NEW PATIENT WELCOME LETTER

Patient Name: ______________________________

Appointment: ____________, ______________, ____________
Day Date Time

Doctor: *Richard L. Harper, M.D.* *Alfonso E. Aldama, M.D.* *Andrew C. Roeser, M.D.*
Taylor L. Gist, M.D. *Loyola V. Gressot, M.D.* *Jonathan N. Sellin, M.D.*

Location:
☐ Medical Center 6560 Fannin St, Scurlock Towers, Suite 1200, Houston, TX 77030

☐ West Houston 18400 Katy Fwy. Medical Building 1, Suite 440, Houston, TX 77094

Dear Patient,

Thank you for choosing our practice for your neurosurgical care. Advance completion of the enclosed forms will help speed the registration process when you come for your appointment. Please **bring your x-ray CD** to your appointment and any other test results.

Between now and your appointment, if your pain or discomfort is intolerable or you develop more significant neurological symptoms, you should call your primary care physician or go to the emergency room.

Please note that it our policy not to refill prescriptions after the initial six week postoperative period. We also will not refill prescriptions on weekends or after office hours. This is due to the risk of making a medication error when the doctor does not have your chart with him. Therefore, please call your prescription refill request to the office Monday through Thursday, between 9:00 a.m. and 4:00 p.m.

Additionally, there are some health problems which cannot be improved by surgery; even when severe. This includes headache, neckache and backache. Our specialty is surgical and we believe the most appropriate care for these non-surgical problems is through your primary care physician.

Thank you again and we look forward to seeing you. Please call us at **713-790-1211** if you need to change or cancel your appointment. *(If it is necessary to bring children, we kindly ask that they be kept quiet and still, as some of our patients are seriously ill.)* **Please note, that we do not accept checks.**

Sincerely,

The Doctors of Neurosurgical Group of Texas, L.L.P.

BRING TO YOUR APPOINTMENT:

- **X-rays/MRI/CT Films**
  (Films preferred, CDs accepted)

- **Medical history form**
  (Enclosed)

- **Insurance card**
  (Referral for HMO)

- **Map on reverse side**

- **We do not accept checks**

PATIENT DEMOGRAPHICS

Date ____________ ☐ **New Patient** ☐ **Update**

☐ Alfonso E. Aldama, M.D. ☐ Richard L. Harper, M.D. ☐ Andrew C. Roeser, M.D.
☐ Taylor L. Gist, M.D. ☐ Loyola V. Gressot, M.D. ☐ Jonathan N. Sellin, M.D.

Name ________________________________ Birthdate ____________
First Middle Last Month Day Year

Address ____
Street City State Zip Country

Age ______ Sex _____ Home Phone (____) ____________ Mobile (____) ____________

Marital Status: ☐ M ☐ S ☐ W ☐ D Email Address ________________________

Employer ________________________ Occupation ________________________

Employer Address ________________________ Work Phone (____) ____________

Spouse/Parent Name ________________________ Birthdate ____________
Parent if Patient is a Minor
Employer ________________________ Occupation ________________________
Employer Address ________________________ Work Phone (____) ____________
Street No. City/State/Zip

EMERGENCY CONTACT ________________________ Day Phone (____) ____________
(Relationship)

Referring Physician ________________________ Phone (____) ____________
Address ____
Street No. City/State/Zip

Primary Care Physician ________________________ Phone (____) ____________
Address ____
Street No. City/State/Zip

Primary source of how you chose us? ☐ My Physician ☐ Someone who was our former patient ☐ Friend
☐ Family Member ☐ Our Website ☐ Internet Search ☐ My Insurance Co. ☐ My Employer

Insurance Information

Medicare Number ________________________
Are you working? ☐ Yes ☐ No

Is this a Workers' Compensation claim? ☐ Yes ☐ No
Date of Injury ____________ Claim No. ____________

____
Policyholder Name **Primary** Insurance Company Policy Number Group Number

____
Policyholder Name **Secondary** Insurance Company Policy Number Group Number

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any Medical or other information necessary to process this claim. I also request payment of Government benefits either to me or to the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned Physician or supplier for services rendered.

SIGNED X ________________________ DATE ____________

SIGNED X ________________________

MEDICAL HISTORY

Patient Name: ______________________________ Today's Date: ______________
Age: ______ Birth date: ______________ Height: ____________ Weight: ______________
What is your reason for visit? ______________________________
Date symptoms began? ______________________________
Is this related to a work injury: ☐ Yes ☐ No Is this related to an automobile accident: ☐ Yes ☐ No
Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
Aggravated by: ______________________________
Relieved By: ______________________________

Spine Check (✓) symptoms you currently have.

Location of Pain

☐ Lower Back
☐ Left Leg
☐ Right Leg
☐ Left Hip
☐ Right Hip
☐ Neck
☐ Left Arm
☐ Right Arm
☐ Left Shoulder
☐ Right Shoulder
☐ Other: ______________________________
☐ No Pain

Radiation of Pain

☐ Left Hip
☐ Right Hip
☐ Left Leg
☐ Right Leg
☐ Left Arm
☐ Right Arm
☐ Right Shoulder
☐ Left Shoulder
☐ Other: ______________________________
☐ No Radiation

Quality of Pain (please choose one or more of the following)

☐ Ache
☐ Diffuse
☐ Localized
☐ Piercing
☐ Stabbing
☐ Burning
☐ Discomforting
☐ Numbness
☐ Sharp
☐ Superficial
☐ Deep
☐ Dull
☐ Throbbing
☐ Shooting

Difficulty with:

☐ Walking
☐ Descending Stairs
☐ Range of motion
☐ Bending
☐ Standing
☐ Ascending Stairs
☐ Sitting

HEAD Check (✓) symptoms you currently have.

Associated Symptoms

☐ Clumsiness
☐ Confusion
☐ Fever
☐ Headache
☐ Hearing Loss
☐ Incoordination
☐ Irritability
☐ Loss of Consciousness
☐ Loss of Sensation
☐ Memory Difficulty
☐ Nausea
☐ Paralysis
☐ Personality Changes
☐ Projectile Vomiting
☐ Prolonged Loss of Consciousness
☐ Restlessness
☐ Seizures
☐ Speech Difficulty
☐ Stiff Neck
☐ Unusual Behavior
☐ Vision Changes
☐ Vomiting
☐ Weakness
☐ No Associated Symptoms

☐ Other: ______________________________

Name: ____________________

Medications List medications you are currently taking

☐ **No medications**

____
____
____
____

Allergies

☐ **No allergies**

____
____
____
____

Preferred Pharmacy: ____________________ **Phone:** ____________________

Review of Systems

Please check **YES** or **NO** and describe if needed.

Constitutional *(fever, chills, weight loss/gain, etc.)*	☐ Yes	☐ No	Describe: ________
Ears *(hearing loss, ringing etc.)*	☐ Yes	☐ No	Describe: ________
Nose *(runny/bloody nose, decreased smell, etc.)*	☐ Yes	☐ No	Describe: ________
Throat *(pain, difficulty swallowing, etc.)*	☐ Yes	☐ No	Describe: ________
Eyes *(loss of sight, glaucoma, cataracts, etc.)*	☐ Yes	☐ No	Describe: ________
Cardiovascular *(chest pain, palpitations, etc.)*	☐ Yes	☐ No	Describe: ________
Respiratory *(shortness of breath, asthma, etc.)*	☐ Yes	☐ No	Describe: ________
Integumentary *(rashes, skin allergies, etc.)*	☐ Yes	☐ No	Describe: ________
Gastrointestinal *(diarrhea/constipation, bloody stool ..)*	☐ Yes	☐ No	Describe: ________
Musculoskeletal *(other than current problem)*	☐ Yes	☐ No	Describe: ________
Hematologic/Lymphatic *(anemia, easy bruising, etc.)*	☐ Yes	☐ No	Describe: ________
Neurologic *(headaches, vertigo, stroke, etc.)*	☐ Yes	☐ No	Describe: ________
Endocrine *(diabetes, thyroid problems, etc.)*	☐ Yes	☐ No	Describe: ________
Psychiatric *(depression, schizophrenia, anxiety, etc.)*	☐ Yes	☐ No	Describe: ________

Conditions Check (✓) conditions you currently have or have had in the past year.

Past medical History

☐ **No medical history**

☐ Anemia	☐ COPD	☐ Migraine Headaches
☐ Angina	☐ Coronary Artery Disease	☐ Multiple Sclerosis
☐ Arrhythmia	☐ Diabetes	☐ Parkinson's Disease
☐ Asthma	☐ Fibromyalgia	☐ Peripheral nerve disorder
☐ Atrial Fibrillation	☐ Hepatitis C	☐ Renal Disease
☐ Blood Clots	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Brain Tumor	☐ Hyperlipidemia	☐ Seizure Disorder
☐ Cerebrovascular Accident	☐ Hypertension	☐ Spinal cord tumor
☐ Cirrhosis	☐ Kidney Failure	☐ Thyroid Disease
☐ Colon Cancer	☐ Liver Disease	☐ Tremor
☐ Congestive Heart Failure	☐ Lung Cancer	☐ Have you had a blood transfusion
☐ Have you had grafted tissues	☐ Do you have Implanted hardware (if yes, please explain below)	

Gender Specific: Male: ☐ Benign Hypertrophic Prostatitis ☐ Prostate Biopsy

Female: ☐ Breast Cancer

IMPORTANT: Please note any health complaints not covered above such as weight loss, rashes, shortness of breath, irregular heartbeats, chest pain, stomach cramps, constipation, blood in stool, urine or sputum; fever or chills etc.

____
____
____

Name: ____________________

Past Surgical Histories

☐ **No surgical history**

Procedure	Year	Procedure	Year	Procedure	Year
☐ Anesthesia reaction	____	☐ Discectomy	____	**Male**	
☐ Aneurysm resection	____	☐ Gastric Bypass	____	☐ Prostate Biopsy	____
☐ Angioplasty with stent	____	☐ Hernia Repair	____	☐ TURP	____
☐ Appendectomy	____	☐ Hip Replacement	____	☐ Vasectomy	____
☐ Arthroscopy knee	____	☐ Knee Replacement	____	**Female**	
☐ Arthrodesis	____	☐ Laminectomy	____	☐ Augmentation Mammo	____
☐ Back Surgery	____	☐ Lasik	____	☐ Bil. Tubal Ligation	____
☐ CABG	____	☐ Muscle Biopsy	____	☐ Breast Biopsy	____
☐ Carotid Endarterectomy	____	☐ ORIF	____	☐ Cesarean Section	____
☐ Carpal Tunnel Release	____	☐ Pacemaker	____	☐ D and C	____
☐ Cataract Extraction	____	☐ Small Bowel Resection	____	☐ Hysterectomy	____
☐ Cerebral Shunt	____	☐ Spinal Infusion Pump	____	☐ Mastectomy	____
☐ Cholecystectomy	____	☐ Thyroidectomy	____	☐ Myomectomy	____
☐ Colectomy	____	☐ Tonsillectomy	____	☐ Red. Mammoplasty	____
☐ Colostomy	____			☐ TAH/BSO	____
				☐ Vaginal Hysterectomy	____

Other: ____________________

Social History

Tobacco Use: ☐ Yes ☐ No ☐ Former

Type: ____________________

Packs per day: ____________________

Years Smoked: ____________________

Year Quit: ____________________

Drinks Alcohol: ☐ Yes ☐ No ☐ Formerly Year Quit: ________

Type: ____________ Frequency: ____________

Amount: ____________ Last Drink: ____________

Do you use recreational drugs: ☐ Yes ☐ No

Type: ____________ Amount daily: ____________

Occupation:

Employer: ____________ Occupation: ____________

Employment status: ____________ Restrictions: ____________

Family Medical History

☐ **No family medical history**

Relative:	What Condition:	Age of Onset:	Cause of death?

Name:______________________________

To the best of my knowledge the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

____ __________________
Signature of patient, parent, guardian, or personal representative Date

____ __________________
Please print name of patient, parent, guardian, or personal representative Date

____ __________________
Reviewed by Date

Updated 2018

HISTORY OF CONSERVATIVE TREATMENT

Patient Name: ______________________________ Date of Birth ______________

MEDICATIONS

Have you taken any medications for your pain? ☐ Yes ☐ No ***If yes, circle all that apply***:

Advil	Hydrocodone	Naprosyn	Robaxin
Aleve	Ibuprofen	Naproxen	Steroid injecton
Anaprox	Kadian	Nerve block	Tegretol
Arthrotec	Lorcet	Neurontin	TENS unit
Avinza	Medrol Dosepak (steroid)	Norco	Topamax
Bextra	Methacarbamol	Oromorph	Tramadol
Celebrex	Methadone	Oxycodone	Tylenol 3 or 4
Darvocet	Mobic	Oxycotin	Ultram
Decadron	Morphine	Percocet	Vioxx
Flexeril	Motrin	Prednisone	Voltaren
		Relafen	

Other pain relievers not listed above: ______________________________

Length of time taken? Number of _____ Days _____ Weeks _____ Months

PHYSICAL THERAPY

1. Did you receive physical therapy treatments ordered by your doctor? ☐ Yes ☐ No
   If yes, describe the type of therapy: _____ Cold _____ Heat _____ Traction _____ Exercises
   How long did you take the treatments? Number of _____ Days _____ Weeks _____ Months

2. Did you have any other type of physical therapy? ☐ Yes ☐ No
   If yes, please describe ______________________________
   How long did you take the treatments? Number of _____ Days _____ Weeks _____ Months

HOME EXERCISES / TREATMENT

Are you doing any exercises or treatments at home? ☐ Yes ☐ No
If yes, describe the type of therapy: _____ Cold _____ Heat _____ Traction _____ Exercises
How long did you take the treatments? Number of _____ Days _____ Weeks _____ Months

CHIROPRACTOR

Did you see a chiropractor? ☐ Yes ☐ No
If yes, what type of treatment was given or prescribed? ______________________________

LIMITATIONS ON PHYSICAL ACTIVITY

1. Do you have problems with any of the physical activities listed below? *(circle all that apply)*

Walking	Bending Backwards	Bending Forward
Standing	Twisting	Lying Down
Sitting	Lifting	Sleeping

   Others not listed ______________________________

2. Are you able to sit without needing back support? ☐ Yes ☐ No
   If no, please explain ______________________________

3. Are you able to perform your normal exercise or sports activity? ☐ Yes ☐ No
   If no, please explain ______________________________

Patient Signature ______________________________ ***Date*** ______________ 2018

PAYMENT POLICY

We appreciate you choosing our practice and want to ensure your understanding of our payment policy prior to receiving professional services. We are not contracted with all insurance companies and/or discounted networks. ***Your insurance benefits will be verified prior to service*** and you will be notified in advance if we are out-of-network.

OFFICE VISITS

Office visit co-pays, co-insurance, unmet deductibles or other appropriate charges, where applicable, are required to be paid at the time of service.

SURGERY

A billing representative will meet with you prior to surgery to discuss your surgical benefits. ***In most cases, there will be a surgical deposit due, which must be paid prior to surgery***. This is usually comprised of an unmet deductible and co-insurance, based on verification of your benefits. Occasionally, a procedure is not a covered benefit or falls into a pre-existing conditions exclusion. These charges must be paid in full prior to surgery. We will bill your insurance and refund you if benefits are paid.

INTERNATIONAL/GLOBAL INSURANCE

International/Global insurance is not accepted and international patients or any patient who resides outside the U.S.A. are considered self-pay. The full charge for office visits is required at the time of service and ***all surgical fees must be paid prior to surgery.***

PAYMENT TYPES

We accept cashier's checks, wire transfers and most credit cards: American Express, Master Card, Visa and Discover. Unfortunately, we cannot accept personal or business checks.

Please answer the follow questions below:

1. Is your insurance coverage under a **COBRA** plan? ☐ Yes ☐ No
2. Is your insurance coverage under a **college student** policy? ☐ Yes ☐ No
3. Is your problem related to an **auto accident or work injury**? ☐ Yes ☐ No
4. Do you have a **lawyer** representing you for this medical condition? ☐ Yes ☐ No

I have read and agree with the above policies.

Print Patient Name ______________________________

Patient Signature ______________________________ Date __________

Revised 2018

RETURN OF X-RAYS
RELEASE FROM LIABILITY

Patient Name ____

Doctor: Aldama Harper Roeser Gist Gressot Sellin

Radiographic films are an important factor used in determining your diagnosis and treatment. However, after surgery, Neurosurgical Group of Texas, L.L.P. does not need your films and does not have space to store them. We prefer that the patient take their films back with them, however, that is not always possible. The following explains our policy about returning your films for you.

Release From Liability

Neurosurgical Group of Texas, L.L.P. is careful in the way we handle films and will use our best effort to return your films to the facility where taken. However, we are not responsible for loss, damage or misplacement of your films, or for non-receipt of films that were mailed or returned via U.S. Mail or other delivery services.

Return of Films Via Pick-Up Service

Films that were taken at the facilities listed below are automatically picked up from our office by these facilities:

MRI Central, Methodist Hospital, St. Luke's Episcopal Hospital, and Medical Center Radiology.

Return of Films Via U.S. Mail or Other Delivery Service

1. Films returned to patient within the United States are charged **$50 handling fee, plus actual postage (USPS/FedEx/DHL)**.

2. Films returned outside the U.S. (International) are charged a total of **$200, which includes duties, handling and postage (USPS/FedEx/DHL).**

I, the patient, have read and understand the above policy and release Neurosurgical Group of Texas, L.L.P, and its agents and employees from any and all liability that may arise in the return of x-rays.

Signature of Patient: ______________________________ Date __________________

Rev. 2018

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

____

____

____

____

Patient Name: ______________________________ Patient Date of Birth: ______________

SIGNATURES:
Patient Name/Legal Representative: ______________________________ Date: ______________

If Legal Representative, relationship to Patient: ____________________ Date: ______________

NOTICE OF CARE PROVIDED TO OUT OF STATE PATIENTS

The patient (including the patient's representative, heirs or beneficiaries) and the health care provider rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient (including employees and agents of the health care provider) agree:

1) That all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient.
2) In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state.

The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

SIGNATURES:
Patient Name/Legal Representative: ______________________________ Date: ______________

If Legal Representative, relationship to Patient: ____________________ Date: ______________

PATIENT CONSENT
UNSECURE Email Communications

This office is dedicated to keeping your medical record information confidential. Our policy is to send emails containing Protected Health Information in a **secure format** to render the information inaccessible to unauthorized individuals.

Despite our best efforts, due to the nature of email, **unsecure email communications** pose the threat that third parties may have unauthorized access to your private health information. When communicating from work, you should be aware that some companies consider email to be corporate property and your message may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that although addressed to the doctor or my medical assistant, my staff and/or colleagues would have access to this information.

I understand and accept the risks that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to MY REQUEST to receive unsecure email communications.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via **unsecure** email, and that we may respond to your emails to us via **unsecure** email.

____________________________ ____________________________
Print Patient Name Date

____
Patient Signature

PATIENT PORTAL – INFORMED CONSENT And USER AGREEMENT

Neurosurgical Group of Texas, L.L.P. offers its patients the use of a secure web-based Portal which provides you with secure electronic access to your medical record and communications between our office and you. To use the Portal you must agree to the Portal policies and procedures by signing the Informed Consent and User Agreement, and by activating your Portal account. Our Practice staff will enroll you and provide you with a confidential "token" and instructions on how to complete your enrollment. Your "token" is your access code to the Portal and will no longer be needed after activation. If unused, it will expire within in 30 days.

Portal Risks and Precautions
Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. Your signature on this form will document that you have been informed of and accept these risks and agree to the conditions of participation.

Privacy Protection of your Health Information
All messages sent to you will be encrypted to keep unauthorized persons from accessing your information. Keeping information secure depends on two factors: the secure message must reach the correct email address and only the correct individual (or someone authorized by the individual) must have access to it. While the likelihood of risks associated with the use of Portal is substantially reduced, there are risks which are important for you to understand. By signing this consent agreement you agree you will follow prudent security measures when you access the Portal and will communicate in a manner that reduces the likelihood of these risks occurring including but not limited to:

- Never use a public computer to access the Portal
- Do not store, send or access messages on your employer-provided computer or hand-held device as information is normally accessible by your employer
- Use a screen saver or close your messages so that others nearby cannot read them
- Keep your username and password safe and private
- If you are accessing the Portal via your mobile handheld device, you should password protect your device in the event your device is lost and/or stolen
- If you think someone has learned your password, you should promptly change it using Portal
- You are responsible for updating your contact information with the Practice any time it changes including the email address you designate for Portal or outside Portal messaging
- If you receive access to health care information which is not yours, immediately stop viewing such information and notify the Practice via a secure message on the Portal or by phone call

Access, Use of Online Communications and Conditions of Participation
- ***Use of Portal is limited to non-emergency communications and requests***
- In an emergency, call 911 or go to the nearest Emergency Room
- The Portal does not provide online medical advice, or replace the services of your provider
- A diagnosis can be made and treatment rendered **only after** your provider sees you
- You may view educational resources on various topics listed in the Portal library
- You may view a clinical summary of your most recent office visit as well as lab and test results

- You may send messages to your provider or staff, and you may view and respond to messages they send to you. All communications will be included in the clinical record maintained by the Practice
- Communications regarding sensitive subject matters such as mental health, HIV, clinical research, employer-related services, etc., are not permitted through the Portal
- When using the Portal please be concise. Confirm that your name and other personal information in a message is correct, and review before sending to make sure it is clear and all relevant information is included
- Your provider or staff, in their judgment, may decline to respond to a communication, and may ask you to call or to schedule an appointment at the office concerning the matter
- Access to the secure web Portal is a service, and we may suspend or discontinue at any time and for any reason
- Messages will be reviewed during normal hours of operation and every attempt will be made to respond to your messages within 48 business hours
- <u>If you have not heard from us after two business days, please call our office at 713-790-1211</u>

Please see our Notice of Privacy Practices for additional information on privacy of your health information.

I have read the Portal Policies and Procedures and consent to the terms and conditions of Portal use.

<u>Patient Information</u>

Name: ______________________________ Date of Birth: ______________

Address: ____

Email Address: ____

Signature: ______________________________ Date: ____________________

*Minors or Users Requiring Caregivers – Acknowledgement of Portal Access to My Health Information to the Following Individual:

Name: ______________________________ Date of Birth: ______________

Relationship to Patient: _________________________

Address: ____

Email Address: ____

Signature: ______________________________ Date: ____________________

_________ Parent/Guardian agreement to waive my right to the above minor's Portal and allow
(initials) him/her to be treated as an adult for Portal enrollment and access.

CONTROLLED SUBSTANCE AGREEMENT

I, ____________________ understand that in order to receive care for the treatment of pain or the use of controlled medications, I agree to and will comply with the following:

A. MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with my physician.

B. USE OF MEDICATIONS: I will take all medication as prescribed. I will speak with my physician before making any change in either the dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Narcotic pain medications must all be obtained from the same pharmacy each time (any exception must be approved by my physician). I will abstain from alcohol use.

C. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medication from any other health care provider unless authorized by my physician. I will not harass or repeatedly speak with the pharmacist about refills which may be early. I will not call the physician after hours about my controlled substance prescription refills.

D. MEDICAL RECORDS RELEASES: I will inform all of my health care providers that I receive pain management and will maintain an unrestricted and current medical records release on file.

E. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand the use any controlled medication not prescribed by my physician may result in termination of care. I authorize the practice to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines. I authorize the practice to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance, including marijuana, may result in termination of care.

F. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by my physician and understand that lost or damaged medications will not be replaced.

G. PRESCRIPTIONS WITH TRAVELING: The practice may provide prescriptions for up to 90 days when patients are traveling out of state. Patients will have to arrange for shipment of controlled substances by their pharmacy at their own expense. Patients who will be out of state longer than 90 days need to arrange for health care at their travel destinations.

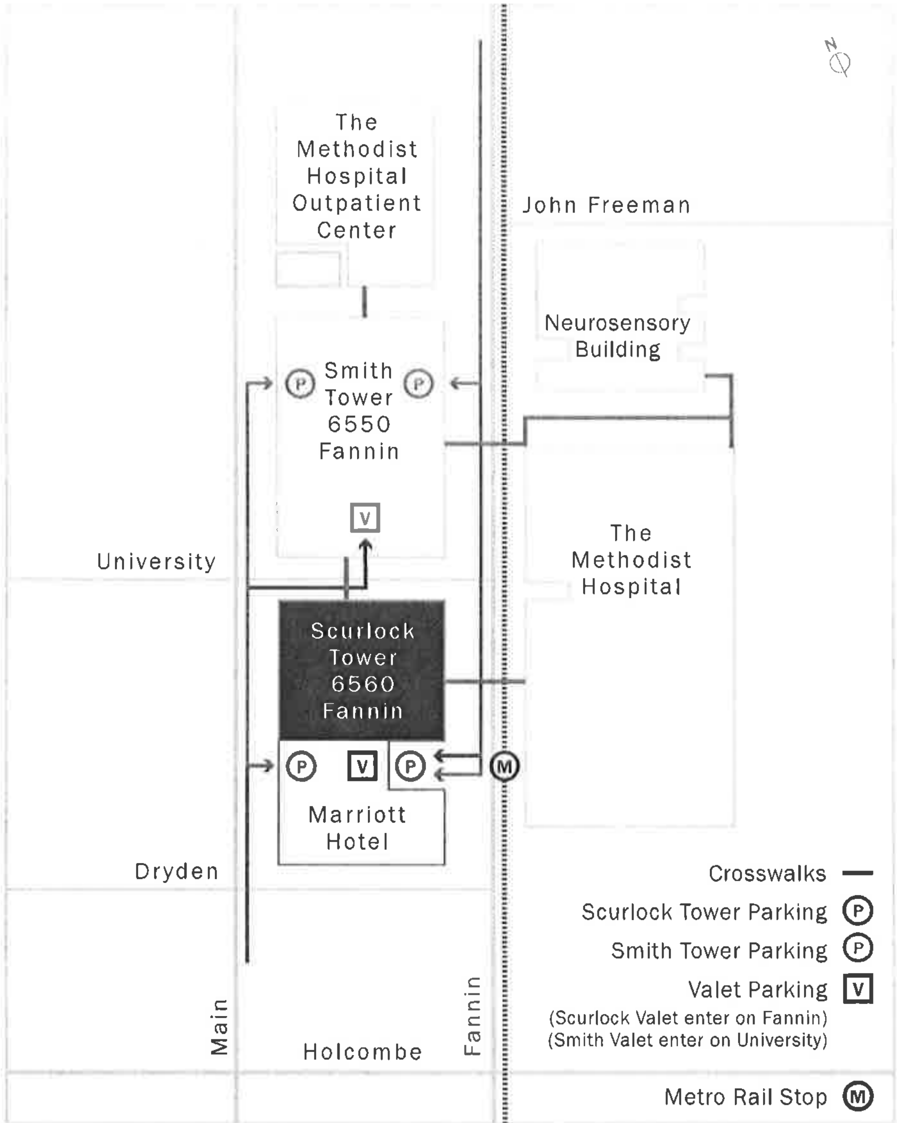
H. DRIVING & OPERATING EQUIPMENT: Many medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any changes in medication dosage and whenever I fell drowsy.

I. TERMINATION: I will no longer be eligible for care if I am in possession of illicit drugs or substances, trafficking in controlled or illegal substance, intoxicated or if arrested for DUI. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for care.

I UNDERSTAND AND AGREE TO THE CONDTIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.

____

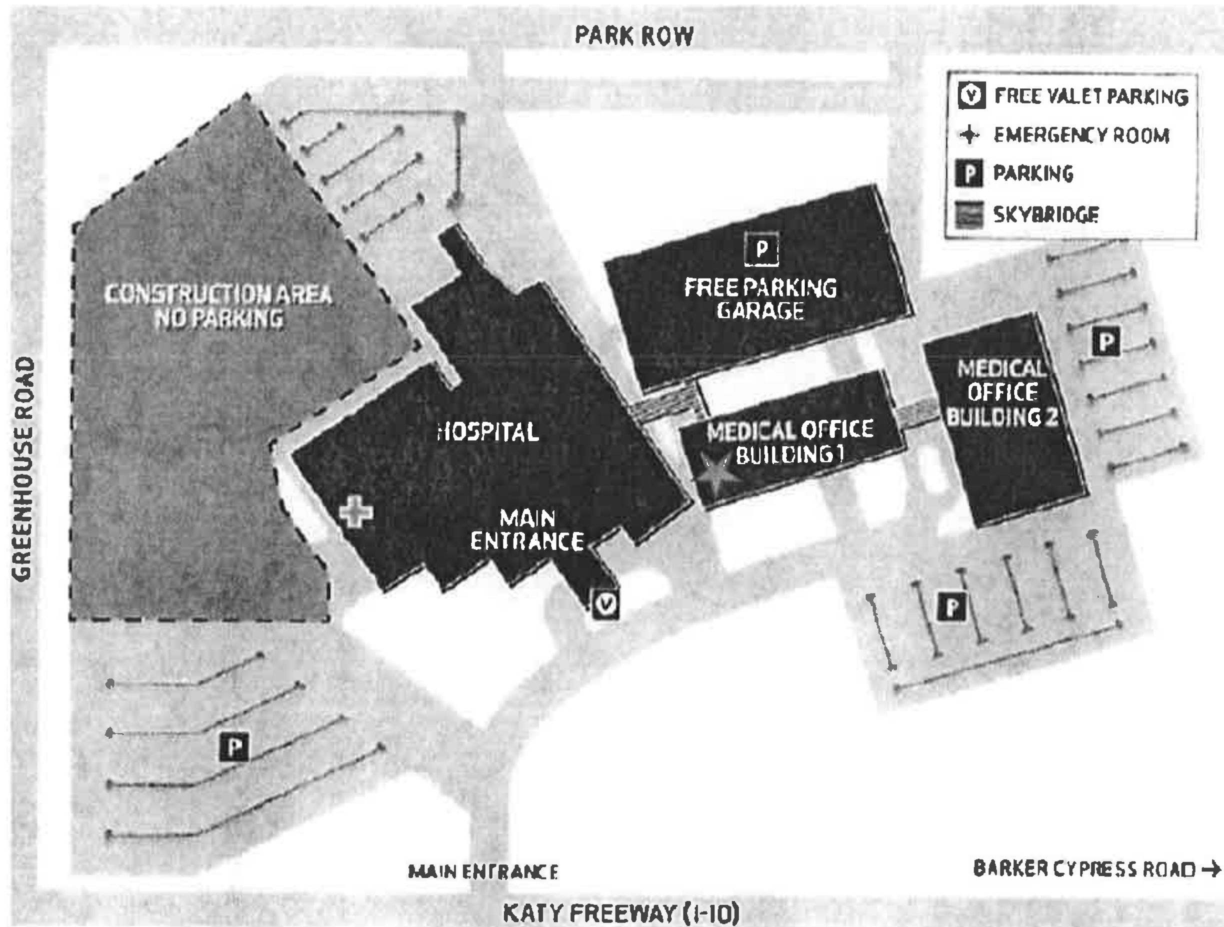
Patient Signature and Date



The Neurosurgical Group of Texas is located in Suite 1200 of Scurlock Tower.
The map above shows how to enter Scurlock Tower from Main or Fannin Streets.

6560 Fannin, Suite 1200, Houston, Texas 77030
Tel 713.790.1211 Fax 713.797.6262
www.neurosurgery-texas.com

NEUROSURGICAL
GROUP OF TEXAS



Neurosurgical Group of Texas, LLP is located in the Medical Office Building 1 on the 4th floor, Suite 440.