THE SPINE CENTER
8279 Fredericksburg Rd,
San Antonio, TX, 78229
Tel. (210) 963-7093 Fax. (832) 553-3211

Registration Forms

PATIENT INFORMATION

Patient Name Last:	First:	Middle Name:	
Street Address:	City:	State:	ZIP Code:
Home phone:	Work phone:	Mobile phone:	
Social Security:	Birth Date:	Age:	
Sex: ❑ M ❑ F	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black ❑ Caucasian ❑ Pacific Islander ❑ Declined ❑ Other ***(Please check one)***		
Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Declined ***(Please check one)***	Language:		
Marital status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed	Home Email:		
Employer Name:	Occupation:		
Employer Address:	City:	State:	ZIP Code:
Emergency Contact Name:	Emergency Contact Number:		

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No (Please give your insurance card to the receptionist)

Health Insurance Carrier		**Auto Insurance Company**	
Primary Insurance Name:		Company Name:	
Insurance ID:	Group#:	Policy Number:	
Group Name:			
Insured Name:		Insured Name:	
Insured SSN:	Insured DOB:	Claim Number:	Insured DOB:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize THE SPINE CENTER, PA. Doctors and staffs to examine me and make such tests and perform such procedures as are reasonable and necessary for diagnosis of my condition and also consent to required treatment. Release of any medical information is necessary in the course of my examination or treatment and for the process of this claim.

ASSIGNMENT OF BENEFITS: I hereby authorize payment from any insurance company or governmental agency directly to THE SPINE CENTER, PA. for any benefits. I also authorize THE SPINE CENTER, PA. to release any medical information necessary to expedite such insurance claims. I hereby agree to pay co-payments, co-insurances, or deductibles that apply to my insurance plans. Also, I hereby agree to pay the entire or remaining amount of my fees if such fees are not covered or paid by my insurance benefits within 90 days of billing. I permit a copy of above to be used in place of original, which has been filed in the office of THE SPINE CENTER, PA. I also understand that THE SPINE CENTER, PA. is required by applicable federal and state law to maintain the privacy of my "Protected Health Information" (PHI). A notice about their privacy practices, legal duties and my rights concerning my "PHI" is on display and offered to me at the front office.

Patient/Guardian signature *Print Name* *Date*

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize The Spine Center to

Release to: _____

Receive from:

_____ _____
Person or Organization Address

_____ _____
Phone Fax

Information/copies from the medical records on:

_____ _____ _____
Patient Date of Birth Social Security

Date of Service:_____

INFORMATION TO BE RELEASED:

__Doctor Visit Notes _____Operative Reports _____Lab Reports
__Radiology Reports _____Billing Records _____Other_____

This information is being released for the following purpose:
__Continued Care _____Attorney/Litigation _____Insurance _____Disability _____Other+

_____
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 that congeniality may be protected by federal law. If so, federal regulations (42 CFR part2) prohibit you from making and further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization form the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART2.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

_____ _____
Print Name of Legally Authorized Rep. Witness-Printed

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HIPAA & NOTICE OF OUR PRIVACY PRACTICE

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Saqib A. Siddiqui MD
The Spine Center P A
4322 E Tradewinds Ave.,
Lauderdale-by-the-Sea, FL 33308

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and diagnostic tests (x-ray, MRI, or EMG). Some may be ordered prior to your initial consultation to maximize the benefit of your visit. Any test ordered prior to your initial evaluation is as a response to the symptoms you provided during your new patient intake questionnaire. You can refuse these suggested tests prior to seeing the physician or care provider. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths

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- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

I have received or reviewed the privacy practice notice (4 pages) for Saqib A Siddiqui MD, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print Patient Name

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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 acknowledgement 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 medication, patients may be requested to have a urine test every three to six months to allow continued usage of these 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 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 90 days 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.

PAIN MEDICATION WILL ONLY BE WRITTEN FOR SURGICAL & POST-OP PATIENTS AND DR. SIDDIQUI WILL BE THE ONLY PRESCRIBING DOCTOR DURING THIS TIME. ALL OTHER PATIENTS WILL BE REFERRED TO PAIN MANAGEMENT.

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

_____
Patient Signature

_____
Print Name

_____
Date