TEXAS NEUROSURGERY, L.L.P

We want to advise you that sending health information to an unsecure email can place the information at risk of being read or accessed by someone else. If you do not want to return this form by email, then please fax completed forms to our secure fax number 214-823-3797 *before* your scheduled appointment date.

PATIENT INFORMATION

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (If different than physical address)

_____

Sex: ☐Male ☐Female ☐Transgender

Marital Status: ☐Single ☐Divorced ☐Married ☐Partnered ☐Widowed ☐Legally Separated ☐Other

Race: ☐American Indian ☐Asian ☐Native Hawaiian ☐Black or African American ☐White ☐Hispanic ☐Other Race

Language: ☐English ☐Spanish ☐Other _____

Employer: _____ Occupation: _____

Home Phone: _____

☐This is my preferred number
May we leave personal/medical information on your voicemail
☐Yes ☐No

Cell Phone: _____

☐This is my preferred number
May we leave personal/medical information on your voicemail
☐Yes ☐No

Work Phone: _____

Email Address:

_____

INSURANCE COVERAGE

Primary Insurance

Carrier: _____

ID #: _____

Group #: _____

Primary Card Holder: ☐Self ☐Spouse/Partner ☐Parent ☐Other

Name of Insured: _____

Insured's Date of Birth: _____

Secondary Insurance ☐**Self Pay**

☐ No Secondary Coverage

Carrier: _____

ID #: _____

Group #: _____

Secondary Card Holder: ☐Self ☐Spouse/Partner ☐Parent ☐Other

Name of Insured: _____

Insured's Date of Birth: _____

Does this visit pertain to a worker's compensation injury, personal injury, or motor vehicle accident? ☐ Yes ☐ No

Date of Injury: _____

Adjuster: _____

Claim Number: _____

Phone Number: _____

Name: _____ DOB: _____

EMERGENCY CONTACTS

Primary Emergency Contact

☐I authorize ☐I do **NOT** authorize
the discloser of my protected health information (PHI) to
the person listed as my Primary Emergency Contact.

Name: _____

Phone Number: _____

Relationship: ☐Spouse ☐Partner ☐Sibling ☐Parent
☐Child ☐Friend ☐Other: _____

Secondary Emergency Contact

☐I authorize ☐I do **NOT** authorize
the discloser of my protected health information (PHI) to
the person listed as my Primary Emergency Contact.

Name: _____

Phone Number: _____

Relationship: ☐Spouse ☐Partner ☐Sibling ☐Parent
☐Child ☐Friend ☐Other: _____

CIRCLE OF CARE

Referring Provider: _____ Phone Number: _____

Primary Care Provider: _____ Phone Number: _____

Cardiologist: _____ Phone Number: _____

Oncologist: _____ Phone Number: _____

Pain Management _____ Phone Number: _____

HOW DID YOU HEAR ABOUT US?

☐Physician/ Provider Referral ☐Family or Friend ☐Website or Search Engine ☐Other _____

PHARMACY

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

MEDICATION ALLERGIES

☐ No Known Drug Allergies

Are you allergic to any of the following? ☐**Latex** ☐**Adhesives** ☐**Contrast**

Name: _____ DOB: _____

CURRENT MEDICATIONS (Please include all Supplement(s), Over the Counter and Prescribed Medications)

Prescription Name	Dose	Frequency	Reason Prescribed

REVIEW OF SYSTEMS

Do you currently have any of the following symptoms? (Within the last 6 months) ☐No Issues

☐Anxiety	☐ Dizziness/Vertigo	☐ Irregular Heartbeat	☐ Seizures	☐ Urinary: Frequent
☐ Back Pain	☐ Easy Bleeding	☐ Joint Pain	☐ Shortness of Breath	☐ Urinary: Painful
☐ Burning w/ Urination	☐ Easy Bruising	☐ Morning Joint Stiffness	☐ Sinus Drainage	☐ Visual Changes
☐ Chest Pain	☐ Fatigue	☐ Nausea	☐ Sore Throat	☐ Vomiting
☐ Cough	☐ Fever/ Chills	☐ Neck Pain	☐ Swelling	☐ Weight Gain
☐ Depression	☐ Headaches	☐ Palpitations	☐ Toothache	☐ Wheezing
☐ Diarrhea	☐ Hearing Loss	☐ Rash	☐ Ulcers/ Lesions	

PATIENT AND FAMILY HISTORY

Personal History

Please place an X in the box if you have been diagnosed with any of the following medical conditions.

☐Anemia	☐Depression	☐Hepatitis	☐Lupus
☐Anxiety Disorder(s)	☐Diabetes Type I	☐ High Blood Pressure	☐ Osteoarthritis
☐Asthma	☐Diabetes Type II	☐ HIV	☐ Rheumatoid
☐Cancer: Type: _____	☐DVT (Blood Clots)	☐ Kidney Disease	☐ Sleep Apnea
☐Coagulation Defects	☐Epilepsy/Seizures	☐ Low Blood Pressure	☐ Stomach Ulcers
☐Colitis	☐Heart Disease	☐ Lung Disease	☐ Stroke

Name: _____ DOB: _____

Family History

Please place an X in the box if one of your immediate family members have been diagnosed with any of the following medical conditions.

☐Anemia	☐Depression	☐Hepatitis	☐Lupus
☐Anxiety Disorder(s)	☐Diabetes Type I	☐ High Blood Pressure	☐ Osteoarthritis
☐Asthma	☐Diabetes Type II	☐ HIV	☐ Rheumatoid
☐Cancer: Type: _____	☐DVT (Blood Clots)	☐ Kidney Disease	☐ Sleep Apnea
☐Coagulation Defects	☐Epilepsy/Seizures	☐ Low Blood Pressure	☐ Stomach Ulcers
☐Colitis	☐Heart Disease	☐ Lung Disease	☐ Stroke

SOCIAL HISTORY

Height: _____ **Weight:** _____ ☐ Right-Handed ☐Left-Handed

Advanced Directive

Do you have a living will? ☐ Yes ☐ No

Do you have a DNR (Do Not Resuscitate)?

If **YES**, will you please provide our office with a copy for your chart. ☐ Yes ☐ No

Blood Products/ Transfusions

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

Vaccination Information

Have you had a flu shot? ☐ Yes ☐ No

If **YES**, when was your last shot? _____

If over 65, have you had a pneumonia vaccine?

If **YES**, when was your last shot? _ _____

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 have a pacemaker? ☐ Yes ☐ No

If YES, do you take a Beta Blocker? ☐ Yes ☐ No

Fall: 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 ☐ One fall without injury in the past year

☐ Two or more falls with injury in the past year ☐ Two or more falls without injury in the past year

Smoking/ Tobacco History

Have you ever smoked? ☐ No ☐Yes If **YES**, how often and how much? _____

Are you currently a smoker? ☐ No ☐ Yes If **YES**, how often and how much? _____

What type of tobacco do you smoke? ☐ N/A ☐ Cigarettes ☐ Pipe ☐ Snuff

If you quit smoking, when? _____

Name: _____ DOB: _____

Alcohol Use

Have you had an alcoholic drink in the past year? ☐ Yes ☐ No

Do you currently drink alcohol? ☐ Yes ☐ No

If YES, what type of alcohol consumed in the past year

☐ Beer ☐ Wine ☐ Liquor

If YES, how often did you have an alcoholic drink in the last year?

☐ Once a month or less ☐ 2 to 3 times a month

☐ 2 to 4 times a month ☐ 4 or more times a week

If YES, how many drinks did you have on a typical day when you drank in the past year?

☐ N/A ☐ 3 to 4 drinks ☐ 7 to 9 drinks

☐ 1 to 2 drinks ☐ 5 to 6 drinks ☐ 10 or more

If YES, how often did you have 6 or more drinks on one occasion in the past year?

☐ N/A ☐ Monthly ☐ Daily or Almost Daily

☐ Less than a month ☐ Weekly

Drug Usage

Do you now or have you ever used recreational drugs? ☐ Yes ☐No

If yes, please explain: _____

_____

_____

PRIOR SURGERIES/ PRIOR HOSPITALIZATIONS

Prior Surgeries	Prior Hospitalizations (Location & Why)

PHYSICIAN ONLY SECTION

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

M.D. Signature: _____ **Date of Service:** _____

Name: _____ DOB: _____

REASON FOR VISIT

☐New Patient ☐Second Opinion ☐Established Patient with New Symptoms

Symptoms: _____

CONSERVATIVE THERAPY

Your insurance may require conservative therapy before approving surgery. The following information will help with the approval of any diagnostic test to be ordered or surgery if needed

Have you had to use a: ☐Cane ☐Wheelchair ☐Walker

Have you tried: ☐Heat ☐Ice ☐Home Exercises ☐Massage

Diagnostic Imaging: (Within a year from Appointment Date)
☐No Current Imaging

☐ Yes X-Ray(s) ☐Cervical ☐Thoracic ☐Lumbar ☐Wrist ☐Other Facility/Location: _____

☐ Yes CT ☐Cervical ☐Thoracic ☐Lumbar ☐Brain ☐Wrist ☐Other Facility/Location: _____

☐ Yes MRI(s) ☐Cervical ☐Thoracic ☐Lumbar ☐Brain ☐Wrist ☐Other Facility Location: _____

☐Yes ☐No **Medication Only** Type: ☐NSAID(s) ☐Steroid(s) ☐ Muscle Relaxer(s) ☐ Anti-Inflammatory(s)
☐Other: _____

☐Yes ☐No **Physical Therapy** Facility/Location: _____

☐Yes ☐No **Chiropractic Care** Physician Name: _____

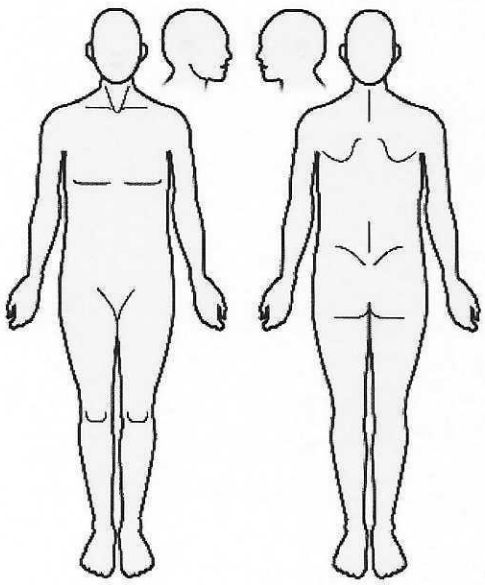
☐Yes ☐No **Pain Management** Physician Name: _____

☐Yes ☐No **Epidural Steroid Injections** ☐Cervical ☐Thoracic ☐Lumbar **Facet Injections:** ☐Yes ☐No

Other Procedure(s) or Treatment(s): _____

Have you missed work for this condition? ☐ Yes ☐ No

PAIN DIAGRAM



Mark these drawings according to where you hurt. Please include all affected areas.

How long have you experienced this pain? _____

Please indicate your pain level now:

No pain 1 2 3 4 5 6 7 8 9 10

If there are multiple locations of pain, please rate each pain on the body diagram.

Texas Neurosurgery, LLP
3600 Gaston Ave, Ste 907
Dallas, Texas 75246

Your Information.
Your Rights.
Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
    - *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
    - *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
    - *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective 04/01/2019

This Notice of Privacy Practices applies to the following organizations.

If you are a patient of an ACO in which we participate, we will share your medical information with other providers via a Health Information Exchange (HIE).

Lisa Crooks
Privacy Officer
Texas Neurosurgery, LLP
Tel: 214-823-2052
Fax: 214-823-3797

TEXAS NEUROSURGERY, L.L.P

FINANCIAL POLICY

Texas Neurosurgery, LLP requires payment in full for any amounts that are the patient's responsibility at the time of services are rendered. This includes co-pays, co-insurance, and /or deductible amounts. Once your claim is processed by your insurance company, any additional amount owed will be billed to you. If the patient's estimated amount due results in an overpaid claim, then a refund will be processed once all claims are settled and there are 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 obtain from your primary care physician prior to your scheduled appointment. If we do not have your referral 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 (LOP), 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 patients with 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.

DISCLOSURE OF PHYSICIAN'S OWNERSHIP INTEREST

Due to your physician's concern over improving the quality of care and controlling the cost of medical procedures, he, along with a number of other physician's has invested in hospitals, and/or other entities where you may be referred for care:

Methodist Hospital for Surgery	**Addison, Texas**
Baylor Medical Center at Uptown	**Dallas, Texas**
Mid Central Neuro Affiliates	**Dallas, Texas**

This investment provides your physician an opportunity to be actively involved in the quality control over your medical procedures and to ensure that your medical costs are reasonable. Your physician's ownership interest in these entities does mean that your physician may benefit financially through these entities. Due to this, your physician hereby advises you that you have the right to choose to be treated at some other facility at which they provide services. Your physician will make arrangements for such an alternative should you so desire.

PATIENT REFERRAL

To serve you with the highest care quality, sometimes it is necessary to have other care providers join our team to complete or continue your medical procedures or treatment. We would like to keep you informed about any referrals to care providers who may be in or out-of-network. Should this Practice or physician refer me to a physician or non-participating provider out of the preferred provider panel, this Practice or physician will disclose to me that the referral is out of the preferred provider panel and any ownership interest. I understand this Practice or my physician is not restricted from referring me to an out-of-network provider, and I may have more out-of-pocket costs from a non-participating provider.

TEXAS NEUROSURGERY, L.L.P

Medication Policy

The following guidelines are intended for your safety and meeting your medication needs in an efficient manner

- Take medication(s) only as prescribed
- Choose only one pharmacy for all of your medications
- To protect your health: Notify our office of all medication changes by other physicians, as this can be a potentially dangerous situation.
- Lost, stolen, or misplaced medications are replaced only with a clinic visit.
- We **do not** prescribe long term medications. Patients requiring long term pain medication will be referred to a pain management specialist or back to your referring physician.

Refill(s)

- Medication refills are only handled during regular office hours.
- Please allow three business days for us to process your refill request
- Prescription refills received at 3:30 may not be processed until the next business day
- Call your pharmacy directly for medication refills
- Instruct pharmacy to fax all request to 214-823-3797
- Early refills will not be honored for any reason

MEDICATION REFILLS WILL NOT BE ADDRESSED AFTER HOURS OR ON THE WEEKEND.

Controlled Substance Medication(s)

- As a scheduled II drug, patients must present a new prescription to the pharmacist each time the medication is filled.
- You will have to be seen in the office before any narcotics will be refilled and per law they can only be written for a 10 day supply.
- I understand that I am responsible for the narcotic prescribed for peri-operative pain management. If prescription is lost, stolen or inappropriately used, it will not be replaced.
- I will not seek narcotic prescriptions or refills from a different provider unless referred to a specific pain management clinic, who from that point forward, will take care of my narcotic needs.
- I understand that if I violate any of the above, my prescriptions may be cancelled immediately.
- I have been made aware of the potential side effects of narcotic over-use, including dependence, tolerance, addiction, and withdrawal.

Formulary Benefits Data Consent

Formulary Benefits Data are maintained for health insurance providers by organizations knowns as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibility are processing and paying prescriptions drug claims. They also develop and maintain formularies, which are list of dispensable drugs covered by a particular drug benefit plan. We may need access to your data as maintained by PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan. This consent will enable Texas Neurosurgery to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with a preference rank (if available) within drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies

TEXAS NEUROSURGERY, L.L.P

PHYSICIAN ASSISTANT INFORMATION GUIDE

Texas Neurosurgery, LLP 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 (PA) is a healthcare professional licensed to practice medicine with supervision by a licensed physician. A physician assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of healthcare services that are traditionally performed by a physician.

Physician Assistants exercise autonomy in medical decision making as determined by their supervising physician. Physician Assistants are educated in the medical model designed to complement physician training.

Under the supervision of the 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, by rather overseeing the activities 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
- Making appropriate referrals

Name: _____ DOB: _____

TEXAS NEUROSURGERY

ACKNOWLEDGEMENT FORM

By signing my name below, I: _____

- Consent to receive the following documents electronically which are available through our website unless I request a non-electronic paper copy of the documents disclosed herein.
  - Texas Neurosurgery's Notice of Privacy Practice
  - Texas Neurosurgery's Financial Policy
  - Texas Neurosurgery's Discloser of Physician Ownership
  - Texas Neurosurgery's Medication Policy/ Agreement
  - Texas Neurosurgery's Physician Assistant Information Guide

- Authorize:
  - The release of any medical and/or other information necessary to process my claim(s)
  - Payment of medical benefits to my treating physician or supplier for services rendered by Texas Neurosurgery.

- **I have read and understand/agree to abide by all the above policies of Texas Neurosurgery.**

_____ _____

Patient/ Guardian Signature **Date**