2813 W. Southlake Blvd, Suite 100, Southlake, TX 76092
Phone: 817-310-8783
Fax: 817-431-0735 / 888-502-5396

Kevin James, M.D.
Aaron Eubanks, M.D.
Sheryl Reif, PA-C

NEW PATIENT PACKET and Office Policies

Appointment Date: _____________ Time: _________ Clinic: __________________________________

Thank you for choosing Advanced Spine & Orthopedics as your health care provider. For your first visit with Dr. James you will want to have the following items available for his office staff:

1. Any diagnostic studies, x-rays, CT or MRI scans that may have been obtained by your referring physician. Please be sure to bring the actual films/CDs and written reports for the doctor's review. **If you do not have these images, please make our staff aware of this. Your appointment will need to be rescheduled.**
2. A complete list of all medications you are currently taking. Please include any over-the-counter medications, vitamins, supplements or herbal remedies you take on a regular basis. If you see a Pain Management doctor, please provide us with their name and telephone number.
3. Any information needed to complete a medical history. Please include any illnesses, injuries, and previous surgeries.
4. **New Patient Paperwork is to be completed prior to your appointment time. Please arrive 30 minutes prior to your scheduled appointment to complete our new patient check-in process.**
5. A valid photo ID and current Insurance card.

Our normal office hours are Monday through Friday 8:00 am to 5:00 pm. If it is necessary to contact our office after normal office hours, regarding a non-urgent matter, you may leave a message with our answering service and a staff member will return your call during normal office hours.

If you have an emergency after normal office hours, you will be directed to go to the nearest hospital emergency room where you will be evaluated by the emergency room physician. They will be in direct contact with our doctor or the on-call doctor from our office.

We will assist you in filing your insurance claims for each visit. We accept most Insurance Plans. Please check your Insurance to verify our participation in your plan prior to coming to your first office visit. You are responsible for paying any claims that are not covered by Insurance. **If your Insurance Plan requires a physician referral authorization, it is your responsibility to obtain the referral and either bring it with you or have it faxed to our office.** You are required to pay your co-payment; co-Insurance and any outstanding patient balance at the time of each office visit.

Medical Records can be obtained through a written request to our office. Your request is then sent to Photostat for processing. If you have a need for a Disability Form to be completed, there is a $25.00 form fee to be paid at the time of request. Turnaround time for a Disability Form is seven (7) business days.

Our office requires a 24-hour notice when canceling an appointment. Please be advised there may be a $40.00 charge for repeated no-show or canceled appointments.

Our Practice Administrator is Pete Rose. Please feel free to contact him directly with any questions or concerns you may have.

Printed Name: _________________________________ Signature: ___________________________

Date: __________

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PATIENT INFORMATION:

Patient Name: ____________________________ Age: ______ Date of Birth: ____/____/____ Sex: ____

Address: ___________________________________ City: __________________ State: ____ Zip: ______

SS#: ____-____-_____ Driver's License #: __________ Single: __ Married: __ Divorced: __ Widowed: ___

Home Phone: _____________________ Cell: ________________________ Work: __________________

Email Address: ____

Emergency Contact: ___________________________________ Phone: ___________________________

REFERRAL INFORMATION:

Date of Injury: _____________________ Reason for Visit: _______________________________________

Did a Doctor refer you? ☐ YES ☐ NO Referring Doctor Name: __________________________

Primary Care Physician: ____________________ Phone: ___________________ City: _______________

PRIVATE PAY: ☐ YES ☐ NO Responsible Party fill out following information:

Parent/Guardian: ____________________________ Date of Birth: ____________ SS#: ____-____-_____

INSURED INFORMATION (Group Insurance):

Insurance Company: _________________________ Address: ___________________________________

City: _____________________ State: ____ Zip: ___________ Phone: _____________________________

Policy#: ____________________________ Member ID: ________________________ Co-Pay: ________

PRIMARY CARD HOLDER'S INFORMATION:

Name on Card: __________________________ Spouse/Parent/Self (Circle One) SS#: _____-____-_____

Date of Birth: ____ Age: _____________

Employer: _______________________________ Address: _____________________________________

City: _______________________ State: _____ Zip: __________ Work #: __________________________

MEDICARE/MEDICAID: Medicare #: ______________________ Medicaid #: _______________________

MEDICARE SUPPLEMENT INSURANCE:

Insurance Name: ____________________________________ Phone: ____________________________

Address: ________________________ City: ______________ State: ____ Work #: __________________

WORKER'S COMPENSATION:

It is important that you make our office aware if this is a work comp injury prior to your visit. Please have all relevant information available in order to quickly complete your check-in process.

EMPLOYER PAY: If your employer is paying for your visit instead of filing worker's comp, we must have payment up front or a signed contract in hand before your visit. We must be notified of any responsibility changes the employer makes within 80 days of first date of service.

By signing this you are acknowledging that all the above information is accurate and correct to the best of your knowledge.

PATIENT OR GUARDIAN SIGNATURE: _______________________________________ **DATE**: ____________________

ADVANCED SPINE & ORTHOPEDICS
PHYSICIAN OWNERSHIP DISCLOSURE STATEMENT

The Centers for Medicare and Medicaid Services (CMS) requires any physician-owned hospital to provide written notice disclosing the following information to you, the patient.

Baylor Medical Center at Trophy Club is a physician owned partnership with Baylor Healthcare System and United Surgical Partners, Inc. The physician, Dr. Kevin James, is a partner in this facility.

If you have any questions, comments or concerns, feel free to contact us Toll Free at 855-265-9500

ADVANCED SPINE & ORTHOPEDICS
CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

PATIENT NAME: ____ DATE OF BIRTH: _________________

I authorize the doctor, **Dr. Kevin James**, to examine me (or the patient I am legally responsible for) and to do any x-rays or other diagnostic tests that may be needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Dr. Kevin James to release to any Insurance company, health plan, or governmental agency such medical information that may be required to process my claim for payment of this medical bill.

I also authorize Dr. Kevin James to release appropriate medical information to any doctor, hospital, or other health care facility that has or will participate in my (the patient's) care. I authorize a photocopy, facsimile, or other electronic transmission of the above Assignments, Authorizations, and Releases, to be used in place of the original until/unless I send written notice to the contrary to the offices of Dr. Kevin James. I further authorize any other doctor, hospital, or health care facility to release to Dr. Kevin James' office any medical information concerning my (the patient's) illness or injury.

FINANCIAL AGREEMENT

I agree to pay all professional fees charged by Dr. Kevin James for my (the patient's) care, irrespective of any insurance benefits to which I may be entitled, except if Dr. Kevin James has agreed to accept insurance benefits as full payment for covered services in accordance with federal or state law (e.g. Medicare, Medicaid) or by contract with a prepaid health plan or managed-care plan, and provided such Insurance benefits are paid within 60 days of claims submission, and provided there is no recovery from a third-party negligence lawsuit (see Injuries and Third-Party Negligence, below). Ultimately, it is your responsibility to understand the coverage that you pay for in a monthly premium to your carrier. If an employer or its carrier denies a claim for payment for a work-related injury, or if a prepaid health plan, managed-care health plan, or Medicare, considers certain services ineligible or uncovered services, then you (patient) agree to pay for those services. It is understood that claims for services remaining unpaid 60 days after claims submission shall be presumed ineligible for insurance reimbursement, and you (patient) shall pay for those services. If patient is a minor – the parent/guardian who requests treatment for a child will be responsible for all fees.

INJURIES AND THRID-PARTY NEGLIGENCE

I understand and agree that if Dr. Kevin James has granted discounts from its usual fees for any reason, including its participation in prepaid or managed-care health plans, and if I (the patient) recover(s) any monies as the result of any judgment, award, or settlement of any lawsuit arising from treated injuries or illness, then I shall give a lien to Dr. Kevin James against such monetary recovery in the full amount of such discounts.

DELINQUENCY

If my (the patient's) account becomes delinquent, I understand that Dr. Kevin James, at its sole discretion, may refer to a collection agency or an attorney as allowed by law.

INSURANCE ASSIGNMENT

I authorize my insurance company or third-party payer to whom a claim for payment has been submitted to pay any eligible benefits directly to Dr. Kevin James. I hereby authorize payment to go directly to Advanced Spine & Orthopedics for medical benefits payable by insurance company _______________________________ (and/or Medicare) and understand that I am responsible for any charge not covered by the terms of my insurance policy. I hereby assign Dr. Kevin James full rights to represent my (the patient's) interests in any complaints of appeals for denial of benefits or reimbursement to the Texas Department of Insurance (State Insurance Commissioner). I hereby authorize said assignee Dr. Kevin James to furnish these agencies such information as may be necessary to support such complaints or appeals.

I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid. **I have read, understand, and do hereby agree to the terms of the forgoing Assignments, Authorizations, and Releases. I also certify that the PATIENT INFORMATION I have provided is true and accurate to the best of my knowledge.**

____ ____

PATIENT, PARENT, OR LEGAL GUARDIAN **DATE**

Kevin B James MD
Aaron Eubanks, M.D.
Sheryl Reif PA-C
Phone: 817-310-8783 Fax: 855-640-3872

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allow for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes No

If YES, please name the members allowed:
____

This consent was signed by: ______________________________
(Print Name Please)

Signature: ____ Date: ____________

Witness: ____ Date: ____________

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Kevin B James MD
Aaron Eubanks, M.D.
Sheryl Reif PA-C
Phone: 817-310-8783/855-265-9500

PRESCRIPTION REFILLS AND PHONE MESSAGES

PATIENT INSURANCE POLICY:

- It is your responsibility to know your insurance and bring your card with you to all appointments
- Is DR. KEVIN JAMES a CONTRACTED PROVIDER of your insurance?
- Do you need PRIOR AUTHORIZATION for procedures?
- Are X-Rays and Supplies included in your COPAY?
- How much is your COPAY for a Specialist?
- Do you have a YEARLY DEDUCTIBLE? If so, has it been met?

PLEASE HELP US HELP YOU. There are hundreds of insurance companies thereby making it almost impossible for our staff to know the specific requirements for each policy. Please call your insurance company prior to your appointment to obtain this needed information.

PROTOCOL FOR PRESCRIPTION REFILLS:

- Please allow 48-72 hours on refill requests.
- Notify your Pharmacy directly on refills

In order to be as efficient as possible these are the policies in effect regarding all prescriptions.

HIPAA EXCEPTIONS (Please check all that apply):

☐ OK to have a message left on my answering machine

☐ OK to leave a message with spouse; name of spouse: ___________________________________

☐ OK to leave a message with any adult who answers my phone

☐ OK to leave a message regarding appointments ONLY

I have read and understand the above information regarding MY INSURANCE POLICY, PRESCRIPTION REFILLS, and the HIPAA EXCEPTIONS AUTHORIZATION for leaving messages.

PATIENT or GUARDIAN SIGNATURE: ____________________________________ **DATE:** _______________________

ADVANCED SPINE & ORTHOPEDICS
MEDICAL RELEASE FORM

I hereby authorize ____ to release to **Advanced Spine & Orthopedics, Kevin B. James, MD,** located at 2813 W. Southlake Blvd., Suite 100, Southlake, TX 76092,
Phone 817-310-8783 Fax 817-431-0735
Information contained in the Medical Records of:

Name of Patient: ____

Date of Birth: ____

Social Security #: ____

<u>Specific Information to be Disclosed:</u>

☐ History ☐ Physical ☐ Therapy Reports

☐ Operative Report ☐ X-Rays ☐ Care Plan

☐ Lab Report ☐ ERG ☐ Office Notes

☐ Immunizations ☐ Psychological Reports

☐ Other: (specify) ____

I give permission for release of any information in my records, including information relevant to substance abuse, psychiatric mental health services or HIV (positive or negative) unless specifically excluded below.

Do Not Release Information Related To:

☐ HIV ☐ Substance Abuse ☐ Psychiatric/Mental Health

☐ Other (specify) ____

THE ABOVE INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE AND THAT PURPOSE ONLY. PURPOSE OF RELEASE:

☐ Medical ☐ Attorney ☐ Insurance ☐ Other

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it; and that in any event, this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event, or condition as follows. I agree that a photocopy of this authorization may be considered valid:

☐ YES ☐ NO

THIS INFORMATION IS PRIVILEGED AND CONFIDENTIAL. IT IS INTENDED FOR THE INDIVIDIUAL ENTITY DESIGNATED. YOU ARE HEREBY NOTIFIED THAT DISSEMINATION DISTRIBUTION, COPY OR OTHER USE OF THIS INFORMATION BY ANYONE OTHER THAN THE RECIPIENT DESIGNATED ABOVE IS AUTHORIZED AND STRICTLY PROHIBITED.

PATIENT or LEGAL REPRESENTATIVE SIGNATURE: ______________________________ **DATE:** _______________

Spine & Orthopedics

Kevin B. James, MD
Phone: 817-310-8783   Fax: 817-431-0735

Narcotic Agreement

Patient Name: ____ **Date:** ________________________

I, ____, understand that after acute operative pain has dissipated 4 to 6 weeks post operatively, Dr. Kevin James will no longer supply narcotics to me.

____   Signed this ______ day of _________________, ____

Patient Signature

I, ___________________________________, understand that if I have not had any form of surgery **by Dr. Kevin James,** I will be referred back to the Treating Physician or Pain Management Doctor for medication control. I further understand that Dr. James will not provide me any type of medication.

____   Signed this ______ day of ________________, _____

Patient Signature

____   Signed this ______ day of _______________, _____

Witness/Nursing Staff Signature

ADVANCED SPINE & ORTHOPEDICS

2813 W. Southlake Blvd, Suite 100, Southlake, TX 76092

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Spine Patient Medical History

PATIENT NAME: ____

Primary Care Doctor: ______________________ **Referred By:** _________________________

Pharmacy: _________________________ **HT:** ________ **WT:** ____________

Chief Complaint (Check all that apply):

☐ Back Pain ☐ Neck Pain

☐ Leg Pain ☐ Arm Pain

History of Illness:

Age: ____________________ Gender: ☐ M ☐ F

Injury: ☐ Y ☐ N Date of Injury: _______________ Work Related Injury? ☐ Y ☐ N

How long have you had this problem/pain: ____

Has it gotten worse recently: ☐ Y ☐ N If yes, when did it get worse? ___________________________

Please rate the severity of your pain (10 is the greatest pain):

Back N/A 1 2 3 4 5 6 7 8 9 10

Neck N/A 1 2 3 4 5 6 7 8 9 10

Leg(s) N/A 1 2 3 4 5 6 7 8 9 10 Which leg is worse? ☐ R ☐ L

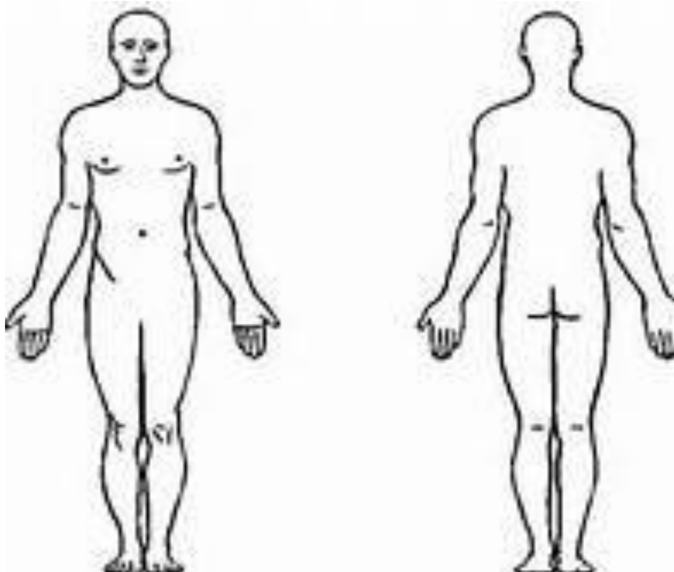
Arm(s) N/A 1 2 3 4 5 6 7 8 9 10 Which arm is worse? ☐ R ☐ L

Bowel Problems ☐ Y ☐ N How long: ___________________________

Bladder Problems: ☐ Y ☐ N How long: ___________________________

Please indicate the distribution of your pain/symptoms on the diagram below:

XXXXXX Pain **000000 Numbness, Tingling, Pins, Needles**



Limitations from the Pain:

Sitting: ☐ Unlimited ☐ Limited to ________________________ ☐ Min ☐ Hrs

Walking: ☐ Unlimited ☐ Limited to ________________________ Feet

Standing: ☐ Unlimited ☐ Limited to ________________________ ☐ Min ☐ Hrs

Does the pain interfere with sleeping? ☐ Y ☐ N

Does the pain interfere with work or play? ☐ Y ☐ N

What makes the pain worse (check all that apply):

☐ Sitting ☐ Standing ☐ Coughing ☐ Leaning backward

☐ Other: ____

What makes the pain better (check all that apply):

☐ Sitting ☐ Standing ☐ Leaning forward

☐ Other: ____

Which of these tests have you had before and when?

MRI ☐ Y ☐ N Date: ______________________

CT Myelogram ☐ Y ☐ N Date: ______________________

EMG/NCS ☐ Y ☐ N Date: ______________________

Discogram ☐ Y ☐ N Date: ______________________

What have you tried for the pain so far?

Physical Therapy: ☐ Y ☐ N

How long ago: ____

Are you satisfied with the effort given: ☐ Y ☐ N

Did therapy help: ☐ Y ☐ N

NSAIDs (Ibuprofen, Naprosyn, Mobic, Celebrex, Relafen, etc.) ☐ Y ☐ N

Did the medicine help: ☐ Y ☐ N

Oral Steroids (Medrol Dose Pack, Prednisone, Methylprednisilone) ☐ Y ☐ N

Did the medicine help: ☐ Y ☐ N

Pain Meds (Vicodin, Norco, Lortab, Darvocet, Oxycontin, Percocet, Morphine) ☐ Y ☐ N

How much: ____

For how long: ____

Injections (Epidural Injections, ESIs, Facet Injections, Nerve Root Blocks) ☐ Y ☐ N

Did injections help: ☐ Y ☐ N

How much: ____________________________________

For how long: __________________________________

Last injection: __________________________________

Back/Neck Surgery (Include dates):

____

____

____

Did surgery help: ☐ Y ☐ N

How much: ____ For how long: ________________________________

Patient Medical History:

Please report if you have had or are currently experiencing any of the following:

Condition	Y	N	Specify
Heart Disease	☐ Y	☐ N	Specify: ______________________
Lung Disease	☐ Y	☐ N	Specify: ______________________
Kidney Disease	☐ Y	☐ N	Specify: ______________________
Neurologic Disease	☐ Y	☐ N	Specify: ______________________
Cancer	☐ Y	☐ N	Specify: ______________________
Liver Disease/Hepatitis	☐ Y	☐ N	Specify: ______________________
Prostrate Disease	☐ Y	☐ N	Specify: ______________________
Psychiatric/Depression	☐ Y	☐ N	Specify: ______________________
Stroke	☐ Y	☐ N	Specify: ______________________

Condition	Y	N	Condition	Y	N
Anemia	☐ Y	☐ N	Muscle Spasms	☐ Y	☐ N
Abdominal pain	☐ Y	☐ N	Nausea	☐ Y	☐ N
Balance Problems	☐ Y	☐ N	Osteoarthritis	☐ Y	☐ N
Bleeding Problems	☐ Y	☐ N	Palpitations	☐ Y	☐ N
Bloody Stool	☐ Y	☐ N	Rash	☐ Y	☐ N
Bloody Urine	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
Blood Clots	☐ Y	☐ N	Speech changes	☐ Y	☐ N
Chest Pain/Angina	☐ Y	☐ N	Swelling	☐ Y	☐ N
Constipation	☐ Y	☐ N	Swollen Glands	☐ Y	☐ N
Cough	☐ Y	☐ N	Stomach Ulcers	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Seizure/Epilepsy	☐ Y	☐ N
Diarrhea	☐ Y	☐ N	Thyroid Disease	☐ Y	☐ N
Fainting	☐ Y	☐ N	Tremor	☐ Y	☐ N
Female organs/Menstrual	☐ Y	☐ N	Urine Retention	☐ Y	☐ N
Fever	☐ Y	☐ N	Vision changes	☐ Y	☐ N
Hearing changes	☐ Y	☐ N	Weight Loss	☐ Y	☐ N
Heat/Cold Intolerance	☐ Y	☐ N			
Hair/Nail changes	☐ Y	☐ N			
High Blood Pressure	☐ Y	☐ N			

Other: ____

Past Surgical/ Hospitalization History:

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? (Being put to sleep for an operation) ☐ Y ☐ N

Have you ever had problems with anesthesia? ☐ Y ☐ N Describe: ____________________

Are your immunizations up to date? ☐ Y ☐ N If no, which ones: ______________

Your Social History:

☐ Work in the home ☐ Employed (occupation): ____

☐ Student ☐ Retired ☐ Other: _____________________________________

☐ Children ☐ Y ☐ N If so, ages: ____

☐ Live Alone? If yes, do you have help or family nearby? _______________________________________

Exercise? ________ Daily ________Weekly _________Monthly __________ Rarely_________ Never_________

What type of exercise? ____

Smoker: ☐ Y ☐ N If so, packs per day: ____________For how long: ________________

Quit Smoking: ___________ within the last year ____________ 2 to 4 years _______________ 5 to 10 years

Chew Tobacco: ☐ Y ☐ N If so, how much: ______________ For how long: ________________

Drink Alcohol: ________daily ________ 1-2x/week ________ 1-2x/month _________ 1-2x/year _________ none

Alcohol preference: ____

Drugs (Marijuana, Cocaine, etc) ☐ Y ☐ N If yes, what: _______________________________

Comments regarding any health issues not covered on this form:

____

____

____

____

____

Medications: Please list all medications you currently take with doses and schedule.

Current Medication	Dose/Schedule	Reason for Medication	Side Effects

List any allergies with current medications

____

____

____

____

Family History:

Member	Alive	Deceased	Age	Health Status/Cause of Death
Father	A	D	_____	____________________________
Mother	A	D	_____	____________________________
Sister/Brother	A	D	_____	____________________________
Sister/Brother	A	D	_____	____________________________
Sister/Brother	A	D	_____	____________________________
Sister/Brother	A	D	_____	____________________________

Family Member History of:

Cardiac Disease ☐ Y ☐ N Who: ____

Stroke: ☐ Y ☐ N Who: ____

Diabetes: ☐ Y ☐ N Who: ____

Neurologic Problems: ☐ Y ☐ N Who: ____

Spine Problems: ☐ Y ☐ N Who: ____

Patient Signature____ Date: _________________

Reviewed by: ____, MD Date: _________________

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