
Dr. Nathan S. Walters

**7115 Greenville Ave, Suite 230**
**Dallas, TX 75231**

**Office 214-888-3888**
**www.SpineDallas.com**

Name: _____ Date: _____ Height: _____ Weight: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Address: Street _____City: _____ State: _____ Zip: _____

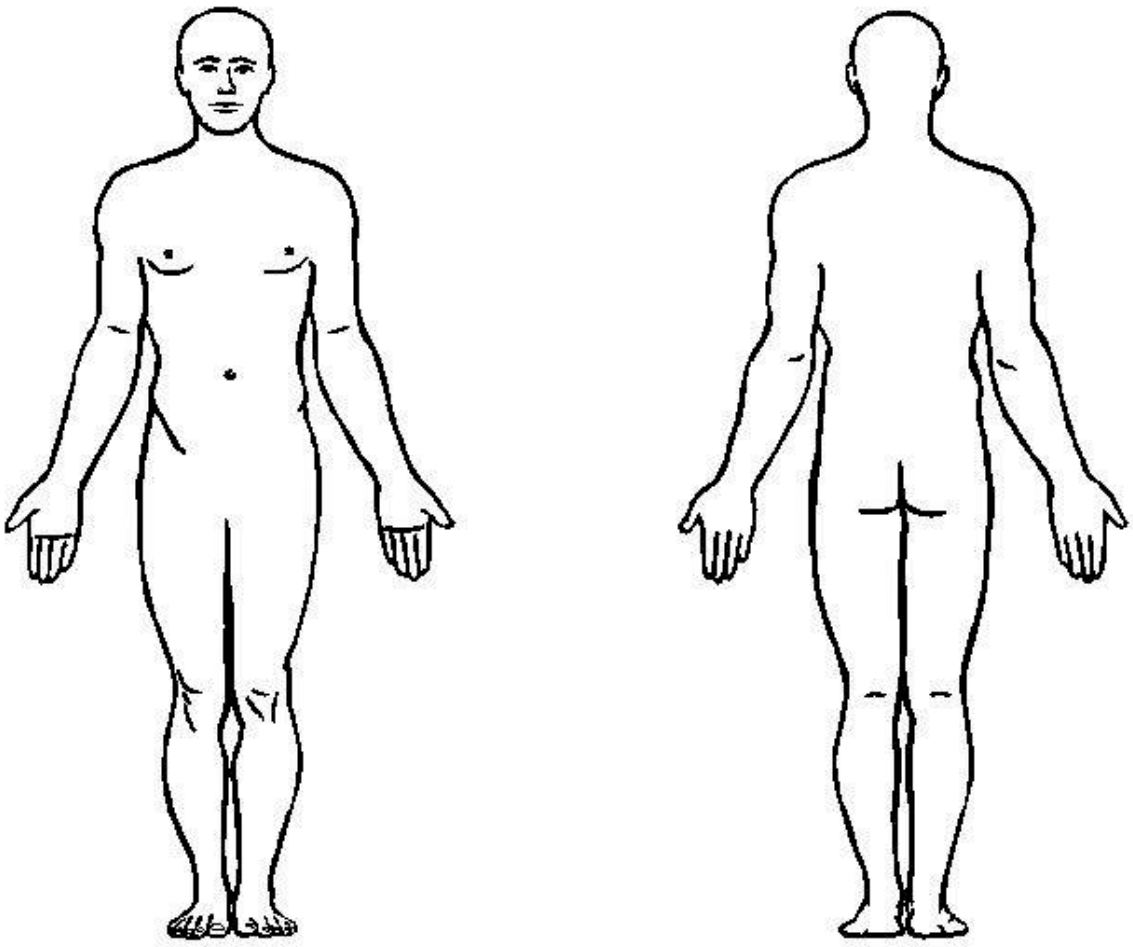
Home phone: _____ Cell: _____

**PAIN HISTORY**

Referring Physician: _____

Primary Care Physician: _____

Please use the diagram below to shade areas that are painful.



**WHEN** did your pain begin? _____

**HOW** did your pain begin? (e.g. "just started by itself", "car wreck", "accident at home/work")
_____
_____

Which activities (e.g. sitting, standing, walking, bending, etc.) **WORSEN** your pain?
_____

Which positions (e.g. sitting, standing, lying down, etc.) **IMPROVE** your pain?
_____

How does the pain affect your lifestyle? (What can you no longer do because of your pain?)
_____

Which **TREATMENTS** have been used for your pain?
___ Pain killers
___ NSAIDS (ibuprofen, Motrin, Advil, Aleve, etc.)
___ Muscle relaxants
___ Physical therapy
___ Chiropractic
___ Massage
___ Ice/heat
___ Cortisone/steroid injections
___ Surgery (what kind and when? _____)

**PAST MEDICAL & SURGICAL HISTORY**

___ Angina/chest pain
___ Angioplasty or stent for heart
___ Anxiety/depression
___ Arrhythmia/atrial fibrillation
___ Asthma
___Bleeding disorder (hemophilia, ITP)
___ Cancer (type:_____)
___ Congestive heart failure
___ DVT (clot in leg)
___ Diabetes
___ Drug or alcohol abuse/addiction
___ Emphysema
___ Fibromyalgia
___ Headache
___ Heart attack
___ Hepatitis (circle A / B / C )
___ High blood pressure
___ HIV or AIDS
___ Implantable defibrillator or pacemaker
___ Kidney failure/dialysis
___ Liver disease/ cirrhosis
___ Neuropathy
___ Pulmonary embolism (blood clot in lung)
___ Seizure or epilepsy
___ Sickle cell disease
___ Stomach ulcer
___ Stroke or TIA
___ Thyroid disease

Past Surgeries:

_____

_____

**ALLERGIES to medications**:

_____

_____

Are you allergic to Iodine contrast dye? (type of reaction: _____)

**CURRENT MEDICATIONS**:

Pain medications:

_____

Other medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take aspirin or any blood thinners? ___ YES ___ NO

Do you currently smoke cigarettes? ___ YES ___ NO

**WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE FOR YOUR PAIN RECENTLY**:

___ X-rays
___ MRI
___ CT
___ Myelogram
___ Discogram
___ EMG/NCS (nerve test)
___ Bone scan

**MEDICARE LIFETIME SIGNATURE ON FILE (<u>FOR MEDICARE PATIENTS ONLY</u>)**

I request that payment of authorized Medicare benefits be made on my behalf to Interventional Spine & Pain, PA. for any services rendered to me by the physicians or medical staff of Interventional Spine & Pain, PA. I authorize any holder of medical information about me to release to the Healthcare Financing Administration (HCFA) and it's agents any information necessary to determine these benefits or benefits payable for related services. A photostatic copy of this agreement shall be considered effective and valid as the original.

_____

Signature of patient or responsible party Date

**FINANCIAL UNDERSTANDING AND ASSIGNMENT OF BENEFITS**

In consideration of the medical services to be rendered to me today and in the future, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF **Interventional Spine & Pain**, PA IN ACCORDANCE WITH THEIR REGULATIONS AND TERMS. I also hereby authorize direct payment to Interventional Spine & Pain, PA of any insurance benefits otherwise payable to me for said services, and I further authorize this office to release any medical information necessary to process my claims. I understand that I am responsible for any charges not covered by this assignment. Should my account be referred to an attorney or licensed collection agency for collection, I shall be responsible for attorney's fees or collection expenses. I understand that, as a courtesy, Interventional Spine & Pain, PA will file a claim with my insurance. If my insurance has not paid within 60 days of the filing date, I understand that I may be made responsible for the total balance of the account. A photocopy of this agreement shall be considered effective and valid as the original.

Regarding anesthesia services for pain procedures: most anesthesia is billed out of network by the company we use, HOWEVER, most plans honor a provision for the anesthesia claim to be processed in network, because the physician and facility is in network. This means that the claim will most likely apply to the in network benefits, and your out of pocket cost would be your in network deductible or co-insurance. You should call your carrier for specifics related to your specific plan prior to any procedures.

Moreover, Dr. Nathan S. Walters has personal investments in PSB, LLC.

In addition, I will be financially responsible for appointments or procedures missed if I do not give 24 hours notice to the clinic. The fee billed is $75 for office visit and $200 for procedures.

_____

Signature of patient of responsible party Date

**INTERVENTIONAL SPINE & PAIN**

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name _____ SS# _____
Address _____ DOB _____
City, State, Zip _____ Phone _____

I hereby authorize:

Name: _____
Address: _____
City, State, Zip: _____
Fax: _____
Purpose for release: _____

To release my records to Interventional Spine & Pain

This authorization is given freely with the understanding that:
- Any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
- A photocopy of fax of this authorization is valid as the original
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period or sooner if noted below. The revocation must be in writing.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon obtaining this authorization.
- Information used of disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Patient printed name Expiration

_____ _____
Patient signature Date

_____ _____
Witness Date

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## PATIENT AUTHORIZATION FOR CONTACT AND DISCLOSURE OF PROTECTED HEALTH INFO

Patient name: _____ Date of birth: _____

I authorize INTERVENTIONAL SPINE & PAIN DOCTORS AND STAFF to discuss my protected health information with the following individuals:

Name _____ Name _____
Name _____ Name _____

with the exception of the following health information (or n/a):
_____

**Expiration or termination of authorization**: This authorization will remain in effect until written request to terminate by patient or legally authorized entity.

Patient of authorized representative signature: _____

Printed name: _____

Date: _____