Steven C. Zielinski, MD, CM, FRCSC
4515 Lake Shore Drive
Waco, Texas 76710

TEXAS SPINE & NEUROSURGERY

Phone: 254.732.3987
Fax: 254.732.3823
www.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 this entire packet of information and sign where indicated. This information will answer many questions you may have regarding your care, as well as explain 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. If you are more than 10 minutes late, we may need to reschedule your appointment. Expect your first appointment to last 1 – 2 hours. Subsequent appointments should 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 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.

Please note: CDs or DVDs of radiological images that are read at in our office will not be returned to you. They will remain in your chart at Texas Spine & Neurosurgery. We do not make copies of radiological images.

Co-pays, co-insurance amounts and applicable deductibles are due *before* you see the doctor. We accept 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:

WACO:
4515 Lakeshore Dr.
Waco, TX 76710

VICTORIA
4405 Lilac Lane
Victoria, TX 77901

HILLSBORO
1323 E Franklin, STE
102 Hillsboro, TX 76645

YOAKUM
1200 Carl Ramert Dr.
Yoakum, TX 77995

FAIRFIELD
764 W. Commerce
Fairfield, TX 75840

TEMPLE
1615 West Ave L
Temple, TX 76504

GROESBECK
Medical Arts Building
801 McClintic Drive
Groesbeck, TX 76642

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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 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

Primary Care Physician: _____ Referring Physician: _____

CHIEF COMPLAINT (Reason for Visit): _____

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
History of kidney dysfunction:	☐ Yes ☐ No	Removal of implant due to infection:	☐ Yes ☐ No

What are the conservative therapies you have received? ☐ NONE

☐ Chiropractic x ____ months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

☐ Physical Therapy x _____ months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

☐ ESI Injection(s) x _____ times
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

☐ TENS Unit x ____ months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

☐ Massage x ___months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

☐ Pain Medication x ___ months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

☐ Exercise x ____ months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ NO

☐ OTC Medication x ____ months
Neck or Back ? (circle one)
What Year? _____
Was it helpful? ☐ Yes ☐ No

Other (please list):

_____

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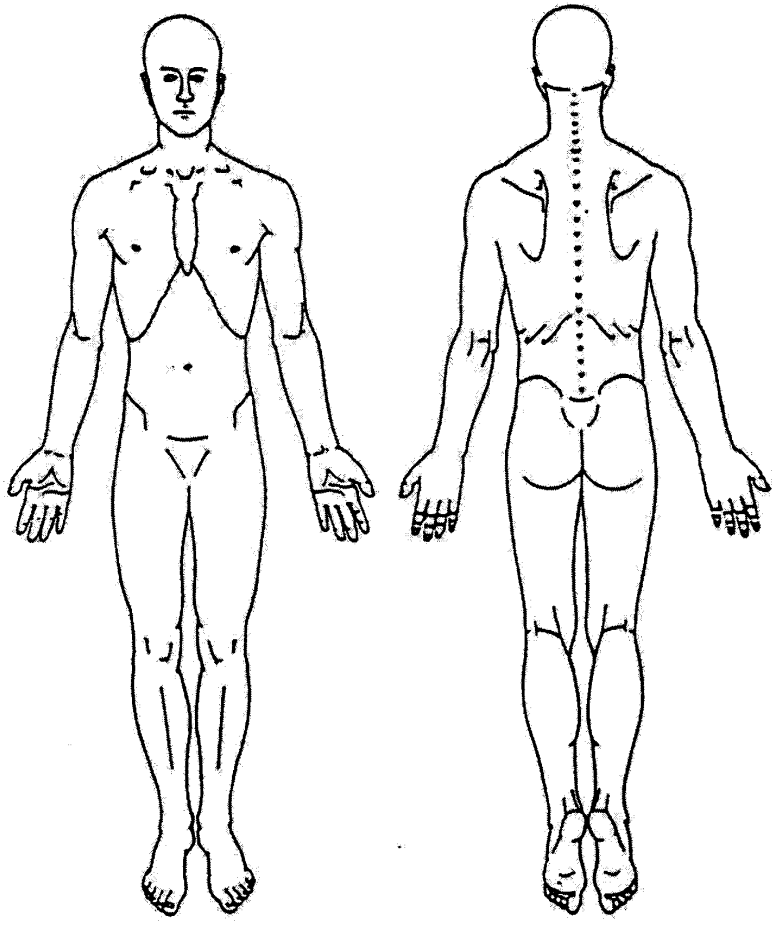
Draw your pain on the diagrams below using the symbols to show the type of pain you feel and answer the coorisponding questions.



Stabbing pain //// Pins & needles VVVV

Numbness - - - - Burning pain OOOO Aching pain XXXX

FOOT SYMPTOMS

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps? _____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

HAND SYMPTOMS

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps? _____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

CERVICAL SYMPTOMS:

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps?_____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

THORACIC SYMPTOMS

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps?_____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

LUMBAR SYMPTOMS

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps?_____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

LEG SYMPTOMS

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps?_____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

ARM SYMPTOMS

1. How would you rate your pain? MILD /MODERATE / SEVERE
2. Is the pain CONSTANT or INTERMITTENT ?
3. Does anything make the symptoms better? Y / N What helps?_____
4. Does Anything make the symptoms worse? Y / N What makes it worse?_____
5. When did your symptoms begin?_____

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Review of Systems: **Answer "yes" or "no" to the following questions:**

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CONDITION(S) NOT LISTED ABOVE:_____

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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:

Preferred Pharmacy/Phone Number:_____

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Patient Medical & Social History: Please select all boxes that apply to you

CONDITION	Patient
Anemia	
Anxiety	
Arthritis	
Asthma	
Back Problems	
BPH (male only)	
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)	

Tobacco Use:

Cigarettes--------- ☐ Smoke Daily ☐ Smoke Occasionally ☐ Never Smoked ☐ Quit
*If applicable, when did you quit Cigarettes ?*_____

Cigars ---------- ☐ Smoke Daily ☐ Smoke Occasionally ☐ Never Smoked ☐Quit
*If applicable, when did you quit Cigars ?*_____

Pipe ---------- ☐ Smoke Daily ☐ Smoke Occasionally ☐ Never Smoked ☐Quit
*If applicable, when did you quit Pipe ?*_____

Chewing Tobacco -- ☐ Smoke Daily ☐ Smoke Occasionally ☐ Never Smoked ☐ Quit
If applicable, when did you quit Chewing Tobacco ? _____

Dipping Tobacco --- ☐ Smoke Daily ☐ Smoke Occasionally ☐ Never Smoked ☐Quit
If applicable, when did you quit Dipping Tobacco ? _____

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

( ) Cocaine ( ) Heroin/IV ( ) Marijuana ( ) Methamphetamine

Last time used: _____

Household - Living Conditions:

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

Have you had any surgeries within the last 5 years? YES NO

List Surgical History:

_____

_____

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

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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 Responsibility

All professional services rendered are charged to the patient and are due at the time of service. For your convenience, we accept 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 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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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

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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 & 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 & Neurosurgery**, or to receive general information from **Texas Spine & 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 & 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

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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 4515 Lake Shore Drive, Waco, TX. 76710.

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 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