_____

☐CT Scan _____

☐Myelogram _____ ☐EMG/NCV _____

☐Discogram _____ ☐Bone Scan _____

13. Treatment done so far:

☐bed rest ☐pain pills ☐muscle relaxants

☐anti-inflammatory non-steroidals ☐ TENS unit

☐chiropractic ☐physical thereapy ☐epidural blocks

☐Other injections (trigger point) ☐Back/ neck brace

☐decompression of nerve ☐removal of disc

☐spinal fusion

14. Previous treatments have been:

☐unsuccessful ☐partially successful ☐very successful

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birthdate:_____

MEDICATIONS:
List all medication you are now taking & what they are for:
_____
_____
_____
_____
_____
_____

ALLERGIES:
List all medications you are allergic to and the reaction you have:_____
_____
_____

PAST HOSPITALIZATION / SURGICAL HISTORY:
Check any previous SPINAL surgeries and indicate the date(s) when they occurred:
☐ NONE Thoracic _____
☐ Lumbar _____
☐ Cervical _____
Check all OTHER surgeries: ☐ NONE ☐ appendectomy
☐ cardiac surgery ☐ tonsil / adenoidectomy
☐ wisdom teeth removal ☐ gall bladder surgery
☐ other orthopedic surgery ☐ thyroid surgery
☐ breast surgery ☐ hernia repair ☐ Cesarean section
☐ Other _____

PERSONAL MEDICAL HISTORY
Vision Problems: □ cataracts □ blurred vision □ glasses □ surgery □ other: _____
Hearing Problems: □ hearing loss □ hearing aid □ vertigo □ ringing in ears □ surgery □ other: _____
Skin Problems: □ rash □ hives □ lesions □ discoloration □other: _____
Cardiovascular: □ heart attack □ heart failure □ angina / chest pain □ mitral valve prolapse □ irregular heartbeats □ shortness of breath □ other: _____
Circulation/Blood flow: □ varicose veins □ leg swelling □ peripheral vascular disease □ blood clots □ high blood pressure □ low blood pressure □ other: _____
Respiratory: □ asthma □ bronchitis □ emphysema □ pneumonia □ COPD □ tuberculosis □ oxygen tank □ other: _____
Bowels/Intestines: □ cramps □ irritation □ Irritable Bowel Syndrome □ other: _____
Kidneys: □ dialysis □ renal failure □ renal insufficiency □ kidney disease □ other: _____
Uterus/Prostate: □ BPH benign prostate enlargement weak urine stream □ prostate disease □ cancer □ fibroids □ other: _____
Mental problems: □ depression □ anxiety □ psychosis □ other: _____
Brain: □ seizure □ stroke □ tumor □ cyst □ hydrocephalus □ aneurysm □ headache □ migraines □ dizziness/fainting □ other: _____
□ Pacemaker or any implanted devices
_____

Other personal medical problems:
_____
_____

REVIEW OF SYSTEMS:
check items that applies to you:
Musculoskeletal / Joints: ☐ Muscular disease Arthritis
Neurological: ☐ Headaches ☐ Seizures ☐ Strokes
Metabolic: ☐ Diabetes ☐ Thyroid problems
Bleeding Disorders: ☐ Anemia ☐ Clots ☐ Bleeding problems
Urinary: ☐ Blood in Urine ☐ Frequent Urination ☐ Trouble Starting Urination ☐ Trouble Stopping Urination ☐ Pain with Urination ☐ Prostate Disease ☐ Kidney Disease
Reproductive: ☐ Infections ☐ Herpes ☐ Venereal Disease
Gastrointestinal: ☐ Stomach Ulcers ☐ Gallbladder Problems ☐ Pancreatitis ☐ Colitis ☐ Blood in Stool ☐ Hiatal Hernia ☐ Liver Disease ☐ Constipation ☐ Loss of Bowel Control ☐ Hepatitis ☐ Jaundice
Cancer: ☐ Lung ☐ Breast / Colon / Intestinal ☐ Stomach ☐ Prostate ☐ Skin ☐ Kidney ☐ Bone ☐ Other Malignancy _____
Immunological Diseases: ☐ HIV Infection / AIDS

Women only: ☐ Endometriosis
Are you on the Pill? ☐ NO ☐ YES
Are you pregnant now? ☐ NO ☐ YES : due date: _____
How long ago was your last complete physical?
_____ yrs _____months
Were there any abnormal findings? ☐ NO ☐ Yes, describe: _____

LIFESTYLE
Do you smoke NOW? ☐ No ☐ Yes:
Packs per day: _____ for _____ years
Did you smoke in the Past? ☐ No ☐ Yes:
Packs per day: _____ for _____ years
Do you drink alcoholic beverages? ☐ No ☐ Yes:
Drinks per week: _____ for _____ years
Do you have a history of drug abuse? ☐ No ☐ Yes:
Please describe: _____
_____

SOCIAL HISTORY:
Patient's Marital Status: ☐ Married ☐ Living common-law ☐ Widowed ☐ Divorced ☐ Separated ☐ Single
Number of children: _____
Hobbies: _____

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Patient Name:_____ Date:_____ Birthdate:_____

FAMILY HISTORY:
Please check any of the problems immediate family have had and indicate the family member:
☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease
☐ Neck Pain ☐ Back pain ☐ Low Blood Pressure
☐ Kidney disease ☐ Depression/mental problems
☐ Alzheimer /Memory loss ☐ Vascular Disease
☐ Stroke/brain tumor/aneurysm
☐ Lung problems ☐ Parkinson's ☐ Multiple Sclerosis
☐ Cancer:_____
OTHER_____

Is there any reason you cannot receive blood or blood product: ☐ no ☐ yes: _____

OCCUPATIONAL HISTORY:
Occupation: _____
Employer: _____
When did this employer hire you? _____
Presently Working? ☐ Yes ☐ No
How long off work? _____

Does your job require you to perform the following activities:
☐ Lift _____ kg / lb
☐ Sit ☐ Stand
☐ Lift over head ☐ Reach over head
☐ Use a computer
☐ Bend
☐ Drive a truck or a forklift
If you are married, does your spouse work?
☐ YES ☐ NO
If no, how long has he/she been off work? _____
How did you hear about us?

☐ Facebook

☐ A Website (please specify) _____

☐ Google Search

ADDITIONAL PATIENT INFORMATION:
_____
_____
_____
_____

I certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

X _____ _____ _____
Signature of Patient or Personal Representative Date Verified by Physician/Nurse/ Medical assistant

DISCLOSURES & ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES
I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective September 1, 2017), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

X _____ _____ _____
Signature of Patient or Personal Representative Date Name (& Description of Personal Representative Authority if applicable)

MEDICAL RELEASE OF INFORMATION:
I hereby authorize the above named healthcare provider(s) to release any Medical Information (from my medical and other records) required to process my claim, to any insurance or third party payor, any other person or entity financially responsible for my care/ treatment, any representative of local, state or federal agencies in accordance with the law, for the purpose of conducting a medical audit, utilization reviews, quality assurance reviews, or to any referring physician or skilled/health care facility.

X _____ _____ _____
Signature of Patient or Personal Representative Date Name (& Description of Personal Representative Authority if applicable)

AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION/ CONSENT TO PUBLICATION/PHOTOGRAPHY
I authorize the above named healthcare provider(s) to take photographs or videos of myself/ my surgery or the below named patient or to use information contained in my medical record such as history and physical, progress notes, consultations, operative reports, laboratory and pathology reports, radiological images and reports, other hospital and clinic documents for the purpose of medical publication and studies. I understand that ***ALL IDENTIFYING INFORMATION WILL BE REMOVED*** if used for that purpose. I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply for information that has already been released. I understand that this authorization is voluntary and I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I fully and completely release the above named healthcare provider(s) from any claims or liabilities arising from the use of this information. I also understand that the information gathered will be the property of the above named healthcare provider(s) I understand that disclosure of this information carries with it the potential of unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

X _____ _____
Signature of Patient or Personal Representative Date

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DEPARTMENT OF STATE HEALTH SERVICES NOTICE OF PRIVACY PRACTICES

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.

When you receive treatment or benefits from any Department of State Health Services (DSHS) facility or program, we receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposes:

- For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
- To comply with workers compensation laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of abuse, neglect, or domestic violence we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;
- For health oversight activities such as audits, investigations, and inspections of DSHS facilities;
- For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;
- To create or share de-identified or partially de-identified health information (limited data sets);
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
- As otherwise required or permitted by local, state, or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

YOUR PRIVACY RIGHTS
Although your health record is the property of DSHS, you have the right to:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.
- Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the DSHS privacy officer or your DSHS provider's privacy office. You can reach DSHS at (512) 776-7111 or (888) 963-7111 or by email at hipaa.privacy@dshs.texas.gov To request results of lab tests performed by the DSHS lab, please call (512) 776-7318 or visit http://www.dshs.state.tx.us/lab/patientresults.aspx.

OUR DUTIES
We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our public website at www.dshs.texas.gov and in waiting room areas. You may request a copy of the revised notice at the time of your next visit.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint by contacting: **DSHS Consumer Services and Rights Protection/Ombudsman Office** by mail at Mail Code 2019, P.O. Box 149347 Austin, TX 78714-9347; or by telephone at (512) 206-5760 or (800) 252-8154 (toll free); and **Office for Civil Rights, Region VI, U.S. Department of Health and Human Services**, by mail at 1301 Young St., Suite 1169, Dallas, Texas 75202; or by telephone at (800) 368-1019, (214) 767-0432 (fax), or (800) 537-7697 (TDD).

For complaints about a violation of your right to confidentiality by an alcohol or drug abuse treatment program, contact the United States Attorney's Office for the judicial district in which the violation occurred.

We will not retaliate against you for filing a complaint.