Complete Spine Center

Date:_____

What is your chief complaint for which you are being seen in Spine Clinic? _____

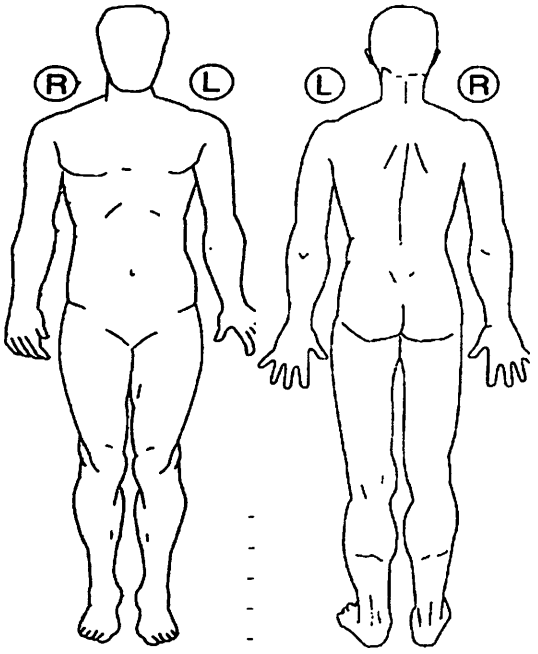
_____

Age:_____

On the diagram, mark the areas you are experiencing pain. Use the following symbols to describe your pain:

Aching: A Burning: B Cramping: C
Numbness: N Pins & Needles: P Stabbing: S
Put an X on the area that hurts the most.

(Front View) (Back View)



How long ago did your symptoms start?

_____

How often do you have symptoms?
All the time Sometimes

If sometimes, how long does your pain last?
____Minutes ____Hours ____Days

Using the pain scale below, please answer the questions:
What is your pain score right now: _____/10
How bad does it get? ____/10
What is the lowest? ____/10

What medications for pain do you take? Helpful?

_____	Yes	No
_____	Yes	No
_____	Yes	No

What activities worsen your symptoms?
Sitting, standing, walking, lifting, driving, exercise
Other: _____

What activities improve your symptoms?
Sitting, standing, walking, lying, exercise
Other: _____

Any history of:

Cancer?	Yes	No
Unexplained weight loss?	Yes	No
Have you had spine surgery?	Yes	No

If yes, when was your operation(s)? _____

_____

What treatments have you had?

	Helpful	Not helpful
__ Physical therapy	_____	_____
__ Ice or Heat	_____	_____
__ TENS unit	_____	_____
__ Acupuncture	_____	_____
__ Massage therapy	_____	_____
__ Chiropractor	_____	_____
__ Yoga or Pilate's	_____	_____
__ Spine Injections	_____	_____

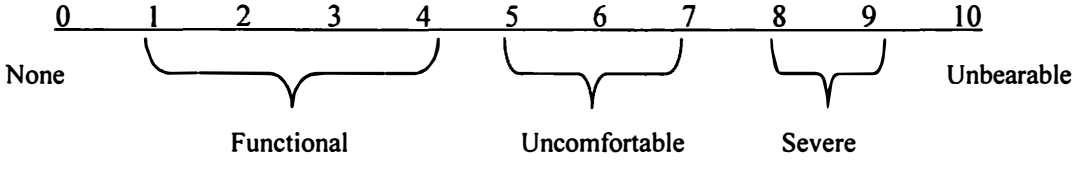
Are you employed? Yes No
If Yes: Full-time Part-time
What do you do? _____
What is your marital status? _____

Do you smoke? Yes No
How much do you smoke? _____ #yrs? _____

Have you ever smoked in the past? Yes No
Date(s) quit? _____
Alcohol Use: None ____ Drinks per _____
Illegal drugs: None _____Type

Over the past two weeks, have you been bothered by:

Feeling down, depressed, or hopeless?	Yes	No
Little interest or pleasure in doing things?	Yes	No
Difficulty sleeping at night?	Yes	No



Name:_____

Signature:_____

History Form – Complete Spine Center, PA

☐ ☐ ☐ ☐

What name do you like to be called?_____

What is the best number to reach you during the day? ( )_____-_____

May we leave a brief message? ☐ Yes ☐ No

Medical History: Have you ever been treated for any of the following medical conditions?

☐ No changes
☐ Arthritis
☐ Diabetes
☐ High blood pressure
☐ Irritable bowel
☐ Osteoporosis
☐ Cancer
☐ Depression/anxiety
☐ Heart problems
☐ High cholesterol
☐ Lung problems
☐ Thyroid problems

Please list any additional medical conditions:

_____

Have you ever been hospitalized overnight? ☐Yes ☐No

Have you ever had surgery? ☐ Yes ☐ No _____

_____

Medications and Allergies will be reviewed by clinic staff.
(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? ☐Yes ☐ No

Family History: Please list any known medical problems for the relatives listed below:

For example: diabetes, breast/colon/ovarian/ prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis.

☐ No changes

Mother:_____

Father:_____

Brothers/Sisters:_____

Children:_____

Other:_____

_____

_____

Medication List:

Work Type:_____

Do you enjoy your job?_____

Any major stresses in your life?

_____

_____

_____

Relationship Status:

☐ Married ☐ Single ☐ Widowed

☐ Divorced/Separated

☐ In a relationship

How long?_____

Who do you live with:_____

How many children do you have?

_____

Do you feel you ever have been abused (verbally, physically, or sexually? ☐ Yes ☐ No

Do you wear seatbelts/helmets?

☐ Yes ☐ No ☐ Sometimes

Do you wear sunscreen?

☐ Yes ☐ No ☐ Sometimes

Do you have an eye exam at least every two years?

☐ Yes ☐ No

Do you have a dental exam at least yearly? ☐ Yes ☐ No

Continue on back.....

REVIEW OF SYSTEMS

Please circle any current symptoms below:

General Symptoms:
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out

Eyes:
Vision loss, eye pain, blurred vision

Ears/Nose/Mouth & Throat:
Sore throat, runny nose, hearing loss, problems with mouth, voice changes

Breasts:
Lumps, skin changes, nipple discharge

Lungs & Heart:
Chest pain/pressure, irregular heart beat, cough, wheezing, breathing trouble

Skin:
Rashes, changing moles, changes in hair/skin/nails

Neurological:
Unusual or new headaches, weakness or numbness, falling

Abdomen:
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

Sleep:
Difficulty falling asleep, frequent awakening

Musculoskeletal:
Joint/muscle pain, muscle weakness

Mood:
Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide

Men Only:
Difficulty starting or weak stream, difficulty getting/maintaining erections, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps, possible sexually transmitted infections

Women Only:
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine

Other:
List any symptoms not mentioned:

_____

_____

_____

*******The following will be completed and used by clinic staff:*******

Mohammad Etminan, MD
Complete Spine Center

Hillcroft Medical Center
Tel: (832) 562-4400

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 to carry out treatment, payment or health care operations and for other purposes that are permitted or required by low. It also describes your rights 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 to your past, present or future physical or mental health or condition, and related health care services.

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 protected 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 protected health information, as necessary, to a home health agency that provides care to you. Another example: your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information 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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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

We may use or disclose your 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; Workers' 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 tine the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to 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 protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of our protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice form us. upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your 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 and will provide you with a copy of any such rebuttal.

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

We reserve the right to change the terms of this notice and will inform you by mail of any changes. 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 privacy 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 protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____

Date _____

Mohammad Etminan, MD
Complete Spine Center

Hillcroft Medical Center
Tel: (832) 562-4400

Patient Agreement for Prescription Opioids

The purpose of this agreement is to structure our plan to work together to treat your chronic pain. This will protect your access to controlled substances and our ability to prescribe them to you.

I (Patient) understand the following:

- Opioids have or will be prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including to work or school. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.
- Opioids are being prescribed to make my pain tolerable but may not cause it to disappear entirely. If that goal is not reached, my physician may end the trial
- Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle or perform other tasks that could involve danger to myself or others.
- Using opioids to treat chronic pain will result in the development of physical dependence on this medication, and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include a runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life-threatening.
- There is a small risk that opioid addiction can occur. Almost always, this occurs in patients with a personal or family history of other drug or alcohol abuse. If it appears that I may be developing an addiction, my physician may determine to end the trial.
- (Males only) I am aware that chronic 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 that my doctor may check my blood to see if my testosterone level is normal.
- (Females only) If I plan to become pregnant or believe that I have become pregnant while I am taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with risk of birth defects; however, birth defects can occur whether the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I agree to the following:

- I agree not to take more medication than prescribed and not to take doses more frequently than prescribed.
- I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.
- I agree not to share, sell, or in any way provide my medication to any other person.
- I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my doctor may check the Texas Prescription Monitoring Program at any time to check my compliance.
- I agree not to seek or obtain ANY mood-modifying medication, including pain relievers or tranquilizers from ANY other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription except from another prescriber, I will advise that prescriber of this agreement, and immediately advise my prescriber that I obtained a prescription from another prescriber.
- I agree to refrain from the use of ALL other mood-modifying drugs, including alcohol, unless agreed to by my prescriber. The moderate use of nicotine and caffeine are an exception to this restriction.
- I agree to submit to random urine, blood or saliva testing, at my prescriber's request, to verify compliance with this, and to be seen by an addiction specialist if requested.
- I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time.

I understand that ANY deviation from the above agreement may be grounds for the prescriber to stop prescribing opioid therapy at any time.

_____ _____

Patient Signature Print Name Date:

Mohammad Etminan, MD
Complete Spine Center, PA

Hillcroft Medical Center
Tel: (832) 562-4400

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Hillcroft Medical Clinic/Complete Spine Center, PA. to (release / obtain) healthcare information of the patient below to:

_____ _____
Person or Organization **Address**

_____ _____
Phone **Fax**

Information/copies from the medical records on:

_____ _____
Patient **Social Security**

_____ _____
Date of Birth **Date of Service**

INFORMATION TO BE RELEASED:

_____Doctor Visit Notes _____Radiology Reports
_____Operative Reports _____Billing Records
_____Lab Reports _____Other _____

This information is being released for the following purpose:

_____Continued Care _____Insurance _____Other_____
_____Attorney/Litigation _____Disability

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here:

TO PATIENT PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Patient Signature (or authorized representative) **Date**

_____ _____
Relationship to Patient (if not Patient **Print Name of Legally Authorized Rep.**

Mohammad Etminan, MD
Complete Spine Center

Hillcroft Medical Center
Tel: (832) 562-4400

MEDICATION POLICY

This practice follows a strict medication policy for all patients and is outlined below. All patients are required to review the policy below and sign an acknowledgment stating they have reviewed the policy and agree to abide by the provisions of the policy.

All clinic personnel have also reviewed the policy and will implement and strictly abide by it. Unless the physician personally consents to a request for a deviation from the protocol, it will be followed explicitly.

1. **We do not give refills in this practice.** You will be given enough post-op pain medication; anti-spasm medications etc. for 2-3 weeks after surgery until we can see you for follow up in the office. You will be given a prescription either on your pre-operative medical conference visit or on the day of your discharge from the surgery center or the hospital. We are a surgical practice and **do not "take over prescribing" your pills or medications from your GP** or referring physician. **Please do not call, email, fax or request refills!** Once again, we do not do refills.

2. All medications are to be taken as prescribed. If there are any questions or problems with the medications, they should be directed to the medical assistant. The medical assistant will notify the physician as necessary. After hours or if there is an urgent or emergent matter, the physician will be notified, and the patient may be directed to proceed to an **Urgent Care facility or Emergency Room** as indicated. A physician from this practice will always be available for **questions from the emergency room staff regarding your medications or condition.**

3. In connection with certain medications, patients may be requested to have a blood test every three to six months to allow continued usage of the medications.

4. Stronger narcotic medications, including those requiring additional paperwork such as triplicate forms or Department of Public Safety or Drug Enforcement Agency stickers, are not used in this practice. **The doctors in this practice do not have triplicate prescription forms or DEA stickers.** Patients requiring these will be referred to a pain management specialist.

5. No narcotic pain medications, tablet, skin patch, or injection, are kept on the premises.

6. Narcotic pain medications are used in this practice for the management of acute post-operative incision pain. Once this period is over your pain medications will once again be prescribed by your GP, internist, or referring physician. If you require chronic pain control you will be referred to a pain management specialist or enrolled in a chronic pain program. **Once again, we do not assume control of or take over management in any way of your chronic pain and pain medications for longer than 2 to 3 weeks after surgery.** After that period this is the responsibility of your GP, internist or pain management physician. If you suffer from severe chronic pain, you may be referred to a pain management physician before surgery to help you lower your usage of pain medications.

After reviewing the medication policy above, I understand and agree to its provisions.

_____ _____

Patient Signature Print Name Date

Mohammad Etminan, MD
Complete Spine Center, PA

Hillcroft Medical Clinic
Tel: (832) 562-4400

Consent for Treatment / Care

I, _____, consent to treatment and care by Hillcroft Medical Clinic (HMC) and by their physician(s) and health care providers. I also consent to treatment and care by health care providers who are not employees or agents of HMC but are authorized by HMC to provide treatment and care to me as a patient of HMC. I understand that my treatment and care include a variety of other medical services depending on my condition, such as laboratory testing, chiropractic services, imaging studies, physical therapy, etc. I am also aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations or procedures.

I understand that I may withdraw this consent in writing. My withdrawal will not be effective for actions already taken by HMC or in process.

PATIENT:

_____ Date: _____ Time_____
Patient Signature (or authorized representative)

Relationship (if not Patient): _____

WITNESS:

_____
Name: Date: Time:

Mohammad Etminan, MD

Physician Disclosure of Financial Interest

Thank you for the opportunity to provide your spinal treatment needs. We are committed to assuring your complete satisfaction.

The purpose of the disclosure notice is to inform you that we, Mohammad Etminan MD, and Complete Spine Center have financial interests in the following facilities in Harris County and Forbend County – Memorial Hermann First Colony, Memorial Hermann Surgery Center Richmond, Kingsland Surgery Center as well Hillcroft Medical Group Imaging.

Your physician may also have a financial interest in the professional component of intraoperative monitoring that is provided during selected surgical procedures. Your physician is also receiving Royalty payments from certain implant companies for designed implants and possible consulting payments from device companies. Your physician has financial interesting in stem cell procurement companies. Your physician may have a financial interest in physical therapy facilities that you may be referred to.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate medical facility, monitoring company or implant company.

You will not be treated differently by your physician if you choose to obtain health care services at another facility, or to utilize another monitoring or implant company, if applicable. We welcome you as a patient and value our relationship with you.

If you have any questions concerning this notice, please feel free to ask your physician. By signing this Disclosure of Physicians Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has a financial interest in the listed facilities and other above stated services.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Type or Print Name of Patient	Type or Print Name of Parent or Guardian (If applicable)

Dated: _____