SPINALWORKS
Medical Group

New Patient Forms

Before coming to the office, please remember to:

- Arrive 15 minutes before your schedule appointment time. 30 minutes if you need to fill out your paperwork at the office.
- Bring your Driver's License/ID and insurance card (if you have insurance) to your visit.
- Bring in the following forms after you have filled them out, this will make your visit much faster with us. You may also save your filled out forms and email them to info@spinalworksdallas.com
- Bring in any radiology reports or images such as x-rays, MRI, CT or other films.

Practice Fusion Portal. You will be given access to a patient portal system. This will give you access to your appointments, your visit information, and other details about your appointments.

Thank you for choosing Spinalworks Medical Group!

Patient Name:_______________________ Preferred First Name:_______________________

Permanent Address:_______________________ City:______________ St:_____ Zip:__________

Birthdate: ________________ SSN #:________________ Gender: ☐ M ☐ F ☐ Prefer not to answer

Cell #:________________ Work #:________________ Home #:________________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ American Indian/Alaskan Native

How did you hear about us? ☐ Internet Search ☐ Groupon ☐ Insurance Website ☐ Friend ☐ Other

Email Address:_______________________ Occupation:_______________________

Employer:_______________________ City, St, Zip_______________________

Emergency Contact:________________ Phone:______________ Relationship:______________

Guardian Information (If patient is a Minor/under the age of 18)

Name:_______________________ Relationship to Patient:_______________________

SSN #:________________ Birth Date:________________ Gender: ☐ M ☐ F ☐ Prefer not to answer

Permanent Address:_______________________ City:______________ St:_____ Zip:__________

Sect. 1) Primary Insurance (Please skip if you have no insurance or you have already given your insurance card)

Primary Company_______________________ Insured's Name_______________________

Policy #________________ Group #________________ Insured's DOB________________

Patient's relationship to Insured: ☐ Parent ☐ Spouse ☐ Self

Secondary Insurance (Please skip if you do not have insurance or you have already given your insurance card)

Primary Company_______________________ Insured's Name_______________________

Policy #________________ Group #________________ Insured's DOB________________

Patient's relationship to Insured: ☐ Parent ☐ Spouse ☐ Self

Sect. 2) Self-Pay Agreement (Complete if you do NOT have insurance)

I agree to pay for medical and therapy services rendered at Spinalworks Medical Group. I understand that I am responsible for letting Spinalworks Medical Group know if I need a payment plan.

X_______________________________________ Date:_______________________

Sect. 3) Release of Information: I authorize Spinalworks Medical Group to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.

X_______________________________________ Date:_______________________

Details of your condition/injury: (Tell us about why you're here)____

____

Is your condition/injury related to an automobile collision? ☐ Yes ☐ No

Medical History (High blood pressure, Diabetes, etc.)____

____

____

Patient Medications: ☐ See attached list ____

____

Pharmacy: ______________________________ Address: ____

HOSPITALIZATIONS/SURGERIES	YEAR	SURGEON/HOSPITAL

Patient Drug Allergies: ____

____

FAMILY HISTORY				FAMILY HISTORY			
Family Member	Alive/Deceased	Age	Health Status	Family Member	Alive/Deceased	Age	Health Status
Grandmother (mom's)	☐ A ☐ D			Mother	☐ A ☐ D		
Grandfather (mom's)	☐ A ☐ D			Sister/Brother	☐ A ☐ D		
Grandmother (dad's)	☐ A ☐ D			Sister/Brother	☐ A ☐ D		
Grandfather (dad's)	☐ A ☐ D			Sister/Brother	☐ A ☐ D		
Father	☐ A ☐ D			Sister/Brother	☐ A ☐ D		

REVIEW OF SYSTEMS (Please check all current or previous conditions as they may apply)

Allergies ☐ ________________________
Blackouts/Fainting ☐ ________________
Seizures/Stroke ☐ __________________
Pain at night ☐ ____________________
Balance Issues ☐ ___________________
Numbness/Tingling ☐ _______________
Dizziness ☐ ________________________
Eyes ☐ ___________________________

Ears, nose, throat ☐ _________________
Lungs, Breathing ☐ _________________
Chest Pain/Heart ☐ _________________
High Blood Pressure ☐ ______________
Diabetes ☐ _________________________
Infection ☐ _________________________
Bleeding/Blood Clots ☐ ______________
Other:____

Acid Reflux/Ulcers ☐ _________________
Bladder/Urinary ☐ ___________________
Arthritis ☐ __________________________
Liver/Hepatitis ☐ ____________________
Kidney Disease ☐ ____________________
Cancer ☐ ___________________________
Depression/Anxiety ☐ ________________

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Work Status: ☐ Working full-time ☐ Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On Leave
Do you drink alcohol? ☐ None ☐ Yes, _____ drinks/week
Do you use smoke/use tobacco? ☐ No ☐ Yes, ______ packs/day _____ times/week
Do you exercise? ☐ No ☐ Yes_____ days/week

Summary Financial Policy:

I agree to assign insurance benefits to Spinalworks Medical Group, PLLC. We will bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. If you have two insurance plans, we will also bill the secondary plan.

I understand that my personal payment (co-payment, deductible and/or coinsurance) is required at the time services are received. Payment can be made in cash, personal check (in-state), credit card (Visa, MasterCard, Discover or American Express), or Care Credit. We will estimate your total payment responsibility at the conclusion of your medical appointment. This amount includes co-payments, deductibles, coinsurance and items not covered by your insurance plan. We will bill you any remaining balance based on your insurance plan's Explanation of Benefits (EOB), which is also sent to you.

We offer payment plans to our patients. If your account is sent to our collection agency, you are responsible for the outstanding balance and the fee charged by the agency. Again, please call us if you cannot make a payment. Spinalworks Medical Group makes every attempt to work with each patient.

I authorize Spinalworks Medical Group to contact me via current and any future cell phone number(s) or wireless device(s) to receive general information from Spinalworks Medical Group or to collect a past due account owed to Spinalworks Medical Group. I authorize Spinalworks Medical Group and its agents and representatives (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls in their effort to contact me.

I understand that I can access, view and/or print the full Spinalworks Medical Group Financial Policy on our website at www.spinalworksdallas.com.

Summary Notice of Privacy Practices

We strive to make sure that your Protected Health Information (PHI) remains confidential. Your medical records, paper and electronic, 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 explains how your medical information may be used and disclosed, is available for your review on our website at www.spinalworksdallas.com or you may ask our front desk for a copy.

Consent of Treatment

I hereby voluntarily consent to treatment from Spinalworks Medical Group encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Spinalworks Medical Group Center's medical Providers and staff, as is necessary in the medical staff's judgment. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

Release of Information:

I authorize Spinalworks Medical Group to release information regarding my care to my insurance company, pharmacist, and to any physician involved with my care. I understand that I may withdraw this consent at any time.

I have read and agree to the above policies.

Patient Signature: ____Date: ____________________________

Authorization for Disclosure of Medical Information

With my signature below, I authorize Spinalworks Medical Group to disclose any protected health information about me to carry out any treatment, healthcare operations, or payments. Please refer to Spinalworks Medical Group's 'Notice of Privacy Practices' for a more complete description of such disclosures. I have the right to review the 'Notice of Privacy Practices' at any time.

I acknowledge receipt of 'Notice of Privacy Practices.' I understand I may receive communication from Spinalworks Medical Group via text, call, or email regarding appointment reminders or to obtain feedback on my experience with the practice. If at any time I wish to revoke the consent to receive that communication, I understand that I have the right to do so by notifying Spinalworks Medical Group of that request.

With My Consent

_____________ (Initials) Spinalworks Medical Group MAY call my cell or home to leave a message on my answering machine/voice mailbox. Spinalworks Medical Group may send mail or email about any items that may assist Spinalworks Medical Group in carrying out any treatment, payments, or operations such as appointment reminders, insurance information, or billing information and any calls pertaining to any clinical care including examination and test results. (Laboratory, X-rays, etc.)

_____________ (Initials) I do not wish for Spinalworks Medical Group to leave any voice mail messages on my answering machine or speak to anyone in my household other than myself.

I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations. I understand and have been provided with a notice of patient privacy handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and I must agree on the use and disclosure of my protected health information. A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

____ ______________________
Signature of Patient Date

____ ______________________
Printed Name Date of Birth

May we speak to anyone regarding your treatment?

I give permission for Spinalworks Medical Group to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc.: ☐ **Only disclose to me**

____ _____________________________________
Individual authorized to receive your health information Relationship/Telephone Number

____ _____________________________________
Individual authorized to receive your health information Relationship/Telephone Number