Texas Spine Consultants, LLP

Date: _____ Height: _____ Weight: _____

Name: _____ _____ _____
Last First M.I.

DOB: _____ Age: _____

Dominant Hand: [ ] Right [ ] Left

Haariss B. Ilyas, M.D.

Please complete this form carefully. Your answers will help us better understand your presenting problem and design the best treatment program for you.

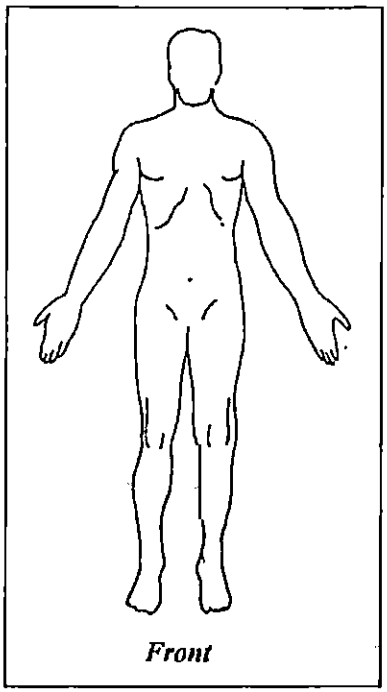
Main Concern: _____

How long has this been an issue? _____

Was there a specific event that started it? ☐yes ☐no If yes, please explain: _____

USING SYMBOLS BELOW, MARK DRAWING ACCORDING TO YOUR PAIN. INCLUDE ALL AFFECTED AREAS (Please draw in your face):

ache/sore: **>>>**	dull: **DDD**	sharp: **sss**	throbbing: **TTT**	numb: **nnn**
cramping: **ccc**	pressure: **ppp**	tingling: **xxx**	pins/needles: **ooo**	stabbing: **/ / /**
	burning: **BBB**	shooting: **+++**		



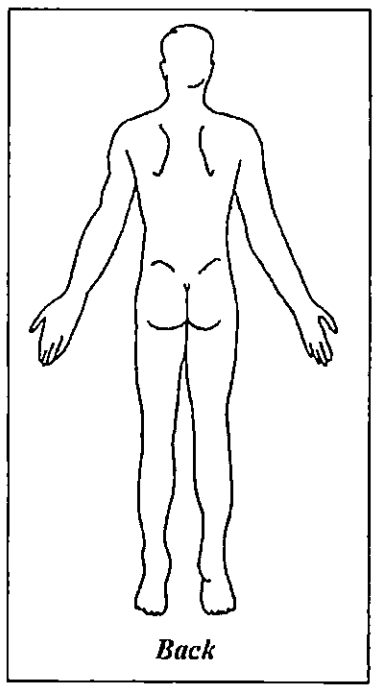
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Pain in arm(s) compared to neck
Worse than _____
Same as _____
Less than _____

Upper Back: Circle Severity Pain Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Low Back Pain: Circle Severity Pain Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Pain in leg(s) compared to back
Worse than _____
Same as _____
Less than _____



Check / Circle / Highlight any that apply :

RATE YOUR USUAL PAIN:

NO PAIN 1 2 3 4 5 THE WORST PAIN IMAGINABLE

DOES PAIN COME ON:
- ☐ Suddenly
- ☐ Gradually

PAIN IS:
- ☐ Constant
- ☐ Good & bad days

PAIN IS WORST
- ☐ When I wake up
- ☐ After I have been active
- ☐ Before I go to sleep

ARE YOU GETTING
- ☐ Better
- ☐ Worse
- ☐ Unchanged

Are you working? ☐yes ☐no If not, when did you stop? _____

Is this problem the result of an on-the-job injury? ☐yes ☐no

Is this problem the result of a motor vehicle accident (MVA)? ☐yes ☐no If yes, please check, circle one of the following:

MVA/Driver (E812.0) **MVA/Passenger** (E812.1)
Motorcyclist (E810.2) **Motorcycle/Passenger** (E810.3)
MVA vs. Bike (E813.6) **MVA vs. Pedestrian** (E814.7) **Pedestrian Hit By Car** (E812.7)

Is this problem the result of a fall? ☐yes ☐no If yes, please check, circle one of the following:

At Home (E888.8) **Stairs** (E880.9) **Chair** (E884.2) **Commode** (E884.6)
Sidewalk/Curb (E880.1) **Tree** (E884.9) **Ladder** (E881.0) **Scaffolding** (E881.1)
Snow Skis (E885.3) **Snowboard** (E885.4) **Inline Skate** (E885.1) **Skateboard** (E885.2)
Water Skis (E835.4)

Which INCREASES your pain/discomfort? Please check or circle.

Standing Sitting Walking Bending forward Bending backward

Lying on back Lying on stomach Lying on side Rising from sitting

Coughing Sneezing Urination Bowel movement

Which DECREASES your pain/discomfort? Please check or circle.

Standing Sitting Walking Bending forward Bending backward

Lying on back Lying on stomach Lying on side Rising from sitting

Coughing Sneezing Urination Bowel movement

What is the approximate amount of time you can perform the following activities?

Sit _____ minutes Stand _____ minutes Walk _____ minutes

Please check all of the treatments you have tried for your pain and then check the appropriate column:

	Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
☐	Physical/Occupational Therapy		☐	☐	☐
☐	Heat/Ice		☐	☐	☐
☐	Traction		☐	☐	☐
☐	Injections (back or neck only)		☐	☐	☐
☐	TENS		☐	☐	☐
☐	Ultrasound		☐	☐	☐
☐	Brace or collar		☐	☐	☐
☐	Massage		☐	☐	☐
☐	Psychotherapy		☐	☐	☐
☐	Chiropractic		☐	☐	☐
☐	Other _____		☐	☐	☐

Have you had surgery for this pain? Yes___ or No___

If yes, what procedure? _____ When? _____

Did it help? Yes ___ or No____

Medications use the back of this page if additional space is needed. Rember antibiotics, blood thinners, insulin and heart medications.

Name	Strength	Frequency
1.		
2.		
3.		
4.		
5.		
Pharmacy Number-		
Occupation-		
Recreational activities/exercises/Hobbies-		
Running Walking Cycling Golf Yoga Treadmill Elliptical Machine Weight/Lifting		
Aerobics Other:		
Physician has reviewed the form and acknowledge the findings.		
Ilyas Haaris, M.D.		

PHYSICIAN FINANCIAL DISCLOSURE FORM

Pursuant to Federal and Texas Law, please note that Dr. Haariss Ilyas has financial/consulting agreements with the following entities:

- Baylor Scott & White Uptown

If you are referred to any of these entities or any other entity related to Texas Spine Consultants, L.L.P., Dr. Haariss Ilyas may receive direct or indirect remuneration. If you have any questions regarding this paragraph, please discuss them with Dr. Ilyas directly.

ACKNOWLEDGEMENT

In treating your condition, I may prescribe an Orthofix bone growth stimulator. I am a supplier of Orthofix products. If you choose to obtain the Orthofix bone growth stimulator directly from me, I may earn a profit for the device. You may choose not to receive the Orthofix bone growth stimulator directly from me and may instead obtain another device that is the same or similar from another supplier, including Orthofix directly.

I acknowledge and agree that I have reviewed this disclosure in its entirety which has been given to me at the time of initial contact. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) DATE

_____

PRINTED NAME

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

Telemedicine Informed Consent

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Texas Spine Consultants, LLP at 214-370-3535.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date

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THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association

Texas Spine Consultants, LLP

Texas Spine Consultants

TSC Policies & Consent to Treat
(Please initial all sections, sign and date form)

_____FINANCIAL RESPONSIBILITY AGREEMENT:

Initials

I agree to assign insurance benefits to Texas Spine Consultants. We bill all primary insurance companies that we are contracted with as "network" providers as a courtesy to our patients.

I acknowledge full financial responsibility for services rendered by Texas Spine Consultants and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Texas Spine Consultants.

In treating your condition, I may prescribe an Orthofix bone growth stimulator. I am a supplier of Orthofix products. If you choose to obtain the Orthofix bone growth stimulator directly from me, I may earn a profit for the device. You may choose not to receive the Orthofix bone growth stimulator directly from me and may instead obtain another device that is the same or similar from another supplier, including Orthofix directly.

_____CONSENT OF TREATMENT:

Initials

I authorize Texas Spine Consultants Physicians and the Physician's Assistants to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies.

_____PHYSICIAN ASSISTANT CONSENT:

Initials

This facility has on staff Certified Physician Assistants (PA-C) to assist in the delivery of orthopedic medical care. I acknowledge a Physician Assistant is not a physician. A PA-C is licensed by the state medical board and under the supervision of a physician can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does NOT require constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. A list of services may be provided that are within the scope of practice for a PA-C upon request. I hereby acknowledge the above information and consent to the services of a Certified Physician Assistant for my health care needs. I understand that at any given time I can request to see the Physician instead of the PA-C.

_____MEDICATION POLICY CONSENT:

Initials

I authorize Texas Spine Consultants Physicians and the Physician's Assistants to obtain a medication history and/or list of current medications via my pharmacy for medical records.

_____HIPAA POLICY:

Initials

I have read and acknowledge the HIPAA Policy

_____MISSED APPOINTMENTS / UNTIMELY CANCELLATIONS:

Initials

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24 hours' notice to avoid being charge. If you miss your scheduled appointment, you will receive a $25.00 charge at your next scheduled appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

_____RETURNED CHECKS / REJECTED ACH WITHDRAWALS:

Initials

A $30.00 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you. These balances must be paid in full prior to your next appointment.

_____DISABILITY OR INSURANCE FORMS:

Initials

There will be a charge of $10.00 per page for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms.

Signature: _____ Date: _____

Texas Spine Consultants
Prescription Policy

Texas Spine Consultants diagnoses and treats conditions of the spine. We may prescribe medications for you to help relieve the pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of medications. Texas Spine Consultants follows those laws.

Our policy:

1. Written prescriptions will not be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. In other words, do not change the frequency of the dose unless otherwise directed by a Texas Spine Consultants professional. If a change does occur, this will be noted in your chart.
3. Certain controlled substances such as Oxycontin, MS Contin and Percocet are written for a 30 day supply. It is necessary to make monthly follow up appointments in order to receive a refill. *By law, controlled substance medications cannot be refilled over the phone.*
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office, prescriptions cannot be refilled.

    - Sleep aids such as: Ambien
    - Anti-inflammatories such as: Vioxx, Bextra, Celebrex
    - Narcotics such as: Hydrocodone, Percocet
    - Muscle Relaxers such as: Soma, Robaxin, Flexeril

5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will not be authorized at night, on weekends or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to Texas Spine Consultants, please check your supply of medication. If you need a refill, please ask.
8. Refill requests for prescriptions not prescribed by a Texas Spine Consultants physician will not be authorized.
9. If you believe you may be pregnant, discover you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately.
10. Urinary drug screens will occur prior to any narcotic regimen and approximately every three months following.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescription(s) refilled.

Signature_____ Date_____

5/20/2020

Texas Spine
Consultants, LLP

Andrew Park, M.D.
Robert Viere, M.D.
Michael Hennessy, M.D.
Chester Donnally, M.D.
Heidi Lee, M.D.
A.J. Rush, M.D.
Haariss Ilyas, M.D.

Comprehensive Care of Neck and Back Disorders
Phone: 214.370.3535 / Fax: 214.370.0004
www.TSCspine.com

Communication Consent

We respect your privacy and the privacy of your protected health information. Please help us by giving us guidelines as to how you would like to be contacted by our office. You may revoke or change this information at any time by completing a new form. We will ask you annually to update the information by completing a new form.

I authorize your office to contact me in the following manner:

Check all that apply

Home Phone # _____

- ☐ OK to leave message on voice mail or answering machine with **detailed message AND call back number**
- ☐ OK to leave message with **call back number only**
- ☐ OK to leave a message with **family member(s).** Please specify who:

  _____

Cell Phone # _____

- ☐ OK to leave message on voice mail with **detailed message AND call back number**
- ☐ OK to leave message with **call back number only**
- ☐ OK to send a **text message appointment reminder**
- ☐ OK to send a **text message with a call back number only**

Work Phone # _____

- ☐ OK to leave message on voice mail with **detailed message AND call back number**
- ☐ OK to leave message with **call back number only**
- ☐ OK to leave a message with **co-worker(s).** Please specify who:

  _____

I authorize the release of medical information to the following:

Name	Relationship	Phone

Printed Name of Patient _____

Signature of Patient or Parent or Guardian _____

Date Completed _____