360 Back & Spine Center
Dr. Melanie Kinchen, M.D.
1600 W College St Ste 685 | Grapevine TX, 76051
Ph. 682-223-1406
Fax 682-223-1346

Patient Information

Patient's Name	Social Security Number	Birth Date Age Sex M F
Street Address	City, State and Zip	Primary Contact Phone Number
Email Address	Occupation	Business Phone Number
Emergency Notification	Relationship	Phone
Patient's Employer	Employer's Street Address	Employer's City, State and Zip
Referring Physician Name		
Referring Physician Address	Referring Physician City, State and Zip	Referring Physician Phone
Primary Care Physician Name		
Primary Care Physician Address	Primary Care Physician City, State and Zip	Primary Care Physician Phone

Responsible Party

Name	Relationship
Address	Social Security Number
Employer	Daytime Phone

Insurance Information

Primary Insurance Carrier	Primary Policy or Subscriber ID#
Primary Name of Policy Holder#	Primary Group #
Primary Relationship to Patient	Primary Policy Holder's Date of Birth
Primary Policy Holder's Social Security #	Secondary Insurance Carrier
Secondary Policy Holder's Social Security #	
Secondary Policy or Subscriber ID#	
Secondary Name of Policy Holder #	Secondary Group #
Secondary Relationship to Patient	Secondary Policy Holder's Date of Birth

Pharmacy Information

Pharmacy Name			
Phone Number			
Address	City	State	Zip

Patient Agreement and Consent

My signature below indicates my consent for treatment of/as patient and responsibility for paying for services rendered. Forms for Authorization to use Protected Health information are attached and will be reviewed and completed.

*Patient's Signature*_____ *Date*_____

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Medical History

Name _____ Date of Birth _____ Date _____

Primary Care Doctor _____ Cardiologist _____

The purpose of this form is to gather your medical history. Please be a thorough as possible.

Cardiovascular
- ☐ Abnormal Heart Rhythms
- ☐ Congenital Heart Disease
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease

Circulatory
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Blood Clot in Leg (DVT)
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lymphedema/swelling limbs
- ☐ Peripheral Artery Disease
- ☐ Thalassemia

Endocrine
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Vitamin D Deficiency

Psychiatric & Neurological
- ☐ ADHD
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Cerebral Aneurysm
- ☐ Claustrophobia
- ☐ Closed Head Injury
- ☐ Dementia
- ☐ Depression
- ☐ Essential Tremor
- ☐ Hydrocephalus
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Seizure Disorder

Musculoskeletal
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Systemic Lupus Erythematosus
- ☐ Past Fractures?_____

Pulmonary
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ COPD
- ☐ Embolism/Blood Clot in Lung
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep Apnea

Gastrointestinal
- ☐ Acid Reflux/GERD/Heartburn
- ☐ Celiac Disease
- ☐ Cirrhosis
- ☐ Crohn's/ulcerative colitis
- ☐ Gastric/Peptic Ulcers
- ☐ Hepatitis
  - ☐ A
  - ☐ B
  - ☐ C
- ☐ Inflammatory Bowel Disease
- ☐ Rectal Bleeding

Nervous System
- ☐ Convulsion
- ☐ Epilepsy / Seizures
- ☐ Nerve injury
- ☐ Peripheral Neuropathy
- ☐ Radiculopathy
- ☐ Stroke/ TIA's

Infectious Disease
- ☐ Joint/Musculoskeletal Disease
- ☐ HIV/AIDS

Urologic
- ☐ Enlarged Prostate
- ☐ Incontinence
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Urinary Retention
- ☐ Urinary Tract Infection

Cancer
- ☐ Yes _____
- ☐ Radiation
  - ☐ No
  - ☐ Yes - last dose _____
- ☐ Chemo
  - ☐ No
  - ☐ Yes - last dose _____

Family History
- ☐ Asthma
- ☐ Stroke
- ☐ Cancer
- ☐ Diabetes

- ☐ **No Medical Problems**
- ☐ **Other** _____

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Surgical History

Name _____ Date of Birth _____ Date _____

The purpose of this form is to gather information concerning past surgeries history. Please be a thorough as possible.

Surgery History

Date & Name of Surgery	Surgeon	Body Part

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Medications

Name _____ Date of Birth _____ Date _____

Medications

☐ N/A

Name of Medication	Prescribed by	Dosage	Date Started

Allergies

☐ Adhesives
☐ Latex

Drug Allergies?

☐ No
☐ Yes (list)

_____

_____

Marital Status

☐ Single
☐ Divorced
☐ Married
Spouse's Name

_____

Social History/Work Status

☐ Employed, Full Time
☐ Employed, Part Time
☐ Retired
☐ Student
☐ Homemaker
☐ On Leave
☐ Disabled
☐ Unemployed
☐ Other _____

Occupation?

_____

Highest level of education?

_____

Do you live Alone?

☐ Yes
☐ No

Substance Abuse

Smoking

☐ No
☐ Yes ( )packs per day

Alcohol

☐ No
☐ Yes
  ☐ Social
  ☐ ( ) per day
  ☐ ( ) per week

Misc. Drugs Use

☐ No
☐ Yes (check all)
  ☐ Marijuana
  ☐ Intravenous Drug Abuse
  ☐ Prescribed Medication
☐ Other (list below)

_____

_____

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Review of Symptoms

Name _____ Date of Birth _____ Date _____

Please select any symptoms you are currently experiencing

General

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain

Misc.

- ☐ Eye Problem
- ☐ Sore Throat
- ☐ Swollen Neck Glands
- ☐ Other

Cardiovascular

- ☐ Chest Pain
- ☐ Leg/Foot Swelling
- ☐ Other

Respiratory

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Other

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Black/Tar-like/Bloody Stools
- ☐ Other

Genitourinary

- ☐ Bladder infection
- ☐ Painful Urination
- ☐ Difficulty with Urination
- ☐ Incontinence
- ☐ Urinary Retention

Neurological

- ☐ Anxiety/Depression
- ☐ Headaches
- ☐ Change in Vision
- ☐ Sleep Disturbance
- ☐ Other

Integument/Skin

- ☐ Rash
- ☐ Open Sores
- ☐ Poor Healing
- ☐ Skin Infection
- ☐ Other

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Accident Injury Details

Patient Name _____ Date of Birth _____ Date _____

Is this visit related to an injury / accident?

- ☐ Yes
- ☐ No

**If yes, please continue to fill out the rest of this page*

Date of Injury / Accident _____

Please give a description of how your accident / injury occurred

_____

_____

Where were you when the accident / injury occurred? _____

Did you go to the ER or other Emergency Care Facility for this accident / injury?

- ☐ Yes
- ☐ No

**If yes, which facility did you go to?*

☐ Baylor Grapevine ER ☐ North Hills Hospital ☐ Harris HEB ☐ Care Now

☐ Other_____

Is there another party responsible for this accident / injury?

(for example: Is this work related? Was this an auto accident? Did you fall at a department/ grocery store?

- ☐ Yes
- ☐ No

**If yes, who is responsible?*_____

The information I have provided is true and complete to the best of my knowledge and should be considered as official documentation for insurance purposes.

_____ _____
Patient's Signature or Parent / Guardian Date

_____ _____
360 BASC Representative Date

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GENERAL CONSENT FOR TREATMENT AND USE OF DISCLOSURE FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I _____ knowing that I am suffering from a condition requiring diagnostic or medical treatment, do hereby voluntarily consent to such procedures and care to such medical, diagnostic or other services under the general and specific instructions of 360 Back and Spine Center, its assistants or designee as is necessary in their judgement.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of the treatments or examination by 360 Back and Spine Center.

I understand that as part of my health care 360 Back and Spine Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care,**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third - party payer can verify that services billed were actually provided, and**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals**

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that i have the following rights and privileges:

- **The right to review the notice prior to signing this consent ,**
- **The right to object to the use of my health information for directory purposes, and**
- **The right to request restrictions as to how my health information may be used or disclosed to carry out treatment , payment, or health care operations**

I understand that 360 Back and Spine Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent , this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information :

_____

_____

I understand that as part of this organization's treatment , payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature **Date**

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Protected Health Information Release Agreement

Patient Name _____ **DOB** _____ **SS#** _____

Address_____ **Phone** _____

The health information you may release subject to this authorization is as follows:

All Medical Record **MRI/Diagnostic Films** **Operative Reports**

X-Ray Films **Other, Please Specify**_____

Release my protected health information to 360 Back and Spine:

Name:_____**Phone:**_____**Fax:**_____

Street:_____**City:**_____**State:**_____**Zip:**_____

The reasons or purpose for this release of information are as follows:

_____

_____

This authorization shall expire one year from the date signed. After one year, 360 Back & Spine Center can no longer use or disclose the patient's protected health information without first obtaining an new authorization form.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at 360 Back & Spine Center.

Attn: Privacy Officer
1600 W College St, Ste 685
Grapevine, Texas 76051
682-223-1406 Fax 682-223-1346

I understand that a revocation is not effective to the extent that 360 Back & Spine Center has relied of this authorization in its actions.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

360 Back & Spine Center will not condition my treatment, payment, or health care operations based on whether I provide authorization for the requested use of disclosure.

_____ _____

Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____

Date **Description of Personal Representative's Authority**

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Office & Financial Policies

We would like to thank you for choosing 360 Back and Spine Center (360 BASC) as your medical provider. To keep you informed of our current office and financial policies, we ask that you read, initial and sign or financial acknowledgment prior to any treatment.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co - pay at the time of your visit , you must provide us a written waiver from your insurance carrier specifically authorizing 360 BASC to waive this obligation.

Initials:_____

HMOS or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

Initials:_____

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Billing Office Representative or Coordinator.

Initials:_____

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting us in your medical claims paid . This information may include:

- **a copy of the police report**
- **a copy of your auto insurance**
- **names and information on the other parties involved**

Payment for any services that we provide will be your responsibility.

Initials:_____

Canceled Appointments: Our office does charge a $25.00 fee for No - Show or Canceled appointments without a 24 hour notice. Please contact the office 2 days in advance to cancel appointments.

Initials:_____

Liability Injury: If your injury is a result from another party's negligence, we request that you provide us with any information that will assist us in obtaining reimbursement for the services rendered to you. This information may include:

- **a copy of the accident report listing claim number and responsible part**
- **a medical coverage and / or attorney information**

Payment for any services that we provide will ultimately be your responsibility.

Initials:_____

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Office & Financial Policies continued...

Workers Compensation: **If your injury is due to an accident in your work place , please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims . Failure to properly report this injury to your employer may result in your claim being denied. Denied claims will be your responsibility.**

Initials:_____

Return Checks: **A $35.00 charge will be added to your account for any check returned by your bank for any reason.**

Initials:_____

Disability or Insurance Forms: **There will be a charge of $20.00 for the completion of medical forms. Pre - Payment is required prior to the form being completed. Please allow 5 - 7 business days for the completion of these forms. If you would like the forms mailed or faxed to you or your insurance company, please provide that request in writing at the time of payment. For extensions or updated forms the fee is $10.00.**

Initials:_____

Medical Records: **The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records . 360 BASC charges up to $25.00 for copies of your medical records, and a reasonable fee for the actual cost of mailing, shipping or delivery. Records are retained until payment is received.**

Initials:_____

Diagnostic Imaging: **For any, diagnostic imaging request, the fees are no more than $10.00 per copy and reasonable fee for the actual cost of mailing, shipping or delivery. Films / disks are retained until payment is received.**

Initials:_____

Minors: **If the patient is a minor , he / she must be accompanied by Parent /Legal Guardian for each office visit . Minor consent must be completed and signed by Parent / Legal Guardian.**

Initials:_____

Disclosure of Ownership: **Some of our physicians are invested in Ambulatory Surgery Centers like Baylor surgical at grapevine. Their investment enables them to have a voice in the administration of policies of these facilities. This involvement helps to ensure the highest quality of surgical care for our patients.**

Initials:_____

Medication Refills: **Medication will not be refilled after hours or over the weekend. Please make sure you allow 48 - 72 business hours for the completion of all medication refill request.**

Initials:_____

Medicaid: We are not a provider for Medicaid and if this is a secondary to your primary insurance you will be billed the remaining balance.

Initials:____

360 BACK & SPINE CENTER

URINE DRUG TESTING POLICY

Urine drug screening is an important component of the treatment plan for patients who are prescribed opioids for pain. The urine drug screen provides us the ability to monitor our patient's treatment adherence as well as possible drug use problems during pain treatment. It also gives us objective information about drug misuse prior to prescribing scheduled medications.

Who:
All patients will be tested.

When:
First Visit: For all patients new to treatment, a sample will be obtained at the beginning of the visit, before a prescription is written. A urine drug screen will also be obtained when pain meds are changed or if the dosage is changed. Also, if there is a decline in a patient's level of functioning. At the MD/nurse's discression.

Frequency:
The decision on how often to collect urine samples will be determined by the physician and nurse and can vary depending on the individual patient.

Failure to comply with the drug screen policy could delay receiving any renewals on prescriptions. This policy is effective August 3, 2015.

_____ _____

Patient Signature/Legal Guardian Date

_____ _____

Staff/Nurse Signature Date

360 BACK & SPINE CENTER

Narcotic Medication and Refill Policy

We at this office understand that sometimes pain medications are necessary to provide you with an improved quality of life. Due to circumstances beyond our control, we find it helpful to institute an agreement between you and your doctor regarding these medications. If you and your doctor decided to add certain medications to your regimen, it is important that you have a thorough understanding of what these medications are, including their expected benefits, side effects, and potentials for becoming habit forming. We will do our best to work with you to find an appropriate medication and dosage regimen that makes you more comfortable.

As part of your pain curriculum, you may be asked to have certain tests performed, given medications, injections, and have procedures done in order to lessen your pain. You may also be asked to participate in other modalities, including physical therapy, exercises, alternative medicine, and psychological counseling. These suggestions are made by your doctor in order to improve your life, and you will be expected to comply with all recommendations made and appointments given. If you have difficulty with anything your doctor prescribes, please discuss it openly and all questions will be answered to the best of our abilities. We ask you to place your trust in our care, as we have your best interests at heart always.

In order to best serve our patients and remain compliant with federal laws, we have developed a narcotic medication and refill policy to help manage these potential issues. Highlights of our policy include:

- We may or may not decide to take over medication management at the initial patient visit depending on the initial evaluation, risk factors, and completeness of the medical record.
- Prescriptions outside of the pain patch/cream and scar cream cannot be mailed to you; you must physically pick them up at the office in order to have them filled
- We will perform initial and random urine drug screens. You have the right to refuse this test, but this will result in cessation of your medication and discharge from this clinic.
- Certain pain medications are classified by the government as "controlled substances" and as such are governed by strict laws designed to protect everyone
- Failure to comply with this will result in your medication being withdrawn, and you may experience unpleasant effects by taking them in ways other than prescribed.
- Excessive use, misuse or abuse of these medications will result in discontinuation of the medications.
- We require 2-3 business days advance notice to refill any medication.
- Requests for early refills cannot be honored, and telephone calls for this will not be returned.
- Medications are the patient's responsibility. Lost or stolen medications will not be replaced.
- We require regular follow-up visit for medication refills.
- Do not use multiple pharmacies because your medication may be stopped.
- Under no circumstances will narcotic pain medication be prescribed beyond a 90-day period. If narcotic pain management is required beyond 90 days, then a referral to a Chronic Pain Specialist will be made.
- If you have already had pain medication prescribed by another physician, it is necessary to have your previous medical records in our clinic prior to having our physician prescribe this or another medication for you.

You will be given a copy of this contract once you read it, agree to it, and sign it. A copy will remain in your chart. Once you agree to accept pain medication from us, please do not ask other doctors for more. Failure to comply with this agreement gives your doctor the right to terminate this contract and you will be discharged from this practice. If you have any questions, please ask your physician.

Patient: _____

Physician: _____

Date: _____

Date: _____

Witness: _____

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BILLING & INSURANCE INFORMATION

As a courtesy to our patients we will file your insurance claims from our office. In order to do this we will require information from you. We ask that at the time of making your appointment , you inform the customer service representative of the type of insurance you have. Additional information will be required for those injuries or illnesses that are a result of a work or auto accident or if your case is under litigation.

We will need all your demographic and insurance information prior to your appointment. We ask that the time of your appointment you bring your insurance card and a photo ID as well as any other information that will assist us in making sure that your claim is filed correctly.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, coinsurance, deductible and non-covered services or items received. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, and Discover) American Express, Care Credit and money orders.

Although we are contracted with several insurance companies, it is your responsibility to make sure that our physical is in your plan. also, if your insurance requires a referral for any services or products, it is your responsibility to obtain the correct referral for those services. It is your responsibility to know your insurance.

Although we will file your insurance forms, payment for your medical services is your responsibility. We will assist you in any way we can help make this process as smooth as possible . We offer as a courtesy verification of your insurance benefits , however; this is only a quote given by your insurance company. Information may vary from the verification obtained to the actual processing your claim. It is your responsibility to know your plan benefits.

I acknowledge financial responsibility for services rendered by 360 Back and Spine Center. I understand that I am responsible for prompt payment any portion of the charges including deductibles, co-pays and co-insurance. My signature authorizes 360 BASC to file claims for me and assigns all medical rights and benefits due for theses services.

Signed_____ **Date**_____

Printed Name _____