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CSC CHARGESHEET

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COMPREHENSIVE SPINE CENTER OF DALLAS

GARLAND RD NORTHWEST HWY ARLINGTON

Friday, May 18, 2012

APPOINTMENT		PATIENT			
Provider:	FARLEY, SCOTT	Name:	BOYD, JENNIFER	Phone:	
Date:		Chart:		DOB:	04-17-77
Time:	888	Address:		DOI:	4-12-12
Reason:		SSN#			

REFERRING PROVIDERS		PRIMARY INSURANCE	
Code:		Insurance:	VECCHIO, JOEL
Name:	FARRELL, MICHAEL	Phone:	
Phone:		Copay:	
		Group:	

DECRIPTION	CODE	MOD	DECRIPTION	CODE	DECRIPTION	CODE
CONSULTATIONS			**T-ESI OR NRB**		**INJECTIONS**	
Focused/Straight	99241		Cervical/Thoracic Single level	64479		
Expanded/Straight	99242		Cervical add level	64480		
Detailed/Low	99243		Lumbar/Sacral single	64483		
Comprehensive/Mod	99244		Lumbar Sacral add	64484		
Comprehensive/High	99245					
			FACET INJ. MEDICAL BRANCH BLOCK			
			Cervical/Thoricic	64490	**TRIGGER POINTS**	
NEW PATIENT- OFFICE VISITS			Cervical/Thoricic 2nd level	64491	Plantar	20550
Minimal	99201		Cervical/Thoricic 3rd level	64493	Inj. Tendon ongin/insertion	20551
Expanded/Straight	99202		Lumbar/Sacral (Caudal)	64493	Inj. Trigger point 1/2 musc	20552
Detailed/Low	99203		Lumbar/Sacral 2nd level	64494	Inject trigger points =3	20553
Comprehensive/Mod	99204		Lumbar/Sacral 3rd level	64495	**JOINTS**	
Comprehensive/High	99205		**FLUROSCOPY**		Small Joint Inj.	20600
			Fluro guidance other than Spine	77002	Intermidiate Joint Inj.	20605
EST. PATIENT- OFFICE VISITS			Fluro guidance, Spine	77003	Large Joint Inj.	20610
Level 1 Brief	99211		Epidurography	72275	Inj. Hip under-fluro	27093
Pre Op	99211		Si Joint Injection	27096	Contrast x-ray of hip	73525
Level 2 Limited	99212		Rad Sacral iliac Joint	73542	Shoulder Inj. fluro	23460
Level 3 Expanded	99213		**MEDICATIONS**		Contrast x-ray of shoulder	73040
Level 4 Comprehensive	99214		Depo 40 mg	J1030	**OTHER**	
Level 5 Comprehensive/Complex	99215		Depo 80 mg	J1040		
EST. PATIENT- OFFICE VISITS			Licodaine	J2001	Greater Occipital Nerve	64405
IME	99391		Mepivacaine	J0670	Pyriformis Injection	20552
Special Reports	99080		Low Osmolar Contrast	Q9966	Carpal Tunnel	20526
Post Op<90 Days Global	99024		**ESI**		**SUPPLIES**	
MRI REVIEW			Cervical	62281	Ringers Lactate	J7120
Cervical	72141	26	Lumbar/Sacral	62282	Gloves Sterile (per pair)	A4930
Thoracic	72146	26	**DISCOGRAM**		Needles only (any size each)	A4215
Lumbar	72148	26	Discography Cervical/Thoracic	62291	Syringe (each)	A4657
CT REVIEW			X-ray c/t spine disk	72285	IV Start Kit	A9999-IV
Cervical	72125	26	Injection Lumbar	62290	Electrodes	A4556
Thoracic	72128	26	S-ray of lower spine disk	72295	Surgical Mask	A4928
Lumbar	72131	26	**MYELOGRAM**		Betadine/Lodine Swabs	A4247
MYELOGRAM REVIEW			Cervical	72240		
Cervical	72240	26	Thoracic	72255		
Thoracic	72255	26	Lumbar	72265		
Lumbar	72265	26	Myelography 2 or more regions	72270		
X-RAY REVIEW			Epidural Bloodpatch	62273	Surgical Tray	A4550
2 View Spine Survey	72010	26	**RHIZOTOMY**			
2 View Cervical Spine	72040	26	Cervical/Thoracic	64626		
2 View Thoricic Spine	72070	26	Cervical/Thoracic each add Level	64627		
Lumbosacral Bends/Unbends	72120	26	Lumbar/Sacral	64622		
			Lumbar/Sacral each add level	64623		
			Intercostal	64620		

KS/SMG BILLING 972-720-9944 #701

Jennifer Boyd

ICD-9 CODES

5-18-12

		LUMBAR SPINE
☐	724.2	Lumbago-low back pain
☐	724.5	Backache unspecified
☐	847.5	Lumbar sprain/strain
☐	724.2	Other symptoms referable to the back Facet syndrome?
☐	922.31	Contusion of the back
☐	922.32	Contusion of the buttock
☐	728.85	Spasm of muscle
☐	722.83	Post-laminectomy syndrome

		LUMBAR RADICULOPATHY
☐	722.10	Displacement or disruption of disc(rupture or radiculitis)
☐	724.4	Lumbar sacral radiculitis
☐	724.3	Sciatica
☐	953.2	Acute injury of the nerve root
☐	355.0	Lesion of the sciatic nerve
☐	355.1	Meralgiaparesthetica (lataeral femoral nerve)

		LUMBAR DISCS
☐	721.3	Spondylosis (facet arthritis, osteroarthritis, spon. w/o myelopathy
☐	721.42	Spondylosis w myelopanthy (spondylogenic comp. of lumbar cord
☐	722.52	Lumbar disc degeneration
☐	722.73	Lumbar disc degeneration with myelopathy

		LUMBAR STERNOSIS
☐	724.01	Thoracic spinal stenosis
☐	724.02	Lumbar spinal stenosis w/o claudication
☐	724.03	Lumbar spinal stenosis w claudication

		SACROILIAC JOINT
☐	846.1	Sacroiliac ligament sprain/strain
☐	846.9	Unspecified site of sacroiliac region s/s
☐	720.2	Sacroilitis not elsewhere classified

		SPONDYLOLISTHESIS/SPONDYLOLYSIS
☐	738.4	Spondylolisthesis
☐	726.2	Congenital spondyloysis

		CERVICAL SPINE
☐	723.1	Cervicalgia
☐	847.0	Cervical Sprain/strain
☐	724.8	Other symptoms referable to the back facet shndrome
☐	722.81	Post-laminectomy syndrome

		CERVICAL RADICULOPATHY
☐	722.0	Radiculopathy due to disc disruption
☐	723.4	Cervical radiculitis
☐	729.2	Neuritis or radiculitis unspecified
☐	953.0	Acute injury to nerve root

		CERVICAL DISC
☐	721.0	Spondylosis w/o myelopathy
☐	721.1	Spondylosis with myelopathy
☐	722.4	Degeneration of cervical intervertebral disc
☐	722.71	Degeneration of cerv intervertebral disc with myelopathy

		OTHER
☐		
☐	☒	Injy to left thumb
☐		possible bxus tendon
☐		Injy
☐		

		SPINE FRACTURES
☐	805.2	Thoracic fracture closed
☐	805.4	Lumbar fracture closed
☐	733.13	Pathologic compression fracture of vertebra
☐	805.08	Multiple cervical fracture
☐	805.04	Multiple cervical fracture (if the 4th bone)

		PAIN and HEADACHES
☐	338.11	Acute pain due to trauma
☐	338.21	Chronic pain due to trauma
☐	339.10	Tension type headache
☐	339.4	New daily persistent headache

		UPPER EXTREMITY SHOULDER
☐	719.41	Pain in the shoulder
☐	726.19	Subacromial bursitis
☐	840.4	Rotator cuff sprain
☐	840.0	A C joint sprain
☐	726.10	Disorders of the bursea and tendons (acute tear)
☐	727.61	Non traumatic rupture of the RTC Complete tear
☐	727.13	Partial RTC tear
☐	726.12	Bicipital tenosynovitis
☐	715.11	Arthritis shoulder
☐	726.0	Adhesive capsulitis shoulder
☐	923.00	Contusion of shoulder
☐	923.03	Contusion of upper arm

		ELBOW JOINT
☐	923.1	Contusion of the elbow and forearm
☐	726.31	Medial epicondylitis
☐	726.32	Lateral epicondylitis
☐	352.2	Cubital tunnel syndrome
☐	723.4	Ulnar nerve neuritis

		HAND AND WRIST
☐	923.2	Contusion to hand and wrist
☐	354.0	Carpal tunnel
☐	842.0	Wrist sprain/strain
☐	842.1	Hand sprain/strain

		LOWER EXTREMITY HIP JOINT
☐	726.5	Bursitis of the hip

		KNEE
☐	924.1	Contusion to the knee and lower leg
☐	844.1	Medial/lateral sprain
☐	844.2	
☐	836.0	Acute tear of medial meniscus
☐	836.1	Acute tear of lateral meniscus
☐	717.3	Old derangement of medial meniscus
☐	717.40	Old derangement of lateral meniscus
☐	715.06	Osteoarthritis of the lower leg
☐	717.7	Chondromalacia of the patella

		FOOT and ANKLE
☐	924.2	**Contusion to the foot and ankle**
☐	845.0	**Ankle/foot sprain/strain**
☐	845.1	

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DFW OPEN MRI

Central Scheduling
Phone 214.320.1400 • Fax 214.320.1402

Eastlake Medical Center Building
10611 Garland Road, Suite 101
Dallas, Texas 75218

The Elan Shops at Bluffview
3840 W. Northwest Highway, Suite 400
Dallas, Texas 75220

www.DFWOPENMRI.com

American College of Radiology ACR Radiology Accredited Facility

TRANSPORTATION NEEDED: ☐ Yes ☐ No Date 5-18-12 ☐ M ☒ F Pregnant ☐ Y ☐ N ☐ Fax Report STAT

Patient Name Jennifer Boyd. ☐ Send Films ☐ CD

Patient Phone Number _____ S.S. # _____ ☐ Pre-Authorization Needed

Diagnosis Wrist Pain. D.O.B. 4-17-77 D.O.I 4-12-12

Referring Physician Scott Farley, D.O. NPI # 1477535912

Office Phone Number 214-782-9222 Fax Number 214-782-9333 Email _____

Date of Exam _____ Time of Exam _____ Contact Perla

Ins. Co./Attorney Name Joel Vecchio. Phone Number _____

ARRIVE AT OFFICE 15 MINUTES PRIOR TO EXAM TIME. PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE.
Weight_____ **ATTENTION:** Please let us know if you weigh over 300 lbs. or have any metal objects in your body.

TYPE OF EXAMINATION : MAGNETIC RESONANCE IMAGING (MRI)

☒ Closed MRI 1.5	☐ Head / Brain	☐ Shoulder	RT___ LT___	☐ Elbow	RT___ LT___
☐ Open MRI - Weight limit 500 lbs.	☐ Pituitary	☒ Hand	RT___ LT☒	☐ Hip	RT___ LT___
☐ Lumbar	☐ With Contrast	☒ Wrist	RT___ LT☒	☐ Pelvis	
☐ Thoracic	☐ Without Contrast	☐ Ankle	RT___ LT___	☐ Abdomen	
☐ Cervical	☐ With/Without Contrast	☐ Knee	RT___ LT___	☐ Other_____	

TYPE OF EXAMINATION: (X-RAY)

☐ Ankle	RT___ LT___	☐ Hip	RT___ LT___	☐ Cervical	☐ Chest
☐ Foot	RT___ LT___	☒ Hand	RT___ LT☒	☐ Thoracic	☐ ABD/KUB
☐ Knee	RT___ LT___	☐ Shoulder	RT___ LT___	☐ Lumbar	☒ Other designated scaphoid view
☒ Wrist	RT___ LT☒	☐ Elbow	RT___ LT___	☐ Pelvis	

MYELOGRAM	ARTHROGRAM		DISCOGRAM	ORTHOPEDIC	ULTRASOUND
☐ Cervical	☐ Knee	RT___ LT___	☐ Cervical	☐ Cervical	☐ Specify Area
☐ Thoracic	☐ Shoulder	RT___ LT___	☐ Lumbar	☐ Lumbar	_____
☐ Lumbar	☐ With MRI	☐ With CT	☐ Levels_____	☐ Extremity	_____
☐ Complete	☐ Other_____			Area: _____	_____

COMPUTERIZED TOMOGRAPHY (CT)			EMG TESTING	PAIN MANAGEMENT	
☐ Head / Brain	☐ Cervical	☐ Extremities	☐ Upper Extremities	☐ Consult	☐ S.I. Joint
☐ Pituitary	☐ Thoracic	☐ Chest	☐ Lower Extremities	☐ Epidural Steroid Injection	_____
☐ Orbits	☐ Lumbar	☐ ABD	☐ Complete Study	Cervical Thoracic Lumbar	☐ Nerve Root Block
☐ Sinuses	☐ With Contrast	☐ Pelvis	☐ SSEP/DSEP Only	☐ Facet Joint Injections	☐ Other _____
☐ IAC's	☐ Without Contrast		☐ NCV Only	Cervical Thoracic Lumbar	_____
☐ TMJ	☐ With/Without Contrast		☐ Other_____	☐ Trigger Point Injection	

SPECIAL COMMENTS * Find a hand Surgeon.

In making this referral, referring physician certifies that it is medically necessary. Please fax insurance card information.

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PREVIOUS RECORDS

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Onto Orthopaedics at Midway Medical Center

3108 Midway Rd., Suite 104
Plano, TX 75093
Phone: (214) 731-3008
Fax: (214) 731-3015
Contact Person: Shawn or Lanya Hayden
Contact Phone: (214) 731-3008

Jennifer Boyd **Patient #:** 7858 **DOB:** 04/17/1977 (35 years)

Date of Encounter: 04/25/2012 03:05 PM

History of Present Illness

Shawn A Hayden, MD, PhD 04/25/2012 04:09 PM

Patient words: DOI: 4/12/12

Pt c/o left wrist and left hand pain. Pt was attacked by a dog that bit her left thumb and caused her to fall and landed on left hand. Went to ER on her own in which she had x-rays, placed with a splint and later sent home with meds. Denies any previous injury or trauma. Has not had any p.t. or any other treatment. feels stiff and painful.

The patient is a 35 year old female who presents with wrist pain. This condition occurred following a specific injury. The patient is right hand dominant. The injury involved the left wrist. This occurred week(s) ago (2). The injury resulted from a fall onto the hand. Symptoms include wrist pain, swelling, stiffness and decreased range of motion. The symptoms occur constantly. The patient describes symptoms as moderate in severity.

History

Mr Matthew Calderon 04/25/2012 03:14 PM

Allergy
No Known Allergies
Other Medical History
DOI: 4/12/2012 wrist and thumb injury - got attack by a dog.
Social
Non Drinker/No Alcohol Use
Tobacco Use: Smokes <1 pack of cigarettes per day
Past Surgical
Tubal Ligation 2000

Review of Systems

Mr Matthew Calderon 04/25/2012 03:14 PM

General: Not Present- Anorexia, Fatigue and Fever.
Skin: Not Present- Pruritus and Rash.
HEENT: Not Present- Headache, Visual Loss, Decreased Hearing and Vertigo.
Neck: Not Present- Neck Pain and Neck Stiffness.
Respiratory: Not Present- Cough and Dyspnea.
Breast: Not Present- Breast Mass and Skin Changes.
Cardiovascular: Not Present- Chest Pain, Edema, Palpitations and Shortness of Breath.
Gastrointestinal: Not Present- Abdominal Pain and Change in Bowel Habits.
Female Genitourinary: Not Present- Change in urinary stream and Dysuria.
Musculoskeletal: Present- Decreased Range of Motion, Joint Pain, Joint Stiffness and Joint Swelling.
Neurological: Not Present- Dysesthesia, Headaches and Weakness.
Psychiatric: Not Present- Anxiety, Depression and Insomnia.
Endocrine: Not Present- Cold Intolerance, Heat Intolerance and Polyuria.
Hematology: Not Present- Anemia and Easy Bruising.
All other systems negative

Vitals *(Mr Matthew Calderon; 04/25/2012 03:14 PM)*
04/25/2012 03:05 PM
Weight: 185 lb **Height:** 63 in
Body Surface Area: 1.93 m^2 **Body Mass Index:** 32.77 kg/m^2
Pain level: 8/10
Temp.: 97.1 °F (Axillary) **Pulse:** 85 (Regular) **Resp.:** 16 (Unlabored)
BP: 148/87 Manual (Sitting, Left Arm, Standard)

Physical Exam

Shawn A Hayden, MD, PhD, 04/25/2012 04:10 PM

General
Mental Status - Alert.
Skin
General: - Normal.
HEENT
Head - Normal.
Neck
Neck - Full range of motion. Non Tender.
Chest and Lung Exam
Auscultation:
Breath sounds: - Normal.
Cardiovascular
Auscultation: Rhythm - Regular. **Heart Sounds** - Normal heart sounds.
Peripheral Vascular
Upper Extremity:
Palpation: - Pulses bilaterally normal.
Lower Extremity:
Palpation: - Pulses bilaterally normal.
Neurologic
Mental Status: - Normal.
Cranial Nerves: - Normal Bilaterally.
Sensory:
Light Touch: Intact - Right C5, Left C5, Right C6, Left C6, Right C7, Left C7, Right C8, Left C8, Right T1, Left T1, Right L3, Left L3, Right L4, Left L4, Right L5, Left L5, Right S1 and Left S1.
Motor:
Tone: - Normal.
Strength: 5/5 normal muscle strength - Neck extensors, Left shoulder rotators, Left shoulder abductors, Left arm extensors, Left arm flexors, Left wrist extensors, Left wrist flexors, Left hip abductors, Left hip adductors, Left hip extensors, Left hip flexors, Left leg extensors, Left leg flexors, Left ankle extensors, Left ankle flexors, Right shoulder rotators, Right shoulder abductors, Right arm extensors, Right arm flexors, Right wrist extensors, Right wrist flexors, Right hip abductors, Right hip adductors, Right hip extensors, Right hip flexors, Right leg extensors, Right leg flexors, Right ankle extensors and Right ankle flexors.
Reflexes (Dermatomes): 2/2 Normal - Left Achilles (L5-S2), Left Bicep (C5-6), Left Knee (L2-4), Left Tricep (C7-8), Left Brachioradialis (C5-6), Right Achilles (L5-S2), Right Bicep (C5-6), Right Knee (L2-4), Right Tricep (C7-8) and Right Brachioradialis (C5-6). **Gait** - Normal.
Musculoskeletal
General
Movements - Full range of motion in all joints. **Joints and Muscles** - Normal joints and muscles.
Cervical spine
Movements - No pain and full range of motion.
Spine
Movements - No pain and full range of motion.
Shoulder
Movements - **Bilateral** - No pain and full range of motion.
Elbow
Movements - **Bilateral** - No pain and full range of motion.
Hand/Wrist
Hand: Swelling / Atrophy - **Left** - Generalized swelling. **Other Characteristics** - **Left** - Generalized tenderness.
Wrist: Swelling - **Left** - Generalized swelling. **Movements** - **Left** - Range of motion decreased, Movements painful, Flexion restricted, Extension restricted, Flexion painful and Extension painful. **Deformities** - **Bilateral** - No deformities. **Other Characteristics** - **Left** - Tender.
Fingers:
1st: Deformities - **Left** - No deformities. **Swelling** - **Left** - Generalized swelling. **Other Characteristics** - **Left** - Generalized tenderness.
Metacarpo-phalangeal: Movements - **Bilateral** - No pain and full range of motion.
Hips
Movements - **Bilateral** - No pain and full range of motion.
Knee
Movements - **Bilateral** - No pain and full range of motion.
Ankle/Foot
Ankle: Movements - **Bilateral** - No pain and full range of motion.

Assessments & Plans

Shawn A Hayden, MD, PhD, 04/25/2012 04:16 PM

OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED, INVOLVING FOREARM (718.83)

Medications
Norco 5-325MG, 1 Tablet every six hours, as needed for pain, #40, 10 days starting 04/25/2012, No Refill, Active.
Procedures
~~X-RAY EXAM~~ OF WRIST (73110) (1 Units)

PAIN IN JOINT INVOLVING FOREARM (719.43)

CONTUSION OF HAND(S) (923.20)

Assessment/Plan Note: Appreciate consultation request from Dr Farrell.

Pt reports left hand and left wrist pain. X-ray shows no gross evidence of fracture. grossly normal appearing joints.

Impression: left hand and left wrist pain/sprain. I am concerned about immobility and possibly RSD developing. I have recommended OT, DC splints and orthotics. Work on movement. Consider warm or cool water bath to assist in movement. I am hopeful that focused therapy will result in improvement in pain and stiffness.

Plan:

1) x-ray
2) o.t. for 3 weeks -- aarom and modalities
3) d'c splint
4) consider MRI if no improvement
5) follow up in 10 days

The encounter was completed by Shawn A Hayden MD, PhD.

Pt claims she did not recieve any meds or Rx from Dr. Hayden

FW CAR LEW

☐ Interpreter

☐ Parent/Guardian Present

FOLLOW-UP MEDICAL EXAM

Patient: Jennifer Boyd M/F DOB: 4.17.77 Age 35 Date: 5.4.12

Present Illness: DOI: 4.12.12 ☐ MVA ☐ WC ☐ PI

☑ Other needs refills on meds

Patient returns today complaining of:

☐ Neck Pain	☐ Headaches resolved	☑ Shoulder Pain (R/L)	☐ Chest Pain
☐ Mid Back Pain	☐ Dizziness	☑ Arm Pain (R/L)	☐ Rib Pain
☐ Low Back Pain	☐ Blurred Vision	☑ Wrist Pain (R/L)	☐ Abdominal Pain
☐ Tailbone Pain	☐ Pain Behind Eyes	☐ Hand Pain (R/L)	☐ Jaw Pain
☐ Pelvic Pain	☐ Nausea	☐ Hip Pain (R/L)	☐ Clicking/Popping Jaw
☐ Tingling/numbness in arm/hand (R/L)	☐ Vomiting	☐ Leg Pain (R/L)	☐ Tooth Pain
☐ Tingling/numbness in leg/foot (R/L)	☐ Memory Loss	☐ Knee Pain (R/L)	☐ Ringing/Buzzing in the ears
☐ Radiating Neck Pain into ____	☑ Trouble Sleeping	☐ Ankle Pain (R/L)	☐ Fatigue
☐ Radiating Back Pain into ____	☐ Loss of Balance	☐ Foot Pain (R/L)	☑ Anxiety

☐ Other

PxH: Allergies: NKDA

Occupation: waitress ☐ Unemployed

Medications: hydrocodone, flexeril, naproxyn, lisinopril

Medical Problems:: ☑ hypertension ☐ diabetes ☐ cancer ☐ heart disease ☐ stroke ☐ none ☐ other

Surgeries:

Fractures:

Females: LMP 4/2012

PEx: Wt: 162 (via pt.) Ht: 5'3 (via pt.) BP: 130/90 P:

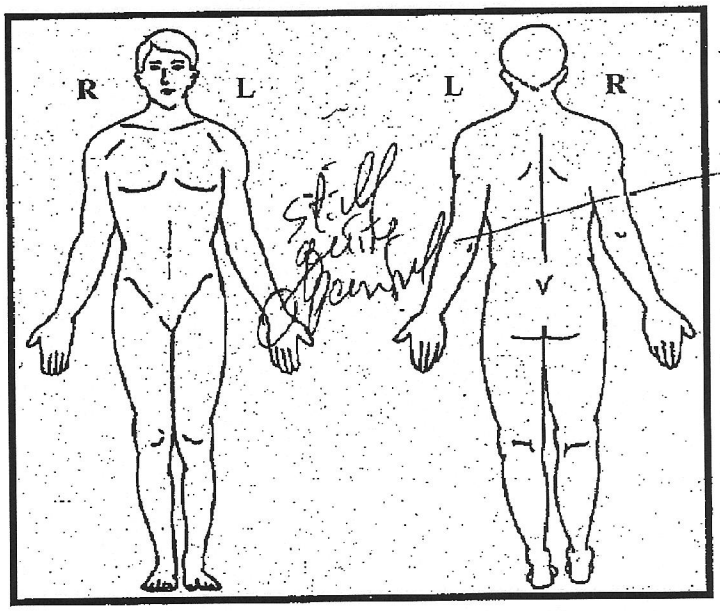
General:

Additional Notes or Diagnosis:

Patient: Jennifer Boyd

Date: 5.4.12

Physical Examination



Lim ~10%

Cervical:

- ☐ pain
- ☐ tenderness/soreness
- ☐ bruising
- ☐ restricted range of motion
- ☐ spasm
- ☐ other_____

Thoracic:

- ☐ pain
- ☐ tenderness/soreness
- ☐ bruising
- ☐ restricted range of motion
- ☐ spasm
- ☐ other_____

Lumbar:

- ☐ pain
- ☐ tenderness/soreness
- ☐ bruising
- ☐ restricted range of motion
- ☐ spasm
- ☐ other_____

Elbow / Hand:

- ☐ pain ☐ right ☐ left
- ☐ tenderness/soreness ☐ right ☐ left
- ☐ bruising ☐ right ☐ left
- ☐ restricted range of motion ☐ right ☐ left
- ☐ spasm ☐ right ☐ left
- ☐ paresthesia ☐ right ☐ left
- ☐ other_____

Shoulders / Arm:

- ☐ pain ☐ right ☐ left
- ☐ tenderness/soreness ☐ right ☐ left
- ☐ bruising ☐ right ☐ left
- ☐ restricted range of motion ☐ right ☐ left
- ☐ spasm ☐ right ☐ left
- ☐ paresthesia ☐ right ☐ left
- ☐ other_____

Hips / Legs:

- ☐ pain ☐ right ☐ left
- ☐ tenderness/soreness ☐ right ☐ left
- ☐ bruising ☐ right ☐ left
- ☐ restricted range of motion ☐ right ☐ left
- ☐ spasm ☐ right ☐ left
- ☐ paresthesia ☐ right ☐ left
- ☐ other_____

Knee / Ankle:

- ☐ pain ☐ right ☐ left
- ☐ tenderness/soreness ☐ right ☐ left
- ☐ bruising ☐ right ☐ left
- ☐ restricted range of motion ☐ right ☐ left
- ☐ spasm ☐ right ☐ left
- ☐ paresthesia ☐ right ☐ left
- ☐ other_____

Notes:_____

Patient: Jennifer Boyd

Date: 5.4.12

Plan: Medications:

- ☐ Lortab 7.5/325 mg # 30 one po hs _____. For at home use only.
- ☐ Flexeril 10 mg # 30 one po hs for muscle relaxation.
- ☐ ~~Mobic 15 mg~~ # _____ one po qd until gone.
- ☐ Naprosyn 500 #60 one po bid. Take with a meal.
- ☐ Soma 350 mg # 60 one po prn muscle relaxant. For day time use only.
- ☐ Tramadol 50 mg # _____ one po hs for pain/sleep.
- ☐ Elavil 25 mg #60 one hs x 7d then two hs thereafter. For pain modification.

☑ The patient has been cautioned concerning drowsiness and instructed not to drive, operate machinery, or take any other substance that might intensify the drowsiness.

☐ Patient requests no medication at this time. ☐ Patient has medication.

☐ No medications indicated at this time.

Recommendations:

- ☑ Continue with present care plan.
- ☐ Recommend physical therapy.
- ☐ Recommend diagnostic testing
  - MRI of (L) Wrist ☐ Now ☐ if symptoms persist
  - CT _____
  - X-ray _____
- ☑ Return for follow-up on 3 wks

ORDERS: Find another ortho for this patient!

J. Michael Farrell, M.D.

Date 5/4/12

New Patient Codes			
99202	99203	99204	99205
MD E2	MD E3	MDE4	

Established Patient Codes				
99211	99212	99213	99214	99215
MD E6	MD E7	MDE8		

Central Scheduling
Phone 214.320.1400 • Fax 214.320.1402

Eastlake Medical Center Building
10611 Garland Road, Suite 101
Dallas, Texas 75218

The Elan Shops at Bluffview
3840 W. Northwest Highway, Suite 400
Dallas, Texas 75220

PLEASE DOCUMENT: Please

TRANSCRIPTION NEEDED: ☐ Yes ☑ No Date 5-7-12 ☐ M ☑ F Pregnant ☐ Y ☑ N ☑ Fax Report STAT

Patient Name Jennifer Boyd ☐ Send Films ☐ CD

Patient Phone Number 469-271-9465 S.S. # ☐ Pre-Authorization Needed

Diagnosis D.O.B. 4-17-77 D.O.I 4-12-12

Referring Physician Michael Farrell MD. NPI #

Office Phone Number 972-862-6460 Fax Number 972-862-6264 Email

Date of Exam Time of Exam Contact

Ins. Co./Attorney Name Vecchio Phone Number 972-380-4445

ARRIVE AT OFFICE 15 MINUTES PRIOR TO EXAM TIME. PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE.

Weight_____ **ATTENTION:** Please let us know if you weigh over 300 lbs. or have any metal objects in your body.

TYPE OF EXAMINATION : MAGNETIC RESONANCE IMAGING (MRI)

☐ Closed MRI 1.5	☐ Head / Brain	☐ Shoulder	RT___ LT___	☐ Elbow	RT___ LT___
☐ Open MRI - Weight limit 500 lbs.	☐ Pituitary	☐ Hand	RT___ LT___	☐ Hip	RT___ LT___
☐ Lumbar	☐ With Contrast	☐ Wrist	RT___ LT___	☐ Pelvis	
☐ Thoracic	☐ Without Contrast	☐ Ankle	RT___ LT___	☐ Abdomen	
☐ Cervical	☐ With/Without Contrast	☐ Knee	RT___ LT___	☐ Other_____	

TYPE OF EXAMINATION: (X-RAY)

☐ Ankle	RT___ LT___	☐ Hip	RT___ LT___	☐ Cervical	☐ Chest
☐ Foot	RT___ LT___	☐ Hand	RT___ LT___	☐ Thoracic	☐ ABD/KUB
☐ Knee	RT___ LT___	☐ Shoulder	RT___ LT___	☐ Lumbar	☐ Other _____
☐ Wrist	RT___ LT___	☐ Elbow	RT___ LT___	☐ Pelvis	

MYELOGRAM	ARTHROGRAM		DISCOGRAM	ORTHOPEDIC	ULTRASOUND
☐ Cervical	☐ Knee	RT___ LT___	☐ Cervical	☐ Cervical	☐ Specify Area
☐ Thoracic	☐ Shoulder	RT___ LT___	☐ Lumbar	☐ Lumbar	
☐ Lumbar	☐ With MRI	☐ With CT	☐ Levels_____	☐ Extremity -	
☐ Complete	☐ Other_____			Area (L) wrist	

COMPUTERIZED TOMOGRAPHY (CT)			EMG TESTING	PAIN MANAGEMENT	
☐ Head / Brain	☐ Cervical	☐ Extremities	☐ Upper Extremities	☐ Consult	☐ S.I. Joint
☐ Pituitary	☐ Thoracic	☐ Chest	☐ Lower Extremities	☐ Epidural Steroid Injection	
☐ Orbits	☐ Lumbar	☐ ABD	☐ Complete Study	Cervical Thoracic Lumbar	☐ Nerve Root Block
☐ Sinuses	☐ With Contrast	☐ Pelvis	☐ SSEP/DSEP Only	☐ Facet Joint Injections	☐ Other _____
☐ IAC's	☐ Without Contrast		☐ NCV Only	Cervical Thoracic Lumbar	
☐ TMJ	☐ With/Without Contrast		☐ Other_____	☐ Trigger Point Injection	

ADDITIONAL COMMENTS

By sending this referral, referring physician certifies that it is medically necessary. Please fax insurance card/information.

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Document Separator

CSC MEDICAL

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COMPREHENSIVE SPINE CENTER OF DALLAS

EVALUATION FORM 5/18/2012 4:00:00 PM

Name: BOYD^JENNIFER (Last / First) Age: 35 DOB: 4/17/1977

Referred By: Dr. James Ferrell

Employer: IHOP

Occupation: Waitress

Work Related Injury / Motor Vehicle Accident

Date of Injury: 04 / 12 / 12

Hand Dominance: (RT) LT

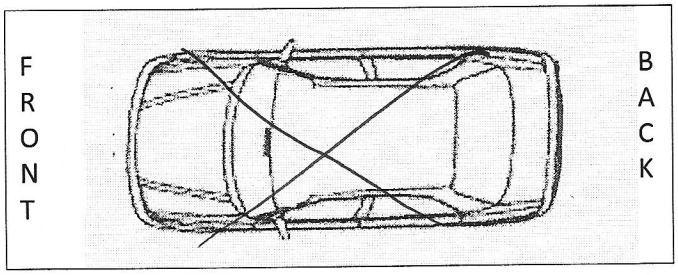
REASON FOR VISIT: left wrist, thumb

THE PAIN STARTED: 4/12/12 Months ago 1 1/2 Years ago ____ Weeks ago ____ Days ago

THE PAIN HAS BECOME SIGNIFICANTLY WORSE OVER THE LAST :

1 Months ago ____ Years ago ____ Weeks ago ____ Days ago

Seat Belt Air Bag Head Injury LOC ER



Physical/Chiro Therapy: NO

Pain Meds: Naproxen, Flexeril, Vicodin.

Brace: NO

Work: Waitress.

Imaging:

CIRCLE IF ANY APPLY:

Back Pain	RT	CNT	LT	Activities of Daily Living that are limited:
Leg Pain	RT		LT	Attacked by a dog on 4-12-12.
Neck Pain	RT	CNT	LT	the dog bite her hand and as
Arm Pain	RT		LT	She turned around to run away he
Shoulder Pain	RT		LT	Knocked her over.
Hip Pain	RT		LT	
Other: Wrist (Left)				

HAVE YOU HAD PREVIOUS BACK/NECK SURGERY? Yes No

List Back Surgeries 1. ____

On a scale of 0-10 0 representing No Pain and 10 representing the worst pain of your life, Mark the scale below

0 1 2 3 4 5 6 (7) 8 9 10

NO PAIN SEVERE PAIN

WHAT MAKES YOUR PAIN BETTER? Ice, meds.

WHAT MAKES YOUR PAIN WORSE? ____

COMPREHENSIVE SPINE CENTER OF DALLAS

PATIENT PAIN DRAWING

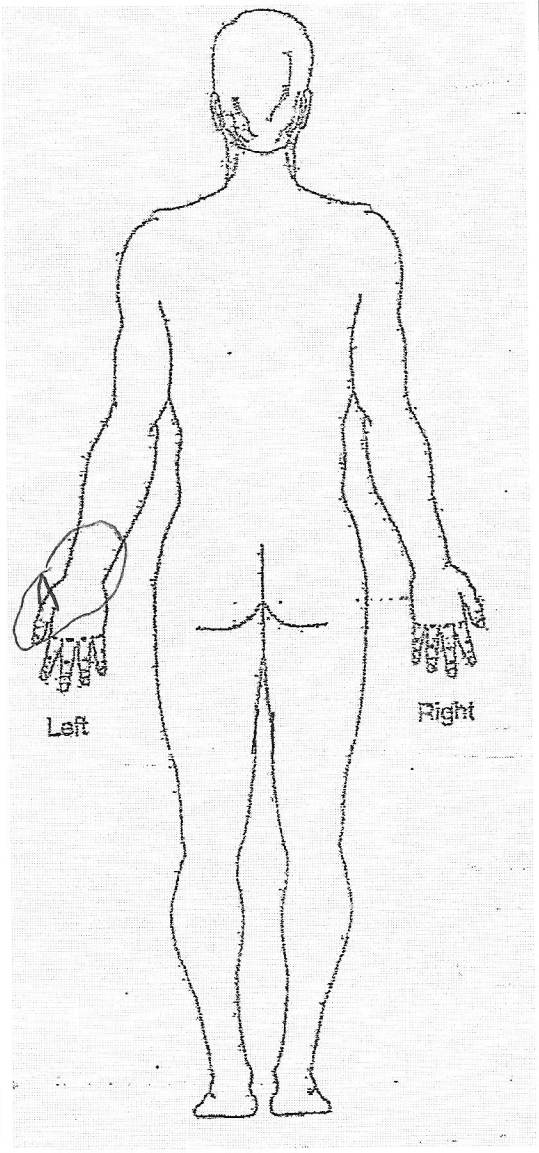
Name: BOYD^JENNIFER

Date: **5/18/2012 4:00:00 PM**

Using the symbols given below, mark the areas on your body
Where you feel the described sensations. Include all affected
Areas, Just to complete to picture, please draw in your face.

Aching	Numbing	Pins and needles	Burning	Stabbing	Other
ΔΔΔΔΔ	= = = = =	**00000**	**XXXXX**	//////	.....

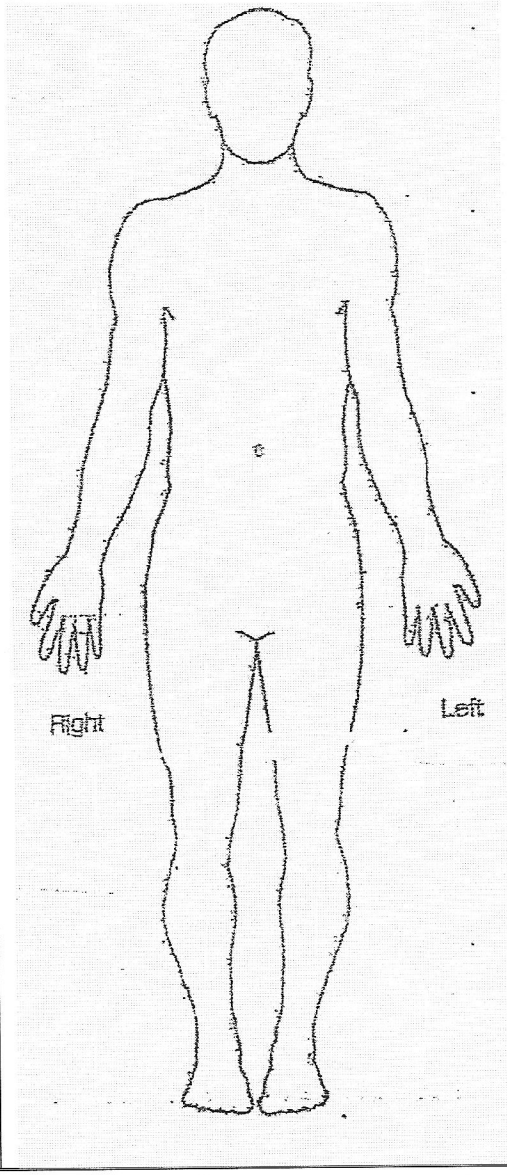
BACK



Pain in arm(s) compared with neck:
- ☐ Worse than
- ☐ Same as
- ☐ Less than

Pain in leg(s) compared with back:
- ☐ Worse than
- ☐ Same as
- ☐ Less than

FRONT



WHAT TREATMENTS ARE YOU CURRENTLY UNDERGOING OF HAVE UNDERGONE?

PHYSICAL THERAPY: Yes No Outpatient Home

Start Date: ____/____/_____ End Date: ____/____/_____

Did Therapy Help? Yes No

PAIN SPECIALIST: Yes No Name: _____

Start Date: ____/____/_____ End Date: ____/____/_____

Did Specialist Help? Yes No

EPIDURAL STEROID INJECTIONS: Yes No Circle One: Cervical Lumber
(Circle and give Dates)

Number of Injections: ____ Date of Injections: 1.___/___/___ 2. ___/___/___ 3. ___/___/___

Who Performed Injections ? _____

Did the Injections Provide Relief For Any Amount of Time? Yes No

FACET INJECTIONS: Yes No Circle One: Cervical Lumber
(Circle and give Dates)

Number of Injections: ____ Date of Injections: 1.___/___/___ 2. ___/___/___ 3. ___/___/___

Who Performed Injections ? _____

Did the Injections Provide Relief For Any Amount of Time? Yes No

MANUAL MANIPULATION: Yes No Did this Help? Yes No
BRACE: Yes No Did this Help? Yes No

WHO ARE YOU CURRENTLY SEEING OR HAVE SEEN IN THE PAST FOR THIS PROBLEM?

PHYSICIAN: Yes No
Name: _____ Date: ____/____/_____
Name: _____ Date: ____/____/_____

CHIROPRACTOR: Yes No
Name: _____ Date: ____/____/_____
Did Therapy Help? Yes No Explain: _____

COMPREHENSIVE SPINE CENTER OF DALLAS

PATIENT HISTORY

ALLERGIES

MEDICATION ALLERGIES 1. NKA. 2. _____

OTHER ALLERGIES 1. _____ 2. _____

MEDICATIONS

List all of your current medications and dosages including over the counter medication, herbal supplements and inhalers.

List Pain Medications/Dose 1. Vicodin 750 · 325 2. _____

3. Naproxin 500 mg 4. _____

List Other Medications 1. flexeril 10mg 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

PAST SURGICAL HISTORY (Circle and Give Dates of Surgery)

Neck Surgery	___/___/___	Knee Replacement	___/___/___	Shoulder Surgery	___/___/___
Back Surgery	___/___/___	Appendectomy	___/___/___	Cataracts	___/___/___
Tonsillectomy	___/___/___	Cardiac Sent	___/___/___	Gallbladder	___/___/___
Cardiac Bypass	___/___/___	Hysterectomy	___/___/___	Hip Replacement	___/___/___
Hernia	___/___/___	Other tubeligation	/1999	Other	___/___/___

SOCIAL HISTORY

Marital Status:	Married	Single	Divorced	Widowed
Children:	Yes	No	Number: 2	
Smoke	Yes	No	Amount _____	
Previously Smoke	Yes	No	Quit When? _____	
Alcohol Use	Never	Occasional	Moderate	Heavy
Drug Use	None	Presently	In the Past	
Education Attained:	Elementary Some College	High School College Degree	Technical or Trade School Graduate School	
Exercise:	None	< 3 times a week	> 3 times a week	
Occupation:	Waitress			

PAST MEDICAL HISTORY

	GENERAL		**HEART**
	Cancer	X	Hypertension
	Hepatitis		Heart Attack
	Alcoholism		Chest Pain/ Angina
	Thyroid Problems		Heart Failure
	Hemophiliac		Blood Clot DVT
	Fever		Heart Murmur
	Night Sweats		Palpitations
	Rapid Weight Loss		Pacemaker
	Fatigue		
	Anxiety? Panic Attacks		**LUNGS**
	Depression		Shortness of breath
	Major Injuries		COPD
			Asthma
			Recurrent Bronchitis
	EYES/EARS/HEAD		Emphysema
	Migraine		Pulmonary Embolism
	Glaucoma		TB
	Cataracts		Pneumonia
	Blindness		
	Contacts		
	Partial Plate/ Dentures		**URINARY TRACT**
	Hearing Loss		Kidney failure
		X	Kidney Stones
			Recent Infections
	ABDOMEN		Prostate Disease
	Peptic Ulcers		Recurrent Bladder Infections
	Heartburn		Recurrent Kidney Infections
	Hernia		Bladder Control Problems
	GERD		Dialysis
	Frequent Nausea		
	Liver Cirrhosis		
			BONE/JOINTS
	ENDOCRINE:		Back Pain
	Diabetes		Gout
			Joint Pain
	NEUROLOGICAL		Muscle Cramps
	Dizzy Spells		Fractures
	Alzheimer's		Rheumatoid Arthritis
	Head Injury		Osteoarthritis
	Memory Loss		Osteoporosis
	Black Out Spells		
	Stroke		
	Paralysis		
	Numbness/Tingling		
	Weakness Arms/Legs		
	Seizure		
✓	Epilepsy Q18a child		

COMPREHENSIVE SPINE CENTER OF DALLAS

ANESTHESIA HISTORY

Date of Last Anesthetic _____/_____/_____

Have you ever had an adverse reaction problem with Anesthesia? Yes No

If yes explain: _____

Has a blood relative ever had an adverse reaction/problem with anesthesia? Yes No

FAMILY HISTORY (Circle and Indicate where Mother or Father)

Stroke	_____	Bleeding Disorder	_____	Alcoholism	_____
Heart Troubles	_____	Depression	_____	Cancer	_____
High Blood Pressure	_____	Arthritis	_____	Blood Clots	_____
Diabetes	_____	Mental Illness	_____	Other	_____

REVIEW OF SYSTEMS

Check only the items you have or have had recently. Add items if not shown

CONSTITUTIONAL		**GU**	
	Weight loss		Incontinence
	Hot or cold Spells		Frequent Urination
	Malaise		
EYES		**SKIN AND BREAST**	
	Reading Glasses		Rashes
	Change in Vision		Ulcers
	Blurring Vision		Masses
EAR/NOSE/THROAT		**ENDOCRINE**	
	Loss of Hearing		Diabetes
	Hoarseness		HTN
	Vertigo		Night Sweats
			Hypoglycemia
CARDIOVASCULAR		**NEUROLOGICAL**	
	Chest Pain		Hand Trembling
	Palpitations		Loss of Memory
	Abnormal Heartbeat		Headaches
	Swollen Ankles		Gait Disturbance
RESPIRATORY		**PSYCH**	
	Short of Breath		Depression
	Asthma		Insomnia
	COPD		Alcohol Abuse
	Cough		Drug Abuse
GI		**OTHER**	
	Hemorrhoids		
	Diarrhea		
	Constipation		
	Abdominal Pain		

TREATMENT PLAN

PATIENT NAME: _____

****

IMAGING

X-RAYS: _____

_____

MRI: _____

_____

CT: _____

_____

ASSESSEMENT:

1. _____
2. _____
3. _____
4. _____
5. _____

PLAN:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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CSC IDENTIFICATION

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USA
TX
Texas
IDENTIFICATION CARD
DIRECTOR
4d ID 09360813
4a Iss 01/11/2012
4b Exp 04/17/2017
3 DOB 04/17/1977
1 BOYD
2 JENNIFER LEE
8 8510 SANTA CLARA DRIVE
FRISCO TX 75034-0000
DONOR
16 Hgt 5-04
15 Sex F
18 Eyes BRO
5 DD 04112230114111045992

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9525347

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9525347
225655258

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CSC DEMOGRAPHICS

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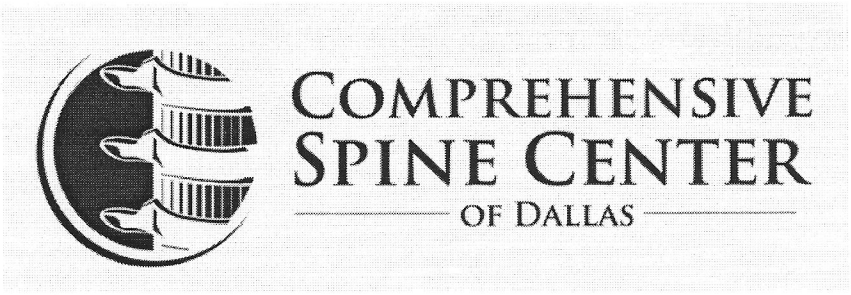

Scott A. Farley,D.O,
George Farley,M.D.

Office Phone: (214) 782-9222
Fax (214) 782-9333
Scheduling Phone: (214) 320-1400
Fax: (214) 320-1402
Billing Phone: (972) 720 9944

Referring Physician: _____
Referring Physician Phone: (___) ____-_____ Referring Physician Fax: (___) ____-_____
Appointment Date: ___/___/____

PATIENT INFORMATION

Name: **BOYD^JENNIFER** Birthdate: **4/17/1977** SS# 555-53-6700
Street Address: 8510 Santa Clara DR City: Frisco State: tx Zip: 75033
Sex: ☐Male ☒Female ☐Married ☐Widowed ☐Single
Cell Phone: (469) 271-9465 Home Phone: (___) ____-_____ Work Phone: (___) ____-_____
Person to contact in case of an emergency: _____ Phone: **(469)271-9465**

RESPONSIBLE PARTY

Name Responsible for this account: _____ Relationship: _____ Phone: (___) ____-_____

REASON FOR VISIT

Were you in an accident? ☑ Yes ☐ No ☐ Work Comp ☐ Auto ☑ Other
Date of Injury: 04/12/12 Claim#: _____ Authorization#: _____
Adjustors Name: _____ Adjustors Phone: (___) ____-_____ Fax: (___) ____-_____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relation to Patient: _____
Birthdate: ___/___/____ SS# ___-___-_____ Phone: (___) ____-_____ Work Phone: (___) ____-____
Employer: _____ Employer Address: _____ City: _____
Insurance Company: _____ ID #: _____ Group#: _____
Address: _____ City: _____ State: ____ Zip: _____

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relation to Patient: _____
Birthdate: ___/___/____ SS# ___-___-_____ Phone: (___) ____-_____ Work Phone: (___) ____-____
Employer: _____ Employer Address: _____ City: _____
Insurance Company: _____ ID #: _____ Group#: _____
Address: _____ City: _____ State: ____ Zip: _____

Patient Signature: Jennifer Boyd Date: 5/18/12
Parent of Legal Guardian if Minor: _____
Do you have a Living Will? ☐ Yes ☐ No

COMPREHENSIVE SPINE CENTER
OF DALLAS

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Billing Phone: (972) 720 9944

OUR OFFICE POLICY

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made either to me or on my behalf to **Comprehensive Spine Center** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to be released to the healthcare financing administration and its agents in the information needed to determine me his benefits or the benefits payable to the related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim if other health insurance is indicated in item 9 of theHCFA-1500 form or elsewhere on other approved health claim forms or electronically submitted claims, my signature authorizes this release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept that charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: Jennifer Boyd Date: 5/18/12

ASSIGNMENT OF BENEFITS: patients with insurance's please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other plans, to **Comprehensive Spine Center** this assignment will remain in effect until revoked by me in writing. Of photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by Santa insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: Jennifer Boyd Date: 5/18/12

MEDICAL RECORDS FAX: I authorize **Comprehensive Spine Center** to transmit my medical records electronically. If they are received by another party in error, I absolve **Comprehensive Spine Center** of any and all liability relating to such submission of said records.

Signature: Jennifer Boyd Date: 5/18/12

I have read, understand, and agree to the financial policy for payment of professional fees. The patient is ultimately responsible for all financial fees. I further understand I am responsible for any legal fees and costs of collecting any unpaid balance.

Signature: Jennifer Boyd Date: 5/18/12

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Fax: (214) 320-1402
Billing Phone: (972) 720 9944

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Patient Name: **BOYD^JENNIFER**

Address: 8510 Santa Clara Dr Frisco TX 75033

Date of Birth: **4/17/1977** Date of Injury: 04/12/12 Date of Request: ___/___/____

As required by HIPAA privacy regulations, protected health information may not be used or disclosed to any third party without patient authorization.

I hereby authorize **Comprehensive Spine Center** and its employees to disclose my protected health information to the following persons, healthcare provider, or business associate:

1. _____
2. _____
3. _____

Patient health information authorized to be disclosed: _____

_____

For the specific use or purpose of: (described in detail): _____

_____

Effective dates for this authorization: ___/___/____ through ___/___/____. this authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the patient health information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Jennifer Boyd 5/18/12

Signature or Patient or Patients Authorized Representative Date

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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.
Comprehensive Spine Center is required, by law, to maintain the privacy and confidentiality of the protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information
Treatment
we may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with **Comprehensive Spine Center."**

"It is our policie to provide a substitute healthcare provider, authorized by **Comprehensive Spine Center/SMG,** in the event your primary health care providers is absent due to vacation, sickness, or other emergency situations."

Payment
we may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected healthcare information, may be reviewed by the designated collection agency or authority.

Workers Compensation
If applicable, we may disclose your health information is necessary to comply with state Workers Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
as required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the food and drug administration problems with products and reactions to medications: and reporting disease or infection exposure.

Judicial and administrative proceedings

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We may disclose your health information in the course of any administrative or judicial proceeding.

Law enforcement
We may disclose your health information to a law enforcement official with purposes such as identifying or locating a suspect, fugitive, material witness or missing persons, complying with a court order or subpoena and other law enforcement purposes.

Deceased persons
We may disclose your health information to coroners or medical examiners.

Organ donation and research
We may disclose health information to organizations involved in picturing, banking or transplanting organs and tissue, or to researchers conducting research that has been approved by an Institutional review board.

Public safety
It may be necessary to disclose health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.
Marketing and Other Communications
We may contact you for marketing purposes for fund-raising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave the reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to occasionally participate in charitable events. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will inform you of the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose health information about you for the purpose of **Comprehensive Spine Center** sponsored fundraising events"
Change of ownership
in the event that **Comprehensive Spine Center** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your health information rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Comprehensive Spine Center** is not required to agree to the restriction that you requested.
2. You have the right to have your health information received or communicated through an alternate method or sent to an alternate location other than the usual method of communication or delivery, upon request.

COMPREHENSIVE SPINE CENTER
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Billing Phone: (972) 720 9944

3. You have the right to inspect and copy your health information.
4. You have the right to request that **Comprehensive Spine Center** amend your protected health information. Please be advised, however that **Comprehensive Spine Center** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with the explanation of our denial reason (s) and information about how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your protected health information made by **Comprehensive Spine Center.**
6. You have the right to a paper copy of this notice of privacy practices anytime requested.

Changes at this notice of privacy practices

Comprehensive Spine Center reserves the right to amend this notice of privacy practices anytime in the future, and will make the new provisions effectively for all information that it maintain. Until such amendment is made, **Comprehensive Spine Center** is required by law to comply with this notice.

Comprehensive Spine Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact: George Farley, M.D. by calling the office 214-782-9222. If George Farley, M.D. is not available, you may make an appointment for a personal conference in person or by telephone within two working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH building
Washington, DC 20201

This notice is effective as of July 21, 2011
by way of my signature, I provide **Comprehensive Spine Center** with the authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the privacy notice.

BOYD^JENNIFER
Patients Name (print)

Jennifer Boyd
Patient's Signature

5/18/12
Date

Comprehensive Spine Center
Authorized Facility Signature

July 21, 2011
Date

COMPREHENSIVE SPINE CENTER
OF DALLAS

Scott A. Farley,D.O,
George Farley,M.D.

Office Phone: (214) 782-9222
Fax (214) 782-9333
Scheduling Phone: (214) 320-1400
Fax: (214) 320-1402
Billing Phone: (972) 720 9944

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Comprehensive Spine Center

As required by the privacy regulations, I hereby knowledge that I have received a current copy of **Comprehensive Spine Center** "NOTICE OF PRIVACY PRACTICES", revision date_____.

As required by the privacy regulations, _____ from **Comprehensive Spine Center** has explained the "NOTICE OF PRIVACY PRACTICES", to my satisfaction.

As required by the privacy regulations, unaware that **Comprehensive Spine Center** has included a provision that it reserves the right to change the terms of its notice and make the new provisions effective for all protected health information that it maintains.

Requests:

- ☐ I. wish to file a "request for restriction" of my protected health information.
- ☐ I. wish to file a "request for alternative communications" of my protected health information.
- ☐ I. wish to object to the following practices of the "notice of privacy practices"

_____

_____

I understand this office is not required to honor any changes to the "notice of privacy practices". This

BOYD^JENNIFER

Patients Name (print)

Jennifer Boyd _____ 5/18/12

Patient's Signature Date

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

The following effort was made to obtain receipt: (describe)

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CSC ASSIGNMENT OF BENEFITS

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COMPREHENSIVE SPINE CENTER OF DALLAS

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION

TO:

I hereby direct any and all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities ('payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illness, past or future ("condition"), to pay directly to, and exclusively in the name of COMPREHENSIVE SPINE CENTER OF DALLAS such sums as may be owing to COMPREHENSIVE SPINE CENTER OF DALLAS for charges incurred by me, including but not limited to charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to COMPREHENSIVE SPINE CENTER OF DALLAS with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be constructed as an election by COMPREHENSIVE SPINE CENTER OF DALLAS to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, if a payer refuses to pay COMPREHENSIVE SPINE CENTER OF DALLAS I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to COMPREHENSIVE SPINE CENTER OF DALLAS as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the office name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office regarding any Funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to the Office upon its request I hereby direct all payers to release to COMPREHENSIVE SPINE CENTER OF DALLAS any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment which pertains to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers, I hereby authorize COMPREHENSIVE SPINE CENTER OF DALLAS to endorse / sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize COMPREHENSIVE SPINE CENTER OF DALLAS to apply any credit balance on charges incurred by me to any other outstanding charges still owed by me, my spouse, or dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due COMPREHENSIVE SPINE CENTER OF DALLAS for their services. This Agreement does not constitute any consideration for this Office to await payment and it may demand payment from me immediately upon rendering services at it's option. If this Office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse DFW MRI L.P. for all cost of such collection efforts, including but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of COMPREHENSIVE SPINE CENTER OF DALLAS and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the term, of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonable and necessary for the protection of the rights and interest of COMPREHENSIVE SPINE CENTER OF DALLAS and me. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): Jennifer Boyd

Patient Signature: Jennifer Boyd **Date** 5-18-12

Name of custodial parent or legal Guardian (please print): _____

Parent/Guardian's Signature: _____

Witness: _____

COMPREHENSIVE SPINE CENTER OF DALLAS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: Jennifer Boyd Date of Birth: 4-18-77

Address: 8510 Santa Clara Dr

City: Frisco State: Tex Zip: 75033

Date Records Requested: ____/____/____ Date Records Released: ____/____/____

I, THE UNDERSIGNED, AUTHORIZE Comprehensive Spine Center Of Dallas TO RELEASE MY MEDICAL RECORDS AND MY MEDICAL BILL TO MY DOCTOR AND / OR MY ATTORNEY:

RELEASED TO DOCTOR ☐

PHONE: ____

RELEASED TO ATTORNEY ☐

PHONE: ____

My request for this particular release of medical records includes the following specific records(please include inclusive dates and/or specific type of records): ALL ☐

MRI REPORTS AND BILLING DATED ____/____/____

Instructions: ____

The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature: Jennifer Boyd Relationship: Self Date: 5/18/12

Notice to person or agency receiving this information: this information has been disclosed to you from records whose confidentially is protected. Statutes and regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it

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CSC- VERIFICATION OF PREGNANCY

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pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other general information is not sufficient for this purpose.

VERIFICATION OF NON-PREGNANCY
TEN DAY GUIDELINES FOR FEMALE PATIENTS

It is the ethical and legal responsibility of Comprehensive Spine Center Of Dallas . To prevent the accidental irradiation of an unrecognized pregnancy. In accordance with national standards, we require the following information of female patients of child bearing age. If the information below indicates even a remote possibility of pregnancy, you may be required to undergo a pregnancy test prior to any examination involving radiation to the pelvic area.

1. Have you had a hysterectomy or already gone through menopause? ☐YES ☑NO
   Date of hysterectomy : _____.
   If "yes" do not complete the rest of this form.

2. Are you now pregnant or do you think you may be pregnant? ☐YES ☑NO
   If "yes" please notify our staff immediately!

3. Please give the first day of your last period. 4-20-12
   Does this fall within the last ten (10) days? Date

4. Are you currently practicing any of the following birth control methods?
   Please check the appropriate box.

Tubal Ligation	☑	Birth Control Pills	☐
Foam	☐	Partner Vasectomy	☐
IUD	☐	Diaphragm	☐
Condom	☐	Norplant	☐
Other	☐	None of the above	☐

5. Have you had any sexual activity since your last menstrual period that may place you at risk of pregnancy?
   YES ☐ ☐NO

I have been fully informed as to the risk of radiation of the unborn fetus. I understand that this risk includes miscarriage, congenital deformities, and on eightfold increased incidence of leukemia during the subsequent childhood. I deny all possibilities of being pregnant at this time and give my consent to having diagnostic radiological procedures performed on me.

Patient Signature: Jennifer Boyd Age: 35
Patient Name printed: Jennifer Boyd
Signature of other Legally responsible person: _____
Relationship to the Patient: _____
Legal responsible person printed: _____
Technologist signature: _____ Date: _____

****

This patient is not within our guidelines for adequate birth control. However, her physician _____,
Insists this patient have x-rays exam performed today.

Radiologist Signature : _____