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

TEXAS SPINE & NEUROSURGERY

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

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

1000 West Highway 6, Suite 430
Waco, Texas 76712
Phone: (254) 732-3987
Fax: (254) 732-3823
info@txspineonline.com
http://www.txspineonline.com

Please fill out the following forms completely, as it will assist us with your care. We are providing you with information regarding our policies and procedures. Please read over these pages and sign them. This information will help with any questions you may have regarding your care. Direct any questions you have to our staff; they will be more than happy to help you.

Our office is open from 9 am to 11 am, and from noon - 5 pm Monday through Thursday, excluding holidays. We close for lunch from 11am – noon Monday through Thursday. We are open from 9 am to 12 pm on Friday, excluding holidays. You may call to discuss appointments, or to obtain information during this time. Patients are seen by scheduled appointment only.

Please be on time to your appointments. Each of our patients, including you, has the right to be seen at his/her scheduled appointment time. If you are late to your appointment, we will likely need to reschedule your appointment. You can expect your first appointment with Texas Spine & Neurosurgery to last 1 – 2 hours. Please plan accordingly. 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 during clinic 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 $25.00 administrative fee. To avoid incurring this fee, cancel or reschedule your appointment at least 72 hours in advance of your scheduled appointment. Co-pays and applicable deductibles are due *before* you see the doctor. We accept cash, money orders, cashier's checks, personal checks, Visa, MasterCard and Discover. If your personal check is returned for insufficient funds, you must pay all bank fees, the original amount of the check, and a $25.00 fee, before you will be scheduled to see the doctor again.

Thank you for choosing Texas Spine & Neurosurgery.

TEXAS SPINE & NEUROSURGERY

Today's Date: _____

Patient Information:

PLEASE PRINT CLEARLY AND COMPLETE EACH ITEM. IF UNKNOWN, WRITE "UNKNOWN". IF NOT APPLICABLE TO YOU, WRITE "N/A"

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

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

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 OR CHECK ONLY

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: _____

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's 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:	☐ Yes ☐ No	History of liver dysfunction:	☐ Yes ☐ No
Previous lumbar spine surgery:	☐ Yes ☐ No	Decreased immunity:	☐ Yes ☐ No
Previous thoracic spine surgery:	☐ Yes ☐ No	History of HIV/AIDS:	☐ Yes ☐ No
Previous spinal fusion:	☐ Yes ☐ No	Diagnosed with Hepatitis B:	☐ Yes ☐ No
Seen another specialist for this Issue:	☐ Yes ☐ No	Diagnosed with Hepatitis C:	☐ Yes ☐ No
Heart attack in the last 6 months:	☐ Yes ☐ No	Diagnosed with MRSA or VRE:	☐ Yes ☐ No
Removal of implant due to infection:	☐ Yes ☐ No	History of kidney dysfunction:	☐ Yes ☐ No

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

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

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?

☐ NONE	☐ Physical Therapy x _____ months	☐ ESI Injection(s) x _____
☐ Chiropractic x ____ months	☐ Pain Medication x ___ months	☐ Exercise x ____ months
☐ Massage x ___months	☐ TENS Unit x ____ months	☐ OTC Medication x ____ months

☐ Other (please list): _____

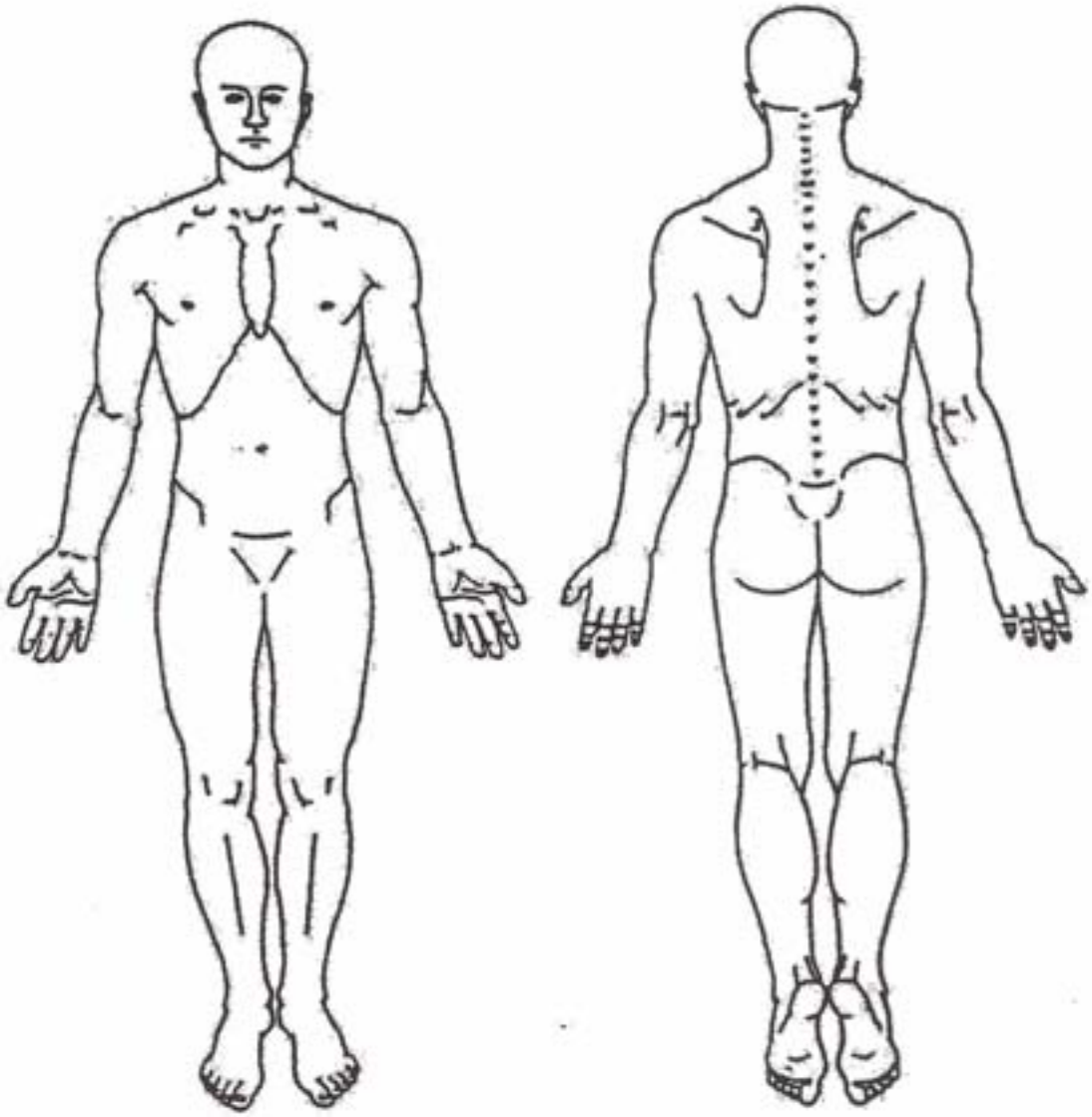
TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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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TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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

Review of Systems:

CONSTITUTIONAL:

Chills:	☐ Yes ☐ No	Decline in Health:	☐ Yes ☐ No	Fatigue:	☐ Yes ☐ No
Fever:	☐ Yes ☐ No	Weakness:	☐ Yes ☐ No	Weight Gain:	☐ Yes ☐ No
Weight Loss:	☐ Yes ☐ No				

EYES:

Blurry Vision:	☐ Yes ☐ No	Cataracts:	☐ Yes ☐ No	Discharge:	☐ Yes ☐ No
Double Vision:	☐ Yes ☐ No	Excessive Tearing	☐ Yes ☐ No	Eye Pain:	☐ Yes ☐ No
Eyeglass Use:	☐ Yes ☐ No	Glaucoma:	☐ Yes ☐ No	Infections:	☐ Yes ☐ No
Pain with Light:	☐ Yes ☐ No	Recent Injury:	☐ Yes ☐ No	Redness:	☐ Yes ☐ No
Unusual Sensations:	☐ Yes ☐ No	Vision Loss:	☐ Yes ☐ No		

ENT - NOSE:

Discharge:	☐ Yes ☐ No	Frequent Colds:	☐ Yes ☐ No	Hay Fever:	☐ Yes ☐ No
Infections:	☐ Yes ☐ No	Nasal Obstruction:	☐ Yes ☐ No	Nosebleeds:	☐ Yes ☐ No
Sinus Infections:	☐ Yes ☐ No				

ENT - MOUTH:

Bleeding Gums:	☐ Yes ☐ No	Change in Dentition	☐ Yes ☐ No	Hoarseness:	☐ Yes ☐ No
Postnasal Drip:	☐ Yes ☐ No	Tongue Burning	☐ Yes ☐ No	Voice Change:	☐ Yes ☐ No

ENT - EARS:

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

ENT – THROAT/NECK:

Frequent Sore Throats:	☐ Yes ☐ No	Lumps:	☐ Yes ☐ No	Tenderness:	☐ Yes ☐ No
Tonsils Enlarged:	☐ Yes ☐ No				

RESPIRATORY:

Asthma:	☐ Yes ☐ No	Cough:	☐ Yes ☐ No	Wheezing:	☐ Yes ☐ No
Bronchitis:	☐ Yes ☐ No	Coughing Blood:	☐ Yes ☐ No	Pain:	☐ Yes ☐ No
Pleurisy	☐ Yes ☐ No	Positive TB Test:	☐ Yes ☐ No	Recent Chest X-Ray:	☐ Yes ☐ No
Short of Breath:	☐ Yes ☐ No	Sputum:	☐ Yes ☐ No	Tuberculosis:	☐ Yes ☐ No

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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

CARDIOVASCULAR:

Chest Pain:	☐ Yes ☐ No	Palpitations:	☐ Yes ☐ No	Varicose Veins:	☐ Yes ☐ No
Extremity(s) Cool:	☐ Yes ☐ No	Extremity(s) Discolored:	☐ Yes ☐ No	Hair Loss on Legs:	☐ Yes ☐ No
Heart Murmur:	☐ Yes ☐ No	Heart Tests (Not EKG):	☐ Yes ☐ No	High Blood Pressure:	☐ Yes ☐ No
History of Heart Attack:	☐ Yes ☐ No	Leg Pain – Walking:	☐ Yes ☐ No	Recent EKG:	☐ Yes ☐ No
Rheumatic Fever:	☐ Yes ☐ No	Short of Breath - Exertion:	☐ Yes ☐ No	Short of Breath – Lying Flat	☐ Yes ☐ No
Short of Breath – Sleeping	☐ Yes ☐ No	Swelling of Legs:	☐ Yes ☐ No	Thrombophlebitis:	☐ Yes ☐ No
Ulcers on Leg(s):	☐ Yes ☐ No				

GASTROINTESTINAL:

Abdominal Pain:	☐ Yes ☐ No	Constipation:	☐ Yes ☐ No	Diarrhea:	☐ Yes ☐ No
Heartburn:	☐ Yes ☐ No	Jaundice:	☐ Yes ☐ No	Liver Disease:	☐ Yes ☐ No
Rectal Bleeding:	☐ Yes ☐ No	Abdominal X-Ray Tests:	☐ Yes ☐ No	Antacid Use:	☐ Yes ☐ No
Black Tarry Stools:	☐ Yes ☐ No	Change in Frequency of BM:	☐ Yes ☐ No	Change in Stool Caliber:	☐ Yes ☐ No
Change in Stool Color:	☐ Yes ☐ No	Change in Stool Consistency:	☐ Yes ☐ No	Decreased Appetite:	☐ Yes ☐ No
Excessive Hunger:	☐ Yes ☐ No	Excessive Thirst:	☐ Yes ☐ No	Gallbladder Disease:	☐ Yes ☐ No
Hemorrhoids:	☐ Yes ☐ No	Hepatitis:	☐ Yes ☐ No	Infections:	☐ Yes ☐ No
Laxative Use:	☐ Yes ☐ No	Nausea:	☐ Yes ☐ No	Rectal Pain:	☐ Yes ☐ No
Swallowing Problem:	☐ Yes ☐ No	Vomiting:	☐ Yes ☐ No	Vomiting Blood:	☐ Yes ☐ No

MUSCULOSKELETAL:

Arthritis:	☐ Yes ☐ No	Joint Pain:	☐ Yes ☐ No	Gout:	☐ Yes ☐ No
Back Problems:	☐ Yes ☐ No	Deformities:	☐ Yes ☐ No	Joint Stiffness:	☐ Yes ☐ No
Muscle Cramps:	☐ Yes ☐ No	Muscle Stiffness:	☐ Yes ☐ No	Paralysis:	☐ Yes ☐ No
Restricted Motion:	☐ Yes ☐ No	Weakness:	☐ Yes ☐ No		

PSYCHIATRIC:

Depression:	☐ Yes ☐ No	Behavioral Change:	☐ Yes ☐ No	Disorientation:	☐ Yes ☐ No
Disturbing Thoughts:	☐ Yes ☐ No	Excessive Stress:	☐ Yes ☐ No	Hallucinations:	☐ Yes ☐ No
Memory Loss:	☐ Yes ☐ No	Mood Changes:	☐ Yes ☐ No	Nervousness:	☐ Yes ☐ No
Psychiatric Disorders:	☐ Yes ☐ No				

NEUROLOGICAL:

Loss of Consciousness:	☐ Yes ☐ No	Blackouts:	☐ Yes ☐ No	Burning:	☐ Yes ☐ No
Dizziness:	☐ Yes ☐ No	Fainting:	☐ Yes ☐ No	Head Injury:	☐ Yes ☐ No
Headaches:	☐ Yes ☐ No	Memory Loss:	☐ Yes ☐ No	Numbness:	☐ Yes ☐ No
Paralysis:	☐ Yes ☐ No	Speech Disorder(s):	☐ Yes ☐ No	Stroke(s):	☐ Yes ☐ No
Tingling:	☐ Yes ☐ No	Tremors:	☐ Yes ☐ No	Unsteady Gait:	☐ Yes ☐ No

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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

ENDOCRINE:

Weakness:	☐ Yes ☐ No	Weight Gain:	☐ Yes ☐ No	Weight Loss:	☐ Yes ☐ No
Cold Intolerance:	☐ Yes ☐ No	Excessive Urination:	☐ Yes ☐ No	Fatigue:	☐ Yes ☐ No
Goiter:	☐ Yes ☐ No	Heat Intolerance:	☐ Yes ☐ No	Increased Thirst:	☐ Yes ☐ No
Neck Pain:	☐ Yes ☐ No	Sweats:	☐ Yes ☐ No	Thyroid Trouble:	☐ Yes ☐ No

HEMATOLOGIC/LYMPH:

Anemia:	☐ Yes ☐ No	Bleeding Easily:	☐ Yes ☐ No	Blood Clots:	☐ Yes ☐ No
Bruise Easily:	☐ Yes ☐ No	Lumps:	☐ Yes ☐ No	Radiation Exposure:	☐ Yes ☐ No
Swollen Glands:	☐ Yes ☐ No	Transfusion Reaction:	☐ Yes ☐ No		

ALLERGIC/IMMUNOLOGIC:

Coughing:	☐ Yes ☐ No	Cough with Exercise:	☐ Yes ☐ No	Hives:	☐ Yes ☐ No
Itchy Eyes:	☐ Yes ☐ No	Itchy Nose:	☐ Yes ☐ No	Recurrent Infections:	☐ Yes ☐ No
Runny Nose:	☐ Yes ☐ No	Sneezing:	☐ Yes ☐ No	Stuffy Nose:	☐ Yes ☐ No
Watery Eyes:	☐ Yes ☐ No	Wheezing:	☐ Yes ☐ No	Wheeze with Exercise:	☐ Yes ☐ No

GENITOURINARY:

Awakening to Urinate:	☐ Yes ☐ No	Bed-Wetting:	☐ Yes ☐ No	Blood in Urine:	☐ Yes ☐ No
Burning:	☐ Yes ☐ No	Difficulty Starting Stream:	☐ Yes ☐ No	Excessive Urination:	☐ Yes ☐ No
Flank Pain:	☐ Yes ☐ No	Frequency:	☐ Yes ☐ No	Incontinence:	☐ Yes ☐ No
Infections:	☐ Yes ☐ No	Pain on Urination:	☐ Yes ☐ No	Retention:	☐ Yes ☐ No
Stones:	☐ Yes ☐ No	Urgency:	☐ Yes ☐ No	Urine Discoloration:	☐ Yes ☐ No
Urine Odor:	☐ Yes ☐ No				

CONDITION(S) NOT LISTED ABOVE: _____

_____

Allergies:

☐ No Known Drug Allergies

☐ Adhesive Tape	☐ Amoxicillin	☐ Aspirin	☐ Betadine	☐ Biaxin	☐ Celebrex
☐ Codeine	☐ Demerol	☐ Erythrocin	☐ Erythromycin Base	☐ Flexeril	☐ Glucophage
☐ Hydrocodone	☐ Ibuprofen	☐ Iodine	☐ IVP Dye, Iodine Containing	☐ Keflex	☐ Latex
☐ Lidocaine	☐ Morphine	☐ Novocain	☐ NSAIDS	☐ Penicillin	☐ Salicylate
☐ Sulfa (Sulfonamides)	☐ Tetanus Toxoid	☐ Tetracycline	☐ Vicodin		

Allergies not listed above: _____

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Medications (list all):

Medication Name:	Dosage:	Frequency:	Prescribing Doctor:

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: _____

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Patient & Family Medical History: Check the box underneath regarding yourself and the family member who has ever experienced the condition listed on the left of the table below. (Also, indicate for all relatives whether they are alive or deceased).

CONDITION	Patient	Mother	Father	Sister	Brother	Other 1st Degree Relative
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)						
Alive						
Deceased						

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please Select All That Apply To You In Each Section:

Social History:

Tobacco Use:

Cigarettes ----------	☐ Smoke Daily	☐ Smoke Occasionally	☐ Quit	☐ Never Smoked
Cigars ----------	☐ Smoke Daily	☐ Smoke Occasionally	☐ Quit	☐ Never Smoked
Pipe ----------	☐ Smoke Daily	☐ Smoke Occasionally	☐ Quit	☐ Never Smoked
Chewing Tobacco ----	☐ Smoke Daily	☐ Smoke Occasionally	☐ Quit	☐ Never Smoked
Dipping Tobacco -----	☐ Smoke Daily	☐ Smoke Occasionally	☐ Quit	☐ Never Smoked

Alcohol Use:

History of Alcohol use:	☐ No			
Beer ----------	☐ Social	☐ Occasional	☐ Light	☐ Heavy
Wine ----------	☐ Social	☐ Occasional	☐ Light	☐ Heavy
Hard Liquor ---	☐ Social	☐ Occasional	☐ Light	☐ 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

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

Surgeries Not Listed Above: _____

TEXAS SPINE & NEUROSURGERY

A copy of this signed authorization must be given to the individual

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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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.

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

ASSIGNMENT OF BENEFITS

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

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, private insurance and any other health/medical plan, to issue payment check(s) 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.

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 further understand that fees are due and payable by cash, personal check, certified check or cashier's check on the date that the services are rendered and agree to pay all such charges incurred 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 Patient or Responsible Party

X _____ _____
Patient or Responsible Party's Signature Date

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, **Texas Spine & Neurosurgery** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare 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 healthcare operations of **Texas Spine & Neurosurgery** such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of **Texas Spine & Neurosurgery's** treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above. I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of how **Texas Spine & Neurosurgery** may use and disclose my protected healthcare information. I further understand that **Texas Spine & Neurosurgery** reserves the right to change its *Notice of Privacy Practices*. Should **Texas Spine & Neurosurgery** change its *Notice of Privacy Practices*, an amended copy will be posted in a prominent location in the practice site, or upon my request an amended copy will be sent to the address I have provided.

I agree that **Texas Spine & Neurosurgery** may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address I have provided;
- Send routine correspondence, such as billing statements, to the address I have provided;
- Leave messages on an answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

X _____ _____

Patient or Responsible Party's Signature Date

X _____ _____

Witness Relationship of Patient to Witness

TEXAS SPINE & NEUROSURGERY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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.

_____ _____

Patient Name (Please print) Date

_____ _____

Printed Name of Patient's Representative 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, TX 76712-3793

TEXAS SPINE & NEUROSURGERY

Phone: 254 732.3987
Fax: 254.732.3823
Email: 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: _____ Today's Date: _____

X _____ _____

Patient's Signature Date