NEUROSURGICAL
GROUP OF TEXAS

Dear Patient,

Thank you for choosing Neurosurgical Group of Texas for your neurosurgical care. Our goal is to provide you with the highest level of care and improve your quality of life. Our specialty is surgery of the spine and brain, there are some health conditions which cannot be improved with surgery; at your appointment you will receive a surgical evaluation of your current health condition and symptoms.

We want to make your first appointment an easy and pleasant experience. Here are a few reminders about our first appointment:

- Please bring the following items to your new patient appointment:
    - Completed new patient forms
    - Medical insurance card, driver's license, and or state ID
    - X-ray, MRI, CT Scan imaging films or CDs
    - Current medication & allergy list
- Please arrive to your appointment 30 minutes prior to your scheduled appointment time, this will allow the staff the opportunity to review your completed new patient forms and register you.
- Be prepared with a list of questions for your physician, this will allow you to effectively communicate all your questions during your appointment.
- Your copay or patient responsibility is due at the time of service, please note we **do not accept checks**.
- If you have been experiencing flu like symptoms or have had fever within 24 hours prior to your appointment please contact our office to cancel and reschedule your appointment.
- If you have any questions regarding your new patient appointment please contact our office at 713-790-1211.
- If your pain becomes intolerable or if you develop more significant neurological symptoms prior to your appointment, please go to the nearest emergency room or contact your primary care physician.

We look forward to meeting you at your first appointment and taking care of your healthcare needs.

Sincerely,

Neurosurgical Group of Texas Physicians

NEUROSURGICAL
GROUP OF TEXAS

PATIENT RIGHTS AND RESPONSIBILTIES

At Neurosurgical Group of Texas, LLP we respect your rights as a patient, and recognize that you are an individual with unique healthcare needs. We want you to know what your rights are as a patient, as well as what your obligations are to yourself, to other patients, and to your physician. We encourage a partnership between you and your healthcare team. Your role as a member of this team is to exercise your rights and to take responsibility by asking for clarification of things you do not understand, by following your physician's recommendations and to promptly report any side effects that may occur.

As a patient you have the right …

- To be informed of your rights and responsibility as a patient of Neurosurgical Group of Texas, LLP.
- To be informed of all rules, regulations, and services provided by the clinic, including the days and hours of service and what to do in an emergency, and clinic telephone numbers.
- To receive care in a safe setting that is free of abuse, neglect, and harassment by physicians and clinic employees.
- To receive considerate and respectful care. We respect your right to:
  - Expect quality treatment within the scope of our mission.
  - Be treated with dignity without discrimination. Your care will not be affected by race, religion, beliefs, cultural values, sex, or age.
  - Choose your own physician.
  - Ask all personnel involved in your care to introduce them-selves, state their role in your care and explain what they are going to do for you.
- To be informed about your treatment and healthcare. Your healthcare team will describe your proposed treatment to you. You can expect the team to explain:
  - A description of our condition and diagnosis.
  - Treatment plan.
  - The alternatives of treatment.
  - The prognosis and any problems related to treatment.
  - Recuperation.
  - The benefit and risks of each treatment option and alternatives.
  - The explanation of risks faced if treatment is not pursued.
- The right to make an informed consent.
- The right to make treatment choices and the right to refuse treatment.
- To be informed of any experimental, investigation, or research activities that involve your treatment. Your healthcare team will:
  - Ask you if you wish to participate in these activities. You have the right to refuse to participate in these activities, or withdraw your previous consent.
- To receive a reasonable estimate of charges for medical care and a payment schedules prior to receiving treatment.
- To have privacy and confidentiality respected. Your healthcare team and clinic staff will:
  - Respect your privacy related to your medical care.
  - Provide confidential treatment of your condition, medical care, medical records, and financial information
- To have access to your personal medical records and obtain copies upon written request.
- To complain or file a grievance with the Clinic Administrator without fear of retaliation or discrimination.

As a patient you have the responsibility to …

- Give the physician and your healthcare team accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about your healthcare.
- Report unexpected changes in your condition to your physician or nurse.
- Inform your physician or nurse of any discomfort/pain and changes in pain.
- Participate in the development of your plan of care, advance directives, and living will.
- Follow the treatment plan and medical directions recommended by your physician and healthcare team.
- Attend all appointments and when unable to do so contact the office 24 hours prior to your appointment to reschedule.
- Follow facility conduct rules, demonstrate good behavior, and assist in maintaining a safe/peaceful environment.
- Report new or changed insurance information, address changes, telephone number changes, email changes, and any other demographic changes to the front desk staff.
- Make sure financial responsibilities are carried out and pay copays/patient responsibility at the time of service.

You have a right to file a formal grievance/complaint against a nurse or physician at the following agencies:

Nurse: Texas Board of Nursing, 333 Guadalupe Street, Suite 3-460, Austin, Texas 78701, (512) 305-6838
Physician: Texas Medical Board, PO Box 2018, Austin, Texas 78768-2018, (800) 201-9353

Patient Copy To Keep

NEUROSURGICAL
GROUP OF TEXAS

HIPAA NOTICE OF PRIVACY PRACTICES

Neurosurgical Group of Texas, LLP is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **TREATMENT** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

- **PAYMENT** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- **HEALTHCARE OPERATIONS** We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, and training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect and have a copy of your protected health information (fees may apply). Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications. You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You have the right to request an amendment to your protected health information. You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

If you believe that your privacy rights as described in this notice have been violated, you may file a complaint with the practice at the following address or telephone number:

Neurosurgical Group of Texas, LLP
Attn: HIPAA Officer
6560 Fannin Street, Suite 1200
Houston, Texas 77030
(713) 790-1211

To file a complaint, you may either call or send a written letter. The practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

NEUROSURGICAL
GROUP OF TEXAS

PATIENT DEMOGRAPHICS

Today's Date _____ ☐ **New Patient** ☐ **Demographic Update**

Physician:

☐ **Alfonso Aldama, MD** ☐ **Richard Harper, MD** ☐ **Andrew Roeser, MD**

☐ **Taylor Gist, MD** ☐ **Loyola Gressot, MD** ☐ **Jonathan Sellin, MD** ☐ **William Steele III, MD**

GENERAL INFORMATION

Patient Name:_____ Date of Birth:_____
Last First Middle

Sex: Male Female Phone: (____)_____-_____ Cell: (____)_____-_____ Email Address:_____

Address: _____
Street City State Zip

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other_____ Race:_____

Primary source of how you chose us?
☐ Referring Physician ☐ Website/Internet Search ☐ Family/Friend ☐ Former Patient ☐ Insurance Carrier

Referring Physician: _____ _____ Phone: (____)_____-_____
Name Address

Primary Care Physician: _____ _____ Phone: (____)_____-_____
Name Address

EMERGENCY CONTACT

_____ _____ Phone (_____) _____
Name Relationship

INSURANCE INFORMATION

Primary Type of Insurance: ☐ Commercial ☐ Medicare ☐ None (Self-Pay)

_____ _____ _____ Phone (_____) _____
Insurance Name Policy Number Group Number

Are you the policy holder? If not please complete the next section:

_____ _____
Policy Holder Name Date of Birth

Secondary Type of Insurance: ☐ Commercial ☐ Medicare ☐ Medicare Supplement

_____ _____ _____ Phone (_____) _____
Insurance Name Policy Number Group Number

Are you the policy holder? If not please complete the next section:

_____ _____
Policy Holder Name Date of Birth

NEUROSURGICAL GROUP OF TEXAS

MEDICAL HISTORY

Today's Date:_____

Patient Name: _____ Date of Birth:_____

Sex: Male Female Current Height:_____ Current Weight:_____

CHIEF COMPLAINT/REASON FOR VISIT

Is this visit related to a work related injury: ☐ Yes ☐ No , if you answered yes please STOP and see the receptionist.

Is this visit related to a motor vehicle accident: ☐ Yes ☐ No , if you answered yes please STOP and see the receptionist.

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location _____
If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest, what is your level of pain **1 2 3 4 5 6 7 8 9 10**

Date symptoms began?_____ Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

Aggravated by: _____ Relieved By: _____

CURRENT SYMPTOMS

Check (✓) symptoms you currently have, please choose all that apply.

SPINE

Location of Pain	Radiation of Pain	Quality of Pain	Difficulty With
☐ Lower Back	☐ Left Arm	☐ Ache ☐ Stabbing	☐ Ascending Stairs
☐ Neck	☐ Right Arm	☐ Burning	☐ Bending
☐ Left Arm	☐ Left Hip	☐ Deep	☐ Descending Stairs
☐ Right Arm	☐ Right Hip	☐ Diffuse	☐ Range of Motion
☐ Left Hip	☐ Left Leg	☐ Discomforting	☐ Sitting
☐ Right Hip	☐ Right Leg	☐ Dull	☐ Standing
☐ Left Leg	☐ Left Shoulder	☐ Localized	☐ Walking
☐ Right Leg	☐ Right Shoulder	☐ Numbness	☐ Other:_____
☐ Left Shoulder	☐ Other:_____	☐ Throbbing	☐ Other:_____
☐ Right Shoulder	☐ No Radiation	☐ Piercing	☐ Other:_____
☐ Other:_____		☐ Sharp	
☐ No Pain		☐ Shooting	

HEAD

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

PAIN MANAGEMENT

Are you under the care of a pain management physician? ☐ Yes ☐ No ***If yes, please list physician below:***

Pain Management Physician _____ **Phone**_____

Patient Name:_____ **DOB:**_____

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please attach a copy to this packet; if you need additional space please ask the front desk for a blank sheet of paper to continue your list.)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. once a day)	Reason for Taking

Are you on blood thinners? ☐ Yes ☐ No

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No if yes please list medications _____

Are you allergic to intravenous contrast? ☐ Yes ☐ No if yes please list your reaction_____

Any other allergies? Incl. Latex ☐ Yes ☐ No if yes please list_____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____

REVIEW OF SYSTEMS

Check (✓) all that apply.

Constitutional	Ear, Nose, &Throat	Eyes	Respiratory
☐ Chills ☐ Fatigue ☐ Fever ☐ Weight Gain ☐ Weight Loss ☐ Other:_____	☐ Hearing Loss/Ringing ☐ Nasal Drainage ☐ Facial Pain ☐ Decreased Smell ☐ Throat Soreness/Pain ☐ Difficulty Swallowing ☐ Other:_____	☐ Burning ☐ Eye Discharge ☐ Pain/Pressure ☐ Loss of Vision ☐ Other:_____ ☐ Other:_____	☐ Chronic Cough ☐ Shortness of Breath ☐ Painful Respiration ☐ Wheezing ☐ Other:_____ ☐ Other:_____
Cardiovascular	**Gastrointestinal**	**Metabolic/Endocrine**	**Neurological**
☐ Chest Pain ☐ Difficulty Breathing ☐ Edema ☐ Palpitations ☐ Syncope ☐ Other:_____	☐ Abdominal Pain ☐ Bloating ☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Other:_____	☐ Cold Intolerance ☐ Heat Intolerance ☐ Hypoglycemia ☐ Insulin Reactions ☐ Other:_____ ☐ Other:_____	☐ Aphasia ☐ Dizziness ☐ Headache ☐ Vertigo ☐ Seizures ☐ Tremors ☐ Other:_____
Psychiatric	**Integumentary**	**Musculoskeletal**	**Hematologic/Lymphatic**
☐ Anxiety ☐ Depression ☐ Insomnia ☐ Other:_____ ☐ Other:_____	☐ Skin Allergies ☐ Rash ☐ Skin Discoloration ☐ Other:_____ ☐ Other:_____	☐ Back Pain ☐ Bone/Joint Pain ☐ Pain in Muscle ☐ Muscle Weakness ☐ Neck Stiffness ☐ Other:_____	☐ Easy Bleeding ☐ Easy Bruising ☐ Abnormal Lymph Nodes ☐ Other:_____ ☐ Other:_____

Patient Name:_____ **DOB:**_____

PAST MEDICAL HISTORY

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

☐ **No Medical History**	☐ Cancer Type:_____	☐ Hypertension	☐ Renal Disease
☐ Anemia	☐ Congestive Heart Failure	☐ Irregular Heartbeat	☐ Rheumatoid Arthritis
☐ Arrhythmia	☐ COPD	☐ Kidney Failure	☐ Seizure Disorder
☐ Blood Clots	☐ Coronary Artery Disease	☐ Liver Disease	☐ Spinal Cord Tumor
☐ Brain Tumor	☐ Diabetes	☐ Lung Cancer	☐ Thyroid Disease
☐ Cerebrovascular Accident	☐ Fibromyalgia	☐ Migraine Headaches	☐ Tremor
☐ Cirrhosis/Liver Disease	☐ Hepatitis C	☐ Multiple Sclerosis	☐ Other:_____
☐ Constipation	☐ HIV/AIDS	☐ Parkinson's Disease	☐ Other:_____
	☐ Hyperlipidemia	☐ Peripheral Nerve Disorder	☐ Other:_____

Gender Specific Conditions: **Male** ☐ Benign Hypertrophic Prostatitis ☐ Prostate Biopsy
Female ☐ Breast Cancer ☐ Gynecologic Cancer Other

Have you had a blood transfusion? ☐ Yes ☐ No, if **Y** please describe: _____

Have you had grafted tissues? ☐ Yes ☐ No, if **yes** please describe: _____

Do you have implanted hardware? ☐ Yes ☐ No, if **yes** please describe: _____

Please list any other health issues not referenced above:_____

SURGICAL HISTORY

Check (✓) all surgeries that you've ever had, please choose all that apply.

☐ **No Surgical History**	☐ Carpal Tunnel Release Year:_____	☐ Hip Replacement Year:_____	**Male:**
☐ Aneurysm Resection Year:_____	☐ Cataract Extraction Year:_____	☐ Laminectomy Year:_____	☐ Prostate Biopsy Year:_____
☐ Angioplasty w/ Stent Year:_____	☐ Cerebral Shunt Year:_____	☐ Lasik Year:_____	☐ TURP Year:_____
☐ Appendectomy Year:_____	☐ Cholecystectomy Year:_____ Year:_____	☐ Muscle Biopsy Year:_____	☐ Vasectomy Year:_____
☐ Arthroscopy Knee Year:_____	☐ Colostomy Year:_____	☐ ORIF Year:_____	**Female:**
☐ Arthrodesis Year:_____	☐ Discectomy Year:_____	☐ Pacemaker Year:_____	☐ Augmentation Year:_____
☐ Back Surgery Year:_____	☐ Gastric Bypass Year:_____	☐ Spinal Infusion Pump Year:_____	☐ C-Section Year:_____
☐ CABG Year:_____	☐ Hernia Repair Year:_____	☐ Thyroidectomy Year:_____	☐ Tubal Ligation Year:_____
☐ Carotid Endarterectomy Year:_____		☐ Tonsillectomy Year:_____	☐ Masectomy Year:_____
			☐ Hysterectomy Year:_____

Have you ever had any **BAD** reactions to general anesthesia? ☐ Yes ☐ No, **if yes please describe** _____

Do you object to blood or donor materials? ☐ Yes ☐ No

Please list any other surgeries you've had not referenced above:_____

Patient Name:_____ **DOB:**_____

SOCIAL HISTORY

Tobacco Use: ☐ Yes ☐ No ☐ Former	**Drinks Alcohol**: ☐ Yes ☐ No ☐ Formerly	**Do you use recreational drugs:** ☐ Yes ☐ No ☐ Formerly
Type:_____	Type:_____	Type:_____
Packs Per Day:_____	Frequency:_____	Frequency:_____
Years Smoked:_____	Amount:_____	Amount:_____
Year Quit:_____	Last Drink:_____	Year Quit:_____
	Year Quit:_____	

OCCUPATION

Employer: _____ Occupation: _____ Status: _____ Restrictions: _____

FAMILY MEDICAL HISTORY

☐ **No Family Medical History**

Mother:	**Alive**	**Deceased**	Age:_____	Medical Condition(s):_____
Father:	**Alive**	**Deceased**	Age:_____	Medical Condition(s):_____
Sister(s):	**Alive**	**Deceased**	Age:_____	Medical Condition(s):_____
Brother(s):	**Alive**	**Deceased**	Age:_____	Medical Condition(s):_____
Grandmother:	**Maternal**	**Paternal**	Age:_____	Medical Condition(s):_____
Grandfather:	**Maternal**	**Paternal**	Age:_____	Medical Condition(s):_____
Aunts:	**Maternal**	**Paternal**	Age:_____	Medical Condition(s):_____
Uncles:	**Maternal**	**Paternal**	Age:_____	Medical Condition(s):_____

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.

_____ _____

Patient/Legal Representative Signature **Date**

_____ _____

Patient/Legal Representative Print Name **Date**

_____ _____

Reviewed by Date

NEUROSURGICAL GROUP OF TEXAS

HISTORY OF CONSERVATIVE TREATMENT

Patient Name: _____ Date of Birth:_____

MEDICATIONS

Have you ever received a pain injection? ☐ Yes ☐ No

If yes what type: ☐ Nerve Block ☐ ESI ☐ Other:_____

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

☐ Advil	☐ Ibuprofen	☐ Naproxen	☐ Tegretol
☐ Aleve	☐ Kadian	☐ Neurontin	☐ Topamax
☐ Anaprox	☐ Lorcet	☐ Norco	☐ Tramadol
☐ Arthrotec	☐ Medrol Dosepak (steroid)	☐ Oromorph	☐ Tylenol 3 or 4
☐ Avinza	☐ Methacarbamol	☐ Oxycodone	☐ Ultram
☐ Bextra	☐ Methadone	☐ Oxycotin	☐ Vicodin
☐ Celebrex	☐ Mobic	☐ Percocet	☐ Vioxx
☐ Decadron	☐ Morphine	☐ Prednisone	☐ Voltaren
☐ Flexeril	☐ Motrin	☐ Relafen	☐ Other:_____
☐ Hydrocodone	☐ Naprosyn	☐ Robaxin	☐ Other:_____

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

PHYSICAL THERAPY

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

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

Physical Therapy Provider _____ **Phone**_____

HOME EXCERCISES/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

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

☐ Walking ☐ Sitting ☐ Lifting ☐ Bending Backwards ☐ Lying Down

☐ Standing ☐ Twisting ☐ Lying Down ☐ Bending Forward ☐ Other:_____

Are you able to sit without needing back support? ☐ Yes ☐ No

If no, please explain _____

Are you able to perform your normal exercise or sports activity? ☐ Yes ☐ No

If no, please explain _____

_____ _____

Patient/Legal Representative Signature **Date**

Rev.11/19

NEUROSURGICAL
GROUP OF TEXAS

Narcotic (Opioid) Medical Policy Agreement

Neurosurgical Group of Texas has a primary goal of providing excellence in care to our patients.

The best practice in Neurosurgery recognizes that patients undergoing operative procedures may require narcotic pain medications. Your physician may prescribe pain medication during your post-operative period with a limited supply and in accordance with The Texas Medical Board regulations.

It is important to understand the physicians at Neurosurgical Group of Texas DO NOT prescribe pain medication pre-operatively (before you have surgery).

The physicians at Neurosurgical Group of Texas do not manage chronic pain, if you need chronic pain management we can provide you a referral to a pain management specialist.

To ensure that we, as the provider, and you as the patient, understand how our practice will ensure high quality and safety in prescribing narcotics you will need to adhere and agree to the policy agreement outlined below.

I, _____ understand that I may receive narcotic medication from Neurosurgical Group of Texas to treat my post-operative pain.

- If I am receiving opioid pain medication from a Neurosurgical Group of Texas physician I will not seek narcotic pain medications from any other provider.
- I understand that if I am receiving long term pain medicine from a pain management physician, I will make arrangements for post-operative pain medication with that physician. I will not receive pain medications post operatively from a Neurosurgical Group of Texas physician.
- I will not take prescribed narcotics in large amounts or more frequently than prescribed.
- I will not buy and use additional narcotics or borrow/use narcotics prescribed to another individual.
- I will not use any illegal or street drugs (ex. Marijuana, Cocaine) while under the care of the Neurosurgical Group of Texas physician.
- I will not purchase or use narcotics which may be available in another country or through mail order.
- I understand that Neurosurgical Group of Texas will not provide refills on narcotics. A new prescription may be provided at the first post-operative visit. Any ongoing need for narcotic pain medication beyond that point will be referred to a pain management specialist.
- I will not drink alcohol while on narcotics.
- I understand it is illegal to refill narcotic medication by phone.
- If I have left over narcotic pain medication, I will dispose of it. I will not donate or sell extra narcotics to another individual.
- Patients having greater than expected amount of post-operative pain will be seen promptly in clinic.
- I understand that if my pain acute post-operative pain medication requirements are beyond a neurosurgeon's scope of practice to manage I will be referred to a pain a management physician. I understand it is my responsibility to follow up and schedule an appointment.

I UNDERSTAND AND AGREE TO THE CONDTIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.

_____ _____ _____

Patient/Legal Representative Print Name **Patient/Legal Representative Signature** **Date**

NEUROSURGICAL
GROUP OF TEXAS

GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

MEDICAL CONSENT: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Neurosurgical Group of Texas and his/her designees as directed in his/her judgement.

NOTICE OF CARE PROVIDED TO OUT OF STATE PATIENTS: I understand that all healthcare rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any healthcare rendered. In the event of a dispute, any lawsuit, action, or cause which in any way relates to healthcare provided it shall only be brought in a Texas court in the county/district where all or substantially of the healthcare was rendered. (consent applies only to out of state patients)

RIGHT TO REFUSE TREATEMENT: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORMATION: I authorize Neurosurgical Group of Texas, LLP to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Neurosurgical Group of Texas. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

FINANCIAL AGREEMENT: I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to Neurosurgical Group of Texas for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Neurosurgical Group of Texas will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to **Neurosurgical Group of Texas, LLP** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (consent applies only when applicable)

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document.

_____	_____	_____
Patient /Legal Representative Signature	**Patient/Legal Representative Print Name**	**Date**

NEUROSURGICAL
GROUP OF TEXAS

OFFICE POLICIES

PAYMENT POLICY

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. We accept many forms of payments including cashier's checks, wire transfers, AMEX, Master Card, Visa, and Discover. **We do not accept any personal or business checks.** Below is a summary of payment expectations:

- **Office Visits** copays, co-insurance, deductibles or any other patient liability is due at the time of service.
- **Surgery Deposits** will be calculated according to your benefits, this is an estimate of your liability for surgery and must be paid prior to surgery. A billing representative will meet with you prior to surgery to review your surgical out of pocket costs.
- **International/Global Insurance** is not accepted by the practice.
- **Uninsured & International Patients (any patient residing outside of the USA)** are considered self-pay. Payment for services is due in full at the time of service, all surgical payments must be paid prior to surgery.
- **Motor Vehicle Accidents/Work Related Injuries/Legal Cases** are not accepted by the practice.
    - **Do you have a lawyer representing you for this medical condition?** ☐ Yes ☐ No

SURGERY CANCELLATIONS

If you must cancel a scheduled surgery, please call our office by 3:00pm (3) business days (Monday – Friday) prior to your surgery appointment to notify us of your cancellation or reschedule. Messages left over the weekend are not considered sufficient notice. **Failure to cancel surgery appointments without proper notice will result in a $150.00 no show/cancellation fee**. You are responsible for this fee and it is not billable to your insurance carrier.

FORMS AND MEDICAL RECORDS

If you require our office to complete any disability, FMLA, personal reimbursement, or work forms there is a charge of $25 for the first form and $15 for each additional form. Payment must be made before your forms can be processed. Your forms will be completed within 10 business days.

If you require a copy of your medical records you must sign a Medical Records Release of Information form and a payment of $25 will be due upon receipt of your request. Your request will be completed within 10 business days.

RETURN OF IMAGING CDS/FILMS

Imaging CDs/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 CDs/Films and does not have space to store them. We will store your CDs/Films for 90 days following your surgery date. After 90 days we will dispose of the CDs/Films in accordance of standards established by the HIPAA Privacy and Security Rules to preserve the confidentiality of your protected health information. Please note you can always get a copy of your CDs/Films from the imaging provider that performed the study as they are required to retain those images for 7 years. We are not responsible for loss, damage or misplacement of your CDS/Films, or for non-receipt of CDS/Films that were mailed or returned via U.S. Mail or other delivery services.

If you request your CDs/Films to be returned within 90 days from your surgery date, the following explains our policy about returning your films for you:

- **Office Pick Up** CD/Films can be picked up for a Neurosurgical Group of Texas office for no charge.
- **U.S. Shipment** CDS/Films returned to the patient within the United States will be charged a $50 handling fee plus actual postage determined by carrier (USPS/FedEx, DHL).
- **International Shipment** CDS/Films returned to the patient outside of the United States will be charged a $200 handling fee plus actual postage determined by carrier (USPS/FedEx, DHL).

Patient Initials_____ Date_____

NEUROSURGICAL
GROUP OF TEXAS

PATIENT COMMUNICATION & DISCLOSURE OF PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I authorize Neurosurgical Group of Texas to communicate with me using the following methods regarding my personal health information, evaluation, and treatment (check all that apply):

(✓)	Method	Messages (Yes or No)
☐	**Home Phone**	☐ Yes ☐ No
☐	**Cell Phone**	☐ Yes ☐ No
☐	**Work Phone**	☐ Yes ☐ No
☐	**Email****	☐ Yes ☐ No

** 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 to secure all communication please note when communicating on a public or employer email server there is a risk that third parties may have unauthorized access to your protected health information.

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. I understand that the identity of designees must be verified before release of PHI.
Authorized Designees:

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

Name:_____ Relationship:_____ Telephone: (____)_____-_____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke this authorization in writing.

- **I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.**
- **I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.**
- **I understand and accept any risks with requests I submit via unsecured email communications.**

_____ _____ _____
Patient /Legal Representative Signature **Patient/Legal Representative Print Name** **Date**

☐ **REVOKE/CANCEL THIS AUTHORIZATION**

_____ _____
Patient/Legal Representative Signature Date

NEUROSURGICAL
GROUP OF TEXAS

PATIENT PHOTOGRAPH/VIDEO &
INFORMATION RELEASE AUTHORIZATION

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____
Last First Middle

AUTHORIZATION

☐ **I AUTHORIZE TO THE USE AND DISCLOSURE LISTED BELOW:**
I authorize the use and disclosure of photographic, video images, and/or testimonials (i.e. picture with the physician, thank you cards, google reviews, etc…) for marketing purposes by the practice Neurosurgical Group of Texas, LLP ("NSGT") and or the physicians of Neurosurgical Group of
Texas.

I understand that the image(s) or testimonials I've authorized for disclosure may be seen by members of general public.

I authorize Neurosurgical Group of Texas, LLP ("NSGT") to take photographs and/or videos, or to allow third parties to take photographs and/ or videos.

I authorize the use and disclosure of photographic, video images, and/or testimonials or the following uses: **(check all that apply)**

For Public/Marketing Relations Purposes
☐ On NSGT or NSGT physician's website or internet sites Including but not limited to social media platforms such as Facebook and Instagram.
☐ In NSGT publications, brochures, office or marketing Materials.
☐ In the public media, such as newspapers, magazines, on the Internet, and on television
☐ In presentations, publications, brochures, advertisements, or Articles by agencies hired and contracted by NSGT

☐ **I DO NOT AUTHORIZE USE OR DISCLOSURE**

INFORMATION RELEASE (please check one)

☐ **I consent to the use of my name.** I understand that I may be identified by name in printed, internet, or broadcast information that might accompany the photo or video image of me.

☐ **I do NOT consent to the use of my name.** I understand that even though my name will not be used, it is possible that someone may recognize me based on image(s) alone.

I understand my authorization can be revoked at any time in writing.

Patient/Legal Representative Print Name **Patient/Legal Representative Signature** **Date**

Rev.11/19

NEUROSURGICAL
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UNENCRYPTED EMAIL COMMUNICATION CONSENT

As a patient of Neurosurgical Group of Texas, LLP you may request that we communicate with you via unencrypted email. Email is now a very popular and convenient way to communicate for a lot of people however it is important you understand the risks and safeguards to protect your information.

Neurosurgical Group of Texas is dedicated to keeping your personal health information confidential; internally we take many safeguards to protect your information. Information stored on our servers and computers is encrypted.

This form provides guidelines for the intended use of this type of communication.

RISKS
Transmitting protected health information by email has a number of risks that patients should consider. These include, but are not limited to the following:

- When you send an email or we send you an email the information is not encrypted. This means a third party may be able to access the information since it is be transmitted over the internet.
- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email senders can easily misaddress an email.
- Backup copies of email may exist even after the sender or the recipient has deleted their copy.
- If you're using an email service (gmail, yahoo, etc...) or employer email account they have a right to inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection by hackers.
- Email can be used to introduce viruses into computer systems.

CONDITIONS FOR THE USE OF EMAIL
Neurosurgical Group of Texas cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Consent to use email includes agreement with the following conditions:

- Emails to or from a patient concerning treatment or care may be printed in full and made part of the patient's medical record.
- Our office may forward emails internally to those involved, as necessary for healthcare operations and other handling. We will not forward emails to third parties without the patient's written consent, except as authorized or required by law.
- Emails are only monitored during business hours Monday – Friday (excluding holidays).
- We will make every attempt to respond to emails within 24 hours or less. If your email requires a response and the recipient does not respond within 24 hours it is the responsibility of the patient to follow up by phone or other means to confirm the recipient received the email.
- Email is NOT appropriate substitute for clinical examinations, depending on your inquiry you may be required to schedule an office visit.
- **Email should never be used for emergency situations or urgent problems. In the event of an emergency call 911, or go to the nearest emergency room.**

HOLD HARMLESS
Patient's and authorized patient designees whether recipient or sender agree to indemnify and hold harmless Neurosurgical Group of Texas including all physicians, partners, staff, and employees due to any communication issues that arise by using unencrypted email communication. Neurosurgical Group of Texas is not responsible for information loss, delay, or breaches in confidentiality.

CONSENT (please check one)

☐ **I consent to the use unencrypted email communication. I understand and accept the risks and authorize use of email communication. I understand in the event I change my email it is my responsibility to update the practice.**

☐ **I DO NOT consent to the use of unencrypted email communication.**

I understand my consent can be revoked anytime in writing.

Patient/Legal Representative Print Name _____ **Patient/Legal Representative Signature** _____ **Date** _____

NEUROSURGICAL
GROUP OF TEXAS

PATIENT PORTAL

Neurosurgical Group of Texas, LLP offers its patients the use of a secure web-based portal which provides you with secure electronic access to some of your medical record and limited communication between our office and you. 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.

Privacy Protection of your Health Information
All messages on the portal are encrypted to keep unauthorized persons from accessing your information. While the likelihood of risks associated with the use of portal is substantially reduced, there are risks which are important for you to understand. 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
- 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 some 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
- When using the Portal please be concise.
- 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
- If you have not heard from us after two business days, please call our office at 713-790-1211

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

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Email Address: _____

Signature: _____ **Date:** _____