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:

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

Please fill out the following forms completely in ink. Do not use pencil! We are providing you with information regarding our policies and procedures. Please read over these pages and sign them. This information will help with questions you may have regarding your care.

Through Oct. 31, 2014, our office is open from 9:00am to 11:00am, and from Noon – 5:00pm Monday through Thursday, excluding holidays. We are open from 9:00am to Noon on Friday, excluding holidays. Beginning Nov. 1, 2014, our office will be open from 8:30am to 11:00am, and from Noon – 4:30pm Monday through Thursday, excluding holidays. We will continue to be open from 9:00am to Noon on Friday, 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 will likely 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 $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.

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.

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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 4 satellite clinics throughout Central 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:

ENNIS (Satellite Location)
Ennis Chiropractic and Wellness Center
109 N.W. Main Street
Ennis, TX 75119

GATESVILLE (Satellite Location)
Coryell Memorial Hospital
1507 W Main Street
Gatesville, TX 76528

GROESBECK (Satellite Location)
Family Medicine Center (Limestone Medical Center)
Medical Arts Building
801 McClintic Drive
Groesbeck, TX 76642

HILLSBORO (Satellite Location)
Hill County Chiropractic
1313 East Franklin Street
Hillsboro, TX 76645

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Appointment Date: _____

Patient Information:

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 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, CHECK, VISA, MASTERCARD OR DISCOVER

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:	☐ 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 _____ times
☐ Chiropractic x ____ months	☐ Pain Medication x ___ months	☐ Exercise x ____ months
☐ Massage x ___months	☐ TENS Unit x ____ months	☐ OTC Medication x ____ months

☐ Other (please list): _____

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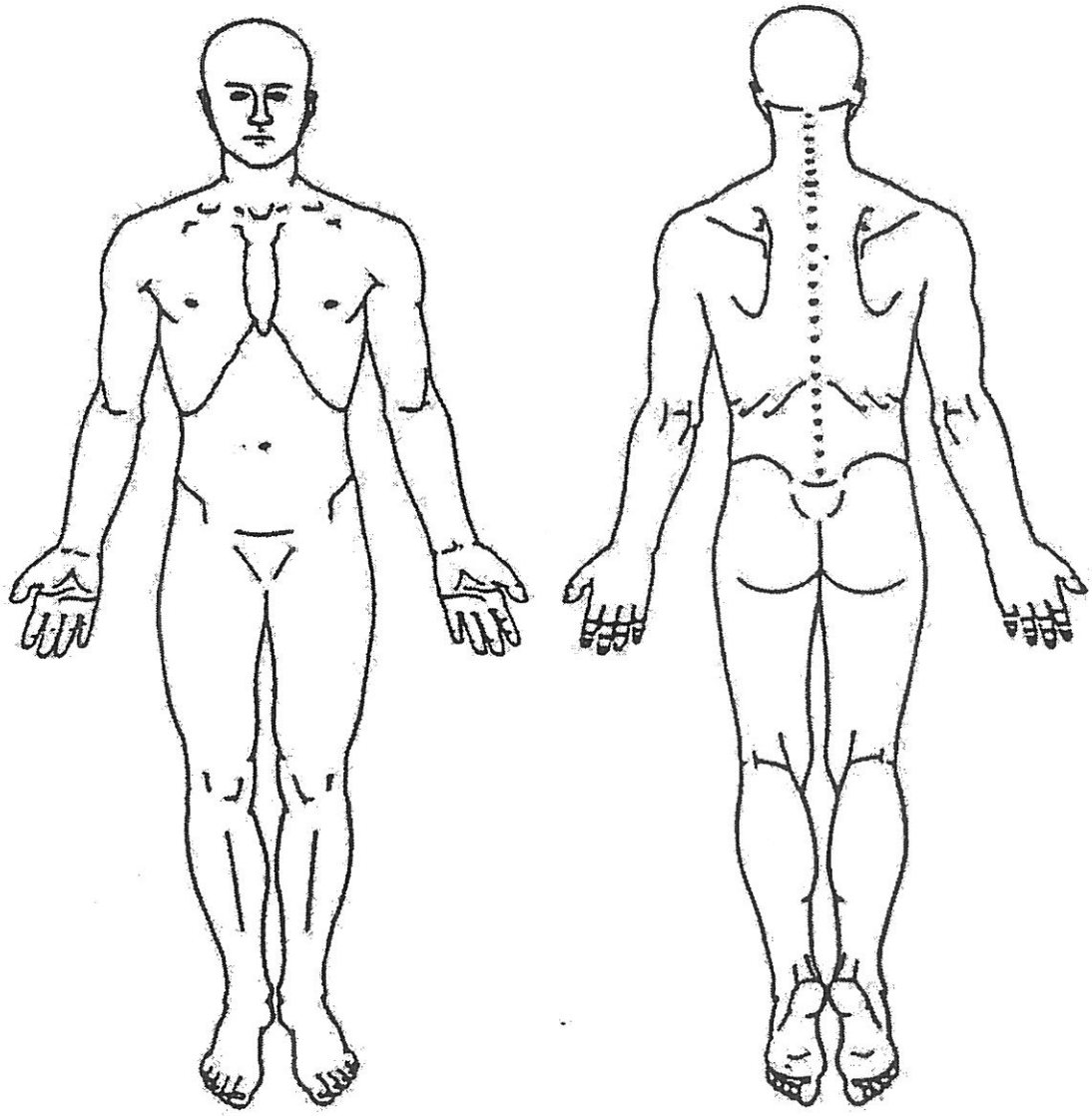
Patient Name: _____ Date of Birth: _____ Appointment Date: _____

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

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	Pain with Light:	☐ Yes ☐ No	Recent Injury:	☐ Yes ☐ No
Redness:	☐ Yes ☐ No	Vision Loss:	☐ Yes ☐ No	Floaters:	☐ 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:

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

RESPIRATORY:

Cough:	☐ Yes ☐ No	Wheezing:	☐ Yes ☐ No	Bronchitis:	☐ 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

CARDIOVASCULAR:

Chest Pain:	☐ Yes ☐ No	Palpitations:	☐ Yes ☐ No	Varicose Veins:	☐ Yes ☐ No
Extremity(s) Discolored:	☐ Yes ☐ No	Heart Murmur:	☐ Yes ☐ No	Leg Pain - Walking:	☐ 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		

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GASTROINTESTINAL:

Abdominal Pain:	☐ Yes ☐ No	Constipation:	☐ Yes ☐ No	Diarrhea:	☐ Yes ☐ No
Jaundice:	☐ Yes ☐ No	Rectal Bleeding:	☐ Yes ☐ No	Antacid Use:	☐ Yes ☐ No
Change in Frequency of BM:	☐ Yes ☐ No	Change in Stool Color:	☐ Yes ☐ No	Change in Stool Consistency:	☐ Yes ☐ No
Hemorrhoids:	☐ Yes ☐ No	Laxative Use:	☐ Yes ☐ No	Nausea:	☐ Yes ☐ No
Vomiting:	☐ Yes ☐ No	Vomiting Blood:	☐ Yes ☐ No	Change in Appetite:	☐ Yes ☐ No

MUSCULOSKELETAL:

Joint Pain:	☐ Yes ☐ No	Deformities:	☐ Yes ☐ No	Joint Stiffness:	☐ Yes ☐ No
Muscle Cramps:	☐ Yes ☐ No	Muscle Stiffness:	☐ Yes ☐ No	Restricted Motion:	☐ Yes ☐ No

PSYCHIATRIC:

Behavioral Change:	☐ Yes ☐ No	Disorientation:	☐ Yes ☐ No	Excessive Stress:	☐ Yes ☐ No
Hallucinations:	☐ Yes ☐ No	Memory Loss:	☐ Yes ☐ No	Mood Changes:	☐ Yes ☐ No
Nervousness:	☐ Yes ☐ No				

NEUROLOGICAL:

Loss of Consciousness:	☐ Yes ☐ No	Dizziness:	☐ Yes ☐ No	Fainting:	☐ Yes ☐ No
Head Injury:	☐ Yes ☐ No	Numbness:	☐ Yes ☐ No	Paralysis:	☐ Yes ☐ No
Tingling:	☐ Yes ☐ No	Tremors:	☐ Yes ☐ No	Unsteady Gait:	☐ Yes ☐ No

ENDOCRINE:

Cold Intolerance:	☐ Yes ☐ No	Goiter:	☐ Yes ☐ No	Heat Intolerance:	☐ Yes ☐ No
Increased Thirst:	☐ Yes ☐ No	Neck Pain:	☐ Yes ☐ No	Sweats:	☐ Yes ☐ No

HEMATOLOGIC/LYMPH:

Bleeding Easily:	☐ Yes ☐ No	Blood Clots:	☐ Yes ☐ No	Easy Bruisability:	☐ Yes ☐ No
Lumps:	☐ Yes ☐ No	Radiation Exposure:	☐ Yes ☐ No	Swollen Glands:	☐ Yes ☐ No

ALLERGIC/IMMUNOLOGIC:

Coughing:	☐ 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		

GENITOURINARY:

Blood In Urine:	☐ Yes ☐ No	Burning:	☐ Yes ☐ No	Difficulty Starting Stream:	☐ Yes ☐ No
Excessive Urination:	☐ Yes ☐ No	Flank Pain:	☐ Yes ☐ No	Incontinence:	☐ Yes ☐ No
Infections:	☐ Yes ☐ No	Pain on Urination:	☐ Yes ☐ No	Retention:	☐ Yes ☐ No
Urgency:	☐ Yes ☐ No	Urine Discoloration:	☐ Yes ☐ No	Urine Odor:	☐ Yes ☐ No

CONDITION(S) NOT LISTED ABOVE: _____

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Patient Name: ______________________ Date of Birth: ___________ Appointment Date: ___________

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: ____

Medications (list all):

Medication Name:	Dosage:	Frequency:	Prescribing Doctor:

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

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 ----------	☐ 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**

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

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

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 Responsibilty

All professional services rendered are charged to the patient and are due at the time of service. For your convenience, we accept cash, VISA, MaterCard, Discover, traveler's or personal checks, and money orders. Of 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 majoy 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 or 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.

_____	X_____	_____
PRINT NAME of Responsible Party	Responsible Party's Signature	Appointment Date

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Patient Name: _____ Date of Birth: _____ Appointment 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

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

Patient Name: _____ Date of Birth: _____ Appointment 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.

_____ _____
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