CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT CLEARLY

Legal Name_____Name you prefer to be called_____

Email address_____Marital Status □M □D □S □W □ SEP

Address_____

City_____State_____Zip_____

Cell Phone_____Hm Phone_____Wk Phone_____

Date of Birth_____Age_____S.S.#_____Male□ Female□

Ethnicity □American Indian or Alaska Native □Asian □Black/African American □Decline to Specify

□Native Hawaiian or other Pacific Islander □ Other Race □Unknown □White

Occupation_____Employer_____

Family Physician_____Phone_____

Pharmacy_____Phone_____

Referred by_____

Emergency Contact_____Phone_____

INSURANCE INFORMATION

Primary Insurance_____Phone_____

ID#_____Group#_____

Policy Holder Name_____DOB_____

Relationship to Patient_____S.S.#_____

Secondary Insurance_____Phone_____

ID#_____Group#_____

Policy Holder Name_____DOB_____

Relationship to Patient_____S.S.#_____

Signature_____Date_____

Relationship to Patient_____

DESCRIBE YOUR PRESENT COMPLAINT:

_____

How long has this been bothering you? _____ Have you had this before? _____

Please rate your condition as: ☐ Mild ☐ Moderate ☐ Severe

Are your symptoms: ☐ Getting Better ☐ Staying the Same ☐ Getting Worse

Do your symptoms: ☐ Come and Go ☐ Constant

How many days a week are you experiencing your symptoms now: ____

MEDICAL HISTORY:

Have you been treated by a medical physician for any condition in the last year? ☐ Yes ☐ No

If yes, please give name of physician and reason for visit_____

_____

Are you taking any medication? ☐ Yes ☐ No If yes, please list them_____

_____

Please list **all surgeries** and/or dates of hospitalization_____

_____

_____

Females: Are you pregnant? ☐ Yes ☐ No If yes, expected delivery date_____

List any other major health conditions _____

_____

_____

Please let us know if there is anything else you would like to tell us about your condition, your medical history, or anything pertaining to you that you feel would be helpful to Dr. Brent Gordon D.O. in evaluating you today:

_____

_____

You may or may not be a candidate for the North Texas Spinal Decompression Program. Every patient is unique and evaluated accordingly to severity and possible positive outcomes. The Doctor is committed to helping you understand your true problem and determining if these procedures are right for your case. If your case is accepted, a treatment plan will be made for your consideration and if an outside referral is in your best interest, it will be handled in a timely manner.

All treatment plans are customized for each individual.

_____ Initial

SIGNATURE: _____ **DATE:** _____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIENS AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, illnesses past or future ("condition") to pay directly to and exclusively in the name of Advanced Spine and Joint such sums as may be owing to Advanced Spine and Joint for charges incurred by me, including but not limited to charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Advanced Spine and Joint with respect to any charges, applicable to all payers; however, I understand that nothing in this Agreement shall be construed as an election by Advanced Spine and Joint to claim protection under any statuary lien law. For the purpose of this Agreement "benefits" shall include, but shall not be limited to proceeds from any settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, disability benefits, workers compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements and any other benefit or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that in the event a payer refuses to pay Advanced Spine and Joint, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Advanced Spine and Joint to the extent of my charges, as well as any and all causes of action that I might have against such payer to prosecute such causes of action either in my name or in the offices name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a Letter of Protection to this office regarding my charges. Upon issuance I hereby agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to Advanced Spine and Joint any information regarding my coverage or benefits which I may have including, but not limited to, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Advanced Spine and Joint to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an amount relating to me, my spouse, or my dependents, regardless of whether these charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Advanced Spine and Joint for their services. This agreement does not constitute and consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect an outstanding balance on my account, I will be responsible for payments and will reimburse Advanced Spine and Joint for all costs of collection efforts, including, but not limited to all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual consent of Advanced Spine and Joint and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of these authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of Advanced Spine and Joint and myself. However, should any provisions of this Agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print):_____

Patient Signature:_____ Date:____/____/_____

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____

Advanced Spine and Joint
3629 Western Center Blvd. Ste 211
Fort Worth, TX 76137

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third parties
- Conduct normal healthcare operations such as quality assessments and physician certification

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Patient or Guardian Signature:_____

Date:_____

Relationship to Patient:_____