New Patient Form

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Irvin Sahni, MD, PA **Brian Forzani, MD** **Greg Nelson, DC, FNP-C**

SPINE CENTER OF TEXAS

Last Name: ____________________ First____________________ Middle Initial_______
Street Address____
City__________________________ State_____________ Zip Code________________
Date of Birth_______/_____/______ SSN____________________ Male □ Female □
Email ____
Primary ph #:_________________________ Secondary ph #:______________________
□ Mobile □ Home □ Work □ Other_______________ □ Mobile □ Home □ Work □ Other_______________
Marital status: □ Married □ Divorced □ Single □ Widowed

Responsible Party **(if different than above)**: Spouse □ Child □ Other □
Last Name: ____________________ First____________________ Middle Initial_______
Street Address____
City__________________________ State_____________ Zip Code________________
Date of Birth___________________ SSN____________________ DL#______________
Primary phone #______________________ Secondary #_________________________

Insurance Information Primary Insurance Co____________________________________
Name of Policy Holder____
Policy Number: _________________________ Group #: _________________________
Date of Birth for Policy Holder _____/_____/______________ **Effective date: __________**

Relationship to patient: Self □ Spouse □ Child □ Other □

Secondary Insurance Co____
Name of Policy Holder____
Date of Birth for Policy Holder______/_____/_____________
Relationship to patient: Self □ Spouse □ Child □ Other □

Automobile Accident Related Injury Date of Accident:____________________________

Work Related Injury Date of injury:________Claim #:______________________________
Employer:____________________________Employer ph #:_______________________
Insurance Co:___________________Adjuster name:_____________________________
Adjuster ph #:___________________

Primary Care Physician **(if known)** Name______________________________________
Address____
Phone_____________________________Fax_________________________________

Pharmacy Information **(if known)** Name____
Phone_____________________________Fax_________________________________

Emergency Contact Name____
Address____
Primary Phone #______________________ Secondary #__________________________
Relationship to patient: Spouse □ Child □ Friend □ Other □______________________

I, the undersigned, attest that the above information is true and complete, to the best of my ability:
Signature:____
Date of Signature:____

Attestations: Please read and initial next to each statement:

______1. **Authorization for treatment:** I hereby authorize the providers and/or assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examination or treatments that may be ordered to be performed by clinical personnel. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees will be offered to me as to the effectiveness of examinations or treatments to be performed.

______2. **Authorization for video/photography:** I understand that these medical facilities are under video surveillance, excluding exam rooms, and that my image may be captured on office security systems. Any images are used for security and safety purposes only. My images will not be used for any other purpose nor shared with any outside party other than law enforcement, should the need arise.

______3. **Release of Medical Information:** I understand and agree that any of the above information may be used, if necessary, for the purpose of communication for appointment changes, accounts receivable, emergencies, etc. Information from any medical records may be released, if necessary, for insurance purposes.

______4. **Assignment of Benefits:** I hereby authorize my insurance company(ies) to make payments as stipulated in my policy for any services rendered and that such payment be made directly to the provider for the services.

______5. **Responsibility for Payment:** I understand and agree that, regardless of my insurance status, I am ultimately responsible for the payment of my account for any professional services rendered and I agree to pay upon demand, or as agreed, for the related changes of remaining charges following my insurance payments.

______6. **Automobile Accident Injuries:** I attest that my injury **IS NOT** the result of an automobile accident **OR,** if my injury is the result of an automobile accident, I am aware that my group health insurance cannot and will not be billed for services and that I will be responsible for full payment for all services rendered, at the time of service. Failure to disclose my injury is due to an automobile injury, where services are billed to my group health insurance company, will result in immediate collection efforts against me and I will be subject to an additional $200 processing fee, per visit.

______7. **Work Related Injuries: Initial this line if your injury IS NOT work related.** I attest that my injury **IS NOT** the result of a work related injury and that no report has been filed with any workers compensation carrier. Failure to disclose my injury is related to a work related event will constitute insurance fraud and I may be subject to prosecution.

□ Yes □ No Treatment for my illness/injury has been authorized by the Veterans Administration.

By my signature below, I attest that I have read, understand, and attested to each of the items contained herein:

Print Your Name:____

Signature:____

Date of Signature:____

Irvin Sahni, MD, PA **Brian Forzani, MD** **Greg Nelson, DC, FNP-C**

SPINE CENTER OF TEXAS

ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement but, in refusing, **we will not be allowed** to submit any claims to your insurance carrier.

I, the undersigned, acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for Irvin Sahni, MD, PA. A copy of this signed, dated acknowledgement shall be as effective as the original. My signature will also serve as a Private Health Information (PHI) document release should I request treatment or radiographs be sent to other attending doctors in the future.

Printed name:____
Legal representative (if applicable):_______________________________________
Description of authority of representative:__________________________________

Please list any other parties who can have access to your PHI
Name:____________________________Relationship:_______________________
Name:____________________________Relationship:_______________________
Name:____________________________Relationship:_______________________

I authorize contact from this office for the purpose of **confirming appointments, treatment, and billing information** via (check all that apply):

□ Cell phone/VM (Voicemail) □ Home phone/VM □ Work phone/VM
□ Text message □ Email □ US Mail □ Any of the above

I authorize **information about my health care/health** to be conveyed via (check all that apply):

□ Cell phone/VM (Voicemail) □ Home phone/VM □ Work phone/VM
□ Text message □ Email □ US Mail □ Any of the above

I approve being contacted about **special services, events, or new health care information** via (check all that apply):

□ Cell phone/VM (Voicemail) □ Home phone/VM □ Work phone/VM
□ Text message □ Email □ US Mail □ Any of the above

Print Your Name:____
Signature:____
Date of Signature:____

SPINE CENTER of Texas

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*********** Please leave the following information below blank, it is meant for staff to fill out if needed ************

I hereby authorize **Dr. Irvin Sahni/Dr. Brian Forzani** to release to:

Name/Facility: _______________________________________ Phone: ____________________
Address: ____
City/State/Zip: ____
Admit/Treatment Date(s):____

The information from the medical records on:
Patient Name: _______________________________________ DOB: _________________
Address: ____
City/State/Zip: ____
Admit/Treatment Date(s):____

****

I hereby authorize the release of all medical records, including, if applicable, any treatment or test results for alcohol and /or drugs, mental health information, or reportable communicable and/or sexually transmitted diseases, including acquired immune deficiency syndrome or human immunodeficiency virus infection.

The above information is released/requested for the following purpose and that purpose only. Any other use is forbidden (state purposes, continuity of care, etc.)

I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written request, to revoke such subsequent revocation will not affect action that already has been taken based on this authorization.

___________ _________________________________ _________________
Date Signature of Patient **Staff Witness**

If the consenting party is other than the patient, I am the authorized Representative/Legal Guardian of
____ and sign on his/her behalf.

________________ ____ _______________
Date Signature of Representative/Legal Guardian **Staff Witness**

Relationship to patient:
____

Irvin Sahni, MD, PA **Brian Forzani, MD** **Greg Nelson, DC, FNP-C**

SPINE CENTER OF TEXAS

Medication Contract

(Please read and initial each line and sign below)

Initials

_______Lost or stolen medication **WILL NOT BE REPLACED FOR ANY REASON**. Medication should be guarded as you would guard cash.

_______Early refills will only be given if the provider authorizes a dose increase.

_______Medications are to be taken ONLY as listed on the prescription bottle. Unauthorized increased dosing (taking more medication than prescribed) can result in illness, injury, or even death.

_______You must notify this office of any side effects for any medication prescribed by our providers.

_______Medications prescribed by our providers are to be used ONLY by that patient. Do not share your medications with others.

_______You will only use ONE pharmacy to fill your prescriptions.

_______**Refill requests must come from your pharmacy** and it is recommended you contact the pharmacy to request refills **72 hours prior to running out.** Phone calls to our office regarding refills will not be accepted. Refills are only authorized during normal business hours.

_______You must allow **72 hours** turnaround time for your refill to be authorized. Do not wait until you run out of medications to request a refill.

_______You must be compliant with providers' recommendations or refills will not be authorized.

_______I will comply with all requests for pill counts and/or frequent visits as the situation dictates.

_______Use of any illicit (illegal) drugs in combination with prescribed medications is not allowed.

_______I will comply with all UDS (urine drug screen) requests by this office.

I hereby acknowledge that I understand the medication policies of this office and agree to abide by the medication policies above. Violations of any of these policies will result in discontinuance of refills for all medication and may result in immediate dismissal from the office and termination as a patient.

Printed name:____

Signature:____

Date of Signature:____

1) Describe the reason for your visit: ____

2) Are you requesting Narcotic Medications (Tramadol, Hydrocodone or Oxycodone): YES NO

3) Did you have a previous pain management doctor? YES NO
If yes, **Doctors name:** ____

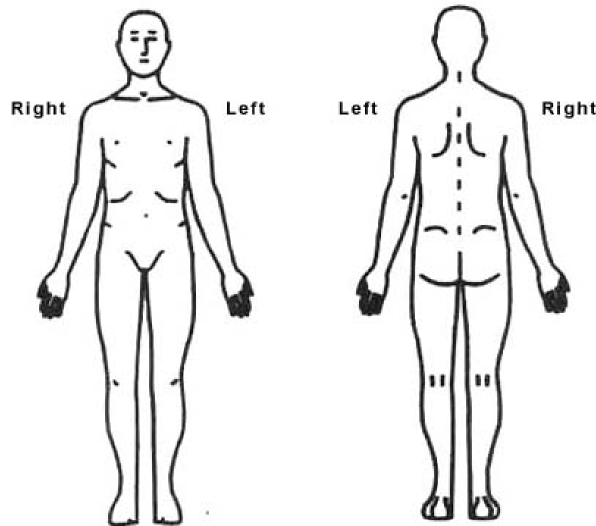
4) When did this begin? **Must provide date:** ____________________________________

5) What do you believe caused this?____

6) Have you seen a surgeon, before today, for this? □ Yes □ No
If yes, **list name of surgeon**:____

7) Have you had prior surgery for this problem? □ Yes □ No
If yes, **list name of surgeon, date of surgery, and type of surgery**:_____________________

Please mark your area(s) of pain on the diagram below.



Are you allergic to any medications? □ Yes □ No
If yes, please list:____

Please list **ALL** medications and dosage you are currently taking, including over the counter medicines. If you have a list, you may simply provide this to the receptionist.
1.____________________2.____________________3.____________________
4.____________________5.____________________6.____________________

List ALL prior surgeries with approximate date:
1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________

Print Your Name____

List ALL Major Family Health Problems:

______________________________	Who: Mother Father Brother Sister
______________________________	Who: Mother Father Brother Sister
______________________________	Who: Mother Father Brother Sister
______________________________	Who: Mother Father Brother Sister

Patient Medical History Below: Please select if you have suffered from any of the following:

General: Obesity

Cardiovascular: Arrhythmia Angina Congestive Heart Failure
Coronary Artery Disease Deep Vein Thrombosis High Cholesterol
High Blood Pressure Hypotension Heart Attack
Other:__________________

Pulmonary: Asthma COPD Emphysema
Tuberculosis Other:__________________

Gastrointestinal: Gallbladder Problems Colon Polyps Diverticulitis
Hepatitis Irritable Bowel Pancreatitis Peptic Ulcer Disease
Other:__________________

Renal: Kidney Failure Kidney Stones Urinary Tract Infection
Urinary Incontinence Prostatitis Dialysis Other:________________

Musculoskeletal: Gout Osteoarthritis Osteoporosis

FALL RISK SCREEN: Have you fallen in the past year? Yes No
Do you feel unsteady when standing or walking? Yes No
Do you worry about falling? Yes No

DATE OF LAST DEXA SCAN (Bone density): ____________________

Rheumatoid Arthritis Restless Leg Syndrome Fractures:____________________
Other:__________________

Endocrine: Diabetes I Diabetes II Goiter
Hyperthyroidism Hypothyroidism Other:________________________

Neurological: Alzheimer's Dementia Migraine Headache
Stroke Myasthenia Gravis Parkinson's Seizures
TIA (mini-stroke) Other:__________________

Hematology: Bleeding disorder Anemia Other:_____________

Allergies: Indoor/outdoor allergies Other:____________________

Mental Health: Anxiety Depression Bipolar____________________

DO YOU GET ANXIETY PRIOR TO ANY TIME OF PROCEDURE/INJECTION? YES / NO

Cancer: Please list type of cancer and if you are currently taking treatment, as well as the name of your oncologist:___
____
____

Social History: Number of Children:___________

Employment: □ Full Time □ Part Time □ Retired □ Disabled
□ Unemployed □ Student

If employed, list occupation:____

Employer:_________________________Employer ph #:_____________________

If student: Grade Level_______________School___________________________

Health Habits: 1. Do you use tobacco? □ Yes □ No If a smoker, how many packs/day?__How long have you been smoking?_________2. Do you drink alcohol? □ Yes □ No If yes, how many drinks/week?______

Irvin K. Sahni, MD., PA
SPINE CENTER OF TEXAS

(830) 379-8800
(830) 372-1600

Nurse Practitioner Consent for Treatment

This facility has on staff a nurse practitioner (Greg Nelson, DC, FNP-C) to assist in the delivery of medical care. Dr. Nelson is also a licensed doctor of chiropractic.

A nurse practitioner is not a physician. A nurse practitioner is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a nurse practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does NOT require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of the nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the nurse practitioner and request to see the physician.

Name:	Date:
Signature:	**Staff Witness:**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _________________________________to release my medical records to:

********* Please leave line above blank for staff to fill out if needed **********

Dr. Irvin Sahni, MD
Dr. Brian Forzani, MD
55 Gruene Park Drive
New Braunfels, TX 78130
P: 830-379-8800
F: 830-372-1600

Dr. Irvin Sahni, MD
Dr. Brian Forzani, MD
1006 E. Kingsbury
Seguin, TX 78155
P: 830-379-8800
F: 830-372-1600

I hereby authorize the release of all medical records, including, if applicable, any treatment or test results for alcohol and /or drugs, mental health information, or reportable communicable and/or sexually transmitted diseases, including acquired immune deficiency syndrome or human immunodeficiency virus infection.

The above information is released/requested for the following purpose and that purpose only. Any other use is forbidden (state purposes, continuity of care, etc.)

I understand that his authorization shall become effective immediately and shall remain in effect for one year from the date of signature until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written request, to revoke such subsequent revocation will not affect action that already has been taken based on this authorization.

____

Date Signature of Patient DOB **Staff Witness:**

Print Your Name____

Consent for Opioid Therapy

I understand that Dr. Sahni/Dr. Forzani **(please circle provider)** is prescribing an opioid medication, sometimes called narcotic analgesics, to me for chronic pain.

Opioid therapy is only part of a comprehensive treatment plan which includes physical therapy, other medications (anti-inflammatories, muscle relaxers, and nerve pain medications), interventional procedures, pain psychology bracing and possible surgery. Continuation of opioids will be based on periodic evaluations in the areas of pain relief and functional improvement. If a clear benefit cannot be defined opioid therapy may be tapered and stopped.

The use of opioids have certain associated risks, including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, addiction, tolerance and possibility that the medication will not provide complete pain relief.

I will not be involved in any activity that may pose harm to me or someone else if I feel drowsy or am not thinking clearly. Such activities include but are not limited to: operating heavy equipment/a motor vehicle or being responsible for another individual who is unable to care for himself/herself.

Physical dependence is the adaptation of the body to a substance. It is a normal, expected result of using opioid medications for a long period of time. It is not the same as addiction, however, if narcotics are abruptly stopped or reversed by some of the agents mentioned below, I may experience withdrawal. This means I may have any or all of the following: runny nose, yawning, dilated pupils, chills, abdominal pain and cramping, diarrhea, irritability, body aches, and flu-like symptoms. Opioid withdrawal is uncomfortable but not life threatening. Should severe medication reactions occur I will notify the practice and/or go to the nearest hospital.

Addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug and feeling the need to use a drug. The risk for addiction is more common in people with a family history of substance abuse. Therefore, I agree to provide a complete and honest personal and family drug history.

I will tell my doctor about all the other medications and treatments that I am receiving. Certain other medications such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol) may reverse the action of opioids and cause withdrawal.

Tolerance occurs when the body adjusts to repeated drug exposure requiring more of the substance to produce the same effect. If it occurs, increasing doses may not always help reduce pain further and may cause unacceptable side effects. Tolerance or failure to respond to opioids may cause my doctor to choose another form of treatment.

(Males only) 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 my doctor may check to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe I have become pregnant while taking pain medication, I will immediately call my obstetric doctor and this office to inform them. I am aware should I carry a baby to delivery while taking these medications the baby will become physically dependent on opioids.
I have read this form or have had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioids.

Patient Name:: ______________________________

Patient Signature: ______________________________

Staff Witness: ______________________________

Date: ______________________________

Irvin Sahni, M.D., P.A.
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PAYMENT POLICY

Spine Center of Texas participates with most PPO Insurance plans, including Medicare. If you are not insured, payment is expected in full prior to each doctor visit. Knowing your insurance benefits is your responsibility. Our insurance coordinator does call to very your benefits but overall it is your responsibility to contact your insurance company with any questions you may have regarding your coverage. **All co-payments and deductibles must be paid at the time of service.** Once our office submits your claim for process, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balances of your claims are your responsibility if you do not have a secondary insurance for us to file too. If your account is over 30 days past due, you will receive a letter from our office stating that you must pay your balance in full. Partial payments will not be accepted unless otherwise negotiated. **Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and the debt will be increased by a 35% collection fee and you may be discharged.** If this is to occur, you will be notified by regular and certified mail that you have X amount of days to find alternative medical care. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:

____ __________________

Signature of patient or responsible party **Date**

Print Your Name ____

OWNERSHIP AND REFERRAL DISCLOSURE FORM

This Disclosure Form is designed to inform you, the patient, of the financial interests and relationships that Dr. Sahni has that may be related to your medical treatment. In addition, it should help ensure that patients have the necessary information to make an informed decision about their medical benefits and care. A physician should notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and whether these are available elsewhere on a competitive basis. Patients also should be informed whether provider to which they are referred are out of network. You will not be treated differently by the physician if you choose an alternate provider or entity, and Dr. Sahni is happy to refer you to an entity that he has no financial interest. Dr. Sahni has an ownership interest in the following medical providers: New Braunfels Sport & Spine Physical Therapy, Hays Surgery Center LLC, River Valley Neurophysiology, Neuro Precision Assisting and Angelina Management Group, LLC. In compliance with the requirements of law, you are being advised that Dr. Sahni has a direct financial interest in the above medical company and facilities. I have reviewed this form prior to treatment for which the referral is being made and I acknowledge the information contained in the form. Some of these providers may be out of my insurance network. I understand that I have the choice of using a participating health care facility provider. If I choose to use a doctor or health care facility that does not participate in my network, my health insurance may not cover the services if my plan does not have out-of-network benefits. I understand that by using my out-of-network benefits I may have higher out-of-pocket costs that I will be responsible to pay. I hereby request and contest to my referral so the provider to which I have been referred. I wish to utilize a health care provider in which my physician has an ownership investment interest, as described in this disclosure form.

PATIENT ACKNOWLEDGEMENT AND CONSENT OF FINANCIAL INTEREST AND POSSIBLE OUT OF NETWORK REFERRAL.

Print Your Name____

Patient Signature: ____

Date: ________________