3450 W Wheatland Rd, Suite 330, POB II
Dallas, TX 75237
972.299.6966
CedarHillSpine.com

NEW PATIENT INFORMATION

GENERAL OFFICE INFORMATION

FRAGRANCE FREE ENVIRONMENT:

Our office is fragrance free due to Dr. Ozanne having severe allergies to fragrances. When coming to our office please *DO NOT wear any fragrances* (i.e. perfume, cologne, aftershaves, fragrant lotions, etc.); however, deodorant is welcomed.

Office Hours:

Closed Mondays, Tuesday – Thursday 8-5pm and close for lunch 12-1pm, and Friday 8-3:30pm closed for lunch 12-1230pm. After hours, we have a recording that will allow you to leave a message. Calls will be returned as soon as possible.

Appointments:

Clinic days are Wednesday and Friday. Patients are seen in the office by appointment only. Dr. Ozanne is a surgeon, he is not in the office every day. However, we do attempt to accommodate your schedule whenever possible.

Appointment Reminders are a courtesy and may not be provided. You are responsible for remembering your appointment date and time. **There is a $25 fee for appointments not cancelled within 24 hours of your appointment.**

Payment is due upon check-in. We collect co-pays, deductibles and/or coinsurance at the time services are rendered based on information provided by your insurance.

Please bring the following items to your appointment:

- ✓ Payment, if applicable. We do not accept American Express or bills larger than a $20.
- ✓ Driver's license or picture ID
- ✓ Insurance card(s)
- ✓ X-ray, MRI or CT film or CD (CD preferred) and the imaging report. If you do not bring the film/CD, your appointment will be rescheduled. We can view some imaging facilities online portal to see these imaging and reports. Please confirm with the clinic staff.
- ✓ Completed New Patient Packet

Prescriptions:

For prescription refills, please call your pharmacy and have them fax the refill request to our office.

FMLA/Disability Forms:

There is a $20 charge for the completion of these forms. Payment is due prior to completing the forms. Please allow 5-7 business days for completion of the disability forms.

**PLEASE DO NOT WEAR ANY COLOGNE OR PERFUME TO YOUR APPOINTMENT.
DOING SO WILL RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.**

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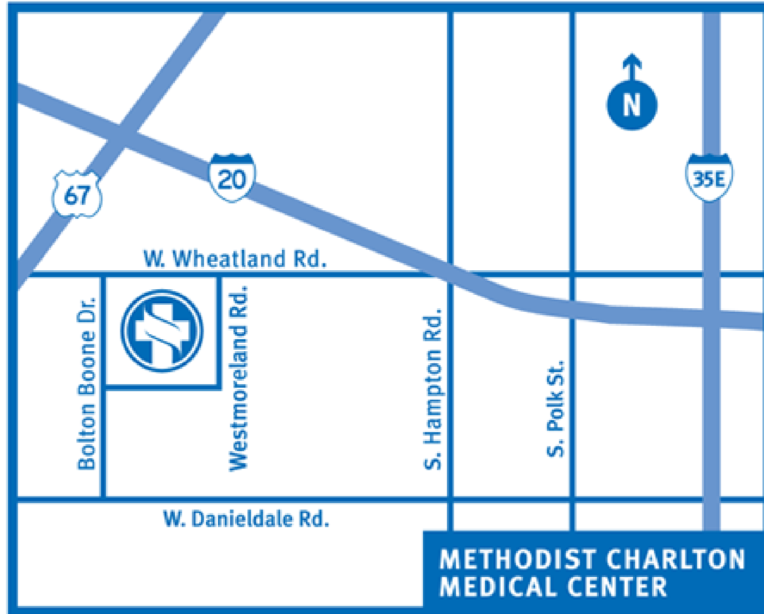
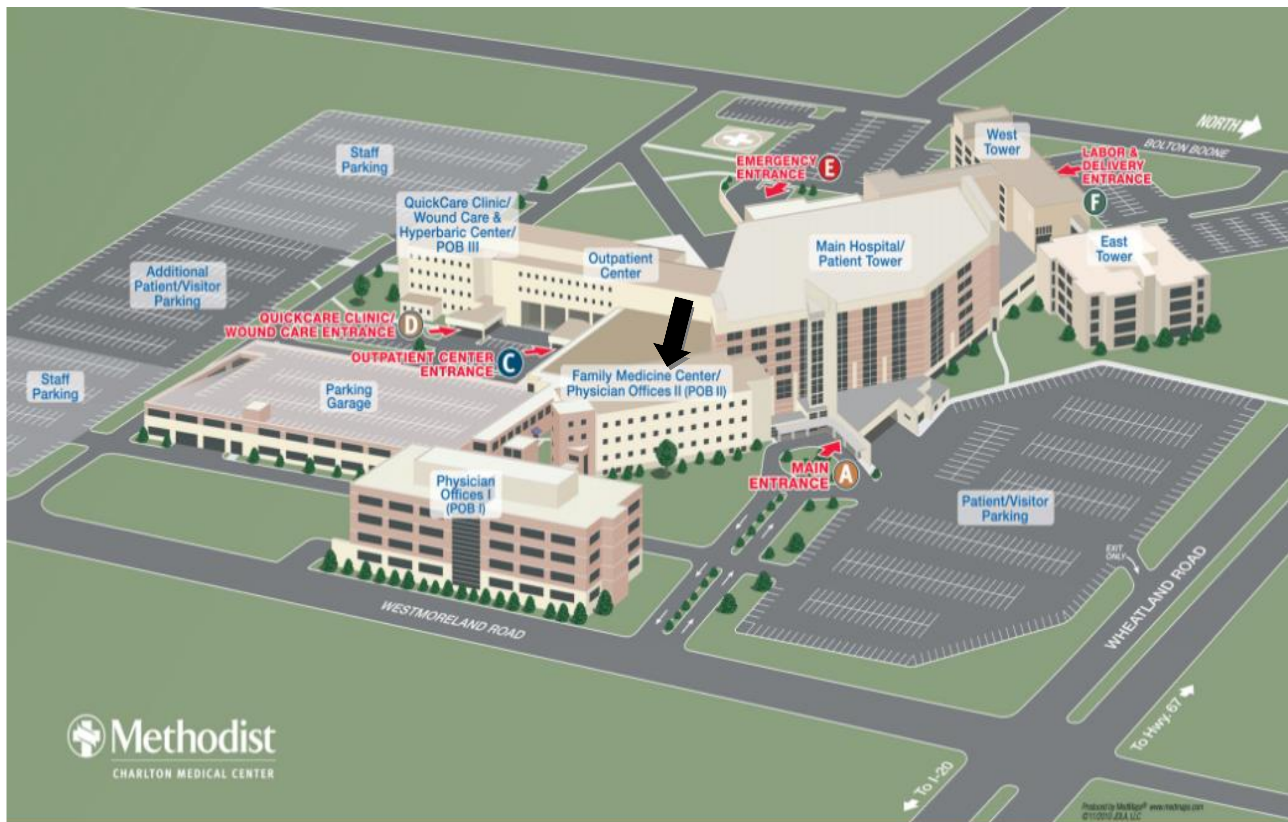


Cedar Hill Spine, located at 3450 W. Wheatland Road in the Physican Offices II (POB II) building Suite 330 near Westmoreland Rd.

- From Highway 67, take the Wheatland Road exit and go east.
- If you are coming from I-20, take Wheatland Road/Hampton exit and go west.
- **Closest parking is in the parking garage**



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Patient Information

Name ____ Today's Date ____________
First *Middle* *Last*

Home Address ____

Home (____) __________________________ Mobile phone (____) ______________________

SSN _______________Birth date __________ Age _____ Sex: ________ ❑ Male ❑ Female

Email Address __________________________ SSN _____________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Race: ❑ African American/Black ❑ White ❑ Asian ❑ American Indian ❑ Hispanic/Latino ❑ Other ____

Emergency, contact _______________________________ Relationship __________________

Home (____) _______________ Mobil or Work (____) ____________

Occupation ____

Employer ____ Years There ____________

Employer's Address ____

City ____ State______ Zip ________

Work Telephone (___) _______________ May we contact you at work? ❑ Yes ❑ No

Name of Spouse __________________________ Birth date _______________ Age ________

Occupation ____ SSN __________________

Employer ____ Years There ____________

Employer's Address ____

City ____ State______ Zip ________

Employer's Telephone (____) ____

Do you wish correspondence to be confidential? ❑ Yes ❑ No
Do you wish phone calls to be confidential? ❑ Yes ❑ No

Complete this section only if someone other than the patient is financially responsible.

Responsible Party _________________________________ Relationship to Patient __________

Home Address _____________________ City ____________State ____ Zip _____

Telephone (____) _______________________ Birth date ________________ Age ________

Occupation ____ SSN __________________

Employer ____ Years There ____________

Employer's Address ____

City __________________ State _____ Zip_______ Employer's PH#: ____________

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Insurance Information

Name ____ Today's Date ________________
First *Middle* *Last*

[Primary Insurance]

Name of Insurance Company ____

Address ____________________________City ____________________State _____Zip _____________________

Insured's Name ____

Policy ID Number _______________________________ Group Number _________________________________

[Secondary Insurance]

Name of Insurance Company ____

Address ____________________________City ____________________State _____Zip _____________________

Insured's Name ____

Policy ID Number _______________________________ Group Number _________________________________

Our office will file Insurance for all reimbursable services, to both your primary and secondary Insurance carriers. Please remember you are responsible for all deductible, co-pay, and non-covered service amounts. See our complete financial policy for details.

____ _____________________________________

Signature of Patient or Responsible Party *Date*

Consent to Treat

I hereby authorize employees and agents of Cedar Hill Spine (including physician, medical assistants, and other staff members) to render medical evaluations and care to the patient indicated below. The duration of the consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

____

Patient Printed Name (Legal guardian/Representative)

____ ________________________

Patient's Signature (Legal guardian/Representative) **Date**

Complete this section ONLY <u>if the patient is a minor</u>

I consent for __________________________ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

____ ________________________

Signature of Parent or Legal Guardian **Date**

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Health History Questionnaire

Date: ______________

Name ____ Birth date ____________________ Age ___________

Was this an on the job injury? ❑ Yes ❑ No If yes, did you report injury to your employer? ❑ Yes ❑ No

Was this an auto accident? ❑ Yes ❑ No If yes, was incident reported to your or responsible parties auto insurance provider? ❑ Yes ❑ No

Primary Care Physician ____________________________

How did you hear about us? ❑ Our website ❑ Internet ❑ Physician, *who?* __________________________

❑ Patient of Dr. Ozanne's, *who?* ______________________ ❑ *Other* ____________________________________

Reason for visit (*please describe*) ____

____

____

Patient Weight ________ Height _______________

Social History

(please check)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you smoke? ❑ Yes ❑ No If yes, packs per day ______ No. of years you have smoked? _______

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per week? ______________________________

Occupation ____ Highest Education Level ______________

Patient Medical History

(please check any illnesses that you currently have, or have had in the past)

❑ Bleeding Disorder (286) ❑ Blood Clots (V12.51) ❑ Cancer (CV10.-) ❑ Osteoporosis (733.00)
❑ Heart Attack (410.-) ❑ Gastric Ulcer (V12.71) ❑ Hepatitis (573 1) ❑ High Blood Pressure (401.1)
❑ HIV (042) ❑ Stroke (431) ❑ Rheumatoid Arthritis (714.0)
❑ Diabetes (250.-) How long? _________________

❑ Other ____________________________________ ____

____________________________________ ____

Past Surgical History

(please check all that you have had)

❑ Tonsils and Adenoids ❑ Appendectomy ❑ Gall Bladder ❑ Heart Surgery
❑ Hysterectomy ❑ Back Surgery
❑ Fracture Repair *(if yes, please specify)* ____
❑ Total Joint Replacement *(if yes, please specify)* ____
❑ Other ____________________________________ ____

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Medications

Use the back of this page if additional space is needed. Please remember to list antibiotics, blood thinners, insulin and heart medications.

Name	Strength	Frequency	Name	Strength	Frequency
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Allergies

(please check all that apply)

❑ No known drug allergies

❑ Anesthetic (V14.4) ❑ Penicillin (V14.0) ❑ Antibiotic (14.1)

❑ Aspirin (V14.6) ❑ Codeine (V14.5) ❑ Morphine (V14.5)

❑ Other ______________________________ ______________________________

Family History

(please check all that apply)

❑ Mother alive ❑ Father alive ❑ I am adopted

❑ Arthritis (V17.7) ❑ Diabetes (V18.0) ❑ Heart Disease (V17.3) ❑ Stroke (V17.1)

❑ Relative with ortho problems (V17.8) if checked, please list ______________________________

❑ Cancer (V16.) if checked, type of cancer ______________________________

❑ Other ______________________________ ______________________________

______________________________ ______________________________

Review of Systems

(please check all symptoms that apply to you from each of the 11 categories)

Constitutional Symptoms

☐ Yes ☐ No Loss of appetite
☐ Yes ☐ No Chills
☐ Yes ☐ No Fever
☐ Yes ☐ No Difficulty sleeping
☐ Yes ☐ No Malaise (feel sick)
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Night sweats
☐ Yes ☐ No Weakness
☐ Yes ☐ No Weight gain
☐ Yes ☐ No Weight loss

Musculoskeletal

☐ Yes ☐ No Joint pain
☐ Yes ☐ No Joint injury
☐ Yes ☐ No Joint stiffness
☐ Yes ☐ No Joint swelling
☐ Yes ☐ No Back pain
☐ Yes ☐ No Neck pain
☐ Yes ☐ No Bone fracture
☐ Yes ☐ No Gout
☐ Yes ☐ No Foot pain
☐ Yes ☐ No Cold/Numb feet
☐ Yes ☐ No Cold/Numb hands

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Ear/Nose/Throat

- ☐ Yes ☐ No Snoring
- ☐ Yes ☐ No Ringing ears
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Vertigo
- ☐ Yes ☐ No Jaw pain
- ☐ Yes ☐ No Neck swelling
- ☐ Yes ☐ No Hoarseness
- ☐ Yes ☐ No Difficulty swallowing

Eyes

- ☐ Yes ☐ No Eye irritation and itching
- ☐ Yes ☐ No Eye pain
- ☐ Yes ☐ No Eye infections
- ☐ Yes ☐ No Vision changes
- ☐ Yes ☐ No Wear glasses or contacts

Cardiovascular

- ☐ Yes ☐ No Leg pain when walking
- ☐ Yes ☐ No Swelling ankles/feet/legs
- ☐ Yes ☐ No Decrease exercise ability
- ☐ Yes ☐ No Cold feet/legs
- ☐ Yes ☐ No Heart murmur
- ☐ Yes ☐ No Phlebitis
- ☐ Yes ☐ No Irregular pulse
- ☐ Yes ☐ No Chest pain
- ☐ Yes ☐ No Shortness of breath

Gastrointestinal

- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Abdominal pain
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Acid stomach
- ☐ Yes ☐ No Trouble swallowing
- ☐ Yes ☐ No Rectal bleeding
- ☐ Yes ☐ No Incontinence of stool

Neurological System

- ☐ Yes ☐ No Ataxia - Stumbling
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Headache
- ☐ Yes ☐ No Impaired balance
- ☐ Yes ☐ No Numbness or Tingling
- ☐ Yes ☐ No Partial paralysis of arm or leg
- ☐ Yes ☐ No Burning sensations
- ☐ Yes ☐ No Pain down arm or leg
- ☐ Yes ☐ No Tremoring
- ☐ Yes ☐ No Muscle weakness

Endocrine System

- ☐ Yes ☐ No Goiter (Thyroid Disease)
- ☐ Yes ☐ No Urination - excessive/frequent
- ☐ Yes ☐ No Sexual dysfunction

Blood and Lymph System

- ☐ Yes ☐ No Easy bruising
- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Slow wound healing

Genito-Urinary

- ☐ Yes ☐ No Pelvic pain
- ☐ Yes ☐ No Urinary incontinence
- ☐ Yes ☐ No Testicular pain
- ☐ Yes ☐ No erectile dysfunction

Psychiatric

- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Substance abuse concerns
- ☐ Yes ☐ No Phobias
- ☐ Yes ☐ No Mental illness
- ☐ Yes ☐ No Memory loss
- ☐ Yes ☐ No Moodiness

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FINANCIAL POLICY

Please sign and return

We are committed to providing you with the best possible care and will be happy to discuss our professional fees. Your clear understanding of our financial policy is important to our relationship. No matter what medical insurance coverage you have, you are solely responsible for all charges. It is your responsibility to know how your plan works and what the plan coverage and requirements are. If there is any question about charges, ASK BEFORE you see the Doctor. Any patient may inquire about his or her account during office business hours at 972-299-6966. We will gladly provide you with information about your account.

MEDICARE, MEDICAID (2ND TO MEDICARE ONLY), AND TRICARE PATIENTS
We are participating Medicare, Medicaid 2nd to Medicare only, and Tricare providers and accept assignment on these plans, but the plans REQUIRE you to pay all deductibles and co-pays. If you have any questions about your coverage or deductibles, ASK YOUR INSURANCE CARRIER before you come to the office. We will file your claims for you; your insurance will then send you an explanation of benefits (EOB) on what was charged and what was paid so that you can stay informed.

COMMERCIAL INSURANCE AND PPO PATIENTS
By law, we are not a party to the contract between you and your insurance company. If you have questions about what your insurance plan will pay, ASK YOUR INSURANCE COMPANY before you come to the office. We will file your insurance claim as a courtesy to you, but we can not become involved in disputes between you and your insurance company about deductibles, covered services, secondary insurance, usual and customary charges, in or out of network, pre-certification, second opinions, etc. other than to supply factual information as necessary. All office visit charges, co-pays, and deductibles are expected to be paid at the time of service. Your insurance claims are filed electronically the business day following service to insure timely notification of your claim to your insurance company. All claims not paid by your insurance company within 60 days will be forwarded to you for payment. If the contract between you and your insurance company obligates them to pay you, you are responsible to pay us.

SELF PAY PATIENTS
If you are a self-pay (non insured) patient, payment is expected prior to your meeting with the Doctor, unless other arrangements have been made IN ADVANCE of your visit. Our billing office will be happy to work out payments arrangements for patients requesting this service. We also accept Visa, Master Card, and Bank Debit Cards for your convenience.

PAST DUE ACCOUNTS
After proper notification, all past due accounts beyond 90 days are turned over to a collection agency. A 10% Administration fee will also be added to your balance.

APPOINTMENT CANCELLATION
You are solely responsible for changing or canceling your appointment prior to your appointment time. Failure to cancel or change your appointment without a 24-hour notice will result in a fee of $25.00 payable by you. This is at the discretion of our office. This also applies to Workers Compo.

*Signature*______________________________________ *Date* ________________________

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ACKNOWLDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

The Health Insurance Portability and Accountability Act (HIPPA) is a federal government regulation designated to ensure you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Cedar Hill Spine is furnishing you with our Notice of Privacy Policies, detailing how our physician(s) and staff may use and/or disclosed protected health information about your treatment, payment, health care operations and as otherwise permitted under federal and state law. **By signing this form, you acknowledge that you have received a copy of Cedar Hill Spine's Notice of Privacy Practices.**

*Signature*_______________________________________ *Date* ______________________________

If not singed by patient, please indicate relationship to patient (e.g. spouse)

Relationship_______________________ Witnessed by _____________________________________

If the patient refuses to sign, indicate your attempt to obtain a signature below.

- Patient refused to sign this Acknowledgement.

Date______________________ Time ______________ Employee Name _________________________

RELEASE FORM

For Individuals Involved in Patient Care

Keeping patient's information private is important to us by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient and legal guardian) that Cedar Hill Spine is allowed to disclose this type of information to, please complete the fields below for each person you wish to be entitled to your personal health information.

This consent is valid until such time I provide Stephen Ozanne, MD written revocation.

____ _________________________________

Name Relationship

____ _________________________________

Name Relationship

If more space is needed, please use back of this form.

____ _________________________________

Patient's Signature **Date**

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To better meet your needs, please list your three most important questions for Dr. Ozanne:

NOTICE OF PRIVACY PRACTICES

EFFECTIVE April 14, 2003
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.

OUR PROMISE TO YOU, OUR PATIENTS
Your information is important and confidential.
Our ethics and policies require that your information be held in strict confidence.
©2003 The Medical Management Institute, Revision 03093

INTRODUCTION

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases and compliance audits and virus intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the offices of Stephen Ozanne, MD, we are committed to treating and using protected health information about you responsibly. Then Notice of Privacy Policies describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each Time you visit Stephen Ozanne, MD, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses treatment and a plan for future care of treatment. This information often referred to as your health or medical record serves as a …

- Basis for planning your care and treatment.
- Means of communication among the many health professional who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- Tools in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged to improve the health of the state and nation.
- Source of data for our planning and marketing and
- Tools by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Stephen Ozanne, MD, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request.
- Inspect and obtain a copy of your health record as provided by 45 CFR 164 524 (reasonable copy fees apply in accordance with state law.)
- Amend your health record as provided by 45 CFR 164 526.
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164 528.
- Request confidential communications of your health information as provided by 45 CFR 164 522(b) and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164 522(a) (however, we are not required by law to agree to a requested restriction).

OUR RESPONSIBILITIES

Our practice is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date on the top right hand corner. In addition, each time you visit our facility for treatment you may obtain a copy of the current notice in effect upon request.

We will not use or disclose you health information in a manner other than described in the section regarding Examples of Disclosures For Treatment, Payment And Health Operations without your written authorization which you may revoke as provided by CFR 164 508(b)(5) except to the extent that action has already been taken.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information you may contact our practice's Privacy Officer, Jacquelyn Jackson at 972.296.6966.

If you believe your privacy rights have been violated, you can either file a complaint with Jacquelyn Jackson or with the Office for Civil Rights, US Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Texas is as follows:

Office for Civil Rights
US Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment.
We may provide medical information about you to health care providers, our practice personnel, or third parties who are involved in the provision, management, or coordination of your care.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical information will be shared among health care professionals involved in your care.

We will also provide your other physician(s) or subsequent health care providers (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.
We may disclose your information so that we can collect or make payment for the health care services you receive.

For example:

If you participate in a health insurance plan we will disclose necessary information to that plan to obtain payment for your care.

We will use your health information for regular health operations. We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal, and quality improvement

activities that are necessary to run our practice and support the core functions.

For example:
Members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like It. This Information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce health, care costs

- Appointment Reminders
  We may disclose medical information to provide appointment reminders (e.g. contacting you at the phone number you have provided to us and leaving a massage as an appointment reminder).
- Decedents
  Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.
- Workers Compensation
  We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.
- Public Health
  As requited by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- Research
  We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review Board/Privacy Board, who has reviewed the research proposal.
- Organ Procurement Organizations
  Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant.
- As Required By Law
  We may disclose health information as required by law. This may include reporting a crime responding to a court order grand jury subpoena, warrant, discovery request, or other legal process or complying with health oversight activities such as audits, investigations, and inspections necessary to ensure compliance with government regulations and civil rights laws.
- Specialized Government Functions
  We may disclose health information for military and veterans affairs or national security and intelligence activities.
- Business Associates
  There are some services provided in our organization through contacts with business associates. Some examples are billing or transcription services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.
- Practice Marketing
  We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example, to notify you of any new tests or services we may be offering).
- Food And Drug Administration (FDA)
  We may disclose to the FDA health information relative to adverse events with respect to food, supplements product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- Personal Representative
  We may use or disclose information to your personal representative (person legally responsible for your care and authorized to act on your behalf in making decisions related to your health care).
- To Avert A Serious Threat To Health/Safety
  We may disclose your information when we believe in good faith that this is necessary to prevent a serious

threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence**.**

- Communication With Family
  Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend health Information relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.
- Disaster Relief
  Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all *non-routine operations*, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.