MODERN SPINE PLLC
PROGRESSIVE SPINAL SOLUTIONS

Kenneth Lee, MD

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

MODERN SPINE PLLC

KENNETH LEE, MD
BOARD CERTIFIED IN ORTHOPAEDIC SURGERY
FELLOWSHIP TRAINED IN SPINAL SURGERY

www.modernspinetx.com
office: (713) 774-6337
fax: (281) 313-7747

ASSIGNMENT OF BENEFITS:

I authorize assignment of my benefits to be paid directly to my physician for eligible medical and/ or surgical services performed during the course of my treatment. I authorize the release of any medical information needed to determine insurance benefits including medical, surgical, psychiatric and/ or substance abuse information. I understand this order does not relieve me of my obligation to pay such bills if not paid by my insurance company or and balance due after payments by my insurance.

PATIENT SIGNATURE: _____ **DATE:**_____

CONSENT TO TREAT:

I consent to necessary medical treatment as recommended by my physician. I understand that insurance my not cover all recommended medical services, such as preventative health exams, immunizations, screening tests, detailed phone consultations, copies of medical records, preparation 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 INFORMATION:

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 authorize Modern Spine to discuss information with the following:

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: _____

Dominant hand: right- handed _____ left- handed _____

Occupation: _____

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:

_____

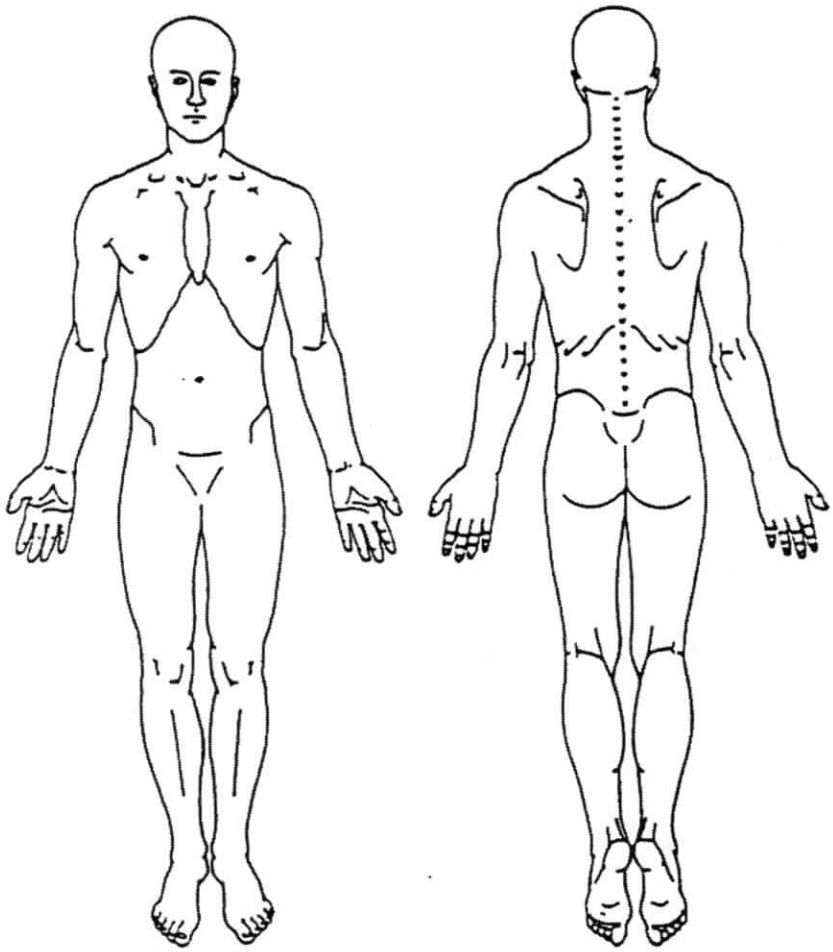
_____

_____

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

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 IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care options (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "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 health care services.

Uses and disclosures of protected health information

Uses and disclosures of protected health information

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

Treatment: We will use and disclose your personal health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your information, as necessary, to a home health agency that provides care to you. Another example would 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 protected health information will be used, as needed, to obtain payment for ypour health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan on order to obtain approval for the hospital admission.

Health care Operations: We may use or disclose, as needed, your personal protected health information 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 students, licensing, and conduction or arranging for other business activities. For example, we may disclose your personal protected health information to medical school students that see patients at our clinic. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate you physician. We may also call your name in the waiting room when your physician is ready to see you. We may use your protected health information to contact you to remind you of your appointment.

We may use or disclose your personal protected health information in the following situations without your authorization. These situations include:

As required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements: Legal Proceedings: 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 the law, we must make disclosures to you and 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 physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your personal protected health information.

You have the right to copy or inspect your personal protected health information

Exceptions under Federal Law are as follows: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and health information that is subject to law that prohibits access to such information.

You have the right to request restricition of your personal protected health information

This means you may ask us to not use or disclose a part of your personal protected health information for the purposes of treatment, payment, or healthcare options. You may also ask us to not use or disclose an part of your personal protected health information to friends or family who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom that restriction applies.

Your physician is NOT REQUIRED to agree to a restriction that you may request if your physician feels that not disclosing this information could compromise your health in any way. You have the right to use another Health Care professional.

You have the right to request to receive confidential communication by us using alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice electronically (via email).

You may have the right to have your physician amend your personal protected health information

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. You have the right to receive a copy of any such rebuttal(s).

You have the right to receive an accounting of certain disclosures, if any of your personal protected health information

We reserve the right to change any information is this disclosure and will contact you by phone or mail if any change has occurred. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or the Secretary of Health and Human Services if you believe your rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your personal protected health information. If you have any objections to this form, please contact our HIPAA COMPLIANCE OFFICER in person or by phone at our main number: 713-774-6337.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

Patient signature: _____ Date: _____

Modern Spine
16929 Southwest Freeway, Suite 100
Sugar Land, TX 77479

Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Modern Spine, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Modern Spine. I understand that diagnosis or treatment of me by **Dr. Kenneth J. H. Lee** 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 protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Modern Spine is not required to agree to the restrictions that I may request. However, if Modern Spine agrees to a restriction that I request, the restriction is binding on Modern Spine and **Dr. Kenneth J. H. Lee.**

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

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

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

Modern Spine 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 calling the office and requesting a revised copy be sent in the mail or to be given at the time of my next office visit.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

Forms
Patients requesting forms to be completed by Dr. Lee and/or staff will be charged:

$25- $50- Disability Forms (FMLA, Short-term Disability, Attending Physician Statement)
$15- Handicap Placard Application
$250 – Narrative Report

Medical Record Copies
Patients requesting copies of medical records will be charged:

$15 – under 20 pages
$20 – 21 to 49 pages
$25 – over 50 pages

Attorneys and Insurance companies will be charged as follows:

$35 – under 100 pages
$45 – over 100 pages
$35 for an itemized bill

A special handling fee of $10 will be charged if records must be delivered within 72 hours of the request.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Assignment of Benefits: I hereby authorize my primary insurance company to make payments directly to Modern Spine. I understand that I am responsible for knowing the details of my insurance policy including the extent of benefits. I am personally responsible for all allowable charges not covered by my insurance and all charges remaining after my insurance has paid the portion for which it is responsible.

Patient Signature:_____ **Date:**_____

Assignment of Secondary Insurance Benefits: I hereby authorize my secondary insurance company to make payments directly to Modern Spine. I understand that I am still responsible for all allowable charges not covered by my primary and/or secondary insurance and all charges remaining after my insurance has paid the portion for which it is responsible.

Patient Signature:_____ **Date:**_____

Release of Information: I authorize Modern Spine to release any and all information required to process a claim for payment as allowed by law.

Patient Signature:_____ **Date:**_____

I have read and understand the Financial Policy and Appointment Policy for Modern Spine. I understand that these policies are subject to change at the discretion of the management and that I have a right to be notified of substantial changes. I agree to abide by these policies.

Patient/Guardian Signature:_____ **Date:**_____

Printed Name:_____

MODERN SPINE PLLC
PROGRESSIVE SPINAL SOLUTIONS

Kenneth Lee, MD

Board Certified Orthopedic Spine Physician

AGREEMENT FOR NARCOTIC MAINTENANCE THERAPY

The long-term use of pain medication is somewhat controversial as there is a risk of developing dependency and abuse. It is necessary that the use of these narcotic pain medicines be accurately monitored and regulated. Please read and initial each of our policies:

- All narcotic medication must always come from one physician as required by law. It is inappropriate as illegal for multiple physicians to be prescribing pain medications.
- No refills will be allowed after 2:00 PM on weekdays and after 12:00 PM on Fridays. No refills provided on weekends. **DO NOT CALL ANSWERING SERVICE REQUESTING REFILL(S).**
- Refills will not be given if you have not been seen in the office within the last 90-days.
- Narcotic medications must all be obtained from same pharmacy. Filling prescriptions at multiple pharmacies in not acceptable. The prescribing physician is authorized to discuss all diagnostic and treatment details with the pharmacist at the dispensing pharmacy at any time.
- Refills should be requested via your pharmacy not our office unless a change of medication needs to be discussed.
- Medications will not be replaced if they are lost, fall in the toilet, eaten by pets, left on airplane, etc. If medications are stolen a police report must be filed in order to get a refill. Otherwise, early refills will not be authorized.
- If it appears that narcotic medications are being used inappropriately and against medical advice the responsible legal authorities may be notified. All confidentiality is waived and consent is given by patient to provide the appropriate authorities with full access to the patient's records.
- I understand that failure to adhere to these policies will result in permanent cessation of all narcotic medication by Dr. Lee.
- If you are under the care and/or being treated by a pain management physician you must obtain a release of care sent to our office before narcotic medication will be prescribed.

I have read and AGREED to the above mentioned terms:

Patient Signature: _____ **Date:** _____

I obtain my pain medication from my primary physician/pain management doctor: Dr. _____ **and will continue to do so until I discuss these changes with Dr. Lee.**

Physician Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

☐ PATIENT REFUSED TO SIGN

MODERN SPINE PLLC

KENNETH LEE, MD
BOARD CERTIFIED IN ORTHOPAEDIC SURGERY
FELLOWSHIP TRAINED IN SPINAL SURGERY

www.modernspinetx.com
office: (713) 774-6337
fax: (281) 313-7747

MODERN SPINE APPOINTMENTS POLICY

Thank for choosing Modern Spine. We realize you have a choice in medical providers and we are pleased you have chosen to seek care with us. Modern Spine strives to exceed expectations in care and service, in order to make your experience with us as comfortable and stress free as possible. Our goal is to provide quality medical care in a timely manner. In order to do so, we have implemented an appointment policy.

OFFICE HOURS:

Monday: 7:30 am- 4:00 pm
Tuesday: 7:00 am- 4:00 pm
Wednesday: 7:30 am- 4:00 pm
Thursday: 7:30 am- 4:00 pm
Friday: 7:00 am- 12:00 pm

SCHEDULED APPOINTMENTS

We understand that delays can happen, however we must try to keep patients and the doctor on schedule. ***For this reason, if you are more than 15 minutes late, your appointment will be rescheduled***. We apologize for any inconvenience and appreciate your understanding.

If you have any questions or concerns regarding our policies, please feel free to contact our office manager, Alice Romero.

Modern Spine, PLLC

Authorization for Use or Disclosure of Medical/PHI

Patient Name: _____ Date of Birth: _____
Social Security: _____

I authorize my physician and/or administrative and clinical staff of _____
to disclose the following protected health information to:

Kenneth J.H. Lee, M.D./ Modern Spine, PLLC
16929 SW Freeway, STE 100, Sugar Land, TX 77479
713.774.6337, fax 281.313.7747 **Att:** _____

Information to be disclosed: (X)

( ) All Records	( ) History	( ) Physical	( ) Progress Notes
( ) Lab Reports	( ) X-Rays/MRI	( ) Care Plan	( ) Operative Reports
( ) EKG Report	( ) Therapy Reports	( ) Summary	( ) Other: _____

Please exclude the following specified information: _____

_____

This authorization covers care provided from _____ to _____.

*** Additional copies of X-ray CD's will be $15.00 each payable in advance**
Purpose of disclosure: (X)

( ) Medical	( ) Employer	( ) Insurance	( ) Attorney
( ) At request of individual	( ) Other _____		

Check One
( ) Release this information one time only.
( ) This release is good from the date signed until _____, at which time authorization to use or disclose this protected health information expires (No longer than 180 days)
( ) This release expires 180 days from today.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 16659 SW Freeway, Ste 151, Sugar Land, TX 77479. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be diclosed 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 authorizaion for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient or Personal Representative Date