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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:	WALKER, TAMARA	Phone:	
Date:		Chart:		DOB:	8-06-62
Time:		Address:		DOI:	4-16-12
Reason:		SSN#			

REFERRING PROVIDERS		PRIMARY INSURANCE	
Code:		Insurance:	LONCAR, BRIAN
Name:	CACOZZA, JOSEPH 887	Phone:	
Phone:		Copay:	
		Group:	

DECRIPTION	CODE	MOD
CONSULTATIONS		
Focused/Straight	99241	
Expanded/Straight	99242	
Detailed/Low	99243	
Comprehensive/Mod	99244	
Comprehensive/High	99245	
NEW PATIENT- OFFICE VISITS		
Minimal	99201	
Expanded/Straight	99202	
Detailed/Low	99203	
Comprehensive/Mod	99204	
Comprehensive/High	99205	
EST. PATIENT- OFFICE VISITS		
Level 1 Brief	99211	
Pre Op	99211	
Level 2 Limited	99212	
Level 3 Expanded	99213	
Level 4 Comprehensive	99214	
Level 5 Comprehensive/Complex	99215	
EST. PATIENT- OFFICE VISITS		
IME	99391	
Special Reports	99080	
Post Op<90 Days Global	99024	
MRI REVIEW		
Cervical	72141	26
Thoracic	72146	26
Lumbar	72148	26
CT REVIEW		
Cervical	72125	26
Thoracic	72128	26
Lumbar	72131	26
MYELOGRAM REVIEW		
Cervical	72240	26
Thoracic	72255	26
Lumbar	72265	26
X-RAY REVIEW		
2 View Spine Survey	72010	26
2 View Cervical Spine	72040	26
2 View Thoricic Spine	72070	26
Lumbosacral Bends/Unbends	72120	26

DECRIPTION	CODE
T-ESI OR NRB	
Cervical/Thoracic Single level	64479
Cervical add level	64480
Lumbar/Sacral single	64483
Lumbar Sacral add	64484
FACET INJ. MEDICAL BRANCH BLOCK	
Cervical/Thoricic	64490
Cervical/Thoricic 2nd level	64491
Cervical/Thoricic 3rd level	64493
Lumbar/Sacral (Caudal)	64493
Lumbar/Sacral 2nd level	64494
Lumbar/Sacral 3rd level	64495
FLUROSCOPY	
Fluro guidance other than Spine	77002
Fluro guidance, Spine	77003
Epidurography	72275
Si Joint Injection	27096
Rad Sacral iliac Joint	73542
MEDICATIONS	
Depo 40 mg	J1030
Depo 80 mg	J1040
Licodaine	J2001
Mepivacaine	J0670
Low Osmolar Contrast	Q9966
ESI	
Cervical	62281
Lumbar/Sacral	62282
DISCOGRAM	
Discography Cervical/Thoracic	62291
X-ray c/t spine disk	72285
Injection Lumbar	62290
S-ray of lower spine disk	72295
MYELOGRAM	
Cervical	72240
Thoracic	72255
Lumbar	72265
Myelography 2 or more regions	72270
Epidural Bloodpatch	62273
RHIZOTOMY	
Cervical/Thoracic	64626
Cervical/Thoracic each add Level	64627
Lumbar/Sacral	64622
Lumbar/Sacral each add level	64623
Intercostal	64620

DECRIPTION	CODE
INJECTIONS	
TRIGGER POINTS	
Plantar	20550
Inj. Tendon ongin/insertion	20551
Inj. Trigger point 1/2 musc	20552
Inject trigger points =3	20553
JOINTS	
Small Joint Inj.	20600
Intermidiate Joint Inj.	20605
Large Joint Inj.	20610
Inj. Hip under-fluro	27093
Contrast x-ray of hip	73525
Shoulder Inj. fluro	23460
Contrast x-ray of shoulder	73040
OTHER	
Greater Occipital Nerve	64405
Pyriformis Injection	20552
Carpal Tunnel	20526
SUPPLIES	
Ringers Lactate	J7120
Gloves Sterile (per pair)	A4930
Needles only (any size each)	A4215
Syringe (each)	A4657
IV Start Kit	A9999-IV
Electrodes	A4556
Surgical Mask	A4928
Betadine/Lodine Swabs	A4247
Surgical Tray	A4550

KS/SMG BILLING 972-720-9944 #701

Tamara Walker

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
☐		
☐		
☐		
☐		
☐		

☒ [redacted] occipital Nerve Entrapement B-lateral

		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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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 AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

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

Patient Name Tamara Walker ☐ Send Films ☐ CD

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

Diagnosis 723.1 D.O.B. 8-6-62 D.O.I 4-16-12

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 Brian Loncar. 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 Flexion/Extension Lateral/ Straight + Lateral	☐ 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: _____	_____

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 (1) Rec Jolley (R) in office sep. branch for in bweeks' Sprain occipital nerve + and trigger ~~Tri~~ Repeats
(2) under fluro TON block B. lateral and branch block and facet

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

COMPREHENSIVE SPINE CENTER
OF DALLAS

2704 N. Galloway Ave., Suite 101 • Mesquite, Texas 75150
(214)782-9222 Fax (214)782-9333

Dr. Scott Farley, D.O. DEA
Dr. George Farley, M.D. DPS

Name Tamara Walker DOB

Address Date 5-18-12

MOBIC 15mg
T PO QD
#30 (thirty)

ULTRAM 50 mg
T PO Q8° PRN PAIN
60 (sixty)

REFILL NR 1 2 3 4 5

Product Selection Permitted

Dispense as Written

COMPREHENSIVE SPINE CENTER
OF DALLAS

2704 N. Galloway Ave., Suite 101 • Mesquite, Texas 75150
(214)782-9222 Fax (214)782-9333

Dr. Scott Farley, D.O. DEA
Dr. George Farley, M.D. DPS

Name Tamara Walker DOB

Address Date 5-18-12.

Medrol dose Pack or equivalent.
#1 (one)
Take as directed.

REFILL NR 1 2 3 4 5

Product Selection Permitted

Dispense as Written

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3840 W. Northwest Hwy * Suite 400 * Dallas, TX 75220
*10611 Garland Road * Suite 101 * Dallas, TX 75218*
Scheduling (214) 320-1400 * Fax (214) 320-1402 * Billing (972) 720-9944

Final Report

DATE OF EXAM: 4/25/2012 4:27:47 PM
PATIENT NAME: WALKER, TAMARA
DATE OF BIRTH: 8/6/1962
DATE OF INJURY: 4/16/2012
REFERRING PHYSICIAN: J CACOZZA DC.,
RADIOLOGIST: DR BRUCE CHEATHAM
EXAMINATION: MRI CERVICAL SPINE W/O CONTRAST

CLINICAL HISTORY: Continuing post traumatic neck and upper extremity radicular pain.

PRIOR COMPARISON EXAMINATION: None available.

TECHNIQUE: Multiple sagittal T1 weighted images are obtained through the cervical spine followed by multiple sagittal fast field echo images. Axial images using fast field echo technique are then obtained. 4.0 or 5.0 mm thickness with fat suppression. Images acquired with the use of a 1.5 Tesla Phillips Intera magnet. A total of 70 sequences images are presented for review.

FINDINGS: We demonstrate comparative lordosis straightening consistent with musculature pain or spasm. MR sequences show homogeneous and expected bony structure densities and appearance without bony compression or fracture or contusion. C7-T1: Usual interspaces widths and densities. Clear foramina and no bony compression or fracture evident. The visualized cervical spinal cord is unremarkable. Paravertebral soft tissues are unremarkable.

Of C2-3, a 2-3 mm posterior central discal substance protrusion/herniation that does not contact the anterior spinal cord surface and best visualized on sagittal T1 sequence image #6.

Of C3-4, a 3-4 mm posterior central to left paracentral discal substance protrusion/herniation that indents the spinal cord and resulting is a moderate degree of central canal stenosis with 8.0 mm and best visualized on axial T2 sequence image #16. Of C4-5, a 3-4 mm posterior central discal substance protrusion/herniation indents the spinal cord and results in a moderate degree of central canal stenosis with 8.0 mm in AP diameter. This finding is best visualized on axial T2 sequence image #13. Of C5-6 and C6-7, minimal or 2-3 mm posterior marginal osteophytic ridges that may contact only the spinal cord. Bony foramina are clear.

FINAL IMPRESSION:

1. **Cervical lordosis straightening suggests musculature pain or spasm.**
2. **C2-3: 2-3 mm posterior central discal substance protrusion/herniation that does not contact the anterior spinal cord surface.**
3. **C3-4: 3-4 mm posterior central to left paracentral discal substance protrusion/herniation that indents the spinal cord and resulting is a moderate degree of central canal stenosis.**
4. **C4-5: 3-4 mm posterior central discal substance protrusion/herniation indents the spinal cord and results in a moderate degree of central canal stenosis.**

Thank you for referring this patient,

BRUCE A. CHEATHAM, M.D., DABR
BC:kab D&T: 04/25/12
E-mail: cheatham.b@verizon.net

FOR BILLING: (972) 682-0601 office

DFW OPEN MRI - 3840 West Northwest Highway, Suite 400, Dallas, TX 75220

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10611 Garland Road, Suite 101
Dallas, Texas 75218

The Élan Shops at Bluffview
3840 West Northwest Highway, Suite 400
Dallas, Texas 75220

TRANSPORTATION NEEDED ☐ Yes ☐ No Date 5/1/12 ☐ M ~~☐ F~~ Pregnant ☐ Y ☐ N ~~☐ Fax~~ Report STAT

Patient Name Tamara Walker ☐ Send Films ☐ CD

Patient Phone Number 214-912-9234 ☐ Pre-Authorization Needed

Referring Physician J Lanzo & PC S.S. # 460-15-1042

Diagnosis 722.0, 723.7, 847.0 D.O.I 4/16/12

Office Phone Number 972-259-4878 Fax Number 214-751-3339 D.O.B. 8/6/62

Date of Exam ____ Time of Exam ____ Contact ____

Ins. Co./Attorney Name Brian Loncar Phone No. 214-747-0422

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 and Without Contrast	☐ Wrist RT___ LT___	☐ Pelvis
☐ Thoracic		☐ Ankle RT___ LT___	☐ Abdomen
☐ Cervical		☐ Knee RT___ LT___	☐ Other____

TYPE OF EXAMINATION: (X-RAY)

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

MYELOGRAM	ARTHROGRAM	DISCOGRAM	MMI IMP. RATING
☐ Cervical	☐ Knee RT___ LT___	☐ Cervical	☐ FCE
☐ Thoracic	☐ Shoulder RT___ LT___	☐ Lumbar	☐ Other____
☐ Lumbar	☐ With MRI ☐ With CT	☐ Levels____	
☐ Complete	☐ Other		

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

SPECIAL COMMENTS

Ortho Consult

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

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COMPREHENSIVE SPINE CENTER OF DALLAS

EVALUATION FORM 5/18/2012 3:00:00 PM

Name: WALKER^TAMARA
Last First

Age: 49 DOB: 8/6/1962

Referred By:
Employer: Dallas ISD
Occupation: teacher
REASON FOR VISIT: neck / back pain

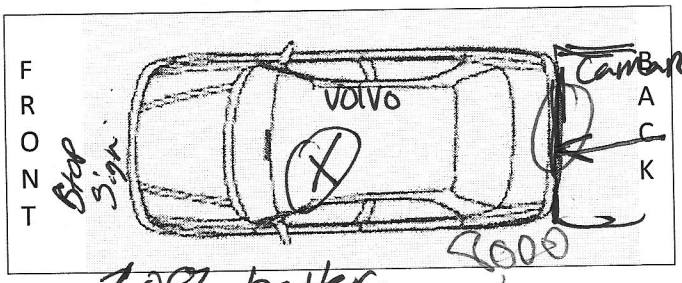
Work Related Injury Motor Vehicle Accident
Date of Injury: 04 / 16 / 12
Hand Dominance: (RT) LT

THE PAIN STARTED: 1 Months ago ____ Years ago ____ Weeks ago ____ Days ago

THE PAIN HAS BECOME SIGNIFICANTLY WORSE OVER THE LAST :
____ Months ago ____ Years ago ____ Weeks ago ____ Days ago

(Seat Belt) ~~Air Bag~~ (Head Injury) ~~LOC~~ (ER) D/S

Physical/Chiro Therapy: 4-2012 → present 3x/week
Pain Meds: Hydrocodone.
Brace: No.
Work: Full time (missed 5 days)
Imaging: MRI



100% better.

CIRCLE IF ANY APPLY:

Back Pain	RT	(CNT)	LT	Activities of Daily Living that are limited:
Leg Pain	RT		LT	
Neck Pain	(RT)	CNT	(LT)	
Arm Pain	RT		(LT)	
Shoulder Pain	(RT)		LT	
Hip Pain	RT		LT	
Other:				

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? Aleve, pain medication, laying flat
WHAT MAKES YOUR PAIN WORSE? Having to work to hold my head up! Lifting anything, moving / looking back a sideway

PATIENT PAIN DRAWING

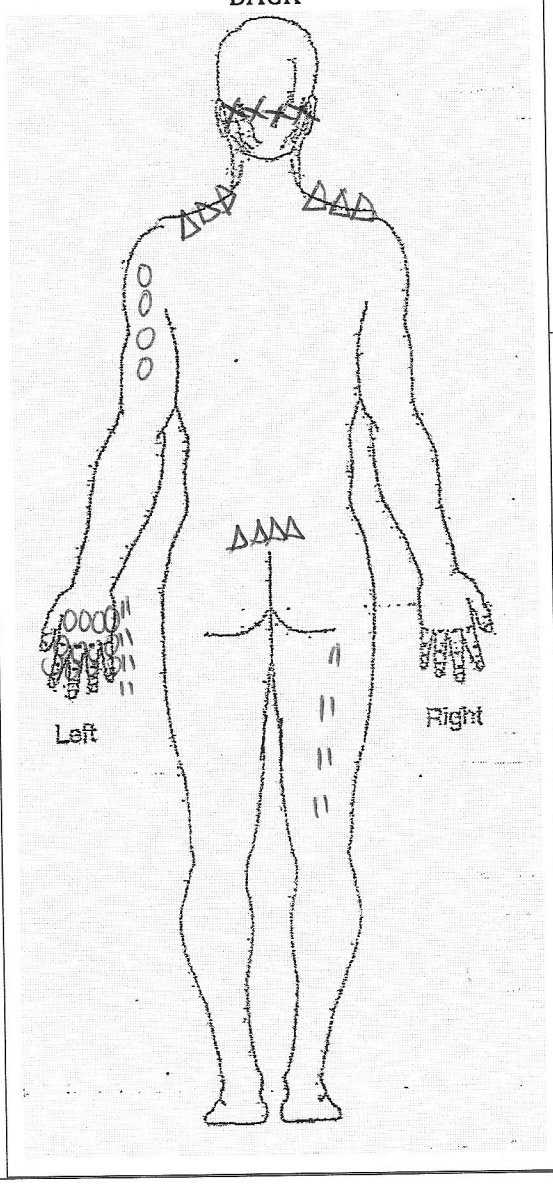
Name: WALKER^TAMARA

Date: **5/18/2012 3:00:00 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**	//////	.....

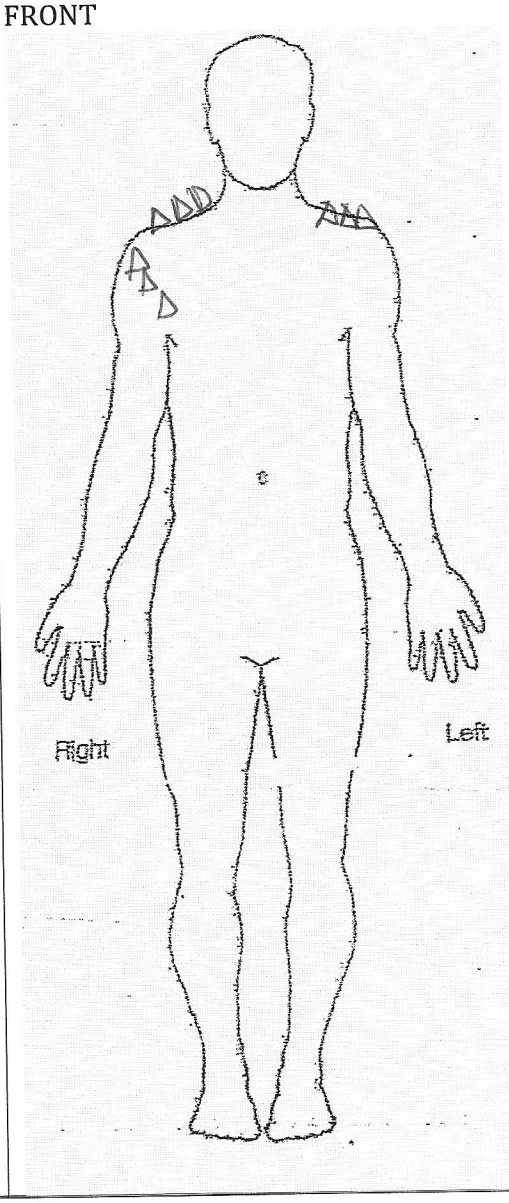
BACK



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: ProCare Date: 04/20/12 ?

Did Therapy Help? Yes No Explain: adjustments make my neck feel better

COMPREHENSIVE SPINE CENTER OF DALLAS

PATIENT HISTORY

ALLERGIES

MEDICATION ALLERGIES 1. none known 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. Hydrocodone 2. T ??

3. _____ 4. _____

List Other Medications 1. _____ 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	07/07/2004	Hip Replacement	___/___/___
Hernia	___/___/___	Other	___/___/___	Other	___/___/___

SOCIAL HISTORY

Marital Status:	Married	Single	Divorced	Widowed
Children:	Yes	No	Number: 3	
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:	teacher			

PAST MEDICAL HISTORY

	GENERAL		**HEART**
	Cancer		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
			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		

None

COMPREHENSIVE SPINE CENTER OF DALLAS

ANESTHESIA HISTORY

Date of Last Anesthetic 07 / 07 / 2004

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: Tamara Walker

****

IMAGING

X-RAYS: @ Baylor hospital 04/16/12

MRI: @ DFW MRI on NW Highway in May

CT: @ Baylor hospital on 04/16/12

ASSESSEMENT:

1.
2.
3.
4.
5.

PLAN:

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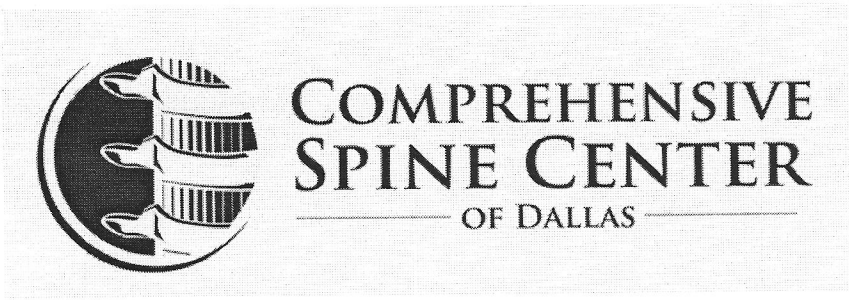

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George Farley,M.D.

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Billing Phone: (972) 720 9944

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

PATIENT INFORMATION

Name: **WALKER^TAMARA** Birthdate: **8/6/1962** SS# 460 15 1042
Street Address: 5534 Goodwin Avenue City: Dallas State: TX Zip: 75206
Sex: ☐Male ☒Female ☐Married ☐Widowed ☒Single
Cell Phone: (214) 912-9234 Home Phone: (___) ___-_____ Work Phone: (___) ___-_____
Person to contact in case of an emergency: _____ Phone: **(214)912-9234**

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: 04/16/12 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: T Walker Date: 05/18/12
Parent of Legal Guardian if Minor: _____
Do you have a Living Will? ☐ Yes ☐ No

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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: _____ Date: 05/18/12

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: _____ Date: 05/18/12

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: _____ Date: 05/18/12

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: _____ Date: 05/18/12

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AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Patient Name: **WALKER^TAMARA**

Address: 5534 Goodwin Ave. Dallas, TX 75206

Date of Birth: **8/6/1962** Date of Injury: 04/16/12 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.

T Walker 05/18/12

Signature of 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.

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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.

WALKER^TAMARA
Patients Name (print)

Walker
Patient's Signature

05/18/12
Date

Comprehensive Spine Center
Authorized Facility Signature

July 21, 2011
Date

COMPREHENSIVE SPINE CENTER
OF DALLAS

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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

WALKER^TAMARA

Patients Name (print)

Patient's Signature _____ Date 05/18/12

(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): Walker

Patient Signature: Tamara Walker **Date** 05-18-12

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

Parent/Guardian's Signature: _____

Witness: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

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: J Walker Relationship:_____ Date: 05/18/12

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 : 07/07/2004.
   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. _____
   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 : _____ Age: 05/18/12
Patient Name printed: _____
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 : _____