ADVANCED SPINE CENTER

2004 VENTURA DR. STE. 200, PLANO, TX 75093
PHONE: 972-499-5457
FAX: 972-499-5342

## NEW PATIENT REGISTRATION FORM

| | | | | |
|---|---|---|---|---|
| Legal Name: | Last First Middle | | | Preferred: |
| Home Address: | Street Apt # City/State/Zip Code | | | |
| Contact Info: | HM #: | Cell#: | | WK#: |
| Email Address: | | Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other: | | |
| Social Security #: | / / | DOB: / / | Age: | DL #: |
| Gender: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow | | Are you being represented by an attorney? ☐ Yes ☐ No If yes, name: | |
| Race/Ethnicity: | ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Pacific Islander ☐ Hispanic ☐ Non-Hispanic ☐ Unknown/Other_____ ☐ Decline to Answer | | | |
| Employer Name: | | Employer Address: | | |
| Employer Phone #: | | Occupation: | | |

How did you hear our ☐ Physician: _____ ☐ Friend _____ ☐ Other: _____
Our practice? ☐ Primary Care Doctor: _____ Doctor Phone #:

**PRIMARY INSURANCE INFORMATION:**

( ☐ FILL IN INSURANCE INFORMATION BELOW OR CHECK BOX IF COPY OF CARD WAS PROVIDED)

Name of Primary Policy Holder: _____ _____
(AS IT APPEARS ON CARD) RELATIONSHIP TO PATIENT

| | | |
|---|---|---|
| DOB: | Insurance Co.: | Insurance Co. Phone #: |
| Policy ID #: | Group #: | SS #: _____/_____/_____ |

**MEDICARE SUPPLEMENTAL INSURANCE INFORMATION:**

Name of Primary Policy Holder: _____ Policy ID/Group #: _____
(AS IT APPEARS ON CARD)

**RESPONSIBLE PARTY INFORMATION:**

Name: _____ Address: _____

| | | | |
|---|---|---|---|
| DOB: | SS #: | Ph #: | Relationship: |

**EMERGENCY CONTACT/LEGAL GUARDIAN:**

Name: _____ Ph #: _____ Relationship: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS. I hereby authorize the above-named agency to release my treatment information requested by attorneys, physicians, insurance companies, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred the treatment of services of Advanced Spine Center, and hereby authorize payment directly to Advanced Spine Center for services rendered. I accept responsibility for payment of any charges not paid for or accepted by my insurance. This authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Legal Guardian Date

ADVANCED SPINE CENTER

Stephen P. Courtney, M.D., P.A
*Board Certified Fellowship Trained Orthopedic Spine Surgeon*

# FORM OF PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST AND OWNERSHIP

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician, Stephen Courtney, M.D., may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

**Avalon Spine, LLC**
**Eminent Spine, LLC**
**PGBH Monitoring, PLLC**
**Eminent Medical Center**
**Spinal Cord Monitoring Concepts, LLC**
**Ternion Management, LLC**

Accordingly, I hereby acknowledge that Stephen Courtney, M.D. has disclosed to me, at the time of initial contact and at the time of referral (I) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred, and (II) that he/she will receive, directly or indirectly, remuneration for the referral to such healthcare provider. Dr. Courtney wants to be fully transparent regarding his financial and ownership interest. I understand that, I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

Patient Name: _____

Patient Signature: _____

Date: _____

ADVANCED SPINE CENTER

# POLICIES & CONSENT TO TREAT

## (PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM)

**_____ FINANCIAL RESPONSIBILITY AGREEMENT:**

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

I acknowledge full financial responsibility for services rendered by Advanced Spine Center, 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 a default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Advanced Spine Center.

Payment is always due at the time of service. We require that patients owing money pay their account balances to zero prior to receiving further services by our practice.

There will be a twenty-five-dollar ($25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.

**_____ CANCELLATIONS/NO SHOW APPT./CHANGE OF SURGERY DATE POLICY:**

Patient may cancel their surgery or injection procedure without penalty with at least **10 days** notice of the surgery date that is initially scheduled by patient. **Should patient cancel surgical procedure within 10 days of the original date the patient shall be subject to a $500 cancellation fee. At least 10 days advance notice required to change injection procedure or you will be charged $75.00. This will not be covered by your insurance company.**

***If an office appointment is not canceled at least 24 hours in advance you will be charged a $50.00 fee for missed office visits.***

**_____ CONSENT OF TREATMENT:**

I authorize Advanced Spine Center 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:**

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 disease 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.

**_____ DISCLOSURE OF FINANCIAL INTEREST:**

The physician at Advanced Spine Center that you are seeing may have a financial interest in the facilities listed on page 2. The facilities and our physician are committed to providing clinical excellence in a safe and attractive environment for you and your family member. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you. Should you have any concerns regarding this notice, please ask your physician or a member of the staff. My initials above verify that I have read and understand the above statement and information.

ADVANCED SPINE CENTER

## POLICIES & CONSENT TO TREAT

**(Please initial all sections, sign & date form)**

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### Effective August 21, 2023, MEDICATION POLICY CONSENT:

Currently, our office receives a large volume of calls daily for medication refill requests outside of an office visit. In an effort to more efficiently, and most importantly, safely manage refill requests, it is necessary for our clinic to implement a new prescription refill policy. We understand that this change will affect you. By keeping you informed of the policy change, we hope to continue working together to ensure safe and high-quality medical care.

↓ **Initial each item in the space provided indicating you have read and attest to it:**

_____ I authorize Advanced Spine Center Physicians and PA-C to obtain a medication history and/or list of current medications via my pharmacy or the prescription monitoring program for medical records.

_____ **WE NO LONGER ACCEPT REFILL REQUESTS BY TELEPHONE, PORTAL, EMAIL OR FAX.**

****Allow 48 hours to process a request for all medications.** If you need a refill on your medications, please call your preferred pharmacy to initiate the request. Narcotic prescriptions are sent electronically and cannot be issued as paper Rx. Refills are approved on a patient-by-patient basis and never refilled over the weekend or after business hours. Do not call the pharmacy to try to get medicine over the weekend. **If pain is too severe to tolerate over the weekend, seek ER treatment.**

_____ **MULTIPLE CALLS ON THE SAME DAY WILL ONLY DELAY YOUR REFILL REQUEST.**

Refill requests **MUST** be called in to the patient's pharmacy. **Refill requests will not be accepted by any other means.** Please call at least two days before your supply of medication runs out.

**"A MISTAKE ON YOUR PART DOES NOT NECESSITATE AN EMERGENCY ON OUR PART"**

_____ We request that you use the same pharmacy for all your prescriptions. Use only one physician to obtain pain medications. **Regardless of whether you are a surgical candidate, Dr. Courtney, will NOT prescribe pain medication or controlled substances long term.** If needed, Dr. Courtney will refer you to a pain management physician. Dr. Courtney specializes in spine surgery, **NOT** pain management.

Place filled pain medication prescriptions in a secure location (ex. locked drawer, cabinet, etc.). A "lost or stolen" narcotic prescription will be noted in your chart and cannot be refilled 7 days before the issued date. Per DEA regulations the theft or loss of an official Schedule II narcotic prescription form must be reported to:

Texas State Board of Pharmacy Prescription Monitoring Program
333 Guadalupe Street
Suite 3-500
Austin, TX 78701
texaspmp@pharmacy.texas.gov

_____ _____ _____

**Patient Printed Name** **Patient Signature** **Date**

ADVANCED SPINE CENTER

# *PATIENT HIPPA & PRIVACY PRACTICES AUTHORIZATION FORM*

## (Required by Health Insurance Portability & Accountability Act)

I hereby authorize Advanced Spine Center to use and/or disclose my protected health information which specifically identifies me, or which can reasonably be used to identify me to carry out my medical treatment, billing, or claims payment and other health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Advanced Spine Center, can refuse to see me. I have been provided with access to either review and/or receive a copy of "Notice of Privacy Practices" for Advanced Spine Center which more fully describes the uses and disclosures, and I consent at any time by noticing Advanced Spine Center in writing. I understand Advanced Spine Center has the right to change its privacy policies and that I can receive such changed notices upon request. I understand that I have the right to request that Advanced Spine Center restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other healthcare options. I understand that Advanced Spine Center does not have to agree to such restrictions, but once such restrictions are agreed to, Advanced Spine Center must adhere to such restrictions.

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION:**

I give Advanced Spine Center authorization for the release of "Medical Records/Privacy Information," which includes your PHI, any medical conditions, billing and/or financial information to the following:

Name: _____ Relationship to Patient: _____

**EFFECTIVE TIME PERIOD/RIGHT TO REVOKE:**
This authorization shall be in force and valid for one year from the signature date or written permission is accepted for withdrawal.

**SIGNATURE AUTHORIZATION:**

I have read this form and agree to the uses and disclosure of the information described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State privacy laws.

**SIGNATURE:** _____ **DATE:** _____

*SIGNATURE OF INDIVIDUAL/LEGAL AUTHORIZED REPRESENTATIVE*

ADVANCED SPINE CENTER

# *UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM*

(All boxes must be completed before seeing a physician)

**Patient Name:** _____ **Today's Date:** _____

Please complete the following statements. Most insurance companies request accident details. This information may be forwarded with your insurance claim or provided to an adjuster to complete your claim.
We **MUST** have a **Box 1: Condition or Date of Injury** completed to file your claim.

1. Please check: ☐ Condition ☐ Injury Injury Date: ____/____/____ (on or about)
2. Give a brief summary. How did the injury occur, what were you doing?

_____

_____

_____

3. Did the injury occur during work? ☐ Yes ☐ No
4. Were you clocked in? ☐ Yes ☐ No
5. Were you at lunch? ☐ Yes ☐ No

**THIRD PARTY LIABILITY**

1. Is there a possible third-party liability? ☐ Yes ☐ No
   **If yes**, a letter of subrogation should be provided before seeing the physician. Your health insurance will deny the claim if the letter is not obtained.

I certify this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury, condition and/or the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request additional information, and that failure to provide requested information may categorize my treatment as a **non-covered** service and may make me personally liable for the charges incurred.

SIGNATURE: _____ DATE: _____

*Signature of Individual/Legal Authorized Representative*

ADVANCED SPINE CENTER

# *IMAGING CONSENT FORM*

The doctor has explained that the purpose of the x-rays about to be taken are to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic unusual finding when reviewing the x-ray, I will be informed. I understand that I must then decide to seek additional advice, diagnosis or treatment for the unusual finding from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

**MINOR PATIENTS ONLY → CONSENT TO EVALUATE A MINOR CHILD**

☐ By my signature below, I, the Parent/Legal Guardian of the minor patina, hereby grant permission for my child to receive chiropractic examinations and x-rays.

**FEMALE PATIENTS ONLY → PREGNANCY RELEASE**

Please read carefully and check boxes, include the date and sign below. Please see our office manager for further explanation or to discuss any questions.

☐ The date of my last menstrual cycle was on _____/_____/_____ date.
☐ I have been provided a full explanation of when I am most likely to become pregnant.
☐ To the best of my knowledge I am not pregnant.
☐ By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child. I have conveyed my understanding of the risks associated with exposure to x-rays.

**ALL PATIENTS**

After careful consideration I hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

**MRI/CT IMAGING**

The Physician or Physician's Assistant will not give imaging results over the phone. Please call and schedule your follow-up appointment once you have been contacted by the imaging facility. The imaging facility will call you once insurance has approved your study**. PLEASE BRING YOUR IMAGING DISC AT THE TIME OF YOUR APPOINTMENT.** Failing to do so can result in being rescheduled without you seeing the physician or the physician's assistant.

**PRINT PATIENT NAME:** _____ **DATE:** _____

**PATIENT SIGNATURE:** _____ **DATE:** _____