Texas Back Institute™

"Getting our patients back to life"

Welcome

Thank you for choosing Texas Back Institute for your healthcare provider. Please remember to bring with you the **New Patient Back Pack** completed, along with your insurance identification card. It is important that you **arrive 30 minutes early** to complete patient check-in. Late arrival or failure to have all of your paper work completed for your appointment may result in it being rescheduled.

If your insurance company requires a referral to see a specialist, you must bring the referral to your appointment or verify that our office has received the referral. If you are not sure whether or not you need an authorization or referral you should contact your primary care physician's office. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company.

It is essential that you bring with you any medical records and x-ray films in order to assist the physician in determining your treatment. Records may also be faxed to 972-608-5068 prior to your appointment to the attention of the doctor with whom you have the appointment. Be sure to include your name and your referring physician's name on your fax cover sheet.

At the time of your visit you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate, and for any services that are not covered. Payments can be in the form of cash, check or credit card.

We look forward to serving you. Should you have any questions, please call us at 972-608-5000 so that we may assist you.

Texas Back Institute

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Office Policies

Office Hours: Office Hours are Monday through Friday, 8:00 am to 5:00 pm.

Prescription Refills – As of Monday, September 1, 2008, we no longer handle prescriptions refill requests over the phone. You are required to ask your pharmacy to fax in the request. Requests may be faxed to: (972) 608-5160. Please allow 24 hours from time of receipt from the pharmacy to process the prescription. Your prescription refill will only be processed if it includes the correct name of the medicine, dosage, and instructions on how you are taking the medicine. Prescription refills will not be processed outside of normal business hours or after 3:00 pm on Fridays, nor weekends and evenings after the office has closed.

Physician Emergency on Call Policy – when the office is closed a physician is on-call 24 hours a day. The physician is to be contacted when the office is closed for MEDICAL EMERGENCIES ONLY. If you wish to make an appointment, have prescriptions refilled, obtain x-ray or lab results you will not be called in over the weekend or when the office is closed. When attempting to contact a physician after office hours please remove any Caller I.D. or Call Intercept features that are operating on your phone line. Otherwise the physicians may be unable to contact you. In case of a true life threatening emergency call 911 or seek treatment at the nearest emergency room on weekends and after hours.

15 Minute Late Policy – If you are 15 minutes or later for your appointment you may be asked to reschedule.

Walk-In Appointments – Texas Back Institute is an appointment only office. Examination by a physician cannot be guaranteed if you present to the office without an appointment.

Payment is expected at the time of service. Due to the high cost of billing, patients unable to make payment at the time of service will be rescheduled. Accepted methods of payment include cash, check, credit card, and debit card.

Form Completion – Please be aware that we need 7 – 10 business days to complete forms. Patients are required to pay a $20 completion fee for disability forms. There is no charge for completing FMLA papers.

Copying of Medical Records – Patients requesting copies of their medical records will be assessed a $25 fee for the first 20 pages and thereafter 50¢ a page. If an abstract is sent

to a continuing care provider, there is no charge. An authorization for release of information must be signed and submitted before any request for records will be processed.

Copying of X - Rays – Patients requesting copies of their x-rays records will be assessed an $8 fee for each film. All films will be duplicated with DICOM (medical grade) software, and put on a CD for release. No original film will be released. An authorization for the release of film must be signed and submitted before any request for film will be processed.

No Show Policy – patients who schedule appointments but fail to show up are documented as "no shows." Patients who continue to "no show" may be charged a $35 fee. In addition, patients with multiple "no shows" may be terminated from the practice. The definition of a "No-Show" is failing to cancel an appointment within 8 hours.

Patient Termination Policy – although it is an infrequent occurrence, a patient may be terminated from the office. Patient termination is at the discretion of the patients' provider. Common reasons for termination include, but are not limited to, use of foul language, chronic noncompliance with recommended therapy, non-compliance with medications, abusive behavior of staff, physicians, visitors or other patients.

6020 West Parker Road
Suite 200
Plano, Texas 75093
(972) 608-5000

Cancellation and No Show Policy

At Texas Back Institute, we understand that all of our patients' time is valuable. So, help us help you by keeping your scheduled appointments.

If you need to reschedule or cancel your appointment, please do so a minimum of 24 hours prior to your scheduled appointment.

Patients who do not cancel or reschedule their appointments may be subject to a fee of $35.00. Our office will make reasonable attempts to confirm appointments one to two days in advance.

It remains the patient's responsibility to keep or reschedule appointments in compliance with the above policy. Exceptions will be made for medical or family emergencies. Please note that the insurance companies cannot be billed for missed sessions.

I have read, understand, and agree to comply with the above policy.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

Periodic Outcomes Evaluation

Texas Back Institute

PAIN DIAGRAM

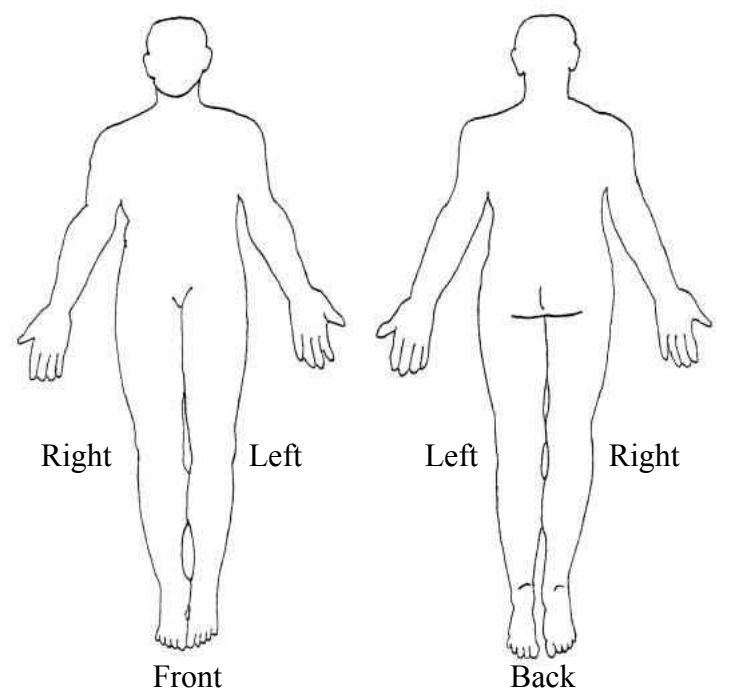
Name _____ DOB _____ Gender M / F Date _____
Please tell us which provider you are seeing today: _____

Follow Up For:

MRI /Facility:	Flare Up /Date:	RX Refill
PT /Facility:	Spine Surgery /Type:	Last Seen _____
Injection /Date:	Referral /By:	Other _____

Ache ^^^^
Numbness 0000
Pins & Needles ====
Burning xxxx
Stabbing ////

Please mark the areas where you experience the following sensations:



Medications: (circle ones to be refilled)
_____
_____
_____

New Medication:
(List all from other doctors)
_____
_____
_____

To be completed by MA:
Allergies/Reactions:
_____
_____

Height	
Weight	
Pulse	
BP	
Temp	
BMI	

Please Circle Your Answer Below

Since your last office visit are you: better worse the same?

How bad is your pain? Place an "X" (_____X_____) on each of the lines below to indicate your current pain.

How bad is your low back pain?

No pain ——————————————————— Worst possible

How bad is your leg pain?

No pain ——————————————————— Worst possible

How bad is your middle back pain?

No pain ——————————————————— Worst possible

How bad is your neck pain?

No pain ——————————————————— Worst possible

How bad is your arm pain?

No pain ——————————————————— Worst possible

BACK PAIN QUESTIONNAIRE

If you have LOW BACK pain complete this page, if you have only neck pain, skip this page.

Please read: Could you please complete this questionnaire. It is designed to give us information on how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer **every section.** Mark **one box only** in each section that most closely describes you today.

Section 1 - Pain Intensity

_____ I have no pain at the moment.
_____ The pain is very mild at the moment.
_____ The pain is moderate at the moment.
_____ The pain is fairly severe at the moment.
_____ The pain is very severe at the moment.
_____ The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc.)

_____ I can look after myself normally without causing extra pain.
_____ I can look after myself normally but it is very painful.
_____ It is painful to look after myself and I am slow and careful.
_____ I need some help but manage most of my personal care.
_____ I need help everyday in most aspects of self care.
_____ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

_____ I can lift heavy weights without extra pain.
_____ I can lift heavy weights but it gives extra pain.
_____ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
_____ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
_____ I can lift only very light weights.
_____ I cannot lift or carry anything at all.

Section 4 - Walking

_____ Pain does not prevent me from walking any distance.
_____ Pain prevents me walking more than 1 mile.
_____ Pain prevents me walking more than 1/2 mile.
_____ Pain prevents me walking more than 100 yards.
_____ I can only walking using a stick or crutches.
_____ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

_____ I can sit still in any chair as long as I like
_____ I can sit in my favorite chair as long as I like.
_____ Pain prevents me sitting more than 1 hour.
_____ Pain prevents me sitting more than 1/2 hour.
_____ Pain prevents me sitting more than 10 mins.
_____ Pain prevents me from sitting at all.

Section 6 - Standing

_____ I can stand as long as I want without extra pain.
_____ I can stand as long as I want but it gives me extra pain.
_____ Pain prevents me from standing for more than 1 hour.
_____ Pain prevents me from standing more than 1/2 an hour.
_____ Pain prevents me from standing for more than 10 mins.
_____ Pain prevents me from standing at all.

Section 7 - Sleeping

_____ My sleep is never disturbed by pain.
_____ My sleep is occasionally disturbed by pain.
_____ Because of pain I have less than 6 hours sleep.
_____ Because of pain I have less than 4 hours sleep.
_____ Because of pain I have less than 2 hours sleep.
_____ Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)

_____ My sex life is normal and causes no extra pain.
_____ My sex life is normal but causes some extra pain.
_____ My sex life is nearly normal but is very painful.
_____ My sex life is severely restricted by pain.
_____ My sex life is nearly absent because of pain.
_____ Pain prevents any sex life at all.

Section 9 - Social Life

_____ My social life is normal and causes me no extra pain.
_____ My social life is normal but increases the degree of pain.
_____ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
_____ Pain has restricted my social life and I do not go out as often.
_____ Pain has restricted my social life to my home.
_____ I have no social life because of pain.

Section 10 - Traveling

_____ I can travel anywhere without extra pain.
_____ I can travel anywhere but is gives me extra pain.
_____ Pain is bad but I can manage journeys over two hours.
_____ Pain restricts me to journeys of less than one hour.
_____ Pain restricts me to short necessary journeys under 30 mins.
_____ Pain prevents me from traveling except to receive treatment.

NECK PAIN QUESTIONNAIRE

If you have NECK pain complete this page, if you have only low back pain, skip this page.

Please read: This questionnaire has been designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize you may consider that two of the statements in any one section relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 - Pain Intensity

___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc.)

___ I can look after myself normally without causing extra pain.
___ I can look after myself normally, but it causes extra pain.
___ It is painful to look after myself and I am slow and careful.
___ I need some help, but manage most of my personal care.
___ I need help everyday in most aspects of self care.
___ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

___ I can lift heavy weights without extra pain.
___ I can lift heavy weights, but it gives extra pain.
___ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
___ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
___ I can lift very light weights.
___ I cannot lift or carry anything at all.

Section 4 - Reading

___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight pain in my neck.
___ I can read as much as I want with moderate pain in my neck.
___ I cannot read as much as I want because of moderate pain in my neck.
___ I cannot read as much as I want because of severe pain in my neck.
___ I cannot read at all.

Section 5 - Headaches

___ I have no headache at all.
___ I have slight headaches which come infrequently.
___ I have moderate headaches which come infrequently.
___ I have moderate headaches which come frequently.
___ I have severe headaches which come frequently.
___ I have headaches almost all the time.

Section 6 - Concentration

___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a lot of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7 - Work

___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can hardly do any work at all.
___ I cannot do any work at all.

Section 8 - Driving

___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight pain in my neck.
___ I can drive my car as long as I want with moderate pain in my neck.
___ I cannot drive my car as long as I want because of moderate pain in my neck.
___ I can hardly drive at all because of severe pain in my neck.
___ I cannot drive my car at all.

Section 9 - Sleeping

___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless).
___ My sleep is mildly disturbed (1 -2 hours sleepless).
___ My sleep is moderately disturbed (2-3 hours sleepless).
___ My sleep is greatly disturbed (3-5 hours sleepless).
___ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 - Recreation

___ I am able to engage in all of my recreational activities with no neck pain at all.
___ I am able to engage in all of my recreational activities with some pain in my neck.
___ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
___ I am able to engage in a few of my usual recreational activities because of pain in my neck.
___ I can hardly do any recreational activities because of pain in my neck.
___ I cannot do any recreational activities at all.

Patient Questionnaire

Instructions: This survey asks for your views about your health. The information will help keep track of how well you are able to do your usual activities.
Please answer each question by marking **one box**. If you are unsure about how to answer please give the best answer you can.

In general would you say your health is ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

The following items are about activities that you might do during a typical day. Does **your health <u>now</u> limit** you in these activities? If so, how much?

(Fill in **one circle on each line**)	Yes limited a lot	Yes limited a little	Not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	○	○	○
Climbing several flights of stairs?	○	○	○

During the **<u>past 4 weeks</u>**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

Accomplished less than you would like.	○ Yes	○ No
Were limited in the kind of work or other activities.	○ Yes	○ No

During the **<u>past 4 weeks</u>**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

Accomplished less than you would like.	○ Yes	○ No
Didn't do work or other activities as carefully as usual.	○ Yes	○ No

During the **<u>past 4 weeks</u>** how much did **pain** interfere with your normal work (including work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

These questions are about how you feel and how things have been with you during the **<u>past 4 weeks</u>**. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the **<u>past 4 weeks</u>**:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Have you felt calm and peaceful?	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○
Have you felt downhearted and blue?	○	○	○	○	○

During the **<u>past 4 weeks</u>**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

Please fill out these forms completely!

We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated.

Thank you for helping us to know you better!

Date:_____

Patient Name:_____
(please print)

Gender: ☐Male ☐Female

Date of Birth:_____
(month/day/year)

Current Age:_____

FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

_____

_____

_____

How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)

☐ I don't know how it began.
☐ It comes and goes.
☐ I've had it a long time. (_____years)
☐ Injury (date of injury_____) On the job? ☐yes ☐no
Please explain how the injury happened.
_____

Are you currently in litigation with regards to your back pain? ☐yes ☐no

Have you been laid off from your job? ☐yes ☐no ☐N/A

Do you have any of the following problems?
(Please check your answer.)

Is your pain worse at night? ☐yes ☐no
Does your pain awaken you from sleep? ☐yes ☐no
Does coughing affect your pain? ☐yes ☐no
Do your legs tire/hurt if you walk too far? ☐yes ☐no
If YES, how far can you walk?
☐less than 1 block ☐1-3 blocks ☐more than 3 blocks
Is this relieved by resting your legs? ☐yes ☐no
Is this relieved by bending forward? ☐yes ☐no

Bladder Control (urine):
☐ No problem
☐ Can't empty bladder
☐ Loss of urine (accidents)

Bowel Control:
☐ No problem
☐ Constipation
☐ Loss of control (accidents)

How does each of the following affect your pain? (check your answer)

Sitting	☐Better	☐Worse	☐No change	
Standing	☐Better	☐Worse	☐No change	
Walking	☐Better	☐Worse	☐No change	
Lying down	☐Better	☐Worse	☐No change	
Rising from chair	☐Better	☐Worse	☐No change	
Physical activity	☐Better	☐Worse	☐No change	
Heat	☐Better	☐Worse	☐No change	☐Don't know
Cold	☐Better	☐Worse	☐No change	☐Don't know

Massage	☐Better	☐Worse	☐No change	☐Don't know

PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

Have you had:

Chiropractic care	☐better	☐worse
Physical therapy	☐better	☐worse
Injections	☐better	☐worse
Psychological consultation	☐better	☐worse
Other:_____	☐ better	☐worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6 mo	< 12 mo
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
Discogram	☐	☐
EMG/NCV(nerve test)	☐	☐

Have you ever had surgery on your back or neck?
☐yes ☐no **If YES, complete the following:**

1) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain ☐better or ☐worse?

2) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain ☐better or ☐worse?

3) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain ☐better or ☐worse?

☐

GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check ☐

☐ Heart attack	☐ Colon problems	☐ Gout	☐ Enlarged prostate
☐ Heart murmur	☐ Diabetes	☐ Anxiety	☐ Menstrual problems
☐ Angina	☐ Hepatitis	☐ Depression	☐ Cancer:
☐ High blood pressure	☐ Cirrhosis	☐ Emphysema	type_____
☐ Stroke	☐ Kidney stones	☐ Tuberculosis	☐ Osteoporosis
☐ Varicose veins	☐ Kidney infection	☐ Chronic bronchitis	
☐ Stomach ulcer	☐ Degenerative arthritis	☐ Frequent pneumonia	Have you used :
☐ Duodenal problems	☐ Rheumatoid arthritis	☐ Asthma	☐ Immuno-suppression?
☐ Anemia (low blood count)	☐ Bleeding tendency	☐ Sexual difficulty	☐ Corticosteroids
			☐ Other_____

List any major surgery you have had, other than on your back or neck.

Type of surgery	Year
1._____	_____
2._____	_____
3._____	_____

Are you allergic to any medications, foods or environmental substances?
☐yes ☐no If YES, list the medications.
_____
_____

Do you take any medications, including herbal, over-the-counter, and prescription?
☐yes ☐no If YES, list all medications you are taking.

Medication	Reason taken	How often taken	Doctor (if prescribed)
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY

☐**I do not know the medical history of my biological parents or other family members.** (Go on to next section.)	Mother: ☐ Alive age:____ ☐ Deceased at age:__ due to_____	Father: ☐ Alive age:____ ☐ Deceased at age:__ due to_____	Number of living brothers/sisters____, Number of deceased brothers/sisters____, cause(s)_____

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply:

☐ Stroke	☐ Heart trouble	☐ Kyphosis
☐ Diabetes	☐ Back problems	☐ Arthritis
☐ Lung disease	☐ Cancer	☐ None of these
☐ High blood pressure	☐ Osteoporosis	☐ Don't know
	☐ Scoliosis	☐ Other_____

SOCIAL HISTORY

Marital Status
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Widow/widower

Education
Check the highest level completed:
- ☐ Grammar school
- ☐ High school
- ☐ College
- ☐ Post-graduate

Smoking
- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Smoker – Current Status Unknown
- ☐ Unknown If Ever Smoked

Patient Smokes: ☐ Every Day ☐ Some Days
Year Started _____
- ☐ Cigarettes Amt: _____ packs/day
- ☐ Cigars Amt: _____ # per week
- ☐ Smokless/Chewing Amt: ____ per Day
- ☐ Has had tobacco cessation counseling

Alcohol
Do you drink:
Beer: ☐yes ☐no Amt: ____ per day
Wine: ☐yes ☐no Amt: ____ glasses/day
Hard" drinks: ☐yes ☐no Amt: ____ day

Frequency of drinking:
- ☐never
- ☐rarely Amt: _____ drinks/day
- ☐socially
- ☐daily

Do you have a history of heavy drinking?
☐yes ☐no

Effect of your back/neck pain on your lifestyle.

I describe my home setting as supportive of me during this time.	☐yes ☐no
I describe my work setting as supportive of me during this time.	☐yes ☐no
My pain has affected my interaction with my family and friends.	☐yes ☐no
The changes in my lifestyle due to my problem have been difficult for me.	☐yes ☐no

What is your ability to enjoy life?
- ☐Excellent
- ☐Very good
- ☐Good
- ☐Fair
- ☐Poor

Please indicate your <u>current work status</u>.
- ☐ Working full time
- ☐ Working part time
- ☐ Seeking employment
- ☐ Not working by choice (retired, homemaker, student, etc.)
- ☐ Physically unable to work <u>due to</u> back/neck problem
- ☐ Physically unable to work <u>not due to</u> back/neck problem

<u>Before</u> having back or neck pain, did you normally work:
☐full time ☐part time ☐neither

What is your usual occupation?
_____

Do you like your work situation?
☐yes ☐no ☐N/A

Has your pain affected your ability to do your job or any other daily activities? ☐yes ☐no

If YES, please explain_____

Is there anything we have failed to ask that you believe is important for us to know?
☐yes ☐no If YES, please explain: _____

REVIEW OF SYSTEMS

Do you have any of the following?

General:
Recent weight loss of more than 10 pounds? ☐yes ☐no
Recent weight gain of more than 10 pounds? ☐yes ☐no
Fever? ☐yes ☐no
Chills? ☐yes ☐no
Night sweats? ☐yes ☐no

Have you seen your primary care physician in the past year? ☐yes ☐no

Cardiac:
Chest pain ☐yes ☐no
Shortness of Breath ☐yes ☐no

Respiratory:
Wheezing ☐yes ☐no
Pneumonia ☐yes ☐no
Chronic cough ☐yes ☐no

Gastrointestinal:
Abdominal pain ☐yes ☐no
Nausea ☐yes ☐no
Vomiting ☐yes ☐no
Diarrhea ☐yes ☐no
Liver problems ☐yes ☐no

Skin:
Open sores ☐yes ☐no
New moles ☐yes ☐no
Poor healing ☐yes ☐no
Skin infection ☐yes ☐no

Hematoligic/Oncologic:
Easy bruising ☐yes ☐no
Blood thinning medications ☐yes ☐no
Blood transfusion ☐yes ☐no
Organ transplant ☐yes ☐no

Bones/Joints:
Shoulder pain ☐yes ☐no
Wrist/hand pain ☐yes ☐no
Hip pain ☐yes ☐no
Knee pain ☐yes ☐no
Lupus ☐yes ☐no
Muscle weakness ☐yes ☐no
Fibromyalgia ☐yes ☐no

Genitourinary:
Abnormal kidney function ☐yes ☐no
Pain with urination ☐yes ☐no
Frequent urinary infections ☐yes ☐no

Mental Health:
Sleep disturbances ☐yes ☐no
Feeling of hopelessness ☐yes ☐no

Nervous System:
Headaches ☐yes ☐no
Tremors ☐yes ☐no
Poor speech ☐yes ☐no
Changes in vision ☐yes ☐no

Endocrine:
Thyroid problems ☐yes ☐no

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.

Texas Back Institute has adopted the following privacy policies:

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. If you have paid out-of-pocket and in full for services, you have the right to request the restriction of certain disclosures to a health plan.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Texas Back Institute. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other that those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

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

Health Information related to an individual who has been deceased 50 years or more is no longer protected.

Research. Our practice may use and disclose your Protected Health Information for research purposes in certain limited circumstances. We will obtain your written authorization to use your Protected Health Information for research purposes except when an Internal Review Board or Privacy Board has approved the research project and its privacy protections.

Psychotherapy Notes. Most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes and disclosures that constitute a sale of Protected Health Information require authorization, as well as a statement, that other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

Fundraising. Should you receive fundraising or marketing information, you have the right to "opt out" of receiving any further communications.

Prohibition Against Sale. Our practice is prohibited from the sale of Protected Health Information without the express written authorization of the individual.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders by mail or to contact you by phone regarding appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information;
2. The right to receive confidential communications concerning your medical condition and treatment;
3. The right to inspect and copy your Protected Health Information;
4. The right to amend or submit corrections to your Protected Health Information;
5. Should an unsecured breach of your Protected Health Information occur, all affected individuals have the right to be notified.
6. Our practice maintains its records in electronic format. Therefore, if you request copies of your records they can be released to you in electronic format if they are requested by you.
7. The right to receive an accounting of how and to whom your Protected Health Information has been disclosed; and
8. The right to receive a printed copy of this notice.

Texas Back Institute's Duties

We are required by law to maintain the privacy of your Protected Health Information and to provide you with this Notice of Privacy Practices. We also are required to abide by the privacy policies and practices that are outlined in this Notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all Protected Health Information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting: **Cheryl Zapata, Privacy Officer, Texas Back Institute, 6020 W. Parker Road, Suite 200, Plano, Texas 75093.**

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: **Cheryl Zapata, Privacy Officer, Texas Back Institute, 6020 W. Parker Rd., Ste. 200, Plano, TX 75093**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is: **Cheryl Zapata, Texas Back Institute, 6020 W. Parker Rd., Ste. 200, Plano, TX 75093**

Effective Date
This Notice is effective on or after September 15, 2013.

TEXAS BACK INSTITUTE PHYSICIANS, PA

ACKNOWLEDGEMENT
To Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, TEXAS BACK INSTITUTE PHYSICIANS, PA ("PROVIDER") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my consent.

The PROVIDER'S *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the PROVIDER reserves the right to change the *Notice of Privacy Practices*.

I have been provided and have reviewed the PROVIDER'S *Notice of Privacy Practices* dated **SEPTEMBER 15th, 2013.**

_____
Signature of Patient or Legal Representative

_____
Print Name of Patient or Legal Representative

Date: _____

I give permission to Texas Back Institute to release my private health information to the following person(s). Please print below.

_____

_____

_____

_____

Texas Back Institute™

ANALGESIC DRUG THERAPY AGREEMENT and INFORMED CONSENT

Patient Name: _____ Patient ID #: _____

BACKGROUND: The Federal Drug Enforcement Administration (DEA) is responsible for identifying and assigning all drugs a classification. Drugs determined to have a potential for abuse are considered *controlled* drugs. *Controlled* drugs are rated in the order of their abuse risk and placed in *Schedules* by the DEA.
Some examples of drugs in these *Schedules* are as follows:

Schedule I (1) — drugs with a high abuse risk. These drugs have NO safe, accepted medical use in the United States and are illegal to possess, use or distribute. Some examples are: heroin, LSD, PCP, and crack cocaine.

Schedule II (2) — drugs with a high abuse risk, but also have safe and accepted medical uses in the United States. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs. Some examples are: morphine, oxycodone (**Percodan®**), drugs containing hydrocodone (**Norco®, Vicodin®, Lortab®**), methylphenidate (**Ritalin®**), and dextroamphetamine (**Dexedrine®**).

Schedule III, IV, or V (3,4,5)— drugs with an abuse risk less than Schedule II. These drugs also have safe and accepted medical uses in the United States. Schedule III, IV, or V drugs include those containing smaller amounts of certain narcotic and non-narcotic drugs, anti-anxiety drugs, tranquilizers, sedatives, stimulants, and non-narcotic analgesics. Some examples are acetaminophen with codeine (**Tylenol® No.3**), Tramadol (**Ultram®**), diazepam (Valium®), alprazolam (**Xanax®**),and pentazocine (**Talwin®**).

Schedule N – drugs with little to no potential for abuse. Some examples are: NSAIDs (**Celebrex®**), and methylprednisolone (**Solu-medrol®**).

DRUG THERAPY AGREEMENT:

1. Texas Back Institute (hereafter "TBI") will only provide Schedule II pain medications for patients:
   A.) experiencing short term pain associated with a spine related condition;
   B.) in need of pain control during the perioperative period;
   C.) determined to be suffering from chronic spine related pain which is being successfully treated.

2. I will take my medications exactly as they are prescribed by my physician. Any adjustments must be approved by my physician. If I run out of medication ahead of schedule, I understand my physician may not provide or approve an early refill.

3. I will avoid consumption of alcohol and all illegal substances. I understand this means I should not drink any alcoholic beverages while taking pain medication and will not use illicit substances while being treated at TBI.

4. If I feel tired or mentally "foggy", I will not:
   A.) drive
   B.) operate heavy equipment
   C.) or perform any service in any capacity related to public safety.
   I understand this symptom is more likely to occur during medicine and dosage adjustments.

5. I will submit to urine drug testing upon request. My doctor may ask a clinic staff member observe me providing the specimen. If my drug screen indicates that I am not following TBI guidelines, I will see the TBI psychologist or behavioral medicine specialist for further evaluation.

6. I understand that I may be required to participate in other therapies as requested by my physician. Other therapies may include, but are not limited to, (a) pain management classes, (b) periodic follow-ups with the psychologist, (c) consultation with the physical therapist for a home based exercise program.

7. I will not obtain any additional Schedule II pain medication prescriptions (e.g. opioids, sleeping pills, tranquilizers, stimulants, etc.) from any non TBI physician without the prior authorization of my TBI physician. If I have an emergency that requires additional pain medicine, when possible, I will first call my TBI physician's office. I will alert the treating physician at the emergency room or hospital of this agreement with Texas Back Institute.

8. I will not share, sell or trade my medication with anyone. I will not take anyone else's prescription medicine.

9. I will safeguard my pain medicine(s) from loss or theft by keeping them in a locked and secure location. If my pain medicines are stolen, I will immediately file a police report. ***I UNDERSTAND THAT LOST OR STOLEN MEDICINES WILL NOT BE REPLACED.***

10. I authorize TBI and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Drug Enforcement Administration (DEA) and the Texas Board of Pharmacy, in the investigation of any possible misuse, prescription forgery, sale, or other diversion of my pain medicine. I understand that illegal substance use may be reported to the proper authorities. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

11. I will inform my doctor of all medicines I am receiving from other physicians. I will provide updated medication information at each clinic visit which will be entered into my medical record.

12. I will allow TBI to receive information from any pharmacy I have used as well as the Texas Department of Public Safety Prescription Access system.

13. I agree to obtain my prescriptions from one pharmacy. The pharmacy I have selected is:
Pharmacy Name:_____
Location:_____City:_____Phone:_____

14. I understand I may see a Physician Assistant for some follow-up visits, but only my TBI physician can order Schedule II drugs and refills.

15. Schedule II pain medications will be continued as long as there is (a) acceptable improvement in pain level, (b) a reported increase in my activity level, (c) no inappropriate drug behavior, and (d) no significant, unmanageable side effects.

16. If it is determined that my pain is out of control, I understand I may need to be hospitalized to obtain further treatment.

17. I understand the terms of this Agreement apply to all Schedule II and Schedule III pain relief drugs prescribed for me by a TBI physician.

18. I understand that two (2) consecutive un-excused clinic visit "no-shows" or excessive cancellations may be grounds for dismissal from TBI.

19. I will notify my treating and/;or prescribing TBI physician or authorized associates of any change in my medical condition. For women: I will do everything I can to avoid getting pregnant while taking these medicines unless otherwise approved by my doctor. To the best of my knowledge, I am not pregnant at this time and should I become or suspect I am pregnant, will immediately notify my TBI physician.

20. I understand that it is fraudulent and illegal to misrepresent my condition to my physician in order to obtain medications.

21. I understand that my pain is my pain, not my family's or spouse's and therefore, I need to be the person to communicate with my physician if at all possible.

22. I understand my physician will not be available to prescribe medication during evenings or weekends. Schedule II prescriptions require a written prescription on a specialized prescription pad which has been pre-registered with the State. It is my responsibility to call my physician at least three (3) business days in advance of running out of medication. I understand that if my pain changes in intensity (increase or decrease), I must make an appointment to be seen in the clinic.

23. I have received a copy of the TBI Narcotic Information Sheet today regarding potential medication side effects which I will retain for future reference.

24. I agree to address any concerns or issues regarding my treatment with my physician or authorized associates.

25. I understand that any violation of the terms contained within this Agreement may result in my permanent and irreversible discharge from Texas Back Institute.

By evidence of my signature below, I have thoroughly read each item contained in this 3 page Agreement. I understand and will comply with this Agreement. I have been given the opportunity to have my questions satisfactorily addressed regarding the above statements.

Patient Name (print): _____ Date: _____

Patient Signature: _____

INFORMED CONSENT

I understand that taking a Schedule II (narcotic) pain medication, especially on a long term basis, has been associated with the following: physical dependence (i.e., onset of withdrawal syndrome following a sudden reduction in dosage), tolerance, addiction (more likely in patients with a past history of drug/alcohol abuse), 'hyperalgesia' (i.e., increased pain and pain sensitivity), altered hormonal activity, immune system changes, increased dental problems from 'dry mouth syndrome', urinary retention, constipation, and alterations in mental functioning (most often as a results of frequent dosage adjustments).

I understand that no warranty or guarantee will be made to me as to result of any drug therapy, treatment or cure of my condition. I have the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment(s) or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment(s) and procedure(s), and I believe I have sufficient information to give this informed consent.

Patient Name (print): _____ Date: _____

Patient Signature: _____

TBI Witness Signature: _____ Title: _____

*Complete **and** sign **ONLY** if refusing schedule II and III pain relief drug therapy*

I may elect to waive/refuse medication management from Texas Back Institute. By doing so, I will not receive drug samples or Schedule II or III drug prescriptions from Texas Back Institute physicians or authorized associates. I may elect or continue to receive these medications from my primary care provider or pain management specialist. If I decide in the future to transfer medication management to Texas Back Institute, I will be required to complete a "Schedule II Drug Therapy Agreement and Informed Consent" before receiving any prescriptions and I may be required to present documentation from a previous prescribing physician of their intent to discontinue medication management.

Patient Name (print): _____ Date: _____

Patient Signature: _____

TBI Witness Signature: _____ Title: _____

Texas Back Institute
Narcotic Information Sheet

Narcotic medications can be an effective and safe treatment of your pain. It is only one aspect of your care. Your cooperation in all aspects of your prescribed management is necessary in order to maximize your condition outcome.

Goals of therapy include pain reduction, improvement in level of function and overall improvement in quality of life. Pain medications should supplement other aspects of your care.

The following is a list of the most common side effects and reactions related to narcotic medication usage. We have also included precautions and potential preventative measures.

POSSIBLE SIDE EFFECT	RECOMMENDED TREATMENT
Constipation	Increase regular exercise, fluid intake and fiber-rich food in your diet. You may require over-the-counter stool softeners.
Nausea and Vomiting	Stop the medication and contact our office.
Drowsiness	Typically improves with medication use. **DO NOT DRIVE OR OPERATE MACHINERY DURING THIS TIME.** Your family should be aware of the medication you are taking and instructed to take you to the Emergency Room if you become difficult to awaken.
Rash or Itching	Contact our office.
Urinary Retention	Contact our office. Extreme situations may require temporary catheterization to drain the bladder.
Insomnia or Depression	Contact our office.
Impotence	Contact our office.
Breathing Difficulty (Slow or shallow breathing)	This is a rare but potentially serious side effect. **Stop the medication, call 911 or take the patient directly to the Emergency Room.**
Impaired Reasoning or Judgment	Contact our office.
Tolerance	The need for increasing amount of drug to achieve the same pain relief. This occurs with long-term use and new medications of equal strength may be substituted.
Physical and Emotional Dependence "...occurrence of an abstinence syndrome after abrupt discontinuance of the drug..."	This is not a problem but does require tapering off the medication to avoid withdrawal. Speak with your physician before discontinuing any medication.
Addiction "...compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite that harm..." AMA Task Force TBME, Vol 15, Number 1	Withdrawal and perhaps detoxification may be required under physician supervision.

PATIENT CONSENT TO MEDICATION MANAGEMENT

I, _____, agree to the following:

- I will notify my treating and/or prescribing Texas Back Institute physician or authorized associates of any change in my medical condition, including pregnancy for females.
- I will take any and all prescribed medications only as directed by my physician and authorized associates. I will not obtain pain medications from more than one physician, request early refills or request replacement of lost or stolen medications or prescriptions.
- I will submit to random urine or blood prescription monitoring testing to ensure medications are utilized properly and as prescribed and that no illegal substances are present.
- I agree to address any concerns or issues regarding my treatment with my physician or authorized associates.
- I have received the "Texas Back Institute Refill Policy" and "Narcotic Information Sheet" today regarding the process for medication refills and potential medication side effects. I also understand that each clinic's policy may vary slightly and it is my responsibility to obtain the Refill Policy for the clinic to which I transfer my care.
- I agree to obtain my prescriptions from one pharmacy. The pharmacy I have selected is:

  Name:_____

  Location:_____ City: _____ Phone:_____
- I understand that any violation of the polices contained within the "Patient Consent to Treatment" amd/or the "Patient Consent to Mediation Management", may result in my permanent and irreversible discharge from Texas Back Institute.
- I have read and now acknowledge my understanding of the "Patient Consent to Treatment" policies as detailed in the previous pages.

PATIENT SIGNATURE:_____DATE:_____

I REFUSE MEDICATION MANAGEMENT:_____

TBI REPRESENTATIVE:_____

PATIENT CONSENT TO TREATMENT

PURPOSE: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather to make you better informed so that you may give or withhold your consent to the proposed treatment.

CONSENT TO TREATMENT: I voluntarily request Texas Back Institute, as my physician, and such associates, assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment at Texas Back Institute. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my condition outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic and therapeutic test results. Accommodations for patients traveling significant distances will be made as much as possible, but patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associates apprised of any changes in my medical condition. Certain diagnostic tests, treatments and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment with Texas Back Institute will notify their prescribing physician if they are on medication therapy.

I understand that treatment of my condition will be directed initially toward conservative management in an effort to avoid surgical intervention, unless I have been directly referred to a Texas Back Institute surgeon. However, failing conservative care, I may then be considered a potential surgical candidate and referred to a surgeon.

E –PRESCRIBING CONSENT FORM: ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. The ability to electronically send prescriptions is an important element in improving the quality of care. ePrescribing greatly reduces medication error and enhances patient safety.

By signing this consent form you are agreeing that Texas Back Institute can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Texas Back Institute Doctors: Invested in Your Future

Industry Relationships

As nationally recognized leaders in back and neck care, Texas Back Institute physicians are at the forefront of advancements designed for patients with disabling spine problems. For over 30 years, the Texas Back Institute's mission has included leadership roles in clinical research, new technological procedures, and helping to develop new medical products to improve patient care. As such, Texas Back Institute physicians are frequently sought out by medical device manufacturers to participate in product development, research and education.

Manufacturers and research organizations realize that surgeons are necessary contributors to the development and improvement of devices and instruments used in the treatment of many orthopedic and spinal conditions. Without contributions by surgeons, engineers working in the medical device industry would lack the real-life experience necessary to fully develop and improve their inventions and advancements in spine care.

Surgeons at the Texas Back Institute work with many companies, both large and small, to help create and improve products for patient care. As such, they are compensated for their intellectual efforts and for their time. This is a standard industry practice. They participate as Consultants, on Scientific Advisory Boards, and even on Boards of Directors. Compensation for such services may come in various forms including, but not limited to: (1) consulting fees for services provided by the orthopedic surgeons, (2) royalty fees for patents based on the sale of products for which the surgeons made important contributions, and (3) equity interests in the manufacturers or distributors of medical products. Some of the products or devices made or distributed by these companies may be used in your medical treatment. However, a doctor's decision as to which, if any, products or devices to be used in your care and treatment is made based upon what is in your best medical interest.

The following is a current list of companies with whom one or more TBI physicians have financial relationships. Please feel free to learn more about these companies from their websites, and to ask your TBI surgeon any specific questions or concerns you may have about a company, product, or your doctor's relationships with the company.

Company Name	Website/Product
4 Web, Inc.	
11A Investment, LLC	
Aeglea Biotherapeutics	www.aegleabio.com
Aesculap	www.aesculapusa.com
Agada Medical	
AlignMed, Inc.	

Alphatec Spine, Inc.	www.alphatecspine.com
Asia Medical Investments, LLC	
Auctus Surgical, Inc.	
Baylis Medical	
Biowave	www.biowave.com
BrainLab	
Centinel Spine	www.centinelspine.com
Choice Spine	
Clariance	
Crocker Spinal Technologies, Inc.	www.crockerspinaltechnologies.com
CrossTrees Medical	www.xtreesmed.com
Depuy Synthes (part of Johnson & Johnson Family of Companies)	www.depuysynthes.com
Episode Solutions	
European Spine Journal	
Excelsius Angel Partners, LLC	
FloSpine	
Fuse Medical	
FzioMed, Inc.	www.fziomed.com
Globus Spine	
Innovasis, Inc.	www.innovasis.com
International Spine & Orthopedic Institute, LLC	
K2M, Inc.	www.k2m.com
Lattice Biologics, Inc.	www.latticebiologics.com
Longitude Capital Management	
Massively Parallel Technologies	
Medacta USA	
Medtronic, Inc.	www.medtronic.com
MiMedx	www.mimedx.com
Misonix	www.misonix.com
Nanovis	
NeoSpine	
Nexus Medical Reviews	
Nocimed	www.nocimed.com
NuVasive	www.nuvasive.com
Orthofix Spine (Orthofix Holdings, Inc.)	www.orthofix.com
Osprey Biomedical Corp.	www.ospreybiomedical.com

PDP Holdings, LLC & Episode Solutions	www.pdpholdings.com
Pingadr/Medelinc	
PorOsteon, Inc.	
Premia Spine	
ProTransit Nanotherapy	www.protransitnanotherapy.com
Providence Medical	
Quadrant Biosciences	
Reiley Pharmaceuticals	
Relievant Medsystems, Inc.	www.relievant.com
Replication Medical, Inc.	www.replicationmedical.com
RTI Surgical	
Safe Orthopedics	
SeaSpine	
SI Bone, Inc.	www.si-bone.com
Silony Spine	
Silver Bullet Therapies	
Simplify Medical	
Sites Medical	
SMC Biotechnology, Inc.	
Spinal Kinetics, Inc.	www.spinalkinetics.com
Spinal Simplicity	
SpineUp	
SpineWelding AG	www.spinewelding.com
St. Jude Medical, Inc.	www.sjm.com
Stimwave	
Stratera Spine	
Stryker Spine	www.stryker.com
Tenon Medical, Inc.	
Texas Health Rockwall MOB 2	
Theracell, Inc./DermOQ	www.theracellinc.com
Theragen	
Titan Spine	
TRAK Surgical, Inc.	
Vertebral Technologies, Inc.	
Woven Orthopedic Technologies	www.wovenorthopedics.com
Zimmer Biomet	www.zimmerspine.com

We hope this helps clarify the nature of our involvement in research and development leading to advances in neck and back care. We are very proud to be leaders in technological innovation that results in better patient care.

Texas Back Institute Doctors: Invested in Your Care

Facility Relationships

Many of the physicians at the Texas Back Institute have financial interests in facilities and providers in North Texas. These facilities and our physicians are committed to providing clinical excellence to our patients in a safe, high quality environment. Their financial interest in these facilities often provides them a voice in administration and in clinical and operational policies. This involvement helps to ensure the highest level of patient care and customer service. Patients of the Texas Back Institute always have the option of utilizing an alternate health care facility or provider. Please ask one of our representatives for a list of alternate facilities. TBI physicians welcome any questions regarding this aspect of their patient's care.

The following is list of providers with whom TBI, a TBI affiliate, or one or more TBI physicians have a financial interest:

- Baylor Scott & White Medical Center at Frisco
- Baylor Scott & White Medical Center at Uptown
- Baylor Scott & White Surgicare of Denton
- Enter Health
- Legacy Physiatry
- Mansfield Surgery Plaza, LLC
- Medical City Denton
- Medical City Plano
- Methodist McKinney Hospital
- Oak Point Surgical Suites
- Patient Physician Network
- Plano Medical Center, LLP (same as Texas Health Center for Diagnostics & Surgery)
- Rockwall Regional (same as Texas Health Presbyterian Hospital of Rockwall)
- Syzygy Medical, Inc.
- Texas Health Presbyterian Plano Center for Diagnostics & Surgery (same as Plano Medical Center)
- Texas Health Presbyterian Hospital of Flower Mound
- Texas Health Presbyterian Hospital of Rockwall (same as Rockwall Regional)
- Texas Health Surgery Center Rockwall
- United Surgical Partners
- Up and Open Imaging

Texas Back Institute Doctors: Invested in Your Future

Patients of the Texas Back Institute always have the option of utilizing an alternate health care facility or provider. TBI physicians welcome any questions regarding this aspect of their patient's care.

Please sign below acknowledging receipt of this disclosure:

_____ _____

Patient's Signature Date