

SPINE CENTER OF TEXAS

Last Name: _____ First _____ Middle Initial _____
Street Address _____
City _____ State _____ Zip Code _____
Date of Birth ____ / ____ / ____ SSN _____ Male Female
Email _____
Primary ph #: _____ Secondary ph #: _____
 Mobile Home Work Other _____ Mobile Home Work Other _____
Marital status: Married Divorced Single Widowed

Responsible Party (if different than above): Spouse Child Other
Last Name: _____ First _____ Middle Initial _____
Street Address _____
City _____ State _____ Zip Code _____
Date of Birth _____ SSN _____ DL# _____
Primary phone # _____ Secondary # _____

Insurance Information Primary Insurance Co _____
Name of Policy Holder _____
Date of Birth for Policy Holder ____ / ____ / ____ Effective date: _____
Relationship to patient: Self Spouse Child Other

Secondary Insurance Co _____
Name of Policy Holder _____
Date of Birth for Policy Holder ____ / ____ / ____
Relationship to patient: Self Spouse Child Other

Automobile Accident Related Injury Date of Accident: _____

Work Related Injury Date of injury: _____ Claim #: _____
Employer: _____ Employer ph #: _____
Insurance Co: _____ Adjuster name: _____
Adjuster ph #: _____

Primary Care Physician (if known) Name _____
Address _____
Phone _____ Fax _____

Pharmacy Information (if known) Name _____
Phone _____ Fax _____

Emergency Contact Name _____
Address _____
Primary Phone # _____ Secondary # _____
Relationship to patient: Spouse Child Friend Other

I, the undersigned, attest that the above information is true and complete, to the best of my ability:
Signature: _____
Date of Signature: _____

Print Your Name: _____

Attestations: Please read and initial next to each statement:

_____ 1. **Authorization for treatment:** I hereby authorize the providers and/or assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examination or treatments that may be ordered to be performed by clinical personnel. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees will be offered to me as to the effectiveness of examinations or treatments to be performed.

_____ 2. **Authorization for video/photography:** I understand that these medical facilities are under video surveillance, excluding exam rooms, and that my image may be captured on office security systems. Any images are used for security and safety purposes only. My images will not be used for any other purpose nor shared with any outside party other than law enforcement, should the need arise.

_____ 3. **Release of Medical Information:** I understand and agree that any of the above information may be used, if necessary, for the purpose of communication for appointment changes, accounts receivable, emergencies, etc. Information from any medical records may be released, if necessary, for insurance purposes.

_____ 4. **Assignment of Benefits:** I hereby authorize my insurance company(ies) to make payments as stipulated in my policy for any services rendered and that such payment be made directly to the provider for the services.

_____ 5. **Responsibility for Payment:** I understand and agree that, regardless of my insurance status, I am ultimately responsible for the payment of my account for any professional services rendered and I agree to pay upon demand, or as agreed, for the related charges of remaining charges following my insurance payments.

_____ 6. **Automobile Accident Injuries:** I attest that my injury **IS NOT** the result of an automobile accident **OR**, if my injury is the result of an automobile accident, I am aware that my group health insurance cannot and will not be billed for services and that I will be responsible for full payment for all services rendered, at the time of service. Failure to disclose my injury is due to an automobile injury, where services are billed to my group health insurance company, will result in immediate collection efforts against me and I will be subject to an additional \$200 processing fee, per visit.

_____ 7. **Work Related Injuries: Do not initial this line if your injury is work related.** I attest that my injury **IS NOT** the result of a work related injury and that no report has been filed with any workers compensation carrier. Failure to disclose my injury is related to a work related event will constitute insurance fraud and I may be subject to prosecution.

Yes No Treatment for my illness/injury has been authorized by the Veterans Administration.

By my signature below, I attest that I have read, understand, and attested to each of the items contained herein:

Signature: _____

Date of Signature: _____

Irvin Sahni, MD, PA

Brian Forzani, MD

Greg Nelson, DC, FNP-C

SPINE CENTER OF TEXAS

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing, **we will not be allowed** to submit any claims to your insurance carrier.

I, the undersigned, acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for Irvin Sahni, MD, PA. A copy of this signed, dated acknowledgement shall be as effective as the original. My signature will also serve as a Private Health Information (PHI) document release should I request treatment or radiographs be sent to other attending doctors in the future.

Printed name: _____

Legal representative (if applicable): _____

Description of authority of representative: _____

Please list any other parties who can have access to your PHI

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office for the purpose of **confirming appointments, treatment, and billing information** via (check all that apply):

- Cell phone/VM (Voicemail) Home phone/VM Work phone/VM
- Text message Email US Mail Any of the above

I authorize **information about my health care/health** to be conveyed via (check all that apply):

- Cell phone/VM (Voicemail) Home phone/VM Work phone/VM
- Text message Email US Mail Any of the above

I approve being contacted about **special services, events, or new health care information** via (check all that apply):

- Cell phone/VM (Voicemail) Home phone/VM Work phone/VM
- Text message Email US Mail Any of the above

Signature: _____

Date of Signature: _____



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize **Dr. Irvin Sahni/Dr. Brian Forzani** to release to:

Name/Facility: _____ Phone: _____
Address: _____
City/State/Zip: _____
Admit/Treatment Date(s): _____

The information from the medical records on:

Patient Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Admit/Treatment Date(s): _____

I hereby authorize the release of all medical records, including, if applicable, any treatment or test results for alcohol and /or drugs, mental health information, or reportable communicable and/or sexually transmitted diseases, including acquired immune deficiency syndrome or human immunodeficiency virus infection.

The above information is released/requested for the following purpose and that purpose only. Any other use is forbidden (state purposes, continuity of care, etc.)

I understand that his authorization shall become effective immediately and shall remain in effect for one year from the date of signature until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written request, to revoke such subsequent revocation will not affect action that already has been taken based on this authorization.

Date Signature of Patient Witness

If the consenting party is other than the patient, I am the authorized Representative/Legal Guardian of _____ and sign on his/her behalf.

Date Signature of Representative/Legal Guardian Witness

Relationship to patient:

SPINE CENTER OF TEXAS

Medication Contract

(Please read and initial each line and sign below)

Initials

_____ Lost or stolen medication **WILL NOT BE REPLACED FOR ANY REASON**. Medication should be guarded as you would guard cash.

_____ Early refills will only be given if the provider authorizes a dose increase.

_____ Medications are to be taken **ONLY** as listed on the prescription bottle. Unauthorized increased dosing (taking more medication than prescribed) can result in illness, injury, or even death.

_____ You must notify this office of any side effects for any medication prescribed by our providers.

_____ Medications prescribed by our providers are to be used **ONLY** by that patient. Do not share your medications with others.

_____ You will only use **ONE** pharmacy to fill your prescriptions.

_____ **Refill requests must come from your pharmacy** and it is recommended you contact the pharmacy to request refills **72 hours prior to running out**. Phone calls to our office regarding refills will not be accepted. Refills are only authorized during normal business hours.

_____ You must allow **72 hours** turnaround time for your refill to be authorized. Do not wait until you run out of medications to request a refill.

_____ You must be compliant with providers' recommendations or refills will not be authorized.

_____ I will comply with all requests for pill counts and/or frequent visits as the situation dictates.

_____ Use of any illicit (illegal) drugs in combination with prescribed medications is not allowed.

_____ I will comply with all UDS (urine drug screen) requests by this office.

I hereby acknowledge that I understand the medication policies of this office and agree to abide by the medication policies above. Violations of any of these policies will result in discontinuance of refills for all medication and may result in immediate dismissal from the office and termination as a patient.

Printed name: _____

Signature: _____

Date of Signature: _____

Print Your Name _____

1. Describe the reason for your visit: _____

1a. Are you requesting Narcotic Medications (Tramadol, Hydrocodone or Oxycodone): YES or NO

1b. Did you have a previous pain management doctor? YES or NO

If yes **Doctors name:** _____

2. When did this begin? **Must provide date:** _____

3. What do you believe caused this? _____

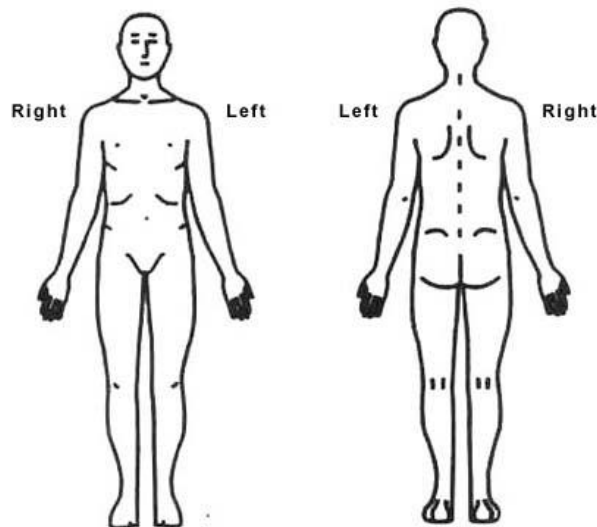
4. Have you seen a surgeon, before today, for this? Yes No

If yes, list name of surgeon: _____

5. Have you had prior surgery for this problem? Yes No

If yes, list name of surgeon, date of surgery, and type of surgery:

Please mark your area(s) of pain on the diagram below.



Are you allergic to any medications? Yes No

If yes, please list: _____

Please list **ALL** medications and dosage you are currently taking, including over the counter medicines. If you have a list, you may simply provide this to the receptionist.

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |
| 10. _____ | 11. _____ | 12. _____ |

List ALL prior surgeries with approximate date:

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

Patient Name _____

List ALL Major Family Health Problems:

Who:	Mother	Father	Brother	Sister
Who:	Mother	Father	Brother	Sister
Who:	Mother	Father	Brother	Sister
Who:	Mother	Father	Brother	Sister

Medical History: Please circle if you have suffered from any of the following:

General: Obesity
Cardiovascular: Arrhythmia Angina Congestive Heart Failure
Coronary Artery Disease Deep Vein Thrombosis High Cholesterol
High Blood Pressure Hypotension Heart Attack
Other: _____

Pulmonary: Asthma COPD Emphysema
Tuberculosis Other: _____

Gastrointestinal: Gallbladder Problems Colon Polyps Diverticulitis
Hepatitis Irritable Bowel Pancreatitis Peptic Ulcer Disease
Other: _____

Renal: Kidney Failure Kidney Stones Urinary Tract Infection
Urinary Incontinence Prostatitis Dialysis Other: _____

Musculoskeletal: Gout Osteoarthritis Osteoporosis

FALL RISK SCREEN: Have you fallen in the past year? Yes or No

Do you feel unsteady when standing or walking? Yes or No

Do you worry about falling? Yes or No

DATE OF LAST DEXA SCAN (Bone density): _____

Rheumatoid Arthritis Restless Leg Syndrome Fractures: _____
Other: _____

Endocrine: Diabetes I Diabetes II Goiter
Hyperthyroidism Hypothyroidism Other: _____

Neurological: Alzheimer's Dementia Migraine Headache
Stroke Myasthenia Gravis Parkinson's Seizures
TIA (mini-stroke) Other: _____

Hematology: Bleeding disorder Anemia Other: _____

Allergies: Indoor/outdoor allergies Other: _____

Mental Health: Anxiety Depression Bipolar _____

Cancer: Please list type of cancer and if you are currently taking treatment, as well as the name of your oncologist: _____

Social History: Number of Children: _____

Employment: Full Time Part Time Retired Disabled
 Unemployed Student

If employed, list occupation: _____

Employer: _____ Employer ph #: _____

If student: Grade Level _____ School _____

Health Habits: 1. Do you use tobacco? Yes No If a smoker, how many packs/day? _____ How long have you been smoking? _____ 2. Do you drink alcohol? Yes No If yes, how many drinks/week? _____

Irvin K. Sahni, MD., PA
SPINE CENTER OF TEXAS

(830) 379-8800

(830) 372-1600

Nurse Practitioner Consent for Treatment

This facility has on staff a nurse practitioner (Greg Nelson, DC, FNP-C) to assist in the delivery of medical care. Dr. Nelson is also a licensed doctor of chiropractic.

A nurse practitioner is not a physician. A nurse practitioner is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a nurse practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does NOT require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of the nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the nurse practitioner and request to see the physician.

Name:	Date:
Signature:	Witness: (optional)



Consent for Opioid Therapy

I, _____ DOB: _____, understand that Dr. Sahni/Dr. Forzani (**please circle provider**) is prescribing an opioid medication, sometimes called narcotic analgesics, to me for chronic pain syndrome (diagnosis).

Opioid therapy is only part of a comprehensive treatment plan which includes physical therapy, other medications (anti-inflammatories, muscle relaxers, and nerve pain medications), interventional procedures, pain psychology bracing and possible surgery. Continuation of opioids will be based on periodic evaluations in the areas of pain relief and functional improvement. If a clear benefit cannot be defined opioid therapy may be tapered and stopped.

The use of opioids have certain associated risks, including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, addiction, tolerance and possibility that the medication will not provide complete pain relief.

I will not be involved in any activity that may pose harm to me or someone else if I feel drowsy or am not thinking clearly. Such activities include but are not limited to: operating heavy equipment/a motor vehicle or being responsible for another individual who is unable to care for himself/herself.

Physical dependence is the adaptation of the body to a substance. It is a normal, expected result of using opioid medications for a long period of time. It is not the same as addiction, however, if narcotics are abruptly stopped or reversed by some of the agents mentioned below, I may experience withdrawal. This means I may have any or all of the following: runny nose, yawning, dilated pupils, chills, abdominal pain and cramping, diarrhea, irritability, body aches, and flu-like symptoms. Opioid withdrawal is uncomfortable but not life threatening. Should severe medication reactions occur I will notify the practice and/or go to the nearest hospital.

Addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug and feeling the need to use a drug. The risk for addiction is more common in people with a family history of substance abuse. Therefore, I agree to provide a complete and honest personal and family drug history.

I will tell my doctor about all the other medications and treatments that I am receiving. Certain other medications such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol) may reverse the action of opioids and cause withdrawal.

Tolerance occurs when the body adjusts to repeated drug exposure requiring more of the substance to produce the same effect. If it occurs, increasing doses may not always help reduce pain further and may cause unacceptable side effects. Tolerance or failure to respond to opioids may cause my doctor to choose another form of treatment.

(Males only) Opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand my doctor may check to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe I have become pregnant while taking pain medication, I will immediately call my obstetric doctor and this office to inform them. I am aware should I carry a baby to delivery while taking these medications the baby will become physically dependent on opioids.

I have read this form or have had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioids.

Patient Name (printed):

Patient Signature:

Witnessed by:

Date:



Irvin Sahni, M.D., P.A.
Greg Nelson, Dc, FNP-C
1006 East Kingsbury Seguin, TX 78155
55 Gruene Park Dr. New Braunfels, TX 78130
830.379.8800/830.372.1600 (f)

PAYMENT POLICY

Spine Center of Texas participates with most PPO Insurance plans, including Medicare. If you are not insured, payment is expected in full prior to each doctor visit. Knowing your insurance benefits is your responsibility. Our insurance coordinator does call to verify your benefits but overall it is your responsibility to contact your insurance company with any questions you may have regarding your coverage. **All co-payments and deductibles must be paid at the time of service.** Once our office submits your claim for process, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claims are your responsibility if you do not have a secondary insurance for us to file too. If your account is over 30 days past due, you will receive a letter from our office stating that you must pay your balance in full. Partial payments will not be accepted unless otherwise negotiated. **Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and the debt will be increased by a 35% collection fee and you may be discharged.** If this is to occur, you will be notified by regular and certified mail that you have X amount of days to find alternative medical care. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to release my medical records to:

Dr. Irvin Sahni, MD
Dr. Brian Forzani, MD
55 Gruene Park Drive
New Braunfels, TX 78130
P: 830-379-8800
F: 830-372-1600

Dr. Irvin Sahni, MD
Dr. Brian Forzani, MD
1006 E. Kingsbury
Seguin, TX 78155
P: 830-379-8800
F: 830-372-1600

I hereby authorize the release of all medical records, including, if applicable, any treatment or test results for alcohol and /or drugs, mental health information, or reportable communicable and/or sexually transmitted diseases, including acquired immune deficiency syndrome or human immunodeficiency virus infection.

The above information is released/requested for the following purpose and that purpose only. Any other use is forbidden (state purposes, continuity of care, etc.)

I understand that his authorization shall become effective immediately and shall remain in effect for one year from the date of signature until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written request, to revoke such subsequent revocation will not affect action that already has been taken based on this authorization.

Date

Signature of Patient

Witness