

Steven C. Zielinski, MD, CM, FRCSC
1000 West Highway 6, Suite 430
Waco, Texas 76712-3793



Phone: 254.732.3987
Fax: 254.732.3823
E-mail: info@txspineonline.com

Welcome to Texas Spine & Neurosurgery. Below is our contact information:

Main Phone Number: (254) 732-3987
Toll Free Phone Number: (844) Meet Dr Z or (844) 633-8379
Fax Number: (254) 732-3823

Please fill out the following forms completely in ink. Do not use pencil! Please read over this entire packet of information and sign where indicated. This information will help with questions you may have regarding your care, as well as our policies and procedures.

Our office is open Monday - Thursday, 8:30am to 11:00am, and from Noon to 4:30pm, excluding holidays. We are open on Fridays from 9:00am to Noon, excluding holidays.

Patients are seen by scheduled appointment only. Please be on time to your appointments. Each of our patients has the right to be seen at his/her scheduled appointment time. If you are more than 10 minutes late to your appointment, we may need to reschedule your appointment. Expect your first appointment with Texas Spine & Neurosurgery to last 1 – 2 hours. Subsequent appointments typically last between 15 minutes and 1 hour.

Due to the nature of our practice, there are rare situations which cause the doctor to run behind or to be unavailable for clinic. If this occurs, your appointment may need to be rescheduled. This can happen for a number of reasons, such as Dr. Zielinski being called to an emergency or running late in surgery. We ask for your patience in the event that a delay occurs in your scheduled appointment time, and apologize in advance if you are inconvenienced due to such an issue. We strive to limit inconvenience to patients, and communicate changes to your appointment with as much notice and courtesy as possible.

All missed appointments will result in a \$75.00 fee, which will be charged to the credit card you provided during your new patient intake phone call. To avoid incurring this fee, cancel or reschedule your appointment at least 72 hours in advance of your scheduled appointment.

Co-pays, co-insurance amounts and applicable deductibles are due *before* you see the doctor. We accept cash, money orders, cashier's checks, personal checks up to \$100.00, Visa, MasterCard, Discover and American Express. If your personal check is returned for insufficient funds or you stop payment on a check you wrote to us, you must pay all bank fees, the original amount of the check, and a \$75.00 fee, before you will be scheduled to see the doctor again.

The best way to communicate with our office is via the telephone. Do not rely on e-mail or other electronic forms of communication to reach us.

Thank you for choosing Texas Spine & Neurosurgery. By signing below, I affirm that I have read, understood and accept all of the policies and procedures discussed above.

Patient Name (Print): _____	Patient Date of Birth: _____
Patient/Guardian Signature: _____	Appointment Date: _____



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Satellite Clinic Locations

Texas Spine & Neurosurgery understands that some patients can be more conveniently served outside of Waco. To accommodate these patients, we have established satellite clinics throughout Texas. Although not all appointments can be scheduled at these locations, most can, including new patient visits, MRI reviews and many post-operative follow up visits. We are affiliated with hospitals and surgery centers near these locations as well. If you prefer a location closer to home, please let us know. Our satellite clinics are in the following locations:

CLEBURNE

1200 W. Henderson St., Suite H
Cleburne, TX 76033

HILLSBORO

1313 East Franklin Street
Hillsboro, TX 76645

CUERO

2500 North Esplanade
Cuero, TX 77954

HARKER HEIGHTS

2025 Memory Lane, STE. 400A
Harker Heights, TX. 76548

ENNIS

109 N.W. Main Street
Ennis, TX 75119

FAIRFIELD

734 W. Commerce
Fairfield, TX 75840

GATESVILLE

1507 W Main Street
Gatesville, TX 76528

MINERAL WELLS

400 SW. 25th Ave.
Mineral Wells, TX. 76067

GROESBECK

Medical Arts Building
801 McClintic Drive
Groesbeck, TX 76642

VICTORIA

1403 Victoria Station Dr.
Victoria, TX 77901

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Patient Information:

Appointment Date: _____

PLEASE PRINT CLEARLY AND COMPLETE EACH ITEM IN INK – DO NOT USE PENCIL OR LEAVE BLANKS!

Patient Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Address (**NO PO BOXES**): _____ City: _____ State: _____ Zip Code: _____

CIRCLE PREFERRED NUMBER: Home Phone: _____ Cell Phone: _____ SS#: _____

Gender (*circle*): MALE FEMALE Marital Status (*circle*): MARRIED SINGLE DIVORCED WIDOWED SEPARATED

Race: White African American American Indian Asian Other Hispanic

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Employer: _____ Work Phone: _____

Emergency Contact Person (not living with you): _____ Phone: _____

Relationship to patient: _____ Patient E-mail Address: _____

How did you hear about us (Check all that apply): Family Physician TV Family/Friend Website

Magazine Wacoan Rambler Waco Today

Insurance Information & Subscriber:

Primary Insurance Information

Insurance Name: _____ ID/Policy #: _____ Grp #: _____

Name of Insured: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Information

Insurance Name: _____ ID/Policy #: _____ Grp #: _____

Name of Insured: _____ DOB: _____ SSN: _____

ALL SERVICES ARE DUE & PAYABLE AT THE TIME OF SERVICE. YOU MAY PAY WITH CASH, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS FOR ANY AMOUNT. FOR AMOUNTS BELOW \$100.00, YOU MAY PAY WITH A PERSONAL CHECK.

TREATMENT FOR INDIVIDUALS HAVING AN EXISTING MEDICAL POWER OF ATTORNEY or THOSE REQUIRING A CARE GIVER:

Individuals with an existing medical power of attorney, who are no longer able to make decisions for themselves, are required to have their appointed agent present at each visit. Individuals who require a care giver or reside in a care facility are required to have a care giver present throughout each visit. These requirements have been established in an effort to maximize the benefits of the care we provide and the outcomes to our patients, and to comply with the law. In the event that a patient meeting any for these criteria arrives for a scheduled appointment without the required individual, the appointment will be rescheduled.

ACCOUNT GUARANTOR AGREEMENT:

I hereby authorize Texas Spine and Neurosurgery to administer clinically necessary treatment and/or procedures. I request the assignment of any and all insurance benefits directly to Texas Spine and Neurosurgery. I agree to pay any charges incurred for approved medical services which are not covered by another payor. I understand that the use of a check for payment is my acknowledgement and acceptance of the terms outlined in Texas Spine and Neurosurgery's posted check acceptance policy.

Patient/Guardian Signature: _____ Date: _____

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Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Primary Care Physician: _____

Referring Physician: _____

Height: ____ feet ____ inches Weight: _____ pounds Females – Are you pregnant? Yes No

CHIEF COMPLAINT (Reason for Visit): _____

Where is your problem located? Low Back Neck Head Mid Back Other: _____

Answer "yes" or "no" to the following questions:

Previous cervical spine surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of liver dysfunction:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous lumbar spine surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased immunity:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous thoracic spine surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of HIV/AIDS:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous spinal fusion:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed with Hepatitis B:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seen another specialist for this Issue:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed with Hepatitis C:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack in the last 6 months:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed with MRSA or VRE:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Removal of implant due to infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of kidney dysfunction:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Past Surgical Complications: No Yes (if yes) What: _____

Past Anesthesia Problems: No Yes (if yes) What: _____

Have you ever experienced an injury to your neck and/or back? Yes No

WHEN: _____ WHERE: _____

What imaging studies/tests have you had? X-Ray MRI CT Scan Ultrasound EMG

WHERE: _____ DATE: _____

Are you claustrophobic? Yes No

Conservative therapies you have received and for how long?

<input type="checkbox"/> NONE	<input type="checkbox"/> Physical Therapy x _____ months	<input type="checkbox"/> ESI Injection(s) x _____ times
<input type="checkbox"/> Chiropractic x _____ months	<input type="checkbox"/> Pain Medication x _____ months	<input type="checkbox"/> Exercise x _____ months
<input type="checkbox"/> Massage x _____ months	<input type="checkbox"/> TENS Unit x _____ months	<input type="checkbox"/> OTC Medication x _____ months

Other (please list): _____

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Draw your pain on the diagrams below using the symbols to show the type of pain you feel.

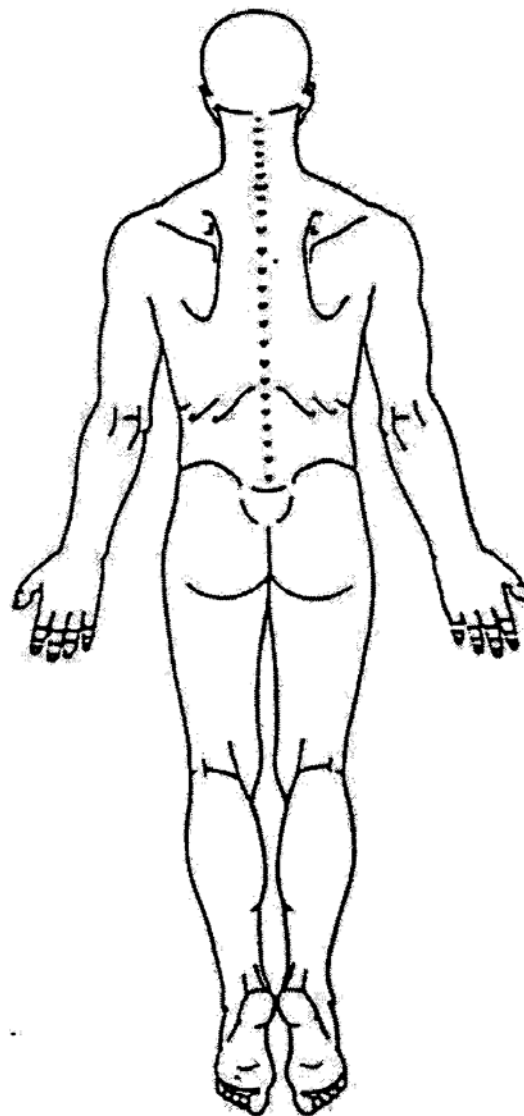
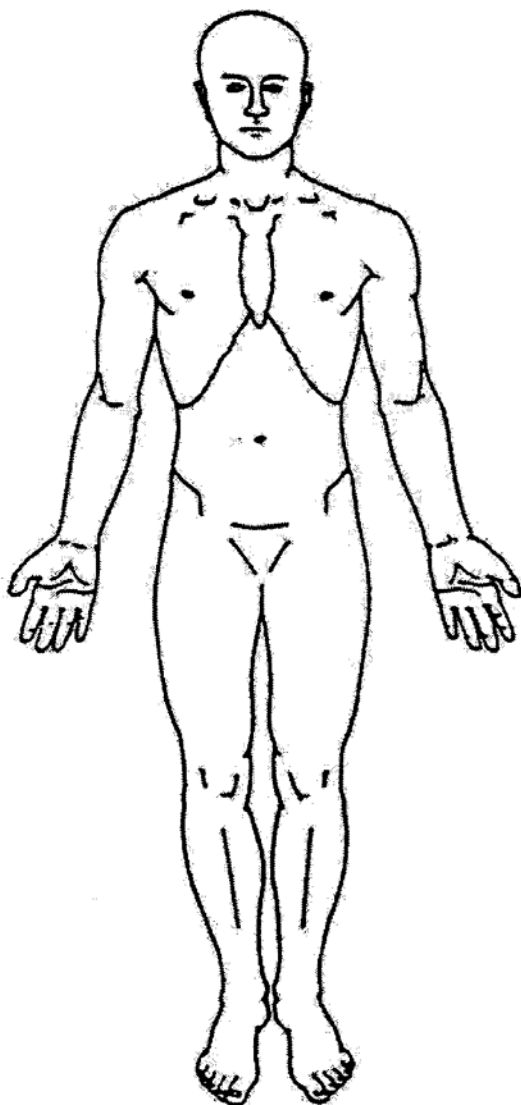
Stabbing pain /////

Pins & needles VVVVV

Burning pain OOOOO

Numbness - - - - -

Aching pain XXXXX





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Review of Systems:

Answer "yes" or "no" to the following questions:

CONSTITUTIONAL:

Chills: Yes No | Decline in Health: Yes No | Fatigue: Yes No
Fever: Yes No | Weakness: Yes No | Weight Change: Yes No

EYES:

Blurry Vision: Yes No | Cataracts: Yes No | Double Vision: Yes No
Eyeglass Use: Yes No | Floaters: Yes No | Pain with Light: Yes No
Recent Injury: Yes No | Redness: Yes No | Vision Loss: Yes No

ENT - NOSE:

Discharge: Yes No | Frequent Colds: Yes No | Nasal Obstruction: Yes No
Nosebleeds: Yes No | Sinus Infections: Yes No

ENT - MOUTH:

Bleeding Gums: Yes No | Hoarseness: Yes No | Postnasal Drip: Yes No
Voice Changes: Yes No

ENT - EARS:

Discharge: Yes No | Hearing Aid: Yes No | Hearing Impairment: Yes No
Infections: Yes No | Pain: Yes No | Ringing in Ears: Yes No

ENT – THROAT/NECK:

Difficulty Swallowing: Yes No | Frequent Sore Throats: Yes No | Tenderness: Yes No
Tonsils Enlarged: Yes No

RESPIRATORY:

Bronchitis: Yes No | Cough: Yes No | Coughing Blood: Yes No
Pain: Yes No | Pleurisy: Yes No | Positive TB Test: Yes No
Short of Breath: Yes No | Sputum: Yes No | Wheezing: Yes No

CARDIOVASCULAR:

Chest Pain: Yes No | Extremity(s) Discolored: Yes No | Heart Murmur: Yes No
Leg Pain-Walking: Yes No | Palpitations: Yes No | Rheumatic Fever: Yes No
Short of Breath-Exertion: Yes No | Short of Breath-Lying Flat: Yes No | Swelling of Legs: Yes No
Thrombophlebitis: Yes No | Varicose Veins: Yes No

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GASTROINTESTINAL:

Abdominal Pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antacid Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Appetite:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in Frequency of BM:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Stool Color:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Stool Consistency:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaundice:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laxative Use:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal Bleeding:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting Blood:	<input type="checkbox"/> Yes <input type="checkbox"/> No

MUSCULOSKELETAL:

Deformities:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Stiffness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle Cramps:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Stiffness:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restricted Motion:	<input type="checkbox"/> Yes <input type="checkbox"/> No

PSYCHIATRIC:

Behavioral Change:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disorientation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Stress:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinations:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood Changes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervousness:	<input type="checkbox"/> Yes <input type="checkbox"/> No				

NEUROLOGICAL:

Dizziness:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head Injury:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Consciousness:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tingling:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unsteady Gait:	<input type="checkbox"/> Yes <input type="checkbox"/> No

ENDOCRINE:

Cold Intolerance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heat Intolerance:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increased Thirst:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sweats:	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEMATOLOGIC/LYMPH:

Bleeding Easily:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bruisability:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lumps:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Exposure:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Glands:	<input type="checkbox"/> Yes <input type="checkbox"/> No

ALLERGIC/IMMUNOLOGIC:

Coughing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itchy Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itchy Nose:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurrent Infections:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runny Nose:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sneezing:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stuffy Nose:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watery Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No		

GENITOURINARY:

Blood In Urine:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Starting Stream:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Urination:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flank Pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infections:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain on Urination:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retention:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urgency:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urine Discoloration:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urine Odor:	<input type="checkbox"/> Yes <input type="checkbox"/> No

CONDITION(S) NOT LISTED ABOVE: _____

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Health Screening: Answer "yes" or "no" to the following questions with approximate date:

- Colorectal Screening? Yes No Date: _____
- Mammography Screening? Yes No Date: _____
- Received an Influenza Immunization for the Flu? Yes No Date: _____
- Received the Pneumococcal Vaccine for Pneumonia? Yes No Date: _____

Patient & Family Medical History: Check the box regarding you and any family member who has experienced the conditions listed below. For all relatives, circle whether they are alive (A) or deceased (D).

CONDITION	Patient	Mother (A or D)	Father (A or D)	Sister (A or D)	Brother (A or D)
Anemia					
Anxiety					
Arthritis					
Asthma					
Back Problems					
BPH					
Breast Cancer					
CAD					
Cancer					
CHF					
Cholesterol High					
COPD					
Dementia					
Depression					
Dermatitis					
Diabetes					
Epilepsy					
GERD					
Glaucoma					
Gout					
Headache					
Hepatitis					
HIV					
Hypertension					
MI					
Migraine					
Pneumonia					
Renal Stone					
Stroke					
Tuberculosis (TB)					
Thyroid Disease					
Ulcer (GI)					

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Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Please Select All That Apply To You In Each Section:

Social History:

Tobacco Use:

- | | | | | |
|----------------------|--------------------------------------|---------------------------------------------|-------------------------------|---------------------------------------|
| Cigarettes ----- | <input type="checkbox"/> Smoke Daily | <input type="checkbox"/> Smoke Occasionally | <input type="checkbox"/> Quit | <input type="checkbox"/> Never Smoked |
| Cigars ----- | <input type="checkbox"/> Smoke Daily | <input type="checkbox"/> Smoke Occasionally | <input type="checkbox"/> Quit | <input type="checkbox"/> Never Smoked |
| Pipe ----- | <input type="checkbox"/> Smoke Daily | <input type="checkbox"/> Smoke Occasionally | <input type="checkbox"/> Quit | <input type="checkbox"/> Never Smoked |
| Chewing Tobacco ---- | <input type="checkbox"/> Smoke Daily | <input type="checkbox"/> Smoke Occasionally | <input type="checkbox"/> Quit | <input type="checkbox"/> Never Smoked |
| Dipping Tobacco ---- | <input type="checkbox"/> Smoke Daily | <input type="checkbox"/> Smoke Occasionally | <input type="checkbox"/> Quit | <input type="checkbox"/> Never Smoked |

Alcohol Use:

- History of Alcohol use: No
- | | | | | |
|-----------------|---------------------------------|-------------------------------------|--------------------------------|--------------------------------|
| Beer ----- | <input type="checkbox"/> Social | <input type="checkbox"/> Occasional | <input type="checkbox"/> Light | <input type="checkbox"/> Heavy |
| Wine ----- | <input type="checkbox"/> Social | <input type="checkbox"/> Occasional | <input type="checkbox"/> Light | <input type="checkbox"/> Heavy |
| Hard Liquor --- | <input type="checkbox"/> Social | <input type="checkbox"/> Occasional | <input type="checkbox"/> Light | <input type="checkbox"/> Heavy |

Drug Use:

- History of Non-Prescription Drug use (check one): No Yes Last time used: _____
() Cocaine () Heroin/IV () Marijuana () Methamphetamine

Employment:

- Full-Time Part-Time Retired Disabled Unemployed Full-Time Student
Occupation: _____ Work Type: () Heavy Physical () Light Physical () Sedentary () Homemaker

Household - Living Conditions:

- Live Alone Live w/spouse Live w/child(ren) & Age(s): _____ Assisted Living Nursing Facility

Lifestyle:

- Do you have any Tattoos: No Yes Where: _____
Do you Exercise: No Yes () Aerobics () Bicycling () Running () Swimming () Walking

Surgical History: (F) Female (M) Male

No Surgical History (I have never undergone a surgical procedure)

- | | | | |
|------------------------------------------------|---------------------------------------------|------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> AAA Repair | <input type="checkbox"/> Aortic Aneurism | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Breast Augment (F) |
| <input type="checkbox"/> Breast Reduction (F) | <input type="checkbox"/> CABG | <input type="checkbox"/> Carotid Endartere | <input type="checkbox"/> Cataract Extract – (R) or (L) |
| <input type="checkbox"/> Caesarean Section (F) | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Duodenal Ulcer |
| <input type="checkbox"/> Ectopic Pregnancy (F) | <input type="checkbox"/> ESWL | <input type="checkbox"/> Fracture | <input type="checkbox"/> Gastric Banding |
| <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Hernia Abdominal | <input type="checkbox"/> Hip Fracture – (R) or (L) | <input type="checkbox"/> Hip Surgery – (R) or (L) |
| <input type="checkbox"/> Hysterectomy (F) | <input type="checkbox"/> Intestinal By-Pass | <input type="checkbox"/> Knee Arthroscopy – (R) or (L) | <input type="checkbox"/> Knee Surgery – (R) or (L) |
| <input type="checkbox"/> Lasik – (R) or (L) | <input type="checkbox"/> LS Spine Surgery | <input type="checkbox"/> Mastectomy (F) | <input type="checkbox"/> Oophorectomy Uni (F) |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prior Surgeries | <input type="checkbox"/> Prostate Biopsy (M) | <input type="checkbox"/> Prostatectomy Retro (M) |
| <input type="checkbox"/> PTCA | <input type="checkbox"/> PVD Procedures | <input type="checkbox"/> Shoulder Arthroscopy – (R) or (L) | <input type="checkbox"/> Shoulder Surgery – (R) or (L) |
| <input type="checkbox"/> Sinusectomy (Nasal) | <input type="checkbox"/> Splenectomy | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Tubal Ligation (F) | <input type="checkbox"/> TURP (M) | <input type="checkbox"/> Vasectomy (M) | |

Surgeries Not Listed Above: _____

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AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Please complete the following Information:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ SSN: _____ D.O.B. ____ / ____ / ____

I, _____, give full authorization to **Texas Spine & Neurosurgery** to discuss my medical treatment, medications, diagnosis, and/or financial information with the following people. I understand that my medical care and treatment will not be discussed with anyone that is not on this list, except as disclosed in the Notice of Privacy Practices information I was provided by **Texas Spine & Neurosurgery**.

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Name Relationship

X _____
Patient's Signature Date

You have the right to revoke this authorization, except to the extent that **Texas Spine & Neurosurgery** has relied on it, by submitting a request to this office in writing.

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ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service. For your convenience, we accept cash, VISA, MasterCard, Discover, American Express, travelers or personal checks up to \$100.00, and money orders. If co-payments, coinsurance and/or deductibles are required by your insurance plan; they are due when services are rendered.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, TriCare, private insurance and any other health/medical plan, to issue payment checks directly to Texas Spine & Neurosurgery for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. In the event that I receive the insurance payment, I realize that I will be billed personally until the balance is paid.

Physician's Participation with Insurance Plans

Texas Spine & Neurosurgery accepts many insurance plans, but not all. Prior to your initial visit, you should contact your insurance carrier to confirm that Dr. Steven C. Zielinski participates in your plan. If he does not participate with your insurance plan, you will be responsible for payment of all charges, in full, at the time of your visit. You will be provided an itemized bill which you may submit to your insurance plan for any reimbursement to which you may be entitled. NOTE: If Dr. Zielinski does not participate in your plan, this office will NOT bill your insurance company and you will be treated as a self-pay patient.

Authorization to Release Information

I hereby authorize Texas Spine & Neurosurgery to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Texas Spine & Neurosurgery on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I agree to pay all charges in full, immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

PRINT NAME of Responsible Party

X _____
Responsible Party's Signature

Appointment Date

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ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

_____ (INITIAL HERE) I understand that payment and financial arrangement for services are my responsibility.

_____ (INITIAL HERE) I will not withhold or delay any payment if my insurance company denies payment for my charges.

_____ (INITIAL HERE) I have read and understand **Texas Spine & Neurosurgery Financial Policy and all other Policies** that have been set forward for the practice, and I agree to be bound by the terms stated above.

_____ (INITIAL HERE) I authorize **Texas Spine and Neurosurgery** to contact me via current and any future cellular phone number(s), emails address, wireless device(s) regarding my delinquent account(s) I owe to **Texas Spine and Neurosurgery**, or to receive general information from **Texas Spine and Neurosurgery**. I also authorize its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment and artificial or pre-recorded voice messages and personal calls, in their effort to contact me for purposes of collecting any portion of my account which is past due. I understand that I may withdraw my consent to call my cellular phone by submitting my request in writing to **Texas Spine and Neurosurgery** or its agents.

Printed Name of Patient's Representative (if not Patient)

Relationship to Patient

Reason for signing on behalf of Patient

X _____
Patient or Responsible Party's Signature

Date

Steven C. Zielinski, MD, CM, FRCSC
1000 West Highway 6, Suite 430
Waco, Texas 76712-3793



Phone: 254.732.3987
Fax: 254.732.3823
E-mail: info@txspineonline.com

Patient Web Portal Release of Liability

TERMS OF USE

Welcome to the Texas Spine & Neurosurgery patient web portal, powered by MediTouch and YourHealthFile. YourHealthFile is your Personal Health Record (sometimes referred to as PHR). Texas Spine & Neurosurgery has upgraded to an Electronic Health Record to modernize the practice of medicine and, more importantly, to increase the quality of your healthcare. YourHealthFile is your view into the Electronic Health Record and gives you access to your Account Information, Medical Records, and Appointments.

USE OF SITE

The use of this website and the services offered to you is subject to the terms and conditions herein. The patient portal services are only available to users who have been provided access by Texas Spine & Neurosurgery. We reserve the right to update or change the Terms of Use at any time for any reason by posting the modified Terms of Use in our office, located at 1000 West Highway 6, Suite 430, Waco, TX 76712.

USE OF SERVICES

1. Online communications should never be used for emergency communications or urgent (time sensitive) requests. These should occur via telephone or the use of a hospital emergency room.
2. Use online communications with caution. If there is information that you don't want transmitted electronically, you must inform Texas Spine & Neurosurgery in writing.
3. Texas Spine & Neurosurgery cannot and will not be held responsible for delays in online communication, or any issues with the transmittal or accuracy of electronic information contained in or transmitted through YourHealthFile.
4. Follow-up regarding electronic information and communications are solely your responsibility. You are responsible for calling or faxing our office should electronic information be inaccurate, or if an online communication goes unanswered.
5. Texas Spine & Neurosurgery routinely complies with HIPAA to protect your PHI. Likewise, you are responsible for taking steps to protect yourself from unauthorized use of online communications and information, such as keeping your password confidential. Texas Spine & Neurosurgery is not responsible for breaches of confidentiality caused by you and an independent third party, including Health Fusion, MediTouch and YourHealthFile.

DISCLAIMER

1. The services on the patient portal are provided "As-Is" and "As Available"; Texas Spine & Neurosurgery does not warrant that actual or perceived defects or inaccuracies will be corrected.
2. Texas Spine & Neurosurgery does not make any express or implied warranties about the patient portal, including but not limited to implied warranties of merchantability, fitness for a particular purposes, or non-infringement.
3. Texas Spine & Neurosurgery disclaims all warranties that the patient portal will meet your needs, or that they will be uninterrupted, timely, secure or error-free. Texas Spine & Neurosurgery also makes no warranty that the services, information and products will be accurate, reliable or complete.

4. You acknowledge that you understand and assume full responsibility for the risks associated with the use of the portal service. Your use of the portal services is at your sole risk.

LIMITATION OF LIABILITY

1. Texas Spine & Neurosurgery will not be liable to you or anyone else for any consequential, incidental, special or indirect damages (including but limited to lost profits or damages that result from the use or loss of use of the patient portal and third party content, inconvenience, or delay). This is true even if Texas Spine & Neurosurgery has been advised of the possibility of such damages or losses.
2. Texas Spine & Neurosurgery will not be liable to you or anyone else for any loss resulting from a cause over which such Texas Spine & Neurosurgery does not have direct control. This includes failure of electronic or mechanical equipment or communications lines (including telephone, cable and internet), unauthorized access, viruses, theft, operator errors, severe or extraordinary weather such as flood, earthquake, or other act of God, fire, war, insurrection, terrorist act, riot, labor dispute and other labor issues, accident, emergency or action of government.

INDEMNIFICATION

As a condition of your use of the patient portal, you agree to indemnify and hold Texas Spine & Neurosurgery and its' employees, including but not limited to its' physicians, nurses and other staff, harmless from and against any and all claims, losses, liability, costs and expenses (including but not limited to attorneys' fees) arising from your use of the patient portal, or from any violation of these Terms.

TERMINATION

Texas Spine & Neurosurgery may terminate your access to the patient portal for any reason, without prior notice.

ACCESS

Your signature below indicates your understanding of the above terms and conditions, and your desire to obtain online access to the patient portal subject to said terms and conditions.

Patient Name: _____

DOB: _____

E-mail Address: _____

Appointment Date: _____

X _____

Patient's Signature

Date