

NEUROSURGERY NEW PATIENT

Patient Name: _____

Date of Birth: _____

Chief Complaint (Reason for visit) : _____

Where is the exact location of your pain today? _____

What were you doing when the pain started? _____

When did you first have this pain? _____

Describe your pain Aching Burning Stabbing Sharp Electric Shooting Cramping
 Throbbing Crushing Other _____

Is the pain constant? Yes | No **How long does the pain last?** _____

When is your pain the worst? Morning Middle of the Day Evening Nighttime

Which of the following worsens your pain? (Check all that apply)

Using your arm or hand Reaching above your head Leaning your head forward or backward Sitting
 Coughing/Sneezing/Straining Lying Down Standing Walking Bending Twisting
 Other _____

Which of the following relieve your pain? (Check all that apply)

Sitting Standing Walking Lying Down Medication Heat / Cold Other _____

Do you have Urinary and/or Bowel problems related to the pain? Yes | No

If yes, explain _____

Preferred Pharmacy: Advanced Rx Other _____

****Advanced Rx pick up or mail next day available (Shipping and Handling included).****

Patient Name:

Date of Birth:

What have you done for the pain? (Check all that apply)

Medications Acupuncture Physical Therapy Chiropractic Yoga Injections Other _____

Type of Imaging	Body Part	Facility Name

Medication History

Name of Medication	Dose	How often do you take it?	What is it for?	Who prescribes it?

Do you have any medication/ drug allergies? Please list: _____

Past Medical History

Have you ever been hospitalized? Yes No Describe: _____

Indicate whether you have had a medical problem or surgery related to each of the following. Please check the appropriate choice when multiple choices are listed. For surgeries, please indicate the approximate year and describe the problem and type of surgery.

	Medical Diagnoses	Surgery	Year	Describe
Eyes (Cataract, Glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, Nose, Sinuses, Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endocrine (Thyroid, Parathyroid, Diabetes, Pituitary, Adrenals)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cardiovascular (Angina, Bypass Surgery, Angioplasty, Stent, Blood Clots, Abnormal Heart Rhythm)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lungs (Asthma, Tuberculosis, Pneumonia, Abnormal Chest X-Ray, Emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Esophagus or stomach (ulcer, GERD)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gastrointestinal (growth removed, bowel intestine, appendix)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver, Gall Bladder (including Hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Patient Name:

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Kidneys or Bladder

Bones, Joints, or Muscles

Back, Neck, or Spine

Brain (Stroke, TIA, tumor, trauma)

Skin

Breasts

Females: Uterus, Tubes, Ovaries

Males: Prostate, Penis, Testes, Vasectomy

Social History

Any tobacco use? Yes | No

Packs per day _____ for _____ years.

Any alcohol use? Yes | No

Drinks per day _____ for _____ years.

Any recreational drug use? Yes | No

Drugs used _____

Any special diet? Lactose free Caffeine Free Diabetic Vegetarian Vegan Other

Marital status? Single Married Divorced Widow/ Widower Are you currently working? Yes | No

If no: Who took you off work? _____ If yes: What is your occupation? _____

When did you stop working (if applicable)? _____

Family History

Father: Alive (Age_____) Deceased (Age_____) Unknown Cause of Death:_____

Mother: Alive (Age_____) Deceased (Age_____) Unknown Cause of Death:_____

Illness/Condition

Family Member

Describe

Cancer

Heart Disease

Diabetes

Stroke/TIA

High Blood Pressure

Additional information

Patient's Name:

Date of Birth:

Review of Systems

	Y	N		Y	N		Y	N
GENERAL			GASTROINTESTINAL			HEENT		
Decreased Appetite			Nausea / Vomiting			Blind Field of Vision		
Unexpected Weight Loss			Abdominal Pain			Cataracts		
Unexpected Weight Gain			Irregular Bowel Habits			Hearing Loss / Ringing		
Fatigue			Loss of Control of Bowels			Sore Throat / Hoarseness		
Fever or Chills			Jaundice			Other		
Other			Gallstones			MUSCOLOSKELETAL		
NEURO			Hepatitis			Joint Pain / Arthritis		
Headache			Cirrhosis			Back Pain		
Strokes / CVA			Fluid In Abdomen			Neck Pain		
Seizures			Pancreatitis			Muscle Aching		
Other			Other			Other		
RENAL/URINARY			CARDIOVASCULAR			PSYCH		
Renal Failure/Insufficiency			Chest Pain			Drug Abuse / Addiction		
Electrolyte Disturbances			Coronary Artery Disease			Depression		
Kidney Stones			High Blood Pressure			Anxiety		
Difficulty Urinating			Swelling In Feet			Suicide Attempt		
UTI			Abnormal Headaches			Other		
Prostate Cancer			Other					
Other			BLOOD/LYMPH					
RESPIRATORY			Anemia					
Sleep Apnea			HIV					
Complications with Sedation			Bruise Easily					
Chronic Bronchitis			Past Blood Transfusion					
Difficult Breathing			Swollen / Tender Lymph Nodes					
Persistent Coughing			Cancer					
Asthma			Other					
Other			ENDOCRINE					
SKIN			Diabetes					
Rash			Thyroid Problems					
Itching			Osteoporosis					
Unusual Hair			Other					

Patient's Name:

Date of Birth:

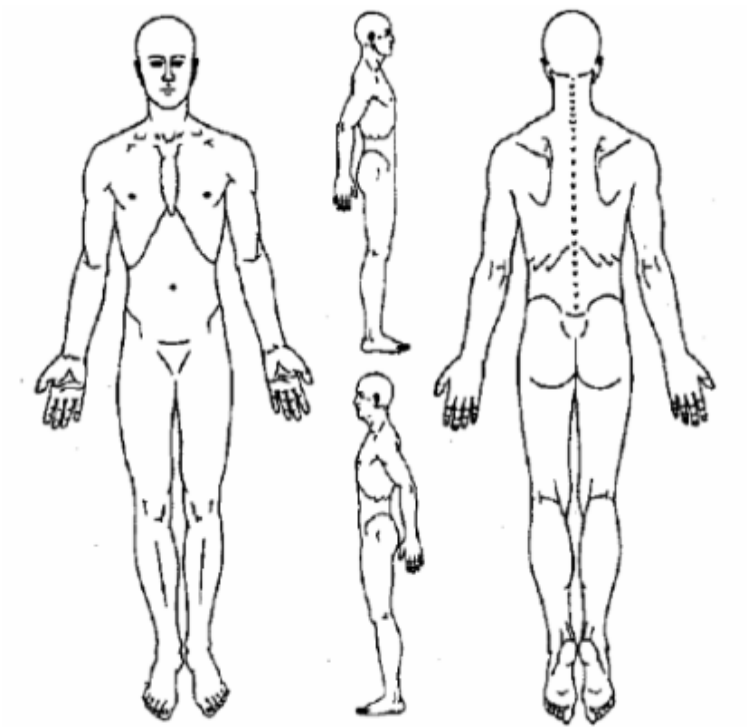
Present Pain Level:

0 1 2 3 4 5 6 7 8 9 10

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Patient Signature: _____ Employee's Initials: _____ Provider's Initials: _____

INFORMED CONSENT- NEUROSURGERY

Patient's Name:

Date of Birth:

PLEASE INITIAL EACH PARAGRAPH SIGNIFYING CONSENT AND UNDERSTANDING

_____ **TO THE PATIENT:** As a patient, you have the right to be informed about your condition and the recommended medical, surgical, or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to undergo the recommended medical, surgical, or diagnostic procedure, or take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to undergo the medical, surgical, or diagnostic procedure or take the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

_____ **I HAVE BEEN GIVEN THE OPPORTUNITY** to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic/surgical procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Neurosurgery, you may be prescribed medication that can be filled at Advanced Rx Pharmacy. The address of the Pharmacy is 2000 South Mays Street Suite 200, Round Rock, TX 78664. You are hereby advised that Advanced Pain Care has an investment interest in the Pharmacy. This information is being provided to help you make an informed decision about your health care. You have the right to choose your pharmacy. You have the option of obtaining the prescription ordered by your physician at Advanced Rx Pharmacy or at any other pharmacy you select. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Rx Pharmacy if you choose to use a different facility.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Neurosurgery (Austin Area Patients), you may undergo procedures that will be performed at Advanced Surgical Center. The address of the Surgery Center is 2000 South Mays Street Suite 400, Round Rock, TX 78664. You are hereby advised that Ryan Michaud, MD has an investment interest in the Surgery Center. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Surgical Center if you choose to use a different facility.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Neurosurgery (Amarillo Area Patients), you may undergo procedures that will be performed at Advanced Surgical Center. The address of the Surgery Center is 1901 Medi Park Drive, Suite 01, Amarillo, TX 79106. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Surgical Center if you choose to use a different facility.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Neurosurgery, you may undergo procedures at Advanced Surgical Center that will be performed with Neuromonitoring. You are hereby advised that Mark Malone, MD has an investment interest in Greater Texas Neuromonitoring, LLC. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Surgical Center if you choose to decline Neuromonitoring.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS, CONSENT FOR TREATMENT, GUARENTEE AND STATEMENT OF SERVICE

Patient's Name:

Date of Birth:

I hereby assign and authorize payment made directly to **Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center** of all of my covered health insurance benefits including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance whether payable directly to me by any or all third party payors.

I UNDERSTAND my health insurance plan or third party payors may not cover part or all of the medical services rendered. *I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center and agree that failure to do so will make me responsible for the entire billed charge.* My assignment of benefits covers Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center physicians and surgical center for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits *supersedes* any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered as valid as the original. I have received a copy of Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center's patient information brochure.

I UNDERSTAND Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center, is a licensed surgical center and multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the physicians at Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center . I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payors, including but not limited to my health insurance and/or managed care plans. I acknowledge *some or all of my care*, including surgical center facility fees, laboratory testing, x-rays, CT, DEXA, MRI, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I HAVE DISCLOSED the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center , of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so may make me fully responsible for the *entire* bill. In consideration of the services furnished to me, I hereby agree to pay any balance due *within thirty (30) days* from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that *TRAVIS COUNTY, TX* will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I UNDERSTAND it is ultimately my responsibility to obtain all required referral authorizations and/or precertifications for medical services that are required by my health insurance plan and/or third party payors. I acknowledge that this is *not* the responsibility of Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center.

I ALSO ACKNOWLEDGE no guarantees have been made by any employee of Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans.

I AGREE to fully cooperate with Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors.

Patient Signature: _____

Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

- I authorize Advanced Pain Care and its sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name	Relationship	Phone Number
------	--------------	--------------

Name	Relationship	Phone Number
------	--------------	--------------

Check all that apply to the above names:

- | | | |
|--|--|--|
| <input type="checkbox"/> Regarding appointment, time & date | <input type="checkbox"/> Discuss Lab Results | <input type="checkbox"/> Discuss Imaging Results |
| <input type="checkbox"/> Discuss medical care, an issue or concern | <input type="checkbox"/> Pick up Prescriptions | <input type="checkbox"/> Pick up Forms |
| <input type="checkbox"/> Discuss Billing Information | | |

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

Patient Signature

Date

Legally Authorized Representative

Relationship to Patient

Witness

Date

FINANCIAL POLICY

Patient's Name: _____

Date of Birth: _____

Thank you for choosing **Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that: **(Please initial all lines below)**

- _____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee of coverage or payment.
- _____ 2. All charges are your responsibility whether your insurance company pays or not.
- _____ 3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
- _____ 4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
- _____ 5. Returned checks will be subject to a \$25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
- _____ 6. No show or cancellations without 24 hour notice are subject to a \$25.00 charge.
- _____ 7. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature _____

Date: _____

Relationship to patient if not patient _____ Authorized Witness: _____

***Mark Malone MD PA includes Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center.**

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____

Date of Birth: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain PATIENT RIGHTS regarding my protected health information.

I understand that Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for: providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

I authorize Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center to communicate with my PCP (Primary Care Physician) : Dr. _____

Phone #: (_____) _____

Advanced Pain Care it's sub-specialties, and Advanced Surgical Center has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '**Notice of Privacy Practices**' before signing this agreement. If I ask, Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center will provide me with most current '**Notice of Privacy Practices**'.

My signature below indicates that I have been given the chance to review such copy of the '**Notice of Privacy Practices**'. My signature means that I agree to allow Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke the consent in writing at any time, except to the extent that Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center has taken action relying on

this consent.

Patient Signature

Date

Relationship to Patient if signed by another party

Date

You may obtain a copy of our '**Notice of Privacy Practices**' including any revisions to our '**Notice of Privacy Practices**' at any time by contacting: Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center at 2000 S. Mays St, Round Rock Texas 78664 or (512) 244-4272.

****** OFFICE USE ONLY ******
Staff initial below when completed

Consent dates have been updated in Centricity _____

Meaningful Use: Demographics

Patient Name:

DOB:

Language

- English
- Spanish
- Other: _____

Race

- American Indian or Alaskan Native
- Asian
- Chinese
- Filipino
- Japanese
- Black or African American
- White or Caucasian
- Native Hawaiian
- Multi-Racial
- Other: _____

Ethnicity

- Hispanic or Latino
- Non-Hispanic or Latino

Portal Email

Please provide email for patient portal access: _____

Patient Signature

Date

****** OFFICE USE ONLY ******
Staff initial below when completed

Race / Ethnicity / Language updated in Centricity _____

Portal Registration: Y or N If No, did you print portal letter? Y or N _____

Authorization to Release Medical Records

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

Patient Name:
Phone Number:

DOB:
Email Address:

RELEASE INFO TO:

Name: _____
Address: _____
City, State: _____ Zip: _____
Phone: _____
Fax: _____

OBTAIN INFO FROM:

Name: _____
Address: _____
City, State: _____ Zip: _____
Phone: _____
Fax: _____

Reason for Disclosure (Please circle one):

- | | | |
|---------------------------|----------------|--------------------------|
| Treatment/Continuing Care | Personal Use | Billing/Claims |
| Insurance | Legal Purposes | Disability Determination |
| School | Unemployment | Other: _____ |

What information can be disclosed? Complete the following by indicating those items that you want disclosed. If entire Medical Record is to be released, then check only the first line.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medication | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology |

Your initials are required to NOT release the following information:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Records (Excluding Psychotherapy Notes) | <input type="checkbox"/> Genetic Information/results |
| <input type="checkbox"/> Drug, Alcohol, or Substance Abuse Records | <input type="checkbox"/> HIV/AIDS test results/treatment |

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SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Signature

Date

Legally Authorized Representative

Relationship to Patient

Witness Signature

Date