SAN ANTONIO
SPINE CENTER
KEVIN RICHARDSON, D.O.

CONSENT/AUTHORIZATION for TREATMENT

1) I consent to services, treatment and diagnostic procedures, including but not limited to medications and lab tests which may be ordered by my provider at San Antonio Spine Center.

2) I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent, I assign all rights, title and interest and authorize direct payment to the San Antonio Spine Center of any insurance benefits or benefits under the Social Security Act for the services. San Antonio Spine Center will assist in billing my insurance company, but I am financially responsible for charges not collected by this assignment. I authorize San Antonio Spine Center to bill my insurance or third-party payor and receive payment from them directly.

3) I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, San Antonio Spine Center may disclose my records to any person, Social Security Administration, insurance or benefit payor, health care service or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges. Furthermore, San Antonio Spine Center may disclose my records to other treating providers, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

4) My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signed:_____ Date: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____Date:_____

SAN ANTONIO
SPINE CENTER
KEVIN RICHARDSON, D.O.

Cancellation Policy/ No Show Policy

1. **Cancellation/No Show policy for Doctor Appointment**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

2. **Scheduled Appointments**
   We understand that delays can happen however we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled time we will have to reschedule/cancel the appointment.

_____	_____	_____
Patient Signature	Patient Printed Name	Date

Acknowledgement of Notice of Privacy Practices

Was a notice of Privacy Practices given to the patient or their personal representation? Y/N

_____	_____
Signature	Date

Release of Billing Information & Assignment of Benefits

By signing this form, I hereby authorize payment directly to San Antonio Spine Center for any surgical and/or medical benefits. I also authorize San Antonio Spine Center to file all necessary papers to insurance and release any copies of medical records requested by my insurance company for determining benefits. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues.

_____	_____
Signature	Date

Patient Questionnaire

How did you hear about us?

□ Internet □ Primary Care Physician □ Friend/Family □ Other_____

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

Primary Care Physician: _____ Referring Physician: _____

Cardiologist: _____ Pain Management: _____

Reason for Visit: My area of pain and symptoms are_____

_____

_____

Date of injury or when symptoms first began:_____

Do you have problems performing daily activities? If yes, please provide examples: _____

Please identify any habits or devices use to walk, move, or do daily chores: _____

Have you had physical therapy for this problem? □ No □Yes Did it help? □ No □Yes

Date of last session: _____

Do you exercise routinely? □ No □Yes If yes, how often?_____

Visit related to Worker's Comp? Y / N Date of Injury:_____

Visit related to Vehicle Accident? Y / N Date of Accident: _____

Please identify any names and dates of other physicians that have treated you for your spinal condition:

Physician	Date	Treatment

Have you ever had any injections to your spine? □ Yes □ No

Date (s) & type (s) of injection?	Number of injection (s)?	Did the injection help?

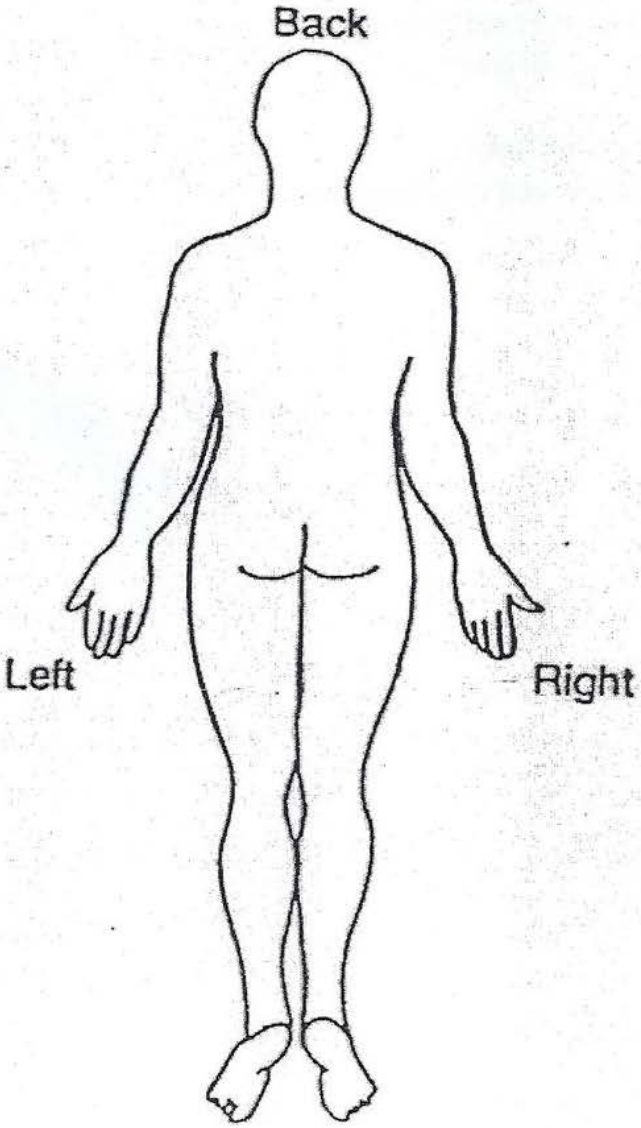
Preferred Pharmacy: _____ Phone: _____

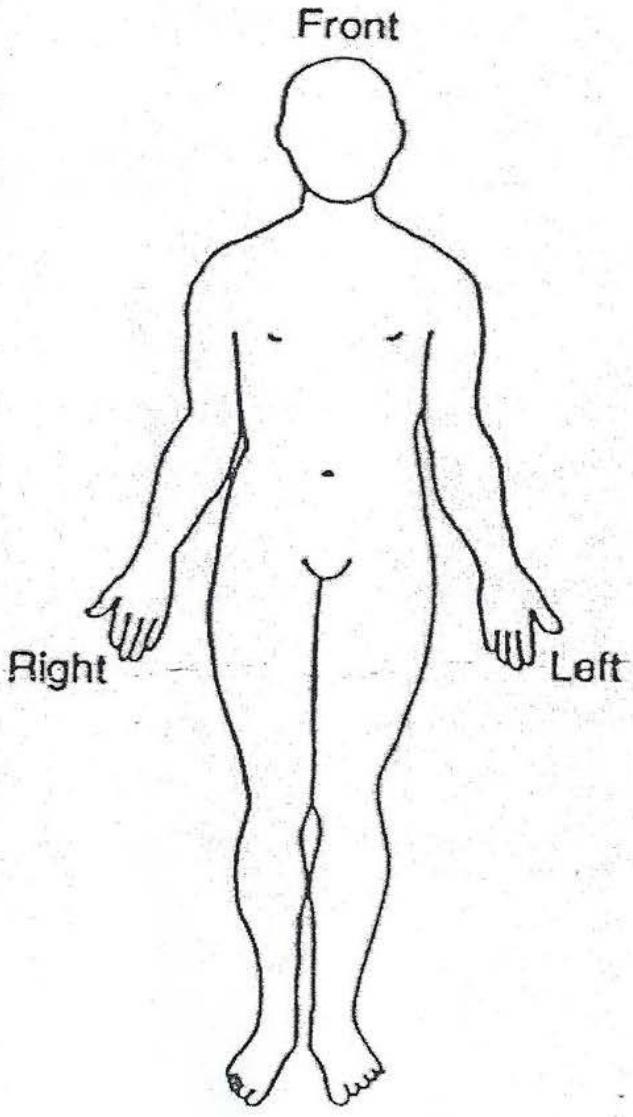
Patient Pain Diagram

INSTRUCTIONS: Check all that apply and rate each.

Pain Severity Scale: MILD 1 2 3 4 5 6 7 8 9 10 INTOLERABLE

□ NUMBNESS
□ DEEP ACHE OR PAIN
□ BURNING
□ STABBING
□ PINS & NEEDLES
□ Other: _____





What aggravates pain: _____

Has there been any changes in your bladder or bowel functions? □ No □Yes If yes, what changes: _____

Please list medications taken for your pain/discomfort.

MEDICATION	WHEN-HOW LONG DID YOU TAKE THE MEDICATION?	DID THE MEDICINE HELP?
ACETAMINOPHEN (Tylenol)		□ YES □ NO □ N/A
Acetaminophen with Codeine (Tylenol #3 or #4)		□ YES □ NO □ N/A
Oxycodone		□ YES □ NO □ N/A
Hydrocodone with Acetaminophen (Norco)		□ YES □ NO □ N/A
Tramadol		□ YES □ NO □ N/A
OTHER ANTI INFLAMMORIES:		
Aspirin		□ YES □ NO □ N/A
Naproxen (Aleve)		□ YES □ NO □ N/A
Ibuprofen (Motrin)		□ YES □ NO □ N/A
Celecoxib (Celebrex)		□ YES □ NO □ N/A
Meloxicam (Mobic)		□ YES □ NO □ N/A
Methylprednisolone (Medrol)		□ YES □ NO □ N/A
Hydrocortisone (solu-Cortef)		□ YES □ NO □ N/A
MUSCLE RELAXERS:		
Cyclobenzaprine (Flexeril)		□ YES □ NO □ N/A
Skelaxin		□ YES □ NO □ N/A
Soma		□ YES □ NO □ N/A

Medications:

Medications	Dosage	Time/day	Medication	Dosage	Time/Day

Drug Allergies:

Medication/food/Other Agent	Reaction or side of effect

Social History:

Tobacco: Y/N	Type: Yrs Smoked: Yr Quit:
Chewing Tobacco: Y/N	Comments:
Alcohol: Y/N	None Occasional Moderate Heavy
Illicit Drug Use: Y/N	Recreational: Y/N Ever use Needles? Y/N
Marital Status: Single Married Widowed Divorced	Comments:
Is blood transfusion acceptable in case of an emergency? Y/N	Comments:

Past Medical History:

Anemia	Y/N	Comments:
Anxiety disorder	Y/N	
Arthritis	Y/N	
Asthma	Y/N	
Autoimmune disease	Y/N	
Bleeding disorder	Y/N	
Bronchitis	Y/N	
COPD	Y/N	
Cancer	Y/N	Type:
Chronic ear infection	Y/N	
Coronary Artery disease	Y/N	
Deep Vein Thrombosis	Y/N	
Depression	Y/N	
Diabetes	Y/N	
Difficulty Swallowing	Y/N	
Diverticulitis	Y/N	
Gout	Y/N	
Head Aches/Migraines	Y/N	
Heart disease	Y/N	
Hepatitis	Y/N	
High cholesterol	Y/N	
Hypertension	Y/N	
Kidney Disease	Y/N	
Kidney Stones	Y/N	
Liver Disease	Y/N	
Nasal Polyps	Y/N	
Osteoporosis	Y/N	
Pulmonary Embolism	Y/N	
Seizures/Epilepsy	Y/N	
Stroke	Y/N	
Tuberculosis	Y/N	
Other:		

Past Surgical History:

Surgery		Date	Surgery		Date
Cervical Spine Surgeries	Y/N		Thoracic Spine Surgeries	Y/N	
Lumbar Spine Surgeries	Y/N		Cardiac Surgery	Y/N	
Other:					

Family History:

Arthritis:	□ Mother	□ Father
Osteoporosis:	□ Mother	□ Father
Cancer: Type	□ Mother	□ Father
Diabetes:	□ Mother	□ Father
Heart Disease:	□ Mother	□ Father
Hypertension:	□ Mother	□ Father
Other:	□ Mother	□ Father