SPINE DISORDERS OF TEXAS PLLC
NEW PATIENT QUESTIONNAIRE

Today's Date: _____

Name: _____Age: _____ Date of birth: _____

Who referred you to our office? _____

When did your problem start? _____

Instructions: Only complete sections A-G below that apply to you. There will be a General Medical section that will need to be completed in full and starts on page 6.

INJURY OR TRAUMA (Section A)

Did a particular accident or injury cause your problem?

☐ No (please **skip** to Section B)

☐ Yes (continue this section)

Check only one:

☐ I never had back/neck problems in this area of my spine before this injury.

☐ I had back/neck problems in this area of my spine before, and this injury made the problem worse.

Check all that apply:

☐ This injury occurred at work.

☐ I have filed a claim through workers compensation.

DO NOT WRITE BELOW THIS LINE. (Continue questionnaire on page 2)

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main 214-285-0987 | fax 214-513-4783 | spinedisorders.net

PAIN AND DISABILITY: (Section B)

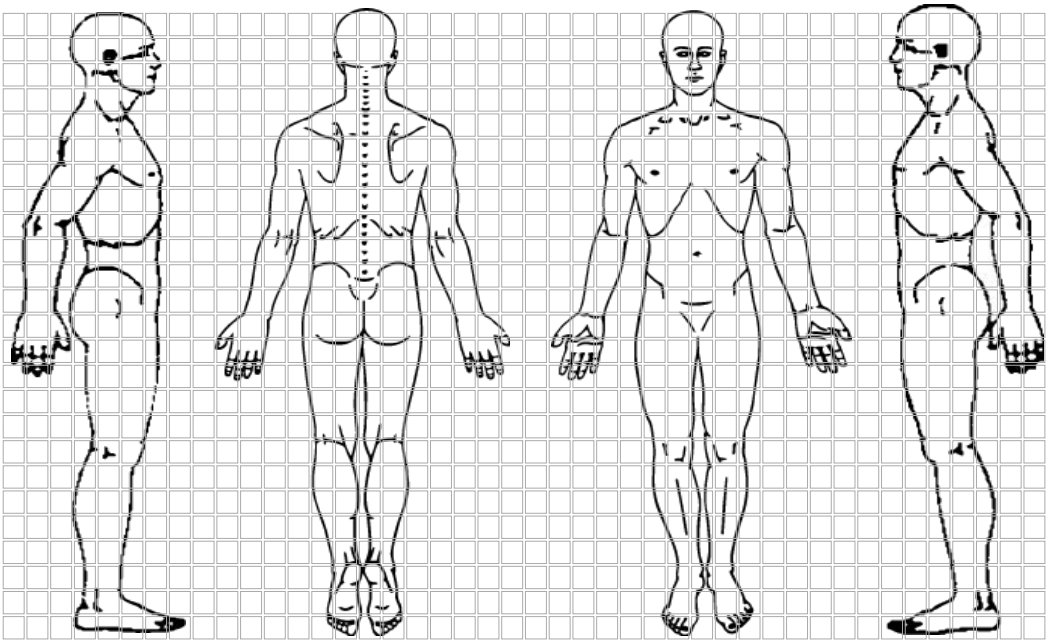
This section pertains to **pain only**. You will have an opportunity to answer questions about numbness and tingling in **section C**.

Does your neck or back problem cause pain? ☐ No (please **skip** to section C)

☐ Yes (Continue this section) Mark your **pain** on the fig below.

Please mark on the figure below to show where you feel **pain**.

RIGHT BACK FRONT LEFT



Pain scale 0-10 (0= No pain, 10= pain severe enough to pass out)

What number would you give your pain today? _____

What number would you give your pain on average? _____

What number would you give your pain at its worse? _____

Please check all that describe your pain:

☐ Burning ☐ Sharp/Stabbing ☐ Tingling ☐ Aching ☐ Throbbing

☐ Shooting ☐ Pulling/Tearing ☐ Cramping ☐ Other: _____

Please check all of the appropriate responses in each category to complete the phrase "My pain... "

☐ began suddenly ☐ began gradually ☐ interrupts my sleep

☐ is constant ☐ comes and goes

My pain is worse.....

☐ during the day ☐ at night ☐ in the AM ☐ in the afternoon

My pain is worse when.....

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ lifting ☐ driving

☐ applying heat ☐ applying ice ☐ exercising ☐ Frequently changing positions ☐ Lying

☐ sports (list)_____ ☐ Over head activity ☐ **Nothing makes my pain worse**

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My pain is better while.....

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ lifting ☐ driving

☐ applying heat ☐ applying ice ☐ exercising ☐ Frequently changing positions ☐ Over head activity

☐ Lying on Back ☐ Lying on Side ☐ Lying on Stomach ☐ Recliner ☐ sports (list)_____

☐ **Nothing makes my pain better**

Overall, which single word or phrase would you use to describe your pain the majority of the time?

☐ Trivial/Minimal ☐ Annoying ☐ Limiting ☐ Disabling ☐ Unbearable

Because of my pain, I am unable to.....

☐ Walk over _____miles ☐ Run over _____miles ☐Sit longer than _____☐min or ☐hours (check one)

☐ Stand longer than ____☐min or ☐hrs (check one) ☐Lift over _____lbs

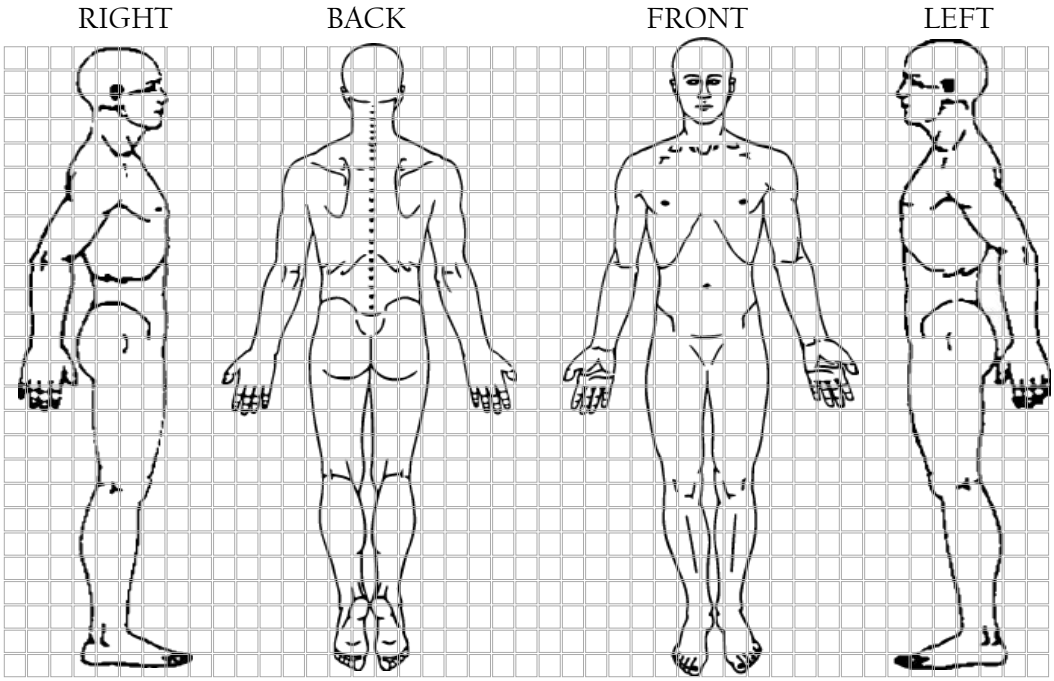
NUMBNESS/TINGLING (Section C)

This section pertains to numbness/tingling **only**. Questions about pain are in the previous section **(section B)**.

Do you feel numbness or tingling? ☐ No (please **skip** to section D)

☐ Yes (continue this section)

Please mark on the figure below to show where you feel **numbness** (loss of feeling) or **tingling** (pins and needles).



My numbness and tingling are made worse while.....

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ lifting ☐ driving

☐ heat ☐ Ice ☐ exercising ☐ Frequently change of position

☐ sports (list)_____ ☐ **Nothing makes my numbness or tingling worse**

My numbness and tingling are made better while.....

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ lifting ☐ driving

☐ heat ☐ Ice ☐ exercising ☐ Frequently change of position

☐ sports (list)_____ ☐ **Nothing makes my numbness or tingling better**

SPINAL DEFORMITY/TUMOR (Section D)

Do you have a curve, lump, or mass near or on your spine?

☐ No (please **skip** to section E)

☐ Yes (complete this section)

Please check all that apply to your situation.

☐ I have a spinal curvature or deformity (scoliosis or kyphosis) that **was present at birth**

☐ I have a spinal curvature or deformity (scoliosis or kyphosis) that **developed in childhood**, and was not present or obvious at birth

☐ I have a spinal curvature or deformity (scoliosis or kyphosis) that **developed as an adult**, and was not present in childhood

☐ I wore a brace when I was younger to help my scoliosis or kyphosis

☐ I am wearing a brace now

☐ I have noticed my spinal curvature getting worse

☐ My clothes no longer fit or hang properly

☐ I have a lump or mass on my spine that is **getting larger**

☐ I have a lump or mass on my spine that is **not getting larger**

☐ The mass is painful

☐ The mass is **not** painful

ASSOCIATED PROBLEMS (Section E)

Please check all that apply to you

☐ Clumsiness in hands

☐ Must look at feet in order to walk

☐ Leakage of bowel contents or staining underwear

☐ Unable to completely empty your bladder

☐ Unable to look forward without bending knees

☐ Frequent falling or stumbling

☐ Unable to stand up straight

☐ Leakage of Urine or staining underwear

☐ Impotence

☐ **I HAVE NONE OF THE ABOVE PROBLEMS**

TESTING AND TREATMENT (Section F)

Which of the following tests have you had in the last year for your spine problem? (check all that apply)

☐ X-Rays ☐ Blood test ☐ Myelogram ☐ MRI ☐ CT (CAT Scan)

☐ Discogram ☐ Bone Density scan ☐ Nuclear Bone Scan ☐ Nerve Study (EMG/NCS)

☐ Other _____

☐ **I HAVE HAD NO TESTS TO EVALUATE MY PROBLEM**

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Your treatment history (Please check all that apply)

		Complete relief	Improved	Unchanged	Worse
	Physical Therapy	☐	☐	☐	☐
	Home Exercises	☐	☐	☐	☐
	Chiropractic	☐	☐	☐	☐
	Epidural Steroid Injection (performed in the Hospital)	☐	☐	☐	☐
	Facet Joint Injection (performed in the Hospital)	☐	☐	☐	☐
	Local or Trigger Point Injection (performed in the office)	☐	☐	☐	☐
	Massage	☐	☐	☐	☐
	Brace, Corset, or other support	☐	☐	☐	☐
	Acupuncture	☐	☐	☐	☐
	Other	☐	☐	☐	☐
	I HAVE NOT STARTED OR COMPLETED ANY OF THE ABOVE TREATMENTS ☐				

Please list all medication you have tried or currently take. Please include last date used, dose, number of pills per day and if the medication helped.
(**examples** = Naproxen, Voltaren, Ibuprofen, Feldine, Orudis, Indocin, Vicodin, Percocet, Oxycontin, Darvocet, Morphine, Soma, Flexeril, Robaxin, Skelaxin, Baclofen, Celebrex, Mobic, Neurontin, Lyrica, Elavil, Cymbalta, Ultram, Trazadone etc)

When last used? mm/yy	Medication (e.g. Motrin)	Dose (e.g. 800mg)	Number of pills per day (e.g. 4)	Did the medication help? (e.g. very helpful)

PRIOR SPINE SURGERY (Section G)

Have you ever had surgery on your spine? ☐ No (please skip to medical history)

(This includes Fusions, decompressions, or any disc procedures) ☐ Yes (complete this section)

Date	Procedure	Rate the outcome of surgery Poor, good or excellent (See Legend below)

Legend: Poor = the surgery had no change or made me worse
Good = the surgery improved my symptoms
Excellent = Dramatically improved or resolved my symptoms

General Medical Section

(Complete all areas below)

MEDICAL HISTORY

Please check any medical problem you currently have or have experienced in the past.

☐	Diabetes(Sugar)	☐	Seizures	☐	Hypertension (high blood pressure)
☐	Stroke	☐	**Heart Disease**	☐	Emphysema
☐	Brain Aneurysm			☐	COPD
☐	Hepatitis	☐	Anemia	☐	Asthma
☐	HIV/AIDS	☐	Blood Clotting Problems	☐	Osteoporosis/Osteopenia
☐	Valley Fever (coccidiomycosis)	☐	Kidney problems (i.e. renal failure, stones, infection)	☐	Cancer (type): _____ _____
☐	Tuberculosis	☐	Thyroid	☐	Stomach Ulcers
☐	Other Joint Pain	☐	Rheumatoid Arthritis	☐	Reflux Disease
☐	Depression	☐	Hiatal Hernia	☐	Psychiatric illness: _____
☐	**I have not had any medical problems**	☐	Other:		

What medications do you take for problems UNRELATED to your spine?

Medication	Dose

Please list all non-spine related surgeries:

Procedure	Date (month/year)

Please list all the Doctors you have seen in the last 2 years:

Doctor	Office Phone Number	Issue or Problem

MEDICATION ALLERGIES

☐ I do not know of any allergies or reactions to any medication

☐ I am allergic to (check all that apply):

Sulfa ☐	Codeine ☐	Penicillin (PCN) ☐	Latex ☐	Contrast Dye ☐	Shellfish ☐

Other medication reactions: (Please use other side if necessary)

Medication	Reaction

FAMILY HISTORY

Please check next to any medical problem that runs in your family.

☐	Diabetes(Sugar)	☐	Seizures	☐	Hypertension (high blood pressure)
☐	Stroke or Aneurysm	☐	Heart Disease	☐	Emphysema/COPD
☐	Hepatitis	☐	Kidney/Bladder problems	☐	Asthma
☐	Tuberculosis	☐	Valley Fever (coccidiomycosis)	☐	Stomach Ulcers or Reflux disease (Peptic ulcer, hiatal hernia, etc)
☐	Osteoarthritis (Degenerative)	☐	Rheumatoid Arthritis	☐	Cancer (type): _____
☐	Depression			☐	Psychiatric illness: _____
☐	**I have not had any medical problems**	☐	Other:		

SOCIAL HISTORY

What is your current occupation? _____
How long? _____

Please check all that apply to your work or school status:

☐ I have missed no time from work or school because of my spine problem

☐ I am currently working full time

☐ I have missed a total of _____ days from work or school because of my spine problem

☐ I am working: ☐Part time ☐Limited Duty

☐ I am unable to work at all because of my spinal problem

☐ I am unable to work at all because of another problem not related to my spine (diagnosis) _____

☐ The last date I worked was: _____

☐ I have been receiving worker's compensation since _____

☐ I have been on disability since _____

What is your marital status (check one)?

☐Single	☐Married	☐Separated	☐Divorced	☐Widowed

What is your living situation (check one)?

☐Homeless	☐with children	☐with spouse	☐with relatives	☐Alone

List your recreations or sports with frequency and duration.

_____
_____
_____
_____
_____

Please check all that apply to you:

☐ I never smoked cigarettes
☐ I quit smoking _____years/months ago
☐ I smoke cigarettes at _____packs per day
☐ I have smoked for _____years
☐ I chew tobacco
☐ I never drink alcohol
☐ I drink alcohol (check one)

☐Very often	☐Daily	☐Weekly	☐Monthly	☐Rarely

☐ I am recovering from a drinking problem
☐ Recreational drug use

☐ I have not, nor do I plan to take legal action related to this injury.
☐ I am considering or have taken legal action as a result of this injury.
☐ Legal action related to this injury is closed or settled.

REVIEW OF SYSTEMS

Please check all problems below that apply to you.

☐	Shortness of Breath	☐	Nausea and Vomiting	☐	Fever
☐	Chest Pain	☐	Fainting	☐	Chills
☐	Memory problems	☐	Loss of Consciousness	☐	Night Sweats
☐	Anxiety or Nervousness	☐	Dizziness	☐	Bowel Incontinence (Uncontrolled defecation)
☐	Chronic Fatigue	☐	Convulsions	☐	Unable to Urinate
☐	Frequent Headaches	☐	Unexplained Weight Loss	☐	Loss of Appetite

Thank you for completing the questionnaire. It will be incorporated into your initial evaluation.

The End

Spine Disorders of Texas PLLC

RELEASE OF INFORMATION AUTHORIZATION/ASSIGNMENT OF BENEFITS FOR MEDICAL PAYMENT OF SERVICES/ ACKNOWLEDGMENT OF OFFICE POLICIES

Authorization for release of Information: I authorize Spine Disorders of Texas PLLC (SDT) to disclose all or any part(s) my medical record to listed insurance companies and any agency conducting reviews concerning Worker's Compensation care.

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to SDT by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer. In the event I receive payment from my insurance company for services at SDT, I will surrender the payment to SDT

Insurance: SDT will file your insurance as a service to you. If our office does not hear from your insurance company within 60 days, we request your help in contacting your insurance company to resolve the payment delay. **The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.**

Payment of Services: I understand that I am financially responsible for all charges and fees related to my care, I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles, and any service not covered by my insurance plan. In the event my account is referred to a collection agency I will be responsible for collection costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPPA): I acknowledge that a copy of the HIPPA Notice of Privacy Practices was made available to me.

Valuables: I (we) understand that SDT is not responsible for valuables and personal property brought to the facility.

Medical Release Forms: I understand that information within my medical record is protected by law and the physicians and staff of SDT **WILL NOT** disclose any information to outside entities without my written consent, this includes my spouse and family members. I also understand that any signed Medical Release forms are good for 1 year unless otherwise noted and therefore must be updated appropriately.

Personal Information: I understand that it is my sole responsibility to keep SDT up to date regarding any changes with my address, contact numbers, insurance plans, etc.

Disability Forms: I understand that SDT is not obligated to complete any disability forms (FMLA for self or a family member, short term or long-term disability, etc.) and offer this as a service. I understand that there are fees associated for this service and that completed forms will NOT be released to myself, my employer, or my disability insurance company until payment is received. I further understand that it takes 7-10 business days to complete disability forms and respond to request for records that are for the purpose of determining disability status. THIS IS NOT THE CASE FOR WORKER'S COMPENSATION PATIENTS.

No Show and Cancellation Policy: Although SDT understands that situations may arise that can lead me to cancel my appointment, I understand that SDT requests a 24-hour notice for cancellations so that another patient can be put in my timeslot. I further acknowledge that SDT will charge a "no show" fee in the event that I do not call and cancel my scheduled appointment/surgery in the amount of $50.00 for office appointments and $100.00 for a scheduled surgery/procedure.

Treatment: I understand that I am responsible for **facilitating** my care and that it is expected of me to be compliant with my treatment plan and communicate with SDT clinical staff if I am unable to finish my course of treatment.

Other Medical Providers: You are responsible for reviewing your insurance benefits regarding coverage for other providers (Anesthesiology, Pathology, Medicine, 1st Assistants, etc) who may be involved in your surgery. Keep in mind that during your hospitalization there may be other providers involved in your case that are integral to your outcome, that may not be contracted with your insurance carrier, and you will be responsible for part or all of their bill.

It is not always possible to have everyone involve in your surgery contracted with your insurance.

I certify I have read and fully understand all of the above information to include the consent for treatment, release of information, insurance authorization, and assignment and payment of services

_____ _____

Patient or Responsible Party Signature Date

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Spine Disorders of Texas PLLC

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Authorized Parties:

By signing below, I authorize Spine Disorders of Texas PLLC, its agents and employees ("Provider"), to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party: Relationship:

_____

_____

_____

_____

Signature:_____ Date:_____

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FINANCIAL POLICY

This is an agreement between Spine Disorders of Texas PLLC and the Patient/ Debtor. In this agreement the words "you", "your" and
"your" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Spine Disorders of Texas PLLC. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Financial Charge: Periodic rate (10 %) to the "30-day overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. Outstanding balance over 60 days will be charged an additional 20% (Total 30%). After 90 days, the total balance will be sent to collections.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this if we have to refer your account to a collection agency, you agree to pay all of the collection cost which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers fees which we incur plus all court cost. In case of suit, you agree the venue shall be in Maricopa County, AZ.

Returned Checks: There is a fee (currently $25) for any checks returned by the bank.

Missed appointment fee: A 24-hour cancellation call must be made by the patient to cancel an appointment. If this call is not received, there will be a $50 "no show" fee for office visits and a $100 "no show" fee for surgery, added to your account.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

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Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral or pre-authorization may result in a lower payment from the insurance company and more patient fees.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires referral/prior authorization, you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment from insurance and higher payment from you.

Financial Charge: Periodic rate (10 %) to the "30-day overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. Outstanding balance over 60 days will be charged an additional 20% (Total 30%). After 90 days, the total balance will be sent to collections.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Peer to Peer Prior Authorization: Occasionally, services other than a standard office visit, require prior authorization from your insurance company. Our office will supply your insurance with all the necessary forms, reports, and documentation needed in order to provide authorization. A peer to peer review occurs when an insurance company requires our doctor to speak directly to an insurance company doctor despite the fact that all of the information given during the peer to peer review has already been supplied to the insurance company in great written detail. In the rare case that a peer to peer review is required for this prior authorization we will charge you a $50.00 fee for the extensive time that these reviews can take. Your insurance company will not pay for this charge and it must be paid prior to the peer to peer review being initiated.

Patient's name: _____

Responsible party: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Spine Disorders of Texas PLLC

Research Release Form

The Physicians and staff at the Spine Disorders of Texas PLLC (SDT) are dedicated to providing evidence-based medicine. In order to ensure that you the patient are receiving such care, it is necessary to utilize our patient's medical history along with their treatment plans as a source of study and information.

By signing this form, you are giving the physicians and staff of SDT permission to utilize your medical records for the purposes of research, lectures, and patient education videos. **Your medical records, for these purposes are defined as your diagnostic images and your medical history.** At no time will your name, date of birth, or social security number be disclosed to anyone.

Please indicate below whether or not you will allow SDT to use your medical information for the purpose of research.

☐ *Do not release any of my medical information for any reason*

☐ *I give permission for SDT to use my medical information for the purposes outlined above.*

_____ _____

Patient Signature Date

From time to time we have patients that have questions regarding their upcoming surgery and request to get in touch with a past surgical patient. If you have had surgery by Dr. Duane Pitt and would be interested in participating in a patient education program to mentor future surgical patients, please sign below. Your signature gives SDT permission to disclose your name and number **ONLY** to another patient for the sole purpose of gaining insight regarding their treatment plan. At no time will any medical history be disclosed.

_____ _____

Patient Signature Date

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Spine Disorders of Texas PLLC
Controlled Substance Protocol

One or more of the medications that your doctor has prescribed to for your pain are classified as **controlled substances.** These medications are very helpful in treating pain and returning patients to work, yet they are subject to abuse. For this reason, the state and federal government closely controls this class of medication. So that we may minimize the possibility of complications associated with the use of controlled medication for pain management, we ask that you read and agree to the following.

Controlled Substances covered by this agreement include, but are not limited to: **Oxycontin, MS Contin, Percocet, Percodan, Norco, Vicodin, Lortab, Lorcet, Darvocet, Darvon, Codeine, Soma, and all barbiturates and tranquilizers**. If you have any questions as to what drugs fall under this agreement, please ask your physician.

Common side effects and complications associated with the use of controlled substances include disorientation, decreased alertness, increased risk when operating motor vehicles and other machinery, drowsiness, confusion, constipation and other problems. Prolonged use of these medications may lead to a problem called **tolerance** (where increasing amounts of medication are needed to provide the same level of pain relief). Tolerance may in turn lead to **habituation and addiction** (where the body becomes used to taking the medication and sudden discontinuation of the drug leads to **withdrawal**).

As a patient of Spine Disorders of Texas PLLC (SDT), I agree to the following:

1. While I am receiving controlled medication from SDT, I will not accept or request any controlled substance from any other physician or source.
2. I am fully responsible for all medication prescribed and will control such medication in my possession. If any medication is lost, stolen, or if I use more than directed, I understand a new prescription will not be written or called into a pharmacy prior to the anticipated end of the original prescription. I am responsible for taking my medication as directed and keeping track of the remaining medication.
3. I understand and agree that refills of controlled substances will only be provided during regular office hours 8am to 4pm. No medication will be refilled on the weekend, holidays, or after hours. Refills requested before 12 Noon will be filled within two business days. I will call in my refill request no later than 4 business days prior to running out of medication.
4. I will provide remaining bottles of medication, with any remaining medication contained therein, to the pharmacist or my physician if requested.
5. Because many illicit drugs and other medication can cause fatal complications when mixed with controlled substances, I agree to drug screening if requested by my physician. Refusal on my part may constitute a violation of this controlled substance agreement.
6. So that potential drug interactions may be avoided, I affirm that I have provided my physician with a complete list of other medication that I am taking.

I understand that this protocol is intended to aid my treating physician, and that it is my responsibility to inform my physician of any side effects or complications that may arise from my use of this medication.

My signature below and, use of the medication prescribed, indicates that I understand and accept the information and conditions outlined above. I agree that if I am unable to adhere to this agreement, my SDT physician will no longer prescribe this class of medication.

Patient Signature: _____Date: _____

Witness: _____Date: _____

Patient Name:_____ Date of Birth: _____

Notice to Patients

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). We support this law and in compliance with the requirements of this law, you are being advised we have a direct financial interest in the following diagnostic or treatment agency or in the following non-routine goods or services (hospital, surgery center, durable medical equipment, neuromonitoring, and other ancillary services). Further, these goods or services we prescribed are available elsewhere on a competitive basis.

Your surgeon may elect to use an FDA approved product in an "off Label" way, if it is judged to be more beneficial to your surgery's success than other methods. An example may include screws in the back of your cervical spine for stabilization.

Bone morphogenic Protein (BMP) has been FDA approved but it is commonly used "off label" to help the spine heal in fusion procedures involving the spine. Your surgeon may elect to use this FDA approved fusion enhancement technology in an "off label" way, if it is judged to be more beneficial to your surgery's success than other methods.

If you have any concerns with the information above, please feel free to discuss them with your surgeon prior to your surgery.

ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS? _X_ Yes ___No
Services at the above facilities or companies are available on a competitive basis. Multiple other healthcare companies offer the same services that may accomplish some of the goals. You are encouraged to ask your physicians their reasons for choosing the facility or company in your treatment.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file and you will receive a copy.

ACKNOWLEDGEMENT: I have read this "Notice to Patients" form, and I understand the disclosures that it contains.

Dated _____

_____ _____
Name of Patient/Legal Representative Signature of Patient/Legal Representative

1029 Long Prairie Rd Ste D | Flower Mound TX 75022
main 214-285-0987 | fax 214-513-4783 | spinedisorders.net

MEDICAL RECORDS RELEASE

Spine Disorders of Texas PLLC | Duane D.H. Pitt, MD

To request release of medical information please complete and sign this form and return via mail or fax to Medical Records.

Patient Information

Patient Last Name_____First Name_____MI_____

Street Address_____City_____State_____Zip_____

Date of Birth_____Day Phone No.:_____

Spine Disorders of Texas has my permission to **release** and or **obtain** information contained in the medical record of the above patient.

Information Requested (please be specific):_____

_____

_____

_____

Restrictions and/or Exclusions (if any):_____

_____

_____

Purpose of release:_____

_____

Spine Disorders of Texas will **provide** the information requested above to the following party:

Name_____

Street Address_____ Telephone_____ Fax_____

City_____State_____Zip_____

I hereby authorize Spine Disorders of Texas, (SDT) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded above. I am aware that SDT cannot control how the recipient uses or shares the information, and those laws protecting its confidentiality at SDT may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 1 year from the signature date. I can however, cancel this authorization in writing anytime.

_____ _____

Signature of Patient (18 years of age or older) Date

_____ _____

Signature of Parent or Guardian (if minor patient) Date

Please make a copy of this release for your records

Authorization for Release of Medical Records Form
Last Modified 21 Jan 2024

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