New Patient Packet

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Welcome!
Thank you for choosing NeuroTexas.

We have complied this New Patient Packet to provide you with information relative to our office's policies and procedures. We understand that patients have questions and concerns and hope to answer many of them on the following pages. Please read through this packet as it should be helpful in preparing you for your upcoming appointment. If after reading this you have unanswered questions, please feel free to give our office a call. You can find a complete list of staff with contact information on our website.

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New Patient Appointment

We have enclosed all New Patient forms in this packet. Please complete them prior to arriving for your appointment. These forms can be found on our website, www.neurotexas.net, should you need additional copies. You may fax the forms in advance to (512) 474-1118.

We ask that all new patients arrive thirty minutes early to our office so that your medical record can be properly and completely assembled for optimal benefit of the new patient encounter.

If you have had an MRI, CT, or other imaging within the last six months, please inform our scheduler of the location and date of the procedure(s). In certain cases, we may be able to obtain the films without your intervention. If we cannot obtain your films on our own, you will be asked to bring a CD to our office on the day of your appointment. Regardless, please bring all films, media, reports, and records in your possession that you feel are pertinent to your condition.

Remember to bring your insurance card(s) with you to your visit.

Office Hours & Appointments

Our office is open from 8:30am to 5:00pm daily, excluding weekends and holidays, during which time you may call to schedule an appointment or obtain information. Phone hours are from 8:30am to 4:30pm. Patients are seen by appointment only. Patients are seen each day in the order of their scheduled appointments.

Please be on time to your appointment as we must respect the right of each patient to be seen at his/her scheduled appointment time. If you are late to your appointment in excess of fifteen minutes, we will reschedule your appointment for another clinic day.

Our physicians are surgeons and thus are on-call for emergencies. Please be aware that situations beyond our control may necessitate the delay or rescheduling of your appointment. We apologize in advance. Our office staff strives to limit any inconvenience to patients and will do our best to communicate any changes to your appointment with as much notice and courtesy as possible.

We understand that at times patients may have a need to cancel or reschedule an appointment. We will happily accommodate your scheduling needs. Please call our office at least 24 hours prior to your appointment date and time so we may offer your slot to another patient.

Emergencies

If you feel that you have an emergency situation during regular office hours, call our office and talk with our medical assistant. If you need the doctor after-hours, our office number will connect you to our telephone answering service. These individuals have special instructions and know where to reach the doctor "on call". Since our physicians share call responsibilities, please understand that you may not be able to communicate directly with your personal physician until the next business day. Please note that the doctor on call will not authorize medication refills or prescribe new medication. If you feel you have a life-threatening emergency, please dial 911 or go to your nearest emergency facility.

Prescriptions

Prescriptions can only be refilled MONDAY through THURSDAY 9:00am to 4:30pm and Friday 9:00am to 12:00pm. All prescription refill requests made after 12:00pm on Friday will be called in the following Monday. Please have your pharmacy contact our office for all refills. Allow 24 hours for all refills. Additionally, please anticipate the need for refills prior to running out of medication.

Financial Policy

Please read our financial policy that is enclosed with your New Patient Forms. Our business office can answer any additional questions that you may have.

Medical Forms

Seven working days are necessary to complete paperwork.

Medical forms CANNOT be completed on the day when you are seen by your doctor. Do not bring forms to surgery as they can easily be misplaced. All forms must be delivered to our office.

Medical Records

All medical records request must either be faxed to 512-474-1118 or emailed to jbravo@neurotexas.net. Our request form is located on our website www.neurotexas.net under patient forms. All other medical records request inquires can be emailed to jbravo@neurotexas.net.

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Location & Parking

CENTRAL
Physicians: Drs. Burnett, Fox, Lauryssen, Waldron, and Webb
Our main office is located at 3000 North IH-35, Suite 600 in the MOB at St. David's. Parking Garage 2 can be accessed off 30th Street between the IH-35 access road and Red River. Once parked in Parking Garage 2, take the central bank of elevators to the 6th floor and NeuroTexas is located right off the elevators.

The garage charges for parking at the rate of $2.00 per hour up to a maximum of $10.00. If you are over the age of 65, parking is free with valid identification. **Please be prepared to pay for parking.** We are often able to provide one validation sticker as a courtesy, but we cannot guarantee our supply.

SOUTH AUSTIN
Physicians: Drs. Burnett, Fox, and Webb
Our South Austin office is located in the Southwest Medical Village at 5625 Eiger Rd., Suite 210, Austin, Texas 78735.

HORSESHOE BAY
Physician: Dr. Fox
Our Horseshoe Bay office is located at 201 Bay West Boulevard.The office is labeled as the Scott & White Specialty Clinic where several other specialty physicians also provide care. Should you need specific directions, the number for the clinic is (830) 598-5968. To reach NeuroTexas staff, you should contact our main office at (512) 474-1114.

SAN MARCOS
Physician: Dr. Burnett
Our San Marcos office is located at 1340 Wonder World Dr., Suite 4301, San Marcos, Texas 78666, in the Live Oak Medicine office.

ROUND ROCK
Physician: Dr. Waldron and Dr Lauryssen
Our Round Rock office is located in the Wyoming Springs Professional Builind at 7200 Wyoming Springs Rd., Suite 1400, Round Rock, Texas 78681.

LA GRANGE
Physician: Dr. Webb
Our La Grange office is located in the St. Mark's Professional Building at Two St. Mark's Place, Suite 104, La Grange, Texas 78945.

LAKEWAY
Physician: Dr. Lauryssen
Our Lakeway office is located at 200 Medical Parkway, Suite 310, Lakeway, Texas 78738.

FREDERICKSBURG
Physician: Dr. Lauryssen
Our Fredericksburg satellite office is located inside the Pedernales Medical Group, 205 West Windcrest, Ste 310, Fredericksburg, TX 78624.

Patient Rights & Responsibilities

We consider you a partner in your care. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. NeuroTexas, PLLC, encourages respect for the personal preferences and values of each individual. It is our goal to assure that your rights as a patient are observed.

- You and your family have the right to access an interpreter if you are deaf or do not speak or understand English.
- All patients have a right to refuse a recommended treatment, to the extent permitted by law, and to be informed of the medical consequences of this action. All patients are responsible for their own actions if they refuse treatment or do not follow the doctor's recommendations.
- All patients have the right to every consideration of privacy. Patients are responsible for being considerate of the privacy of other patients. Telephones, televisions, radios, and lights should be used in a manner agreeable to others.
- All patients have the right to expect that all communications and records pertaining to their care will be treated as confidential, except in cases such as suspected abuse and public health hazards, when reporting is permitted or required by law.
- All patients have the right to receive considerate care that respects their personal values and belief systems. We ask our patients to be considerate and respectful of medical center personnel.
- All patients have the right to examine and receive an explanation of their bill, regardless of the source of payment. Patients have the responsibility to provide information necessary for claim processing and to be prompt in payment of their bills.
- All patients have the right to know the rules and regulations that apply to patient care and conduct and are responsible for following those rules and regulations.
- All patients have a right to receive an explanation of their treatment program and to ask for further clarification if the course of treatment is not understood. Patients have the responsibility to cooperate in their treatment program.

Notice of Privacy Rights

Each time you visit NeuroTexas, PLLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your Personal Health Information (PHI), serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of this state and the nation
- Source of data for our planning and marketing
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

NeuroTexas, PLLC, are required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

WORKER COMPENSATION
We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

LEGAL PROCEEDINGS
We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to subpoena, discovery request or other lawful process.

ABUSE/NEGLECT
We may disclose your PHI to a public health authority by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONORS
We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death, or for the medical examiner or coroner to perform other duties authorized by law. We may disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ or tissue donation purposes.

INMATES
We may use or disclose your PHI if you are an inmate of a correctional facility, and your physician created or received your PHI in the course of providing care to you.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

LAW ENFORCEMENT
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

REQUIRED USES AND DISCLOSURES
Under the law, we must make disclosure to you and when required to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of CFR Section 164.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our office or directly to the Secretary of Health and Human Services. To file a complaint, you must do so in writing within 180 days of the suspected violation, providing as much detail regarding the suspected violation as possible and mail to:

NeuroTexas, PLLC • 3000 North IH-35, Suite 600 • Medical Office Building at St. David's • Austin, TX 78705

There would be no retaliation for your filing a complaint. For more information or additional questions you may contact our practice administrator at 512.474.1114.

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Patient Registration Form

Patient Information:

Patient Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Home Phone: ______________ Work Phone: ______________ Cell: ______________

DOB: _____ / _____ / _____ SSN: ______________ Sex: ❐ F ❐ M

Marital Status: ❐ S ❐ M ❐ D ❐ W Employer: ______________

Email Address: ______________ Contact Via Email: ❐ Yes ❐ No

Primary Language: ______________ Race: ______________ Ethnicity: ______________

Emergency Contact:

Name: ______________ Relationship: ______________

Phone 1: ______________ Phone2: ______________

Insurance:

Insurance Name: ______________ Name of Insured: ______________

DOB: _____ / _____ / _____ (if not the patient)

Relationship to Patient: ❐ Self ❐ Spouse ❐ Child ❐ Other ______________

Member ID: ______________ Group #: ______________

Secondary Insurance Name: ______________ Name of Insured: ______________

Relationship to Patient: ❐ Self ❐ Spouse ❐ Child ❐ Other ______________

Member ID: ______________ Group #: ______________

Is this Visit related to an:

On the job injury ❐ Yes ❐ No

Auto Accident ❐ Yes ❐ No

How did you hear about our NeuroTexas? ______________

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Initial Visit History *Please use black ink only*

Name: ______________________ Date: ____________

D.O.B.: ____/____/____ Height: ____'____" Weight: ____________ lbs

Referring Physician: ______________ Primary Care Physician: ______________

What is your chief complaint/purpose of your visit today?

____

How long have you had this problem?

❒ ____ Days ❒ ____ Weeks ❒ ____ Months ❒ ____ Years

Where is your problem located?

❒ Lower Back ❒ Neck ❒ Head ❒ Middle Back ❒ Other: ____________

Does it radiate anywhere?

Leg: ❒ Left ❒ Right ❒ Both ❒ Above Knee ❒ Below Knee

Arm: ❒ Left ❒ Right ❒ Both ❒ Above Elbow ❒ Below Elbow

On a scale of 1-10, how bad is your pain? ____________

When do your symptoms occur?

❒ Bending or stooping ❒ Coughing or straining ❒ Driving ❒ Prolonged sitting

❒ Prolonged standing ❒ Walking up stairs ❒ Lying down ❒ Weight bearing

❒ Physical activity ❒ Twisting ❒ Walking ❒ Lifting ❒ Constantly ❒ With Activity

❒ At Rest ❒ Other: ____________

Under what circumstances did your pain begin? (Check one box)

❒ Accident at work ❒ At work (not accident) ❒ Accident at home ❒ Motor vehicle accident

❒ Following surgery ❒ Following illness ❒ No apparent reason ❒ Other: ____________

If accident, in what state were you when it occurred? ______________________

Date of occurrence? ______________________

When is your pain the worst? (Check all that apply)

❒ In the morning ❒ Later in the day ❒ At the end of the day ❒ At night
❒ Various times during the day ❒ Other: ______________

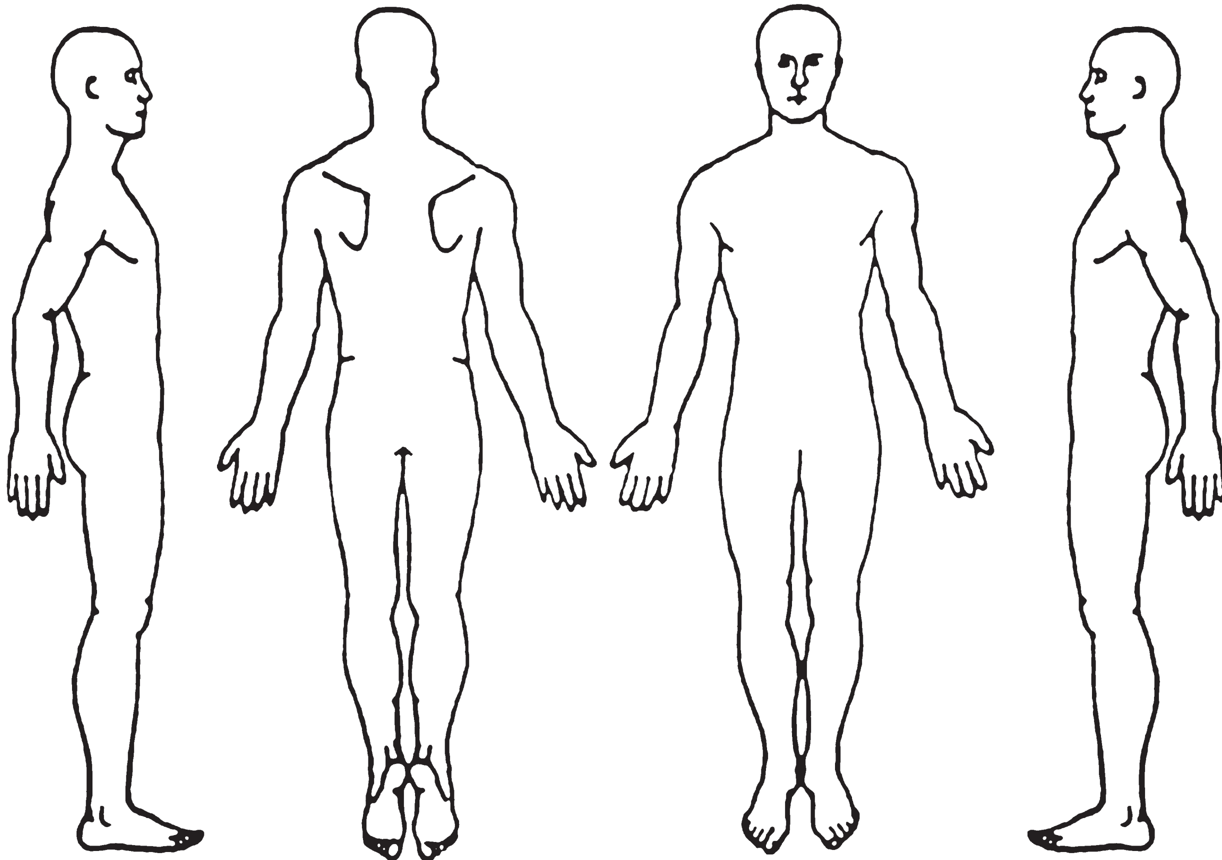
Do you have any associated symptoms? (Check all that apply)

❒ Throbbing ❒ Shooting ❒ Stabbing ❒ Sharp ❒ Cramping ❒ Burning ❒ Aching
❒ Heavy ❒ Numbness ❒ Tingling ❒ Weakness ❒ Headache ❒ Dizziness ❒ Nausea
❒ Vomiting ❒ Fatigue ❒ Balance Problems
❒ Bowel or Bladder Problems ❒ Other: ______________

Does anything make your pain worse? (Check all that apply)

❒ Bending ❒ Sitting ❒ Twisting ❒ Standing or Walking Too Long
❒ Lifting ❒ Lying Flat ❒ Can't Find a Comfortable Position ❒ Other: ___________

Place an **X** on the areas where you are experiencing pain.



What treatments have you already had for this condition?

TREATMENTS	YES	NO	WHERE?
Physical Therapy	❒ Yes	❒ No	
Pain Injections	❒ Yes	❒ No	
Chiropractor	❒ Yes	❒ No	
Ibuprofen/Aspirin	❒ Yes	❒ No	
Prescription Painkillers	❒ Yes	❒ No	
Past Surgery	❒ Yes	❒ No	
Oral Steroids	❒ Yes	❒ No	
Acupuncture	❒ Yes	❒ No	
Bed Rest	❒ Yes	❒ No	
Exercise	❒ Yes	❒ No	

Does your pain medication:

❒ Relieve most of your pain? ❒ Relieve about 75% of your pain?

❒ Relieve about 50% of your pain? ❒ Relieve about 25% of your pain? ❒ Relieve only a slight amount of pain?

❒ How long does your relief last after taking your pain medication?: ____________ hrs

Which of the following have been adversely affected by your painful condition?

❒ Activities of daily living ❒ Normal lifestyle ❒ Work activities ❒ Sleep

Please check the aids or devices that you use:

❒ Wheelchair ❒ Crutches ❒ Walker ❒ Cane **Use:** ❒ Recent ❒ Longterm

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Patient History

Name: ______________________ Date: __________

Have you previously had any films taken? ❒ Yes ❒ No

Facility: ______________________

Type of Film: ______________________ Date: __________

Facility: ______________________

Type of Film: ______________________ Date: __________

Facility: ______________________

Type of Film: ______________________ Date: __________

Please list any medications you are currently taking:

MEDICATION	DOSAGE	FREQUENCY	DURATION

Please continue on back if necessary.

Name: ______________________________

List any medication you are allergic to and your reaction to them:

____

____

Are you allergic to contrast iodine? ❒ Yes ❒ No

Are you claustrophobic? ❒ Yes ❒ No

Do you have any metal in your body? ❒ Yes ❒ No

If yes, please describe:

____

____

Do you have a history of kidney problems? ❒ Yes ❒ No

If yes, please describe:

____

____

List any past medical history (e.g. heart attack, cancer, diabetes, high blood pressure, etc.):

____

____

List any family medical history (e.g. heart attack, cancer, etc.) and identify relative:

____

____

List any surgeries you have had along with the approximate year of each surgery.

____

____

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What is your marital status? ❐ Married ❐ Never Married ❐ Divorced/Separated
❐ Widowed ❐ Number of children (if applicable)? ___________

What is your occupation? ____

Do you drink (beer, wine, or liquor)? ❐ Yes ❐ No Frequency ___________

Do you now use, or have you used illegal drugs? ❐ Never used
❐ IV drugs still use _____________ quit when _____________
❐ Marijuana still use _____________ quit when _____________
❐ In recovery how long? _____________
❐ Currently addicted

Do you use tobacco? If yes, for how long? _____________ **years.**
❐ Never ❐ Smoke _____ cigarettes per day ❐ Smoke _____ cigars per day
❐ Smoke _____ pipefull(s) per day ❐ Chews _____ pouches per week ❐ Dips _____ cans per week

Do you live in a house with a smoker? ❐ Yes ❐ No

Do you exercise? ❐ Yes ❐ No ❐ Unable to due to pain
❐ Type: ____
❐ Frequency: ____

Do you have an Advanced Care Plan? (I.e. Will, Medical Power of Attorney) ❐ Yes ❐ No
If yes, who is named to make decisions on your behalf if the need should arise?_________________

Have you received a flu vaccine this season/year? ❐ Yes ❐ No
Have you received a pneumonia vaccine this season/year? ❐ Yes ❐ No

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Please check anything you are experiencing or have recently experienced.

GENERAL/CONSTITUTIONAL:
❒ Fever ❒ Chills ❒ Change in Appetite ❒ Nausea ❒ Headaches ❒ Breast Discharge ❒ Weakness ❒ Fatigue

EYES:
❒ Cataracts ❒ Glaucoma ❒ Blurred Vision ❒ Double Vision ❒ Eye Pain ❒ Eye Inflammation
❒ Eye Trauma ❒ Visual Loss

EARS/NOSE/THROAT:
❒ Hearing Loss ❒ Recurrent Ear Infections ❒ Nose or Throat Problems ❒ Ringing in ears ❒ Nosebleeds
❒ Vertigo ❒ Taste abnormality ❒ Voice changes

CARDIOVASCULAR:
❒ Heart Attack ❒ Congestive Heart Failure ❒ Cardiac Bypass ❒ High Blood Pressure ❒ Palpitation
❒ Murmur/Irregular Heartbeat ❒ Chest pain ❒ Ankle edema ❒ Significant cardiac history ❒ Vascular disease
❒ Syncope

RESPIRATORY:
❒ Asthma ❒ Chronic Bronchitis ❒ Emphysema ❒ COPD ❒ Shortness of Breath ❒ Breathing Difficulty
❒ History of pneumonia

GASTROINTESTINAL:
❒ Bowel Incontinence ❒ Peptic Ulcer ❒ GERD ❒ Crohn's Disease ❒ IBS ❒ Abdominal Pain
❒ Constipation ❒ Diarrhea ❒ Nausea ❒ Vomiting ❒ Weight changes

GENITOURINARY:
❒ Repeated Urinary Tract Infections ❒ Blood in Urine ❒ Discharge ❒ Urinary Incontinence

MUSCULOSKELETAL:
❒ Posture abnormalities ❒ Arthritis ❒ Abnormal muscles ❒ Muscle pain ❒ Swelling ❒ Wasting or atrophy
❒ Night cramps ❒ Recent trauma or injury ❒ Fractures ❒ Migratory pain ❒ Muscular weakness ❒ Abnormal joints

SKIN:
❒ Rash ❒ Dryness ❒ Boils ❒ Skin eruptions ❒ Significant skin disorders

NEUROLOGICAL:
❒ Stroke ❒ Tremors ❒ Dizziness ❒ Numbness ❒ Tingling Sensation ❒ Paralysis ❒ Muscle Weakness
❒ Speech Problems ❒ Gait disturbance ❒ Seizures

PSYCHIATRIC:
❒ Anxiety ❒ Depression ❒ Forgetfulness ❒ Memory Loss ❒ Irritability ❒ Adjustment problems
❒ Hallucinations/delusions ❒ Taking Psychiatric medication

ENDOCRINE:
❒ Diabetic symptoms ❒ Change hand or feet size ❒ Diabetes family history ❒ Obesity ❒ Abnormal skin pigments
❒ Abnormal sex developments ❒ Sterility ❒ Thyroid disease ❒ Unusual weakness ❒ Weight change
❒ Abnormal growth ❒ Abnormal hair distribution ❒ Abnormal head size ❒ Abnormal body proportion

Practice Financial Policy

MEDICAL INSURANCE

Providing quality medical care to our patients is our primary concern. In order to accommodate the needs of our patients, we have enrolled and contracted with many health plans. With your cooperation and assistance, you should be able to receive all of the benefits offered to you by your health plan allowing our physicians the opportunity to concentrate on caring for your medical needs. In order to facilitate your care, we ask that you read and follow these guidelines:

- Please bring your insurance card to all office appointments.
- If you have an HMO or other managed-care policy, you must obtain a referral from your PCP as instructed by your insurance company. Due to HMO regulations and restrictions, we may have to cancel or reschedule your appointment until a referral is obtained.
- Depending on your particular plan, the referral may be good for one year or only two visits. So that you are better informed, please verify the number of visits permitted. You will be responsible for any visit not authorized.
- We will collect all applicable co-pays, co-insurances, and deductibles at the time of service.
- In all cases, our office collects an estimate of your financial responsibility. We submit all claims to your insurance carrier and the insurance company then designates the definitive patient responsibility. We will credit any overpayment in a timely manner. If you have a responsibility greater than what was originally collected, our office will send you a statement for the additional portion. You may contact our Financial Counselor to make arrangements for payment.

THIRD PARTY LIABILITY CARRIER

Third party liability insurance is not accepted by this Practice.

WORKER COMPENSATION

Worker Compensation claims are handled directly with the carrier and we work closely with their case managers in your recovery. Your recovery and returning to work takes a partnership with you, your case manager, and our physicians. If your claim has been accepted or deemed compensable there will be no charges incurred by you. Should your claim be denied or deemed not compensable by the worker compensation carrier, all charges will be your responsibility.

SELF PAY

Payment is expected at the time service is rendered. However, treatment decisions are based solely on the patient's medical needs. NeuroTexas will not deny critical care to anyone due to their inability to pay or lack of insurance. Patients who have financial constraints should speak to a financial counselor for assistance.

METHODS OF PAYMENT

Should you have a balance remaining after your insurance carrier has paid, and for patients without insurance the following options are offered:

Cash, Check, Visa, Master Card, Discover, American Express

Should your balance be substantial, a short-term repayment agreement can be arranged by speaking with one of our financial counselors.

COLLECTION POLICY

Any account balance older than six months that has not been discussed with our billing department will be turned over to an outside collection agency. Failure to maintain payment arrangements may also provide cause to pursue more aggressive collection activities.

A patient that has been placed in collections must pay any balance owed directly to the collection agency.

Once the balance has been satisfied, please contact our office so that we may confirm your status with the collection agency before scheduling a new appointment.

I have read and understand the Financial Policy of Neurotexas:

Signature: ____ Date: ____________________

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Neuro Texas Patient HIPAA Acknowledgement and Consent Form

Name: ______________________________ Date of Birth: ______________

_______ (Patient initials) **Notice of Privacy Practices**. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practices Notice of Privacy Practices.

_______ (Patient initials) **Release of Information**. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purposes related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for the payment of a Medicare claim or to the appropriate state agency for the payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne, diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and other listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

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Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communication/information at that email or text address from the practice.

______ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is ______________________ .
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is ______________________ .
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: ____

Patient/Patient Representative Signature: ______________________________

Date: ______________________ Time: ______________________

______ (Patient initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Patient Signature: ____ Date: ______________________

neurotexas, PLLC®
Brain & Spinal Surgery

Pain Management Medication Agreement

The vast majority of our patients use pain medications appropriately, but pain medications have a potential for misuse and are therefore closely controlled by local, state, and federal authorities. Tolerance with repeated use is a characteristic feature of these medications and is a potential limitation to their use in pain management. To prevent any misunderstanding between you and your doctor, we have developed the following rules.

I agree to accept responsibility to know whether there are any Controlled Substances in any medications that I take.

1. I agree to not ask multiple doctors for Controlled Substance medication prescriptions.
2. No prescriptions will be refilled early.
3. No prescription will be refilled if I lose or destroy any of my medication.
4. I will get all of my prescriptions filled at one pharmacy which is:
   Name: ______________________ Phone: ______________
5. Refills will only be authorized during normal clinic hours of 8:30 AM – 4:00 PM Monday – Thursday, 8:30 AM – 12:00 PM Fridays. Refills will not be made on weekends, holidays or at night. Please do not call the after-hours medical service for this reason.
6. NeuroTexas does not have the ability to manage long-term pain. Our office will prescribe appropriate medications pre- and post-surgery up to 4-6 weeks post-operatively per physicians' orders. Any patient requiring medications for a longer duration will be referred to pain management for additional care.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present a valid picture identification and sign for the prescription.

______ (Patient initials) I wish to designate the following family member / friend to pick-up an order on my behalf:

Name: ______________________ Date: ______________

Name: ______________________ Date: ______________

______ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

I understand and agree to follow these patient rules for Pain Management while under the care of NeuroTexas. The NeuroTexas staff has answered any and all questions to my satisfaction. If I do not follow these rules completely, the clinic physicians and staff reserve the right to stop any further prescribing of these medications. I have received a copy of this agreement.

____
Signature of Patient

______________________ ______________________
Printed Name of Patient Date