Texas Spine Consultants, LLP

Date: _____ Height: _____ Weight: _____

Name: _____
Last First M.I.

DOB: _____ Age: _____

A.J. Rush, M.D.

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

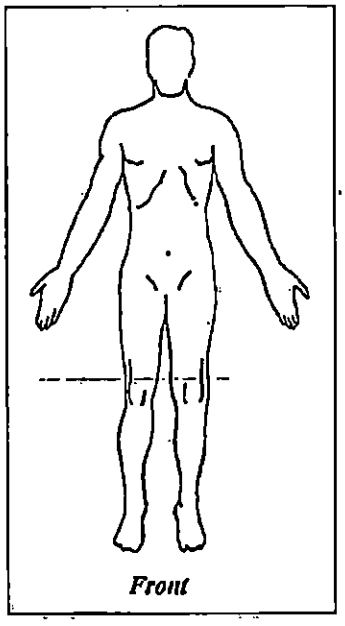
Chief Complaint/Main Problem: _____

When did your current problem start? ____/____/_____(month/day/year)

Have you ever had similar problems before? ☐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: +++		



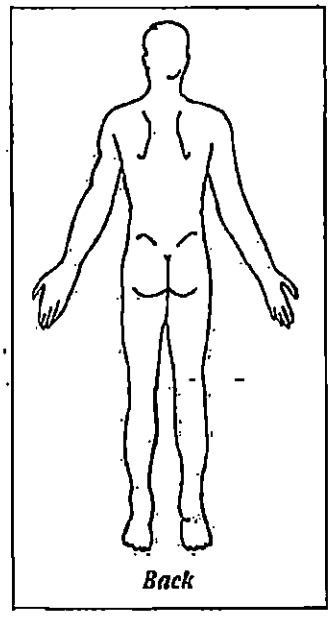
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

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

ARE YOU GETTING:
- ☐ Better
- ☐ Worse

ARE YOU USUALLY IN:
- ☐ Mild discomfort
- ☐ Moderate discomfort

PAIN IS WORSE IN THE:
- ☐ Morning (6am – Noon)
- ☐ Afternoon (1 – 8)

☐ Unchanged ☐ Severe discomfort ☐ Night (8 pm – 6am)

DOES PAIN COME ON:
☐ Suddenly
☐ Gradually

PAIN IS:
☐ Constant
☐ Good & bad days

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 _____		☐	☐	☐

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

Name	Strength	Frequency	Name	Strength	Frequency
1.					
2.					
3.					
4.					
5.					
6.					

Pharmacy Name/Number:_____

RECREATIONAL ACTIVITIES/EXERCISE/HOBBIES:

Running Walking Cycling Golf Yoga Treadmill Elliptical Machine
Weightlifting

Aerobics class
Other_____

Please do not write below this space

Physician has reviewed the form and acknowledges the findings:

_____
Signature - A.J. Rush, MD

PHYSICIAN FINANCIAL DISCLOSURE FORM

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

- Consultant Orthofix/ Sea Spine
- Consultant Augmedics
- Consultant Theragen
- Consultant Axis Spine
- Royalties and Consultant Osseous Fusion Systems
- National Neuromonitoring

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

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.

ACKNOWLEDGEMENT

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)

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: _____

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

The Texas Medical Association acknowledges the Texas Medical Association Special Funds Foundation for its support of this document through funds awarded by The Physicians Foundation.

THE PHYSICIANS FOUNDATION

RELEASED: March 2020, Texas Medical Association

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_____

5/19/2021

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.

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 _____

Authorization for Release of Information Form

Attachment to IP.PRI.010

Section A: This section must be completed for all Authorizations

Patient Name:	**Recipient's Name:** Augustus Rush, JR, MD / TXSpine
Patient's Phone:	**Recipient Address:** 17051 Dallas Pkwy STE. 400
Date of Birth:	**City:** Addison **State:** TX **Zip:** 75001
Last 4 digit SSN (optional)	**Recipient's Phone:** 214-370-3535 x114
Request Dates of Service: All	**Email (for releases to email):** Rgreen@texasspineconsultants.com
Facility Name(s) and Addresses: Texas Back Institute	**Purpose of disclosure:** ☒ At the request of the individual; or ☒ Other 3rd party recipient (please specify purpose): *Continuation of care

Request Delivery (If left blank, a paper copy will be provided): ☒ Paper Copy ☐ Electronic Media, if available ☒ Encrypted Email ☒ Unencrypted Email There is some level of risk that a third-party could see your information without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email. Note: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). Fax: 214-821-5826

This authorization will expire after 180 days or on the following (please choose only one):
Expiration Date: **Expiration Event:** date of signature

Is this request for psychotherapy notes? ☒ No, then you may check as many items below as you need.
☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

Description of information to be used or disclosed:

☐ **All Pertinent Records includes those listed below**

- ☐ Consultation
- ☐ Discharge Summary
- ☐ ER Report
- ☐ EKG Report
- ☐ History and Physical
- ☐ Clinical / Laboratory Report
- ☐ Medication List
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Problem List
- ☐ Radiology Report

Other Records:

- ☐ Discharge Instructions
- ☐ Labor and Delivery Record
- ☐ Specialty Test / Therapy
- ☐ Physician Orders
- ☐ Progress Notes
- ☒ Other whole record

For USCDI Release Requests: to include all elements as defined in the United States Core Data for Interoperability. Requires Direct Address or National Provider Identifier:

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. Specify any information you want to exclude:

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the recipient is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☒ No
If yes, the health plan or health care provider must complete Section B; otherwise, skip to Section C.

Will the Provider receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☒ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☒ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**