Name: _____

Institute of Spinal Disorders

Dear Patient,

Failure to produce the required paperwork and Films from any prior testing WILL result in the rescheduling of your appointment.

In regards to your upcoming appointment with Dr. Myles. you will need the following:

You will need to bring ALL Films for ANY prior X-rays, MRI's, CT Scans, Discograms or Myelograms, along with all reports associated with these tests. These may come in the form of actual films or they may be in the form of a disc. Also, any testing or procedure reports for EMG/NCV's, ESI (Epidural Steroid Injections), or Rhizotomy, for the body part we will be seeing you for. Please bring along with the completed new patient paperwork, your driver's license or photo ID and insurance cards.

Even if the referring doctor's office is to send these films and tests, we ask that you request your own copy to bring to the appointment to avoid rescheduling your appointment.

Please arrive 30 minutes before your scheduled appointment time if your paperwork is not complete to allow time to complete paperwork. If paperwork is complete then please arrive 15 minutes early.

Our **Hurst** office is located at 729 W. Bedford-Euless Rd. Ste 206. Hurst. TX 76053. Please call for directions

Our **Decatur** office is located at 1101 Eagle Dr.. Suite B Decatur. TX 76234. Please call for directions.

You can reach us by calling 817-288-0084; our fax is 817-445-1039. If you need to cancel your appointment please give us 24 hour notice or you could be charged $50.

Failure to produce the required paperwork and Films from any prior testing WILL result in the rescheduling of your appointment.

Thank you!
INSTITUTE OF SPINAL DISORDERS

Appointment Date:_____ Time:_____

Name: _____

Institute of Spinal Disorders

Please use BLUE or BLACK ink only to complete this form. Please print.

Patient Information

Date:_____/_____/_____

Last Name:_____First Name:_____Middle:_____
Address:_____City/State/Zip:_____
DOB: _____ Age:_____ Sex:_____Male_____Female (*Check One*)

SSN_____ Marital Status:_____Married_____Single ____ Divorced_____Widowed

Race:_____Ethnicity: Hispanic Non-Hispanic Language:_____
EMAIL ADDRESS:_____
Home Phone: (_____)_____ Cell Phone: (_____) _____
Employer:_____Phone Number (_____)_____
Address:_____City/State/Zip_____
Employment Status: Full Time Self Employed Retired Unemployed Full Time Student *(Circle One)* Emergency Contact Name:_____Phone #:_____
(Person outside your household)
If patient is a Minor:
Guardian's Name: _____ DOB: _____ SSN _____

Who may we thank for referring you to our office?_____
Who is your Primary Care Physician?_____Phone:_____

What is the name of your pharmacy?_____
What city?_____Phone number:_____

Primary Insurance

Primary Insurance: _____
Address:_____City/State/Zip: _____
Insured's Name: _____ DOB:_____SSN_____
(Required)

Insured's ID #:_____Group#:_____Relation: _____

Additional Insurance

Secondary Insurance: _____
Address:_____City/State/Zip: _____
Insured's Name:_____DOB:_____SSN_____
(Required)
Insured's ID #:_____ Group#:_____ Relation:_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed Insurance Company(ies) and assign directly to THE INSTITUTE OF SPINAL DISORDERS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
By my signature I consent to medical treatment by THE INSTITUTE OF SPINAL DISORDERS.

Responsible Party Signature_____Relationship_____Date _____

Name: _____

FINANCIAL POLICY

We are dedicated to providing you with quality medical care. In order to achieve this goal we require you have a complete understanding of not only our need for a complete medical history but also the financial policies of this office.

1. We will file Medicare and most secondary insurances. However, you must present us with complete and accurate information.
2. We will verify your insurance coverage prior to your visit and file your HMO or PPO. You will be responsible for making your co-payments, deductibles and co-insurance at the time of your visit.
3. For our surgical patient, you will be contacted by this office prior to your surgery and advised of any amount you will owe. Payment is expected prior to your surgery date.
4. If for any reason your insurance claims are pended for information that must be received from you and you have not responded to your carrier within their allotted time frame you will be responsible for the balance in full. Examples of these situations are claims pended for accident details, co-ordination of benefit or a child's student status.
5. We will be happy to complete Disability forms or FMLA paper work. This process usually takes from two to three weeks. The cost is $25 per form. Completed paperwork must be picked up from our office, at which time the $25.00 fee will be collected. We will not fax these forms, they must be picked up.

We appreciate your cooperation. If you should have questions, please feel free to discuss them with the staff.

Robert Myles, M.D.
Anil Kesani, M.D.

I have read and received a copy of the above financial policy of Institute of Spinal Disorders.

_____ _____

Responsible Party Signature Date

Name: _____

NOTICE OF PRIVACY POLICIES AND PRACTIES

Dear Patient,

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At the Institute of Spinal Disorders, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information, it also describes your rights as they relate to your protected health information. This Notice is effective April 14,2013 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit the Institute of Spinal Disorders, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

Name: _____

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

THE INSTITUTE OF SPINAL DISORDERS is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION :

We will use your health information for treatment Your health information may be used by staff members of disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, *an&* providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted

We will use your information for payment Your health plan may request and receive information on dates of service, the services provided and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of THE INSTITUTE OF SPINAL DISORDERS. For example: information on *the* services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information In order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any person that is involved in your care or that

Name: _____

you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training. We may use your information for the purpose of research, teaching and training.

Healthcare Oversight Federal law requires us to release your information to an appropriate health agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections, facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminder. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or a brief non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods please inform the practice.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed about requires your specific written authorization. If you change your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of THE INSTITUTE OF SPINAL DISORDERS please contact:

Jennifer Sipe
INSTITUTE OF SPINAL DISORDERS
729 W. Bedford-Euless Rd.
Suite #206
Hurst, Tx. 76053
Phone: 817-288-0084
Fax: 817-445-1039

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below.

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Service
200 Independence Avenue, S.W., Room 509F, HHH Building
Washington, D.C. 20201

Name: _____

Institute of Spinal Disorders

PRIVACY INFORMATION

Patient Name:_____

1. Please list **the** names of family **members or** other persons, if any, who we may inform about your general medical condition and your diagnosis:_____
   _____

2. Please list the names and phone numbers of family members or significant others, if any, whom we may inform about your **medical condition ONLY** IN AN EMERGENCY:_____
   _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.
   _____
   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":
   YES **NO**

5. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number :*( )*_____

6. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?
   YES **NO**

7. If you do not have voicemail, can a confidential message be left at your place of employment?
   YES **NO**

Patient/Guardian signature_____ Date:_____

By my signature below, I acknowledge that I have received the **NOTICE** OF PRIVACY POLICIES AND PRACTICES for Institute of Spinal Disorders.

Patient/Guardian signature:_____ Date:_____

Name: _____

729 w. Bedford-Euless Rd. Suite 206
Hurst, Texas 76053
Phone: 817-288-0084
Fax: 817-445-1039

New Medication / Refill Medication Protocol

Dr. Robert T. Myles M.D.
Dr. Anil Kesani, M.D.

New:

If medications are needed, they will be given at the time of a new visit appointment. Please be sure to ask the physician if any prior medication should be continued or discontinued.

Refills:

Medication refills will be called in or faxed to your pharmacy within 72 hours of your request.
No medication will be filled after clinic hours or during weekends. Please have your pharmacy fax all/any refills to the office prior to 3pm. Please do not continue to phone prior to 3pm for it will only delay your medication request.

Disclosure:

If discovered you are obtaining medication from more than one physician and/or pharmacy or you are abusing narcotic medication, you will be immediately dismissed from the practice at the physician's discretion. Should the physician choose to continue to see you as a patient, he may continue to treat your illness, though he will no longer prescribe narcotic medication. Lost or misplaced medications will not be replaced prior to their respective refill date unless a letter is supplied from the Police Department or Fire Department.

Patient Name:_____Date:_____

Patient Signature:_____

Name: _____

Institute of Spinal Disorders

Robert Myles, M.D. Anil Kesani, M.D.

HISTORY FORM FOR:
CERVICAL, THORACIC OR LUMBOSACRAL SPINE

Today's Date: _____

Name: _____ **Age:** _____ **Sex:** _____

Referred by Doctor/Other: _____ **PCP**
(Primary Care Physician)

Date of Injury or Onset of Problem:____**Auto Accident:**___**Yes**_____**No On the Job**

Injury:_____**Yes**_____**No**

If you answered "yes" answer occupational requirements

OCCUPATIONAL REQUIREMENTS

Lifting	Heavy	Moderate	Light
Standing	>8 hours	8 – 6 hours	6 – 2 hours
Sitting	>8 hours	8 – 6 hours	6 – 2 hours
Walking	>8 hours	8 - 6 hours	6 – 2 hours

CHIEF COMPLAINT: (Circle all that apply)

Neck pain only	R	L	Both
Neck and shoulder pain	R	L	Both
Neck and arm pain	R	L	Both
Arm pain only	R	L	Both
Thoracic pain only	R	L	Both
Thoracic and rib/abdominal pain	R	L	Both
Low back pain only	R	L	Both
Low back and leg pain	R	L	Both
Leg pain only	R	L	Both

Name: _____

MECHANISM OF INJURY (How did you hurt yourself?)

Fall MVA Altercation
Lifting Twisting Bending Other (Explain) _____

CHARACTER OF PAIN (What does your pain feel like…)

Sharp Burning Stabbing Dull ache Shooting Knife-like

WHEN DOES THE PAIN OCCUR?

Constant With Activity Daily Weekly Monthly Occasionally
Does the pain radiate into your arm or leg when you cough, sneeze or strain from bowel movement?_____Yes_____No
Does the pain awaken you from sleep?_____Yes_____No

0=NO PAIN 10=MOST SEVERE PAIN

Rate your pain from 0-10 with activity
Rate your pain from 0-10 without activity:
What hurts worse, your neck or arm/shoulder?
What hurts worse, your back or buttocks/leg?
How would you rate your pain %_____%Neck_____%Arms_____%Back ____%Legs

WHAT MAKES YOUR PAIN WORSE?

Walking	Sitting	Typing	Standing	
Lifting	Writing	Reaching	Riding in car	Twisting

If you answered that standing or walking increases your pain, does that pain radiate to your legs?_____Yes_____No
If yes, how do you make the pain go away?_____Sit_____Stand_____Lie down

HAVE YOU EVER HAD PHYSICAL THERAPY?_____Yes_____No
If yes, how many sessions or weeks? _____
Are you currently in physical therapy? _____
When was your last session? _____

WHAT TREATMENTS DID YOU HAVE IN PHYSICAL THERAPY?
Please circle all that apply:

Heat/cold pack Massage Ultrasound Back exercises Neck exercises
Chiropractic manipulations or adjustments? Pool Therapy?

Did therapy help your pain?

None Mild Moderate Complete relief from pain

Name: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS DONE? (Cervical, Thoracic, Lumbar)

If so, please write the dates these were done in the space provided.

Test	**Date**
MRI – with or without contrast C T L	
CT Scan	
Myelogram	
Discogram	
Facet joint injections C T L	
EMG - Electromyelography / NCS Nerve Conduction Studies	
Other	

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS?
DID TREATMENTS GIVE YOU RELIEF AND FOR HOW LONG?

Anti-inflammatories	How long?	Relief?
Trigger point injections	How many ?	Relief?
Facet point injections	How many ?	Relief?
ESI's	How many ?	Relief?
Rhizotomy	How many?	Relief?
Oral steroids	How many?	Relief?

PAST MEDICAL HISTORY

Are you allergic to any drugs? Please list:

List all the medications and dosages you are currently taking:

Name: _____

PAST MEDICAL ILLNESSES: (Please circle if you have ever had any of the following conditions?)

Diabetes	Y	N	AIDS/HIV	Y	N
High blood pressure	Y	N	Stroke	Y	N
Angina	Y	N	Tuberculosis	Y	N
Heart attack	Y	N	Fibromyalgia	Y	N
Kidney disease	Y	N	Glaucoma	Y	N
Stomach ulcers	Y	N	Anemia	Y	N
Osteoarthritis	Y	N	Bleeding problems	Y	N
Osteoporosis	Y	N	Rheumatoid arthritis	Y	N
Blood clots in legs	Y	N	Chest Pain	Y	N
Cancer	Y	N	Emphysema	Y	N
Hepatitis	Y	N	Migraine headaches	Y	N
Asthma	Y	N	Lupus	Y	N
Epilepsy	Y	N	Ulcerative colitis	Y	N
Thyroid Disease	Y	N	Crohn's disease	Y	N
Jaundice	Y	N	Other (please list)		

PREVIOUS SURGERIES: Have you ever had any of the following surgeries?
Please list the dates of the surgeries and indicate if it occurred on the right or left side.
C=Cervical, T=Thoracic, L=Lumbar

Laminectomy/discectomy C T L	Y	N	Hip replacement	Y	N
Lumbar spinal fusion	Y	N	Carpal tunnel release	Y	N
Cervical spinal fusion	Y	N	Foot surgery	Y	N
Thoracic fusion	Y	N	Fracture repair	Y	N
Abdominal surgery	Y	N	Hysterectomy	Y	N
Cardiac stent placement	Y	N	Shoulder	Y	N
Heart surgery	Y	N	Hernia repair	Y	N
Gall bladder	Y	N	Cubital tunnel release	Y	N
C – section	Y	N	Total knee replacement	Y	N
Hip surgery	Y	N	Knee surgery	Y	N
Appendectomy	Y	N	Other	Y	N

Name: _____

FAMILY HISTORY

	Mother	**Father**	**Siblings**
Age			
Alive			
Deceased			
Back problems			
Diabetes			
Heart Disease			
Thyroid			
CVA			
High Blood Pressure			
Lung Disease			
Cirrhosis			
Cancer			
Other			

SOCIAL HISTORY:

Do you smoke?	Y	N	Number of packs per day , years__		
Do you chew tobacco?	Y	N	Now much per day , years___		
Do you drink alcohol?	Y	N	How much per week?		
Do you use illegal drugs?	Y	N	Explain:		
Married	Y	N	Single	Y	N
Live alone	Y	N	Live with family or significant other	Y	N
Occupation					

PSYCHOLOGICAL MEDICAL HISTORY:

Depression	Y	N	Anxiety	Y	N
Bi-Polar	Y	N	Attention Deficit Disorder	Y	N
Obsessive compulsive disorder	Y	N			

REVIEW OF SYSTEMS: Have you had any of the following lately? Circle all that applies:

Fever	Y	N	Chills	Y	N
Night sweats	Y	N	Loss of weight	Y	N
Loss of appetite	Y	N	Other:	Y	N
Sudden loss of bladder/bowel control	Y	N	Do you wear glasses or contacts	Y	N
Do you wear dentures/partials	Y	N	Other:		

FEMALE (please answer the following)

Last pap/pelvic exam:	Last mammogram
Last menstrual period:	Are you pregnant:
How many pregnancies:	How many births:

Height:_____ **Weight:** _____

Form updated 10/6/16