TYPE OF VISIT:

◯ New Patient ◯ Work Comp ◯ Established

FIELDS IN RED ARE REQUIRED

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

DOB: ______ / ______ / ______ SSN: ____________________

Address

Number: ____________________ Street: ____

City: ____________________ State: ______________ Zip: ______________

Mailing Address: (If different than above address) ____

____

Cell Phone: ____________________ Home Phone: ____________________

Work Phone: ____________________ Email: ____________________

Who referred you to our office? ____________________ Phone Number: ____________________

Who is your primary care doctor? ____________________ Phone Number: ____________________

Location of primary care doctor: ____________________

Who is your cardiologist? ____________________ Phone Number: ____________________

Who is your oncologist? ____________________ Phone Number: ____________________

Emergency Contact: ____________________ Phone Number: ____________________ Relationship: ____________

◯ Male ◯ Female

Marital Status: ◯ Married ◯ Single ◯ Other: ______________

Race: ◯ Caucasian ◯ Black ◯ Hispanic ◯ Asian ◯ Native American ◯ Other: __________

Ethnicity: ◯ Hispanic ◯ Non-Hispanic/Non-Latino ◯ Other/ Non-determined

Languages Spoken: ☐ English ☐ Spanish ☐ Other:

Occupation: ______________________________ Employer: _________________________ Phone: __________________

Does this visit pertain to a workers compensation injury or a personal injury? ◯ Yes ◯ No If Yes,

Date of Injury: ____________________ Claim #: _________________________ Adjuster name: _____________________

Phone: __________________________

Is there a lawsuit planned, relating to your problem or injury, whether it be from a workers compensation claim or motor vehicle accident? ◯ Yes ◯ No

INSURANCE INFORMATION

Primary Insurance: ____________________________

Subscriber ID #: ______________________________

Group #: ____________________________________

Primary Card Holder: ◯ Self or ◯ Spouse ◯ Parent ◯ Other: ________________

Name of Policy Holder: _________________________

Date of Birth of Policy Holder: ______ / ______ / _______

CoPay: $ ___________________

Secondary insurance: _______________________________

Subscriber ID #: ___________________________________

Group #: ____

Secondary Card Holder: ◯ Self or ◯ Spouse ◯ Parent ◯ Other: ________________

Name pf Policy Holder: ______________ ___ _____

Date of Birth of Policy Holder: ______ /________ / ________

Besides regular mail, I authorize Texas Neurosurgery to contact me by the following methods:

☐ Cell Phone ☐ Text Messaging ☐ Home Phone ☐ None

Sign: ____ Date: ______ / _________ / __________

Patient name: ____ Date: ______ / _________ / __________

Texas Neurosurgery, L.L.P.

Patient Name: ____________________ DATE: ___ / ___ / ___

THE REASON FOR YOUR VISIT:

PHARMACY INFORMATION

PREFERRED PHARMACY: ____________________ PHONE #: ____________________

PHARMACY ADDRESS: ____________________

MEDICATION ALLERGIES

No Known Drug Allergies Yes I have known Drug Allergies (Please list name and symptoms)

1.
2.
3.

No Other Allergies (latex, contrast or adhesives..) Yes I have Other Allergies to things like latex, contrast or adhesives (Please list name and symptoms)

1.
2.

CURRENT MEDICATIONS/SUPPLEMENTS

LIST ALL THE CURRENT MEDICATIONS, SUPPLEMENTS, AND OVER THE COUNTER MEDS YOU ARE TAKING

NAME:	DOSE	FREQUENCY	REASON PRESCRIBED:

I understand that prescription refills should be handled at the time of the office visit whenever possible. It is my responsibility to know when my prescription is about to run out. A good rule of thumb is to always have at least a three day supply in hand. Medication refills are only handled during regular business hours and will not be addressed after business hours or on weekends.

Signature of Patient/Guardian: ____________________ DATE: ____ / ____ / ____

Texas Neurosurgery, L.L.P.

Patient Name: ______________________ Date: ____ / ____ / ____

REVIEW OF SYSTEMS AND PAST FAMILY SOCIAL HISTORY

ROS Does the patient currently have any of these issues? Please choose yes or no

System		Item		Item		Item		Item	
Constitutional	No to all	Fatigue	No Yes	Fever/Chills	No Yes	Weight Gain	No Yes	Weight Loss	No Yes
Neurologic	No to all	Seizures	No Yes	Dizziness/Vertigo	No Yes	Headaches	No Yes		
Musculoskeletal	No to all	Joint Pain	No Yes	Back/Neck Pain	No Yes	Morning Stiffness	No Yes		
Skin	No to all	Rash	No Yes	Ulcers/Lesions	No Yes				
Pulmonary	No to all	Short of Breath	No Yes	Wheezing	No Yes	Cough	No Yes		
Cardiology	No to all	Chest Pain	No Yes	Palpitations	No Yes	Irregular Heart Beat	No Yes		
		Swelling	No Yes						
Gastrointestinal	No to all	Diarrhea	No Yes	Nausea/Vomiting	No Yes	Abd Pain/Blood in Stool	No Yes		
Genitourinary	No to all	Freq Urine	No Yes	Pain Urinating	No Yes	Burning with Urination	No Yes		
Eyes/Ears/Nose	No to all	Nasal Drainage	No Yes	Change of Vision	No Yes	Loss Of Hearing	No Yes		
Mouth and Throat	No to all	Sore Throat	No Yes	Tooth Ache	No Yes				
Hematologic	No to all	Easy Bruising	No Yes	Easy Bleeding	No Yes				
Psychiatric	No to all	Anxiety	No Yes	Depression	No Yes				

If you checked yes to any of the above, are you under treatment for this issue with a physician? No Yes

If so, who is the physician treating you? ______________________

PFSH Has the patient or family member ever been diagnosed with any of the following medical conditions?

	FAMILY MEMBERS ☐ No to all	PATIENT ☐ No to all	IF YES FOR PATIENT, PLEASE COMMENT
Heart Disease (CAD)	○ No ○ Yes	○ No ○ Yes	
Diabetes	○ No ○ Yes	○ No ○ Yes	
Stroke	○ No ○ Yes	○ No ○ Yes	
Cancer	○ No ○ Yes	○ No ○ Yes	
Coagulation Defects	○ No ○ Yes	○ No ○ Yes	
DVT (Blood Clots) in legs	○ No ○ Yes	○ No ○ Yes	
Anemia	○ No ○ Yes	○ No ○ Yes	
Hepatitis / HIV	○ No ○ Yes	○ No ○ Yes	
High Blood Pressure	○ No ○ Yes	○ No ○ Yes	
Kidney Disease	○ No ○ Yes	○ No ○ Yes	
Lung Disease or Asthma	○ No ○ Yes	○ No ○ Yes	
Sleep Apnea	○ No ○ Yes	○ No ○ Yes	
Stomach Ulcers	○ No ○ Yes	○ No ○ Yes	
Colitis	○ No ○ Yes	○ No ○ Yes	
Rheumatoid /Osteoarthritis	○ No ○ Yes	○ No ○ Yes	
Lupus	○ No ○ Yes	○ No ○ Yes	
Epilepsy or History of Seizures	○ No ○ Yes	○ No ○ Yes	
Depression /Anxiety Disorders	○ No ○ Yes	○ No ○ Yes	

If you checked yes to any of the above, are you under treatment for this issue with a physician? ○ No ○ Yes

If so, who is the physician treating you? __________

PRIOR SURGERIES	PRIOR HOSPITALIZATIONS
Please list any surgeries you have had	Please list any hospitalizations you have had

Signature of Patient/Guardian: __________ DATE: ___ / ___ / ____

Texas Neurosurgery, L.L.P.

Patient Name: ____ DATE: __ / __ / __

SOCIAL HISTORY AND OTHER HEALTH RELATED ISSUES

○ Right Handed ○ Left Handed Height: ____ Weight: ____

Tell me about your smoking/tobacco history:

- Are you current smoker? ○ Yes ○ No
- Do you smoke ○ cigarettes ○ smoke a pipe ○ snuff user ○ N/A

  If yes, How often and how much? ____

- Have you ever smoked? ○ Yes ○ No

  If yes, How often and how much? ____

Alcohol Use/Screening:

- Do you drink alcohol? ○ Yes ○ No
  - Do you drink ☐ Wine ☐ Beer ☐ Liquor ☐ N/A
  - Have you had a drink containing alcohol in the past year? ○ Yes ○ No ○ N/A
- If yes, how often did you have a drink containing alcohol in the past year?

  ○ N/A

  ○ Monthly or less

  ○ 2 to 4 times a month

  ○ 2 to 3 times a week

  ○ 4 or more times a week
- If yes, how many drinks did you have on a typical day when you were drinking in the past year?

  ○ N/A ○ 1 to 2 drinks ○ 3 or 4 drinks ○ 5 or 6 drinks ○ 7 to 9 drinks ○ 10 or more drinks
- If yes, how often did you have 6 or more drinks on one occasion in the past year?

  ○ N/A ○ Less than monthly ○ Monthly ○ Weekly ○ Daily or almost daily

Blood Products/Transfusions:

Do you have any objections to receiving blood or blood products? ○ No ○ Yes

Drug Usage

Do you now or have you ever used drugs ○ Yes ○ No

If Yes Explain ____

Vaccination information:

- Have you had a flu shot? ○ Yes ○ No
- If so, when did you have it? [ ]

- If over 65, have you had a pneumonia vaccine? ○ Yes ○ No
- If so, when did you last have one? [ ]

Falls: Risk Assessment:

- If over 65, have you had any falls in the past year? ○ Yes ○ No
- If Yes, Please check one of the following about your fall?

○ One fall with injury in the past year

○ Two or more falls with injury in the past year

○ One fall without injury in the past year

○ Two or more falls without injury in the past year

Diabetes:

- Do you have diabetes? ○ Yes ○ No
- If Yes, when was your last foot exam? (Enter N/A if not sure) [ ]

Ischemic Vascular Disease and Aspirin Use:

- Have you had an MI, CABG, or coronary interventions? ○ Yes ○ No
- If Yes, do you take aspirin? ○ Yes ○ No

Coronary Artery Disease & Prior Myocardial Infraction or Left Ventricular Dysfunction:

- Do you have coronary artery disease? ○ Yes ○ No
- If Yes, do you take a Beta Blocker? ○ Yes ○ No

Imaging and Low back Pain Diagnosis:

- Have you been diagnosed with lower back pain? ○ Yes ○ No
- If Yes, within 28 days of your diagnosis? ○ Yes ○ No
- Do you have a plain X-ray? ○ Yes ○ No MRI? ○ Yes ○ No CT Scan? ○ Yes ○ No

Signature of Patient/Guardian: [ ] DATE: [ ] / [ ] / [ ]

PHYSICIAN ONLY

I have reviewed the listed ROS/PFSH/Screening with the patient and noted the positive/negative findings for this visit.

SIGNATURE OF MD: ______________________ DATE: ______________

Texas Neurosurgery, L.L.P.

RELEASE OF INFORMATION TO OTHERS(HIPAA)

Often times following office/hospital consultations or surgery, it might be necessary for spouse, family members, or others to receive/obtain medical health information or advice on your behalf. Please list two individuals who are authorized to receive/obtain information from Texas Neurosurgery. Texas Neurosurgery reserves the right to contact or speak to others not listed in an emergency situation.

What level of information can we release?

- All information including office notes, operative reports and radiology reports and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).
- Only test results, post operative care and medications

To whom can we release information (please list names):

Name	Phone=	Relationship to Patient

- No one except the patient can obtain information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

Signature of Patient/Guardian: ______________________ DATE: ____ / ____ / ____

FINANCIAL POLICY

Texas Neurosurgery, LLP requires payment in full for any amounts that are the patient's responsibility at the time services are rendered. This includes co-pays, co-insurance, and/or deductible amounts. Once your claim is processed by your insurance company, any additional amounts owed will be billed to you. If the patients estimated amount due results in an overpaid claim, then a refund will be processed once all claims are settled and there is no additional amounts owed by the patient.

You are responsible for knowing the specific rules of your insurance carrier. If your insurance carrier requires a referral, it is your responsibility to work with your primary care physician to obtain this referral prior to your scheduled appointment. If we do not have your referral number the day prior to your appointment, then you will be contacted to reschedule your appointment. If you are seen by one of our physicians without a valid referral, then all charges will be responsibility of the patient.

Texas Neurosurgery, LLP does not accept Letters of Protection and we do not file claims with automotive insurance companies.

Failure to provide your current insurance information prior to services being rendered may result in denial of your claim. We assist our patient's in receiving reimbursement from your insurance company, however please understand that you, the patient, have the final responsibility for your bill.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which i am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Texas Neurosurgery, LLP.

I have read and understand the Texas Neurosurgery Financial Policy. My signature indicates compliance and understanding of this policy.

Signature of Patient/Guardian: ____________________ DATE: ____ / ____ / ____

Texas Neurosurgery, L.L.P.

Patient Name: DATE: / /

MEDICATION REFILL

Medication Refill Policy

Medication refills are only handled during regular office hours. Please allow 24 hours for us to process your refill request, as your doctor and physician assistant may be in surgery all day. Prescription refills faxed or called in after 3:30 PM may not be processed until the next business day. It is your responsibility to know when you prescription is about to run out. A good rule of thumb is to have at least a three day supply on hand. MEDICATION REFILLS WILL NOT BE ADDRESSED AFTER HOURS OR ON WEEKENDS.

Effective October 6, 2014

Due to a change in Federal Regulations, the DEA has moved Hydrocodone Combination Products to a more restrictive Schedule II class. All medications that contain hydrocodone will become Schedule II controlled substances. A new, written prescription from your prescriber is required every time you need a hydrocodone prescription filled, no exceptions. Therefore, Texas Neurosurgery **is no longer able to "call in" new prescriptions or refills for Hydrocodone**.

With this new law in place, Texas Neurosurgery has made updated protocols to the prescribing of Hydrocodone.

1). Patients must pick up their RX in the office. We will only mail Hydrocodone prescriptions to the patients that live 100 miles away or under extenuating circumstances. Please use the medication as it is prescribed by the doctor. Any early refill request will be denied.

2). The physician will continue to only refill Hydrocodone for a maximum of 90 days following surgery. If the patient feels that they still need the pain medications after 90 days of surgery, then we will refer the patient to pain management.

3). For the patients that have had a microdiskectomy, laminectomies, and one level ACDF's, we will wean the patients to Tramadol which usually takes place at their first post-operative appointment. Your first post-operative appointment is 10-14 days after surgery. This will be determined on a case by case basis.

Signature of Patient/Guardian: DATE: / /

Texas Neurosurgery, L.L.P.

Patient Name: ______________________ DATE: ___ / ___ / ___

PHYSICIAN/PHYSICIAN ASSISTANT CONSENT FOR TREATMENT FORM

Texas Neurosurgery is committed to providing the highest quality of healthcare. Our practice is centered on each patient who walks into our office. In order to assist you with your healthcare needs, our practice has dedicated physician assistants who work closely with the physicians so you can receive the best possible healthcare in an efficient and timely manner. The physicians and their physician assistants are here to provide you with a complete understanding of your condition and to offer you the best personalized care possible.

A physician assistant is not a doctor, however they are healthcare professional's licensed by the state board to practice medicine with supervision by a licensed physician. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and responsibility for the medical services provided.

Services provided by our physician assistant may include:

- Obtaining histories and performing physical exams.
- Ordering diagnostic procedures.
- Formulation of a working diagnosis.
- Developing and implementing a treatment plan.
- Monitoring the effectiveness of therapeutic interventions.
- Assisting in surgery.
- Counseling and education.
- Writing prescriptions (where allowed by law).
- Making appropriate referrals

I have read the above and hereby consent to the services of the physicians and physician assistant here at Texas Neurosurgery for my health care needs.

Signature of Patient/Guardian: ______________________ DATE: ___ / ___ / ___

Texas Neurosurgery, L.L.P.

Patient Name: ____________________ DATE: ____ / ____ / ____

PRIVACY POLICY

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence**.
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:

- was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
- is not part of your medical or billing records;
- is not available for inspection as set forth above; or
- is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.

1. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:

- to carry out treatment, payment and health care operations as provided above;
- to persons involved in your care or for other notification purposes as provided by law;
- to correctional institutions or law enforcement officials as provided by law;
- for national security or intelligence purposes;
- that occurred prior to the date of compliance with privacy standards (April 14, 2003);
- incidental to other permissible uses or disclosures;
- that are part of a limited data set (does not contain protected health information that directly identifies individuals);
- made to patient or their personal representatives;
- for which a written authorization form from the patient has been received

1. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
2. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Lisa Crooks, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Texas Neurosurgery or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Texas Neurosurgery, LLP
Lisa Crooks
Privacy Officer
3600 Gaston Ave., Suite 907
Dallas, Texas 75246
Tel: 214-823-2052
214-823-3797

Patient Name: ____________________ DATE: ____ / ____ / ______

Texas Neurosurgery, L.L.P.

Patient Name: ______________________ DATE: ____ / ____ / ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I here by acknowledge I have received a copy of Texas Neurosurgery, L.L.P.'s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient/Guardian: ______________________ DATE: ____ / ____ / ____

Printed name of Patient's Representative (if applicable)

Relationship to Patient (If applicable)

- Parent or guardian of unemancipated minor
- Court appointed guardian
- Executor or administrator of decedent's estate
- Power of attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices on the following date, --------------------------------- but acknowledgement could not be obtained because:

- Patient/representative refused to sign it.
- Emergency situation prevented us from obtaining acknowledgment at this time.(will try at later date).
- Communication barrier prohibited from obtaining (explain).

- Other(specify)

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you.

Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

Signature of Patient/Guardian: ______________________ DATE: ____ / ____ / ____