SpineVue
COMPREHENSIVE AND COMPASSIONATE

## Patient Registration

**Patient Name**: _____
Last First Middle Maiden

**Date of Birth:** _____ **Sex:** _____ **Social Security #:** _____ **Marital Status:** _____

**Physical Address**: _____ **City/State/Zip:** _____

Mailing Address: _____ City/State/Zip: _____

**HOME PH:** _____ **CELL:** _____ Phone: _____

**Patient's Email**: _____

**Employer Name**: _____ Employer Phone: _____

Employer Address: _____ City/State/Zip: _____

Per Government Mandate please complete the following: (If you wish to decline, please write "declined")

Language: _____ Race: _____ Ethnicity: _____

**Consents and Emergency Contacts**: Please indicate a person(s) with whom we may discuss your health/account. If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. NOTE: if the patient is a minor, parent(s) must be listed.

Name: _____ Relationship to Patient: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

Name: _____ Relationship to Patient: _____

Phone 1: _____ Phone 2: _____ Phone 3: _____

**Primary Insurance**: _____ Policy ID #: _____

Group #: _____ Policyholder: Last: _____ First: _____ Middle: _____

Relationship to Pt: _____ Social Security #: _____ Date of Birth: _____

**Secondary Insurance**: _____

Policy ID #: _____ Group #: _____

**Worker's Comp Insurance:** _____ **Date of Injury:** _____

**Adjuster:** _____ **Claim #:** _____ **Phone:** _____

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**Is this visit related to a Work Injury or Motor Vehicle Accident?** (select one)_____

**Date of Injury/Accident:** _____ **Claim#:**_____

**Adjuster Name:**_____ **Adj Phone:** _____

**Law Firm Name:** _____

**Lawyer Name:** _____ **Lawyer Phone:** _____

---

**Pharmacy Name:** _____ **Phone:** _____ **City:** _____

Your Care Team:

**Primary Care Physician Name:** _____ **Phone:** _____

**Referring Physician Name:** _____

**Pain Management Physician Name (If Any):**_____

**Ef dt: 1/29/26**

**Patient Name:**_____ **Date:** _____ **DOB:**_____

## Patient Waivers, Financial Responsibility Policies and Agreements

***Your Insurance***

We may require showing your insurance card at each visit, so we can verify the information that is in our system.

In-Network: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment and any additional percentage (co-insurance and/or deductibles) due. You could be billed for any remaining amount that insurance didn't pay after the services are rendered. **It is your responsibility for any amount not covered by insurance**.

If you are an HMO patient, we will work towards obtaining the appropriate referral from your primary care provider. If we are unable to obtain the appropriate referral before your appointment, then we can re-schedule your appointment or you can pay the self pay office visit charge of $300 for new patient or $250 for follow up patient. This payment is due at the time of service.

If you are a patient who purchased an Exchange insurance plan and become terminated or ineligible for your insurance. It is your responsibility for all unpaid charges.

Out-of-Network: We do not contract with all insurance companies licensed to do business in Texas. In the event your insurance company is not contracted with us, we will honor your in-network out of pocket amounts. It is critical to make sure your insurance has "Out Of Network" benefits (OON) under your policy. If you do not have OON benefits and you elect to receive care from Spine Vue, you may not receive ANY insurance reimbursements. If you have OON benefits, your claim will be processed using the prevailing "Usual-Customary and Reasonable" (UCR) rates for the services provided. We will not balance bill you for the remainder.

***Payment & Collection Policies***

It is our office policy to collect the co-payment/co-insurance/deductible when you arrive for your appointment. Unless other arrangements have been agreed upon in advance, full payment is due at the time of services provided. This also includes any other outstanding balances. Outstanding balances are due within 30 days, unless prior arrangements have been made in writing. You have 90 days from the date of notification (can be by phone, statement or email) to pay your balance before your account becomes delinquent. **If your account becomes delinquent and you have not established or made payment arrangements with our billing office, your account will be turned over to a collection agency and <u>we may ask you to seek your medical care from another medical office</u>**. We reserve the right to reschedule your appointment until such payments can be made. For your convenience, our office accepts cash and debit/credit cards.

***Patient's Request for any type of paperwork that is to be completed by physician***

In accordance with Federal Law, our office requires a written request (for available upon request) for the release of any type of forms. In some cases, we will need 15 business days (Monday through Friday) to process your request. According to the HIPAA privacy law, you may need to show identification that you have legal rights to this information. There is a fee of **$25 per page** for these form(s) and you may be required to see a physician.

***Method(s) of Communicating with Patients***

For your convenience, Spine Vue will call, text or email to remind you about your upcoming appointments based on the information you provide on your registration form.

***Forms of Payment***

We accept Cash and MasterCard and Visa only. We no longer accept checks as a form of payment. If there are any unpaid balances on your account, you will need to pay the unpaid balance in full prior to your next appointment. **Failure to pay will result in delayed treatment and/or termination from practice unless previous arrangement has been made in writing.**

***Disability,Handicap or Insurance Forms***

There will be a **$25 per page** charge for completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms.

***Medical Lifetime Authorization (MEDICARE PATIENTS ONLY)***

I authorize any holder of medical or other information about me to release to the Social Security Administration and HealthCare Financial Administration or its intermediaries or carriers that have any information needed for this or any related Medicare claim(s). I permit a copy of this authorization to be used in lieu of the original and request payment of the medical insurances benefits to the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

***Missed Appointments/ Untimely Cancellations***

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment please give 24 hours notice to avoid being charged. There is a **$25 charge for missed or untimely canceled appointments**. **Excessive abuse of scheduled appointments may result in termination from the practice.** If you arrive later than 30 minutes after your scheduled appointment, you may be asked to reschedule at a later time and date.

***Estimates and Interests***

An estimate of cost will be provided if requested by an uninsured patient, a patient not covered by a government program or an insured patient seeking out-of-network services.

***Disclosures***

Dr. Jones-Quaidoo is the owner of Spine Vue, PLLC and has ownership and/or investment interests in the following companies; Granthem, Bo Ching Medical, EBJ Holdings, NeuroAccuracy, Neuro Sense, Nuance IOM, Parkhill Imaging, Premier Physician Surgical Associates, Athens Anesthesia. Dr. Jones-Quaidoo has ownership shares in Baylor Medical Center at Uptown and Eminent Medical Center. Services may be provided by any of these facilities may be out of network and as a result you may receive an out of network bill. However, you have the right to choose the provider of your healthcare services. You also have the option to use the healthcare facility of your choice. You will not be treated differently by Dr. Jones-Quaidoo or Spine Vue, PLLC if you choose to have services performed at a different facility. By signing you have read and acknowledged the Disclosure of Physician Ownership at Spine Vue, PLLC.

***Consent to Treatment***

I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. I hereby consent to recording by audio or video of my visit for the purpose of using a virtual scribe when necessary. If I request or initiate a telehealth visit, I hereby consent to participate in such telehealth visit and its recording. I acknowledge that neither my provider nor any of his staff have made any guarantee or promise as to the results that I will obtain.

***Imaging CDs/films***

Imaging CDs/films will be kept in our files for a maximum of 6 months from date of service of the exam. Any CD or films older than 6 months will be destroyed unless picked up by the patient.

***Facsimile or Reproduction Waiver***

I understand that Spine Vue may transmit my medical information electronically. I authorize Spine Vue and any of its subsidiaries to send and/or receive the confidential electronic health care information as defined by Health Insurance Portability Accountability Act of 1996, 45CFR, Parts 160-164 (HIPAA) with full knowledge that it may be received in error by a third party. I absolve Spine Vue of any responsibility for issues that might arise from such error. I may revoke this authorization by giving Spine Vue 10 day written notice. This revocation will not pertain to information released prior to the date of the receipt of the revocation by Spine Vue.

***Assignment of Benefits (required for filing insurance claims)***

I hereby assign my interest and title to all medical benefits to which I am entitled to Spine Vue and any of its subsidiaries. I hereby authorize my insurance carrier to issue payments directly to Spine Vue for medical services rendered to myself regardless of my insurance benefits. I understand Dr. Sean M. Jones-Quaidoo may require a Physician Assistant to assist in my surgery, and in consideration for receiving medical services provided pursuant to my health insurance policy, I assign payment of my insurance benefits directly to Granthem, PLLC (“Granthem”). I understand that the charges for these services will be billed by Granthem to my insurance company. I understand my Surgeon participates in my health plan as an in-network provider and, therefore, I may be liable for applicable deductible and co-payments for covered services.

In the event that my health insurance plan refuses to pay for medically necessary surgical assist services, I assign all my appeal rights, either fully-funded or self-funded (*ERISA) rights, to a full and fair review process to Granthem for any and all paid, partially paid or denied surgical assist claims. In consideration for this assignment, Granthem agrees to potential non-payment and/or undertaking responsibility for the denial determination appeal process under the terms of my health care plan. I understand that if the surgical assistant prevails in any such payment dispute, I may be liable for applicable deductible and co-payment for the contested services.

I give consent to release medical and financial information contained in my insurance file to Granthem or its designated representative specifically for the purpose of the surgical services and treatment that were necessary for my care to my insurance company. I understand this information is privileged and confidential and will only be released as specific in this authorization, or as required or permitted by law.

**Our Prescription Policy**

Written prescriptions will not be replaced if lost, stolen or misplaced. Prescriptions are to be taken as directed. In other words, do not change the frequency of the dose unless otherwise directed by a Spine Vue professional. If a change does occur, this will be noted in your chart. Certain controlled substances such as Oxycontin, MS Contin and Percocet are written for a 10 day supply for non-surgical patients. It is necessary to make monthly follow up appointments in order to receive a refill. **By law, controlled substance medications cannot be refilled over the phone**. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment. **Refills will not be authorized at night, on weekends or holidays. All refills will require at least 48hrs for fulfillment**. Refill requests for prescriptions not prescribed by a Spine Vue physician will not be authorized. If you believe you may be pregnant, discover you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately.

***Motor Vehicle Accidents***

I hereby authorize the release a copy of my medical records as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury of condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a “non-covered” service and may make me personally liable for the charges incurred.

***AI use***

**AI use** in clinical visits is helpful for the efficiency and accuracy of documenting patient’s history, symptoms and treatment plan. Dr. Jones-Quaidoo utilizes AI recording with the help of a virtual scribe to add an extra layer of accuracy to documentation. If you have any questions regarding the use of AI, you may verbally direct this request with Dr. Jones-Quaidoo prior to your visit.

***Authorization of Release of Information (required for filing insurance claims)****

I hereby authorize Spine Vue and any of its subsidiaries to:

1) Release any information necessary to insurance carriers, physicians, attorneys, employers, healthcare providers or any other entity which may be concerned with the payment of charges incurred for the treatment of services.

2) Process insurance claims generated in the course of examinations and treatments.

3) Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Spine Vue and any of its subsidiaries on my behalf and understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized.

**I have read the Office and Financial policy and agree to its terms.** I understand and agree that the term of this financial policy may be amended by the practice at any time without prior notification to me. I am aware that for my safety and protection, video and audio surveillance may be used on Spine Vue premises, in public areas only. I, the undersigned, as patient or on behalf of patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the physician on duty. I am also aware that my photograph may be taken for documentation of my patient chart. I understand that no guarantee or assurance has been made as to the results, which may be obtained. I understand that I have the right to revoke this consent, in writing, except where Spine Vue has already made disclosures in reliance on your prior consent. A photocopy of this signature is as valid as the original.

Patient Signature:_____ Date:_____

# Notice of Privacy Practices

To our Patients:

This notice describes how health information about you (as part of this practice may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

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

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces(including veterans) and if required by the appropriate officials.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions of law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

**Your rights regarding your health information**

**1.** Communications: You can request that our practice communicate with you about your health and related issue in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.

**2.** You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

**3.** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Spine Vue, 8440 Walnut Hill Lane, Ste 230, Dallas, TX 75231.

**4.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for amendment.

**5.** Right to a copy of this notice. You are entitled to receive a copy of this notice. You may ask us to give you a copy of this notice at any time.

**6.** Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or to the Secretary of the Department of Health and Human Services. To file a complaint with our practice, submit in writing your complaint to Spine Vue, 8440 Walnut Hill Lane, Ste 230 Dallas, TX 75231. You will not be penalized for filing a complaint.

**7.** Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice of permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please notify us. I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices.

Signature: _____ Print Name: _____

Spine Vue
COMPREHENSIVE AND COMPASSIONATE

8440 Walnut Hill Lane, Suite 230, Dallas, TX 75231 Phone: 214-452-7705 Fax: 214-377-8831

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

TO: ___(Leave Blank)_____

DOCTOR OR HOSPITAL

ADDRESS: _____

Fax#: _____ Phone#: _____

**I hereby authorize and request you to release**

TO: Spine Vue- Dr. Sean Jones-Quaidoo

ADDRESS: 8440 Walnut Hill Lane, Suite 230, Dallas, TX 75231 **FAX: 214-377-8831**

the **COMPLETE medical record** or _____

in your possession, concerning my illness and/or treatment during

the period from _____ to _____

Patient Name: _____ Signature: _____

Date of Birth: _____ Date: _____

Witness (if signed by other than patient): _____

Relationship to Patient: _____

# Pain Management Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to ensure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Medications are intended to help reduce pain. No medication will remedy pain entirely.

1. It is against the law to give or sell your medications to any other person.
2. Prescribed medications must be taken strictly as ordered.
3. You are responsible for keeping your pain medication in a safe and secure place. Lost or stolen medication should be reported to the police and your physician immediately. Prescriptions will not be refilled early.
4. You must not use any illicit substances and avoid combining opioid with alcohol or other sedating substances.
5. Do not drive or use dangerous equipment when taking pain medication.
6. It is the patient's responsibility to comply with all laws and regulations while taking these medications.
7. Understand there is a possibility for adverse reaction, opioid overdose and addiction to these medications, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder.
8. Suddenly stopping these medications could be dangerous.
9. Understand there are narcotic overdose reversal medication such as naloxone that can be obtained without a prescription from your pharmacy.
10. Inform your provider of receiving a benzodiazepine as these can have adverse affects when taken with narcotics.
11. Medication plans may be altered at any time for any reason per the physician's professional judgment.
12. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory authority to obtain or to provide information about your care or actions if the physician deems it necessary.

I understand that the above list is not complete, I will be careful to exercise with caution and common sense, asking question where a full understanding is not met or if I feel that I may be having trouble with treatment provided.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____