Houston Spine Institute

Patient Registration

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last)*_____ *Primary Language*_____

*E-mail address:*_____ Date of Birth _____

Age _____ Race_____Ethnicity_____ Gender: Male / Female Marital Status: S M W D

Address_____ Apt#_____ City _____State _____ Zip_____

Phone Number _____Social Security # _____ Driver's License #_____

Employer _____ Phone_____

Referring Physician_____Primary doctor _____

If Student, School Name _____ Full-Time / Part-Time

Responsible Party

Name _____Relationship to Patient _____

Address_____

Phone Number _____ Social Security # _____ Date of Birth _____

Emergency Contact _____ Relation_____Phone Number _____

Pharmacy Name and Phone Number _____

Insurance Information

Insurance Company _____Phone Number _____

Address _____

Group # _____ Member ID # _____

Policy Holder Name _____ **Relationship** to Patient: Self/Spouse/Dependent

Insured's Employer _____ Phone Number _____

Employer Address_____

Policy Holder Social Security # _____ **Date of Birth** _____ Male / Female

I hereby assign, transfer, and set over to Houston Spine Institute all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

HOUSTON SPINE INSTITUTE

PATIENT CONSENT TO TREAT

I hereby give my consent to Houston Spine Institute and authorize him or her to provide my medical treatment. I understand that Houston Spine Institute will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Houston Spine Institute to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Name _____

Patient Signature _____ Date _____

Parent or Legal Guardian Signature (for minor) _____

Relationship to the Patient _____

Signature of Treating Provider _____ Date _____

HOUSTON SPINE INSTITUTE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number _____

I acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices for Houston Spine Institute located in the white binder in the waiting room.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

HOUSTON SPINE INSTITUTE

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand Houston Spine Institute's authorized by me to use or disclose my protected health information ("PHI") for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

I specifically authorize Houston Spine Institute or its designated employee(s) to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization if I do so in accordance with the steps set forth below.

Description of the information to be used or disclosed *(please choose one)*

☐ **I do not authorize my medical records to be disclosed**.

☐ My entire record

Note: This requires an explanation of any information you <u>do not</u> want to be disclosed, otherwise the entire record will be disclosed.

_____

_____

_____

Please disclose the above information to:

Name _____Phone Number _____

Address _____

I ☐do ☐do not authorize this information to be faxed. If yes, fax number _____

***Continued on next page**

HOUSTON SPINE INSTITUTE

Purpose(s) for the disclosure of the information:

Houston Spine Institute will accept written revocations of this authorization via:

Certified U.S. mail
Facsimile at this number: 832-321-4080

All revocations must be sent to Houston Spine Institute and are not effective until received.

This authorization shall expire one year from signature date. After this date, Houston Spine Institute can no longer use or disclose my PHI for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient Name _____

Patient Signature _____ Date _____

Name of Representative (if applicable) _____

Relationship to Patient _____

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on _____.
☐ Authorization verified by _____ on_____.
☐ Patient has been provided with a copy of the signed authorization.