



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

Phone: 817-310-8783

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Kevin James, M.D.
Aaron Eubanks, M.D.
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Nathan Mahanirananda, 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 the provider, you will want to have the following items available for the 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: _____

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.

National Neuromonitoring, Andaz and Spine Surgical Services, PLLC are physician owned partnership with Advanced Spine and Orthopedics. The physician, Dr. Kevin James, is a partner in these entities.

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 Advanced Spine and Orthopedics providers, 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 Advanced Spine and Orthopedics providers 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 Advanced Spine and Orthopedics providers 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 Advanced Spine and Orthopedics providers for my (the patient's) care, irrespective of any insurance benefits to which I may be entitled, except if Advanced Spine and Orthopedics providers 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 Advanced Spine and Orthopedics providers 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 Advanced Spine and Orthopedics providers, 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 Advanced Spine and Orthopedics. 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 Advanced Spine and Orthopedics providers 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 Advanced Spine and Orthopedics providers 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

Nathan Mahanirananda, 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.

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

If YES, please name the members allowed: _____

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

Signature: _____

Date: _____

Witness: _____

Date: _____



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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 our provider 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.
- **Refill requests will only be addressed Monday thru Thursday.**

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

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**, 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 #: _____

Specific Information to be Disclosed:

- | | | |
|---|--|---|
| <input type="checkbox"/> History | <input type="checkbox"/> Physical | <input type="checkbox"/> Therapy Reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> X-Rays | <input type="checkbox"/> Care Plan |
| <input type="checkbox"/> Lab Report | <input type="checkbox"/> ERG | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> All of the medical records |
| <input type="checkbox"/> 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Psychiatric/Mental Health |
| <input type="checkbox"/> Other (specify) _____ | | |

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

- | | | | |
|----------------------------------|-----------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Attorney | <input type="checkbox"/> Insurance | <input type="checkbox"/> 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:

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

THIS INFORMATION IS PRIVILEGED AND CONFIDENTIAL. IT IS INTENDED FOR THE INDIVIDUAL 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:** _____



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Narcotic Agreement

Patient Name: _____ Date: _____

I, _____, understand that after acute operative pain has dissipated 4 to 6 weeks post operatively, **Advanced Spine & Orthopedics providers** will no longer supply narcotics to me.

Patient Signature

Signed this _____ day of _____, _____

I, _____, understand that if I have not had any form of surgery **by Advanced Spine & Orthopedics**, I will be referred back to the Treating Physician or Pain Management Doctor for medication control. I further understand that **Advanced Spine & Orthopedics** will not provide me any type of medication.

Patient Signature

Signed this _____ day of _____, _____

Witness/Nursing Staff Signature

Signed this _____ day of _____, _____

Patient Medical History

PATIENT NAME: _____

Primary Care Doctor: _____ **Referred By:** _____

Pharmacy: _____ **HT:** _____ **WT:** _____

Chief Complaint (Check all that apply):

- | | | | |
|------------------------------------|---|--|-------------------------------------|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Ankle / Foot Pain | <input type="checkbox"/> Elbow Pain |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Other 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):

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

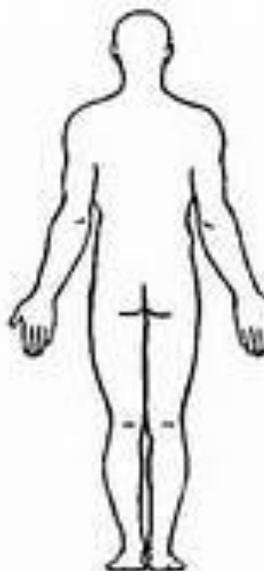
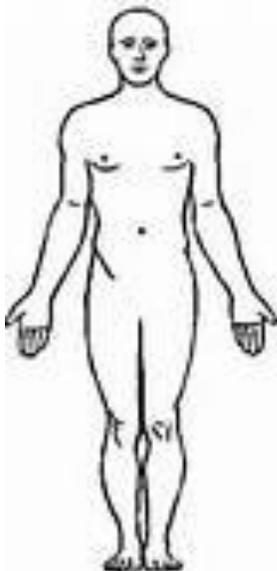
Bowel Problems Y N How long: _____

Bladder Problems: Y N How long: _____

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

XXXXXX Pain

00000 Numbness, Tingling, Pins, Needles



Patient Medical History:

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

- | | | | |
|-------------------------|----------------------------|----------------------------|----------------|
| Heart Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Lung Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Kidney Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Neurologic Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Cancer | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Liver Disease/Hepatitis | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Prostrate Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Psychiatric/Depression | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |
| Stroke | <input type="checkbox"/> Y | <input type="checkbox"/> N | Specify: _____ |

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