MODERN SPINE PLLC

Kenneth Lee, MD & Sarah Ngo, PA-C

Board Certified Orthopedic Spine Physician

Today's Date: _____

PATIENT INFORMATION

DATE OF BIRTH: _____

Name: _____ _____ _____
First *Middle* *Last*

Mailing Address: _____
Street Address/P.O. Box *City/State/Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred by: _____ Primary Care Physician: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student

Occupation: _____ Employer: _____

Employer Address: _____

IS TODAY'S VISIT A WORK RELATED ISSUE? ☐ YES ☐ NO

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

BILLING INFORMATION

****PLEASE PROVIDE INSURANCE CARDS WITH PAPERWORK SO WE MAY MAKE A COPY****

PRIMARY PLAN	**WORKER'S COMPENSATION**
_____ **NAME**	_____ **INSURANCE COMPANY**
_____ **INSURED NAME**	_____ **EMPLOYER/GROUP NAME**
_____ **RELATION TO PATIENT**	_____ **ADJUSTER NAME**
_____ **INSURED DOB/INSURED SOCIAL SECURITY #**	_____ **CLAIM NUMBER/ DATE OF INJURY**
_____ **ID NUMBER/GROUP NUMBER**	_____ **ADJUSTER PHONE NUMBER**

Do you have secondary insurance coverage? ☐ YES ☐ NO If so, please provide copy with your insurance card

CONSENT TO TREAT

I consent to necessary medical treatment as recommended by my physician. I understand that insurance may not cover all recommended medical services, such as preventative health exams, immunizations, screening tests, detailed phone consultations, copies of medical records, preparations of reports and forms or summaries.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These authorizations shall remain valid until written notice is given by me revoking said authorization.

Patient Signature: _____ **Date:** _____

PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside of this office who is involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document.

Patient Signature: _____ **Date:** _____

RELEASE OF INFORMATION

I authorized KL Modern Spine to discuss information with the following:

☐ Family Members ☐ Coaching/training staff at my school

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Signature: _____ **Date:** _____

EMERGENCY CONTACT INFO

Name: _____ Phone: _____

Relation: _____

MODERN SPINE PLLC

Kenneth Lee, MD

Board Certified Orthopedic Spine Physician

New Patient ☐ Established Patient (New Problem) ☐ Today's Date: _____

Name: _____

DOB: _____ AGE: _____ SEX: ☐ **M** ☐ **F** HT: ____ ' ____ " WT: _____ LBS

Primary Care Physician: _____ Phone: _____

How did you hear about us? ☐ Doctor Referral ☐ Family/Friend ☐ Internet ☐ Insurance ☐ Other:_____

HISTORY OF COMPLAINT

IS THIS A WORK RELATED INJURY? ☐ **Yes** ☐ **No** Date of Injury: _____

Describe how you were injured: _____

_____

If this is not an injury, when did your pain start? _____

Location of pain: _____

Does pain radiate into extremities? ☐ **R Arm** ☐ **L Arm** ☐ **L Leg** ☐ **R Leg** ☐ **Buttocks**

Intensity: **0 1 2 3 4 5 6 7 8 9 10**

What helps with pain? _____ What makes pain worse? _____

Have you previously had: ☐ PT ☐ Acupuncture ☐ Chiropractic ☐ ESI Inj. ☐ Pain Medication ☐ Other: _____

Which studies have you had done for this injury? ☐ X-ray ☐ MRI ☐ CT Myelo ☐ CAT Scan ☐ EMG ☐ Other: _____

DRUG ALLERGIES

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

CURRENT MEDICATIONS

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

FAMILY HISTORY & SOCIAL HISTORY

	Mother	Father	Grandmother	Grandfather	Sibling
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
RA	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

Do you smoke? ☐ **Yes** ☐ **No** If yes, how many packs a day? _____ # years smoked: _____

Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, how many drinks a day/week? ____ /____ # years smoked: _____

Do you exercise regularly**?** ☐ **Yes** ☐ **No** If yes, how many days per week? _____ # years exercised: _____

Martial Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

REVIEW OF SYSTEMS

When was your last physical examination? _____ ☐ More than 5 years ago

Have you ever had any of the following conditions? **(Circle all that apply)**

Cancer	High Blood Pressure	Blood clots in legs
Heart Disease	Migraine Headaches	Excessive Fatigue
Stroke	Hepatitis (A B C)	Irregular Heartbeat
Diabetes	Asthma	Previous Blood Transfusion
Seizures	Psoriasis	Headaches (not relieved by medication)
Constipation	Depression	Difficulty Breathing
Other: _____	Other: _____	Other: _____

I have not had any of the above conditions: _____ ***(Initial Here)***

Please list all previous surgeries: _____

_____

PRIOR EVALUATION

Please list the name of any physicians/facilities you have been seen for your current condition:

_____

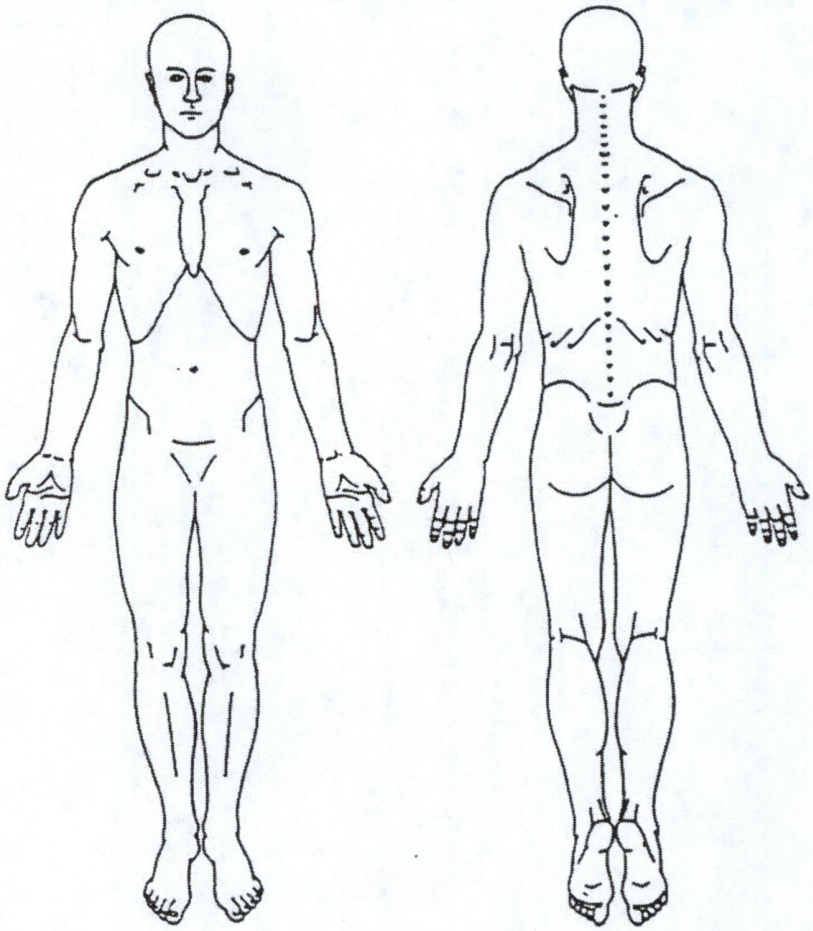
_____

_____

Please list any prior BACK or NECK surgeries you have had:

Procedure	Levels	Date
Lumbar Disc Surgery		
Lumbar Fusion		
Cervical Fusion		
Other:		

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



I have reviewed the current symptoms, pas/t medical, family and social history.

Kenneth Lee, MD/Sarah Ngo, PA-C

MODERN SPINE
PROGRESSIVE SPINAL SOLUTIONS PLLC

Dear Friends and Patients,

Welcome. Thank you for choosing ***Modern Spine***.

Modern Spine is centered on compassionate, conservative and evidenced-based care with patient education being one of our highest priorities.

We have organized our practice to include services that complement our treatment philosophy so that you can feel confident that you are receiving the best care possible:

- Digital x-rays and electronic medical records
- Durable Medical Equipment (DME) to include lumbar and cervical braces
- Nutritional Supplements: DynaMaxx and Ameriscience, two of the most highly recognized nutritional supplements supported by clinical research performed by NASA among many other well known scientific institutions

If surgery is the treatment option recommended for you, Dr. Lee is affiliated with several highly acclaimed surgical centers conveniently located in Sugar Land as well as the Medical Center.

- First Street Surgical
- Victory Hospital
- River Pointe

These facilities are staffed with experienced nurses and support staff who work closely with Dr. Lee to provide the highest quality specialized care in an efficient and personal manner. These facilities are equipped with state of the art equipment specific for spine patients who are having an outpatient procedure as well as those who require an overnight stay.

Financial Disclosure

We feel it is your right to know that Dr. Lee does have ownership in the surgical facilities listed above as permitted by both state and federal law.

If you have questions or concerns, please let us know. We would be happy to discuss this further with you.

We appreciate the opportunity to serve you and your family and look forward to helping you feel better and get your life back!

_____ _____

Patient Signature **Date**

MODERN SPINE

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

Kenneth Lee, MD/Modern Spine, PLLC
16929 Southwest Freeway, Suite 100
Sugar Land, TX 77479
(713) 774-6337 Fax (281) 313-7747

I consent to the use or disclosure of my protected health information (PHI) by Modern Spine, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Modern Spine, PLLC. I understand that diagnosis and/or treatment of me by Dr. Kenneth Lee and his healthcare team may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. Modern Spine, PLLC is not required to agree to the restrictions I request. However, if Modern Spine, PLLC agrees to the restriction that I request, the restriction is binding on Modern Spine, PLLC and Dr. Kenneth Lee.

I have the right to revoke this consent in writing at any time, except to the extent that Dr. Kenneth Lee or Modern Spine, PLLC has taken action in reliance of this consent.

My PHI means health information, including my demographic information, collected from me or created or received by my physician, another health care provider, health plan, my employer or health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe that the information may identify me.

I understand I have the right to review Modern Spine, PLLC Notice of Privacy Practices prior to signing this document. The Modern Spine, PLLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of Modern Spine, PLLC. The Notice of Privacy Practices also describes my rights and Modern Spine, PLLC's duties with respect to my PHI.

Modern Spine, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a copy be sent via mail or given to me at the time of my next office visit.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Representative Relationship to Patient

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare options (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates your past, present or future physical or mental health or condition and related healthcare services.

USES AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician practice and any other use required by law.

TREATMENT

We will use and disclose your PHI to provide, coordinate and/or manage your health care and any related services. This includes the coordination or management of health care with a third party. For example, we would disclose your information as necessary to a home health agency who provides care to you. Another example would be that we disclose your information to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you.

PAYMENT

Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan in order to obtain approval for hospital admission.

HEALTH CARE OPERATIONS

We may use or disclose as needed your personal PHI in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment activities, employer review activities, training of medical staff and conduction or arranging for other business activities. For example, we may disclose your PHI to a medical student who trains in our clinic. In addition, we may use a sign-in sheet at the front desk where you are asked to sign your name. We may also call your name in the waiting room when we are ready to call you to the back for the physician. We may use your PHI to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization:

As required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Procedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Worker's Compensation, Inmates Required Uses and Disclosures. Under law we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO REJECT UNLESS REQUIRED BY LAW.

YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, EXCEPT THE EXTENT THAT YOUR PHSICIAN OR THE PHYSICIAN'S PRACTICE HAS TAKEN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

MODERN SPINE PLLC

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL/PRIVATE HEALTHCARE INORMATION (PHI)

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY #: _____

I authorize my physician and/or administrative and clinical staff of _____ to disclose the following Protected Health Information (PHI) to:

Kenneth Lee, MD/Modern Spine, PLLC
16929 Southwest Freeway, Suite 100
Sugar Land, TX 77479
(713) 774-6337 Fax (281) 313-7747

Please release the following information:

☐ All Records ☐ X-ray/MRI ☐ Progress Notes ☐ Op Notes

☐ Lab Records ☐ Therapy Notes ☐ Care Plan ☐ Other

Please exclude the following specified information (*if any*):

_____

This authorization covers care from _____ to _____

Purpose of disclosure: ☐ Medical ☐ Insurance ☐ Patient Request

Check One: ☐ Release this information one time only

☐ This release expires in 180 days from today's date

I understand I have the right to revoke this authorization in writing at any time by sending written notification to Modern Spine at the address shown above. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure except if my health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Representative **Relationship to Patient**