

When you come to see the doctor, please bring your actual x-ray, CAT and MRI scan films with you.

We require a 24-hour notice (by noon Friday for Monday appointments) for cancelled or rescheduled appointments.

If a 24-hour notice is not given, there will be a fee for the broken appointment.

Thank you.

The office of Dr. Donald Mackenzie

Pre-Registration Package

Spine Solutions

By Donald Mackenzie, MD

Relieving the pain | Healing the spine | Rejuvenating the person

Part A. - Patient Registration Information (Please print).

Designation: Mr. _____ Ms. _____ Mrs. _____ Dr. _____ Other _____

Sex: Male _____ Female _____ Marital Status: Married _____ Unmarried _____ Other _____

Last Name _____ First Name _____ Middle init. _____

Nickname _____ S.S.N. _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Spouse / Parent's Name _____ S.S.N. _____

Spouse / Parent's Occupation _____ Work Phone (____) _____

Who referred you to this office? _____

What is the reason for your visit? Illness _____ Personal Injury _____ Work-related Injury _____ Auto Accident _____

Emergency Contact Information.

Next of Kin (not living with you) or other designated emergency contact person:

Name _____ Relationship _____

Address _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Part B. – Medical Insurance / Payment Information.

How will you pay for your care? Cash _____ Check _____ Visa / MC _____ Insurance _____ Medicare _____ Other party _____

Name of Insurance Company _____

Address _____

Policy Number _____ Group Number _____

It a Third Party is paying for your care:

Name of Responsible Party _____

Address _____ City _____ State _____ Zip _____

What is their Relationship to Patient? _____ Home Phone(____) _____

Name of their Employer _____ Work Phone(____) _____

Part C. – About Your Present Illness / Injury

1. When (date or length of time) did your present pain / symptoms start? _____

2. Are you still able to work? Yes _____ No _____ If No, date last worked _____

3. How did the symptoms begin?

Suddenly _____ Gradually _____ No apparent cause _____
Lifting _____ Pulling _____ Twisting _____ Bending _____
Fall _____ Sports _____ Auto Accident _____ Work Injury _____

4. What activities make the pain / symptoms worse?

Exercise (during) _____ Exercise (after) _____ Standing _____ Walking _____
Bending Forward _____ Bending Backward _____ Coughing _____ Sneezing _____
Sitting _____

5. What reduces the pain / symptoms?

Lying down _____ Sitting _____ Standing _____ Walking _____
Manipulation _____ Exercises in Therapy _____ Pain Pills _____ Muscle Relaxers _____
Aspirin _____ Injections for Pain _____ Nothing _____ Other _____

6. How long have you had these symptoms? _____ years _____ months _____ days _____

7. How long have you had similar symptoms? _____ years _____ months _____ days _____

8. Have you had any of the following diagnostic tests for this complaint? If yes, please write in approximate date:

Plain x-rays _____ CT Scan _____ Myelogram _____
MRI scan _____ Discogram _____ EMG _____

9. Have you had any of the following treatments for this condition? If yes, please give dates:

Injections into the spine _____
Hospitalized for pain _____
Surgery of the spine _____

10. Please list the names and dosages of all medication you are taking now. _____

_____, _____, _____
_____, _____, _____
_____, _____, _____

11. Do you have allergies to any medications? Yes _____ No _____ If yes, please describe _____

12. Do you take antacids? Yes _____ No _____

Do you smoke or use tobacco products? Yes _____ No _____

If yes, daily amount _____

Do you drink alcoholic beverages? Yes _____ No _____

If yes, describe frequency and amount _____

13. What other types of doctors have treated you for this condition? _____

14. Do you plan to be at your regular job in 6 months time? _____

15. Do you have any other information that would be helpful in understanding your problem? _____

16. What is your height? _____ feet _____ inches

17. What is your present weight _____ pounds

Part D. – Other Medical Conditions.

Do you now have, or have you ever had, any of the following medical conditions?

	Never	Past	Currently
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Bladder problems	_____	_____	_____
Bowel problems	_____	_____	_____
Cancer (If yes, type _____)	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy	_____	_____	_____
Gout	_____	_____	_____
Heart problems	_____	_____	_____

If yes, what type of heart problems _____

Do you have a pacemaker? _____

High Blood Pressure _____

Infections – Chicken Pox _____

Hepatitis _____

Polio _____

Rheumatic Fever _____

Tuberculosis _____

Other _____

Sexual difficulties unrelated to pain _____

Stomach and intestinal problems _____

Stroke _____

Thyroid problems _____

Weight loss / gain _____

Other (explain) _____

Part E. – Surgical History.

Please list all the surgeries you have had with the approximate dates (year is sufficient).

Do you take any of the following herbal remedies that would make surgery dangerous?

Echinacea	Yes _____	No _____
Garlic tablets	Yes _____	No _____
Ginger	Yes _____	No _____
Gingko Biloba	Yes _____	No _____
Ginseng	Yes _____	No _____
St. John’s Wort	Yes _____	No _____
Metabolife or anything similar	Yes _____	No _____
Kava Kava	Yes _____	No _____
Feverfew	Yes _____	No _____
Ephedra	Yes _____	No _____

Part F. – Appointment Cancellation.

If you need to cancel or reschedule an appointment, please give at least 24 hours notice (or by noon on Friday for Monday appointments) so that your time may be given to another patient. A missed appointment will be charged if this is not done.

I have read and understand the policy on **appointment cancellation.** Initial _____

Part G. – Medical Refills.

In order to protect your health and avoid medication errors, and because state and federal regulatory agencies require clinical evaluation of a patient before prescribing many medications, including narcotic pain killers, we cannot refill medications by telephone except in cases of adverse reaction to your prescription.

All medication refills must be done in person at a scheduled visit with your physician. Please be sure that you are given sufficient medications and/or enough refills to last until your next appointment.

IF YOU HAVE AN ADVERSE REACTION TO A MEDICATION THAT YOU HAVE BEEN PRESCRIBED, CALL THE PHYSICIAN AT ONCE.

I have read and understand the policy on **medication refills.** Initial _____

Part H. – Billing for Services Provided.

1. Office visits are billed based upon medical complexity and/or the time spent with a patient according to CPT (current procedural terminology) codebook guidelines.

When you are referred out for radiological studies, including plain x-rays, CT scans, myelograms and MRI scans, you are billed by the radiology facility for the technical component (actual taking of the films) and for the services of a radiologist who reads the films, interprets the findings and produces a report for the radiology facility (professional component).

Patients frequently wonder why surgeons also charge a fee to interpret these radiological studies. Primarily it is because the surgeon is held responsible for treatment decisions, many of which are based upon the interpretation of such studies. Interpreting radiological findings is complex and time-consuming yet no surgeon would operate on the basis of a radiologist's written report. Because of the time and complexity involved, a charge to reinterpret the films is both justified, appropriate and in accordance with AMA and specialty society guidelines.

PLEASE NOTE:

If you undergo a surgical procedure the fee for the surgery includes follow-up office visits for 90 days after the procedure is performed. It does not include the interpretation of any x-rays that may be taken to monitor your post operative progress and itemized charges will appear if such x-rays are taken. A deposit is required before surgery can be performed. The usual deposit amount is \$500 for cervical spine procedures and \$1000 for lumbar spine procedures.

I have read and understand the policy of **billing for services.** Initial _____

2. To control costs, we ask patients to pay for their office visit at the time services are provided.

I, _____ understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or in my health insurance. If I am a member of an HMO or PPO group and the insurance company has not paid the claim within 90 days of the visit, I understand that I am responsible for the balance due.

Signed _____ Date _____

3. Due to contract language between physician and certain insurance companies, I understand that I am financially responsible for all charges deemed to be "non-covered benefits" by my insurance company. Even if the insurance company's Explanation of Benefits states that the procedure is a "non-covered benefit" and "patient is not responsible". I have read and understand the policy on "non-covered benefits" Initial _____

Part I. - Privacy Practices.

Your medical information is confidential. As noted in the Notice of Privacy Practices, we follow HIPAA guidelines in limiting access to your medical information.

I have read and understand the **Notice of Privacy Practices.**

Initial _____

Patient Consent for the Disclosure of Information

I understand that by signing this form, section part I., I consent to the following:

- a. **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) In order to provide me with quality care and the educational / wellness programs specified in my insurance plan.
- b. **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to, benefit determination and utilization review) as well as your representatives involved In the billing process (including, but not limited to, claims representatives, data warehouses and billing companies).
- c. **Sharing of Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office including but not limited to the credentialing process, peer-review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient's Printed Name _____

Patient's Signature _____ Date _____

Witness (optional) _____ Date _____

Part J. – Notice concerning Complaints.

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
1812CentreCreekDrive -Suite300
P.O. Box 149134
Austin, Texas 78714-9134

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

PATIENT PAIN DRAWING

Name _____ Date _____

Where Is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

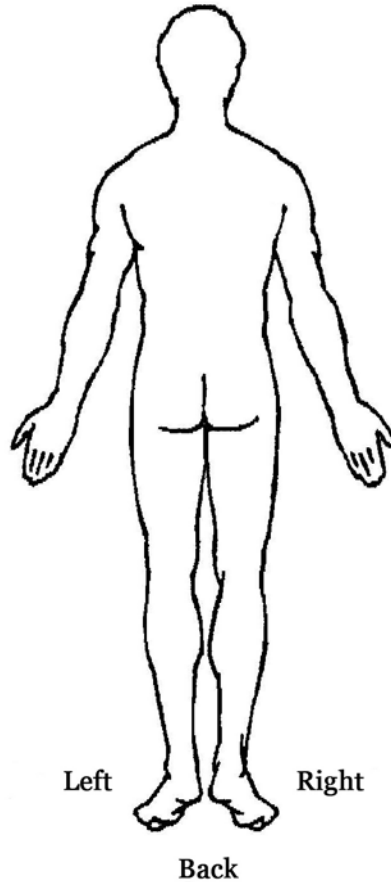
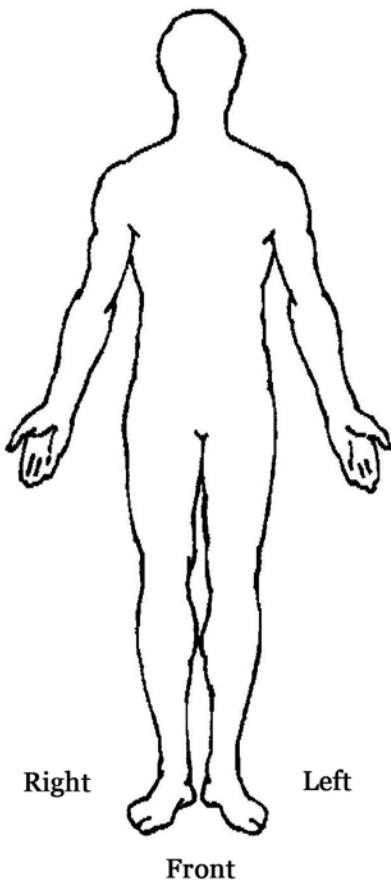
Aching
△ △ △

Numbness
= = =

Pins and needles
○ ○ ○

Burning
X X X

Stabbing
/ / /



Pain Intensity.

Please mark with an X on the body form where the pain is worst now.

Please mark on the line how bad your pain is now:

