NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.

Please thoroughly complete this form before turning in. Thank you!

PLEASE PRINT | DOCTOR YOU ARE SEEING TODAY | DATE

PATIENT INFO

LAST NAME FIRST M.I.	DATE OF BIRTH MO.____DAY____YEAR____	AGE	MARITAL STATUS ___M___S___W D SEP	SEX M____F____
ADDRESS	APT #	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	RESIDENCE PHONE NUMBER ( )	CELLPHONE NUMBER ( )	EMAIL ADDRESS	
EMPLOYER	OCCUPATION	DOMINANT HAND LEFT____ RIGHT____		
EMPLOYER ADDRESS	CITY	STATE	ZIP	PHONE ( )

SPOUSE INFO OR INSURED

LASTNAME FIRST M.I.	DATE OF BIRTH MO.____DAY____YR____	AGE	SEX M____F____
SOCIAL SECURITY NUMBER	EMPLOYER	OCCUPATION	CELLPHONE NUMBER ( )
EMPLOYER ADDRESS	CITY	STATE	ZIP	PHONE ( )	RELATIONSHIP

	NAME	ADDRESS	CITY	STATE	ZIP	PHONE
Referring Physician						( )
Primary Physician						( )
Treating Physician						( )

Primary Insurance

INSURANCE COMPANY	POLICY #	GROUP #
INSURED'S NAME	INSURED'S DOB MO____DAY____YEAR____	NETWORK

Secondary Insurance

INSURANCE COMPANY	POLICY #	GROUP #
INSURED'S NAME	INSURED'S DOB MO____DAY____YEAR____	NETWORK

EMERGENCY CONTACT AT DIFFERENT ADDRESS	NAME	ADDRESS CITY STATE ZIP	PHONE	RELATIONSHIP

PREFERRED METHOD OF CONTACT Please indicate your preferred method(s) of contact in the event you need to be reached regarding appointment scheduling or other issues:
____ Home Phone ____ Cell Phone ____Work Phone ____Email _____Postal Mail

I hereby give permission for Neurosurgical Associates to leave message(s) on my voicemail concerning my appointment information at the following phone number:_____

EMPLOYER AT TIME OF INJURY	DATE OF INJURY	WORKERS COMPENSATION INSURANCE COMPANY	NETWORK

ON-THE-JOB INJURY

NAME	NAME
ADDRESS	ADDRESS
CITY	CITY
STATE ZIP	STATE ZIP
CLAIM FILED YES___NO____ CLAIM #	ADJUSTOR NAME ADJUSTOR PHONE ( )

ACCIDENT RELATED

ARE YOU REPRESENTED BY AN ATTORNEY? YES_____ NO _____		ATTORNEY'S FULL NAME		
AUTO_____OTHER_____	STATE INJURY OCCURRED IN: _____	STREET ADDRESS		
DATE OF INJURY	CITY	STATE	ZIP	PHONE ( )

ASSIGNMENT OF BENEFITS

I, hereby authorize Neurosurgical Associates of San Antonio, P.A. to release any information acquired in the course of my examination or treatment to the Social Security Administration or its intermediaries and/or insurance companies as needed for this or any related Medicare and/or insurance claims. I permit a copy of this authorization to be used in place of the original, and request that benefits be assigned to Neurosurgical Associates of San Antonio, P.A.

SIGN HERE | Date

Revised May 2014

Patient Name: _____ **Date of Birth:** _____

CHRISTOPHER A. BOGAEV, M.D.
PATIENT HEALTH HISTORY

The Physicians of Neurosurgical Associates are pleased that you have come in today.
Please take a few minutes to answer some general medical questions.

Current Age: _____ **Occupation:** _____**Date :** _____

BP _____ Pulse _____ Temp _____ Weight _____Height_____ **Dominant Hand:** Right___ or Left___

Who is your family doctor or internist: *Please include full name* _____

Who referred you here?_____

List any and all operations that you have had in the past, *including dates:*_____

_____

_____

List any medical conditions that you may have: _____

_____

_____

List allergies and reaction to medications that you may have: _____

_____

_____

List medications and doses you are currently taking:_____

_____

_____

List any relatives or friends who may have seen a doctor in this group and which doctor:

_____

Have you ever had any of the following?

High blood pressure	Yes ___	No ___	Heart attack	Yes ___	No ___
Diabetes	Yes ___	No ___	Phlebitis/blood clots	Yes ___	No ___
Bleeding problems	Yes ___	No ___	Ulcers	Yes ___	No ___
Asthma	Yes ___	No ___	Kidney problems	Yes ___	No ___
Pneumonia	Yes ___	No ___	Hepatitis	Yes ___	No ___
Major infections	Yes ___	No ___	Liver problems	Yes ___	No ___

Office Use Only
DX:_____
Ear Medical Group: Perry / Syms / King Neurology Endocrinology PT /OT / Speech / Chara
Shunt Reprogrammed To: _____
Surgery Procedure: _____
CPT Codes: _____
# of Hours: _____ Stealth MRI:_____ CNM:_____
Additional Instructions: _____
Films: _____

Patient Name:_____**Date of Birth:**_____

Smoking Status:

____Current every day smoker_____packs of cigarettes per day for_____years.

____Current periodic smoker_____cigarettes per day for_____years.

____ Yes, I smoke cigars or a pipe ____everyday _____some days.

____ No, I have never smoked.

____ No, I quit____years ago. At that time I was smoking_____packs per day for____years.

Do you use alcoholic beverages ? *Yes___or No____If yes, how much?*_____

List any illnesses or medical problems that run in your family:

Family Member	Alive	Deceased	Age	Status or Cause of Death	Medical Condition
Grandmother (mom)					
Grandfather (mom)					
Grandfather (dad)					
Grandmother (dad)					
Father					
Mother					
Sister/Brother					
Sister/Brother					

Please describe complaint, which brings you to the doctor today:

_____

_____

What activity, if any, makes your symptoms:

Better:_____
Worse:_____

Have you missed any work since your symptoms began ? *Yes___or No____.*

If yes, how long were you out? _____
Are you working now? *Yes___or No____.*

PATIENT NAME: _____

REVIEW OF SYSTEMS

Are you currently, or have you had, problems with:

Constitutional	*Check Yes or No*	
Fever	Yes___	No___
Weight Loss	Yes___	No___
Excessive Fatigue	Yes___	No___
Night Sweats	Yes___	No___
Eyes		
Wear Glasses---Date of Last Exam: _____	Yes___	No___
Infections	Yes___	No___
Injuries	Yes___	No___
Glaucoma	Yes___	No___
Cataracts	Yes___	No___
Ear, Nose, Throat and Mouth		
Wear Hearing Aids-----Date of Last Exam: _____	Yes___	No___
Hearing Loss	Yes___	No___
Ear Pain	Yes___	No___
Ear Infections	Yes___	No___
Ringing in Ears *Circle*:___Left ___Right ___Both	Yes___	No___
Balance Disturbance (e.g., Vertigo, Spinning)	Yes___	No___
Nosebleeds	Yes___	No___
Nasal Congestion	Yes___	No___
Nasal Drainage----Amount_____ Color_____	Yes___	No___
Inability to Smell	Yes___	No___
Sinus Problems	Yes___	No___
Sinus Headaches	Yes___	No___
Sore Throats	Yes___	No___
Mouth Sores	Yes___	No___

*PATIENT SIGNATURE:*_____ *Date:* _____

PATIENT NAME: _____

Cardiovascular

Chest Pain or Angina----Date of Last EKG:_____	**Yes___**	**No___**
High Blood Pressure	**Yes___**	**No___**
Irregular Pulse	**Yes___**	**No___**
Heart Murmur	**Yes___**	**No___**
High Cholesterol	**Yes___**	**No___**
Swelling in Feet or Hands	**Yes___**	**No___**
Leg Pain while Walking	**Yes___**	**No___**

Respiratory

Asthma	**Yes___**	**No___**
Chronic cough	**Yes___**	**No___**
Emphysema	**Yes___**	**No___**
Shortness of Breath	**Yes___**	**No___**
Bronchitis	**Yes___**	**No___**
Pneumonia	**Yes___**	**No___**
Lung Cancer	**Yes___**	**No___**
Bloody Sputum	**Yes___**	**No___**

Date of Last Chest X-ray: _____

Gastrointestinal

Indigestion or Pain with Eating	**Yes___**	**No___**
Nausea	**Yes___**	**No___**
Vomiting	**Yes___**	**No___**
Blood in your Vomit	**Yes___**	**No___**
Liver Disease	**Yes___**	**No___**
Jaundice	**Yes___**	**No___**
Abdominal Pain	**Yes___**	**No___**
Change in your Bowel Habits	**Yes___**	**No___**
Ulcers or Gastritis	**Yes___**	**No___**
Colon Cancer	**Yes___**	**No___**

Genitourinary

Urinary Tract Infections	**Yes___**	**No___**
Painful Urination	**Yes___**	**No___**
Blood in Your Urine	**Yes___**	**No___**
Difficulty Starting or Stopping Stream	**Yes___**	**No___**
Incontinence	**Yes___**	**No___**
Kidney Stones	**Yes___**	**No___**
Prostate Cancer (males)	**Yes___**	**No___**
Endometriosis (females)	**Yes___**	**No___**
Uterine or Cervical Cancer (females)	**Yes___**	**No___**

*PATIENT SIGNATURE:*_____ *Date:* _____

PATIENT NAME: _____

Musculoskeletal

Broken Bones----List: _____	**Yes___**	**No___**
Arm or Leg Weakness	**Yes___**	**No___**
Back Pain	**Yes___**	**No___**
Arm or Leg Pain	**Yes___**	**No___**
Joint Pain or Swelling	**Yes___**	**No___**
Arthritis	**Yes___**	**No___**

Integumentary

Skin Disease	**Yes___**	**No___**
Skin Cancer	**Yes___**	**No___**
Breast Pain, Tenderness or Swelling (female)	**Yes___**	**No___**
Nipple Discharge (females)	**Yes___**	**No___**
Date and Result of Last Mammogram (females) _____		

Neurological

Fainting Spells or "Blacking Out"	**Yes___**	**No___**
Seizures	**Yes___**	**No___**
Problems with Your Memory	**Yes___**	**No___**
Disorientation	**Yes___**	**No___**
Difficulty with Your Speech	**Yes___**	**No___**
Inability to concentrate	**Yes___**	**No___**
Double or Blurred Vision	**Yes___**	**No___**
Face Weakness	**Yes___**	**No___**
Coordination in Arm and/or Legs	**Yes___**	**No___**

Psychiatric

Anxiety	**Yes___**	**No___**
Depression	**Yes___**	**No___**
Other Psychiatric Disorder/Treatment: _____	**Yes___**	**No___**

Endocrine

Diabetes	**Yes___**	**No___**
Thyroid Disease	**Yes___**	**No___**
Increased Appetite	**Yes___**	**No___**
Excessive Thirst or Urination	**Yes___**	**No___**
Hormone Problems	**Yes___**	**No___**

Hematologic/Lymphatic

Anemia	**Yes___**	**No___**
Hemophilia	**Yes___**	**No___**
Bleeding Tendencies	**Yes___**	**No___**
Persistent Swollen Glands or Lymph Nodes	**Yes___**	**No___**
Blood Transfusion	**Yes___**	**No___**
If yes, when? _____		

Allergic/Immunologic

Food Allergies	**Yes___**	**No___**
Inhalant (nasal) Allergies	**Yes___**	**No___**
Immunologic Disorders	**Yes___**	**No___**

*PATIENT SIGNATURE:*_____ *Date:* _____

PATIENT NAME: _____

Is this problem the result of an accident/injury ? *Yes___or No___. (IF NO, SKIP THIS BOX)*

1. **Check one:**_____On-the-job _____Auto_____Other

2. **Date of Injury:** _____

3. **Briefly describe what happened and where:**
_____
_____
_____
_____
_____

4. **Is there an attorney involved in your case ?** *Yes___or No___.* ***If yes,***

Full Name of Attorney: _____
Full Address: _____
_____
Phone Number: _____

I hereby authorize you to release to my attorney any information including the diagnosis and records of any treatment or examination rendered to me.

Signature_____Date:_____

*PATIENT SIGNATURE:*_____ *Date:* _____

*MA SIGNATURE:*_____ *Date:* _____

Authorization to Release Information to Individuals/Family Members

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), in order for your healthcare provider or staff of Neurosurgical Associates of San Antonio, P.A. to discuss your condition with members of your family or other individuals that you designate, we must obtain authorization prior to doing so. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ I **DO NOT** authorize Neurosurgical Associates of San Antonio, P.A. to release any or all Information concerning my medical care to any individual except as set forth by Notice of Privacy Practices

_____ I **authorize** Neurosurgical Associates of San Antonio, P.A. to verbally release any or all information concerning my medical care to the following individuals.

1. _____ **Relation to Patient:**_____
2. _____ **Relation to Patient:**_____
3. _____ **Relation to Patient:**_____
4. _____ **Relation to Patient:**_____
5. _____ **Relation to Patient:**_____

_____ ___/_____/_____
Patient Name (PLEASE PRINT) DOB

_____ _____
Patient Signature Date

Neurosurgical Associates of San Antonio, P.A.

Patient Pharmacy Information

Date: _____

Patient Name:_____ DOB:_____

Please provide the name and contact information of your preferred pharmacy. It is preferred that you choose one pharmacy. If you use multiple pharmacies, please provide the information for each one.

Pharmacy Name:_____

Phone Number: _____

Address/Cross Streets:_____

Pharmacy Name:_____

Phone Number:_____

Address/Cross Streets:_____

Pharmacy Name:_____

Phone Number:_____

Address/Cross Streets:_____

It is important to provide complete information to ensure your medications can be prescribed electronically.

Neurosurgical Associates of San Antonio, P. A.

4410 Medical Drive Suite 610
San Antonio, TX 78229

NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP

This is a notice informing you that **Dr. Christopher A. Bogaev** has NO financial relationships with any medical device development, manufacturing, and/or distributing companies.

If you have any questions regarding this notice, please let us know.

By signing below, you are acknowledging that you have received a notice of the information provided above.

Date_____

_____ _____ _____
Signature of Patient Signature of Guardian (if applicable)

_____ _____
Printed Name of Patient Print Name of Guardian (if applicable)

Patient DOB: _____

North **C**entral **O**ffice
1139 E. Sonterra Blvd., Suite 301
San Antonio, Texas 78258-4347
(210) 477-1956
Fax (210) 477-1965

Downtown Office
1303 McCullough Ave., Suite 264
San Antonio, Texas 78212-5609
(210) 614-2453
Fax (210) 614-2462

Neurosurgical Associates of San Antonio, P.A.

Thank you for choosing Neurosurgical Associates of San Antonio for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if minor) is ultimately responsible for payment for treatment and care.
- We will bill your insurance for you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.
- Provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks- $ 40.00

By signing below, I agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. My signature verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

Patient Name (Please Print) _____ **DOB** _____

Patient/ Guardian Signature_____ **Date** _____

NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Neurosurgical Associates of San Antonio, P.A. (NASA) uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You may request a copy of this notice at any time.

How Neurosurgical Associates of San Antonio, P. A. May Use or Disclose Your Medical Information

Treatment: NASA may use and disclose your medical information to those involved in your treatment. For example, the physicians in our office are specialists. When we provide treatment, we may request that your primary care and/or referring physician share your medical information with us. Also we may provide your primary care and/or referring physician information about your particular condition so that he/she can appropriately treat you.

Payment: NASA may use and disclose your medical information to bill and collect payment for the services provided to you. For example, a claim may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the claim may contain information that identifies you, your diagnosis, and treatment provided.

Medication History: NASA has implemented an electronic medical record system in order to improve the quality of our services and patient care. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other physicians have prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. This information will become part of your medical record. Your medication history might not include over the counter medicines, supplements or herbal remedies which you will be required to list on our patient intake form. Therefore it is important for you to disclose all medications you are currently taking (prescribed and over the counter).

Health Care Operations: NASA may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff
- Assess the quality of care and outcomes in your case and similar cases
- Learn how to improve our facilities and services
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointment Reminders and Treatment Calls. NASA may contact you by telephone, mail, or both to provide appointment reminders, information about your treatment plan, medication or test results. When contacts are made via telephone, messages may be left on answering machines with physician name, person calling, and telephone number.

Disclosures That Can Be Made Without Your Authorization: There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization, in writing, to stop futures uses and disclosures. However, any revocation will not apply to disclosure or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight: NASA may use or disclose your medical information for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Legal Proceedings and Law Enforcement: NASA may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court or appropriate legal process. NASA may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors. When a research project and its privacy protection has been approved by an Institutional Review Board or privacy board, we may release medical information to researchers. Your health information may be used or disclosed for organ or tissue donation purposes. Health information may be disclosed to funeral directors or coroners to enable them to carry out their duties.

Required by Law: NASA may release your medical information where the disclosure is required by law.

Workers Compensation: NASA may disclose your medical information as required by The Texas workers' compensation law.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent NASA has taken action in reliance on such. Examples of uses and disclosures which require your authorization include uses or disclosures (i) of psychotherapy notes except in certain circumstances, (ii) for certain marketing purposes, and (iii) in the case of the sale of your PHI to a third party.

Your Rights Under Federal Privacy Regulations

You have the right to:

- Request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do not have to agree to this restriction except in situations where you request that we restrict disclosure of your medical information to a health plan and the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law to be disclosed and the medical information solely pertains to an item or service to you, or another individual on your behalf, has paid NASA in full,. If we do agree to a restriction, we will comply with your request under circumstances
- Inspect and obtain a copy of your health record
- Request that your health record be amended. Any such request must be made in writing to NASA's Privacy Officer
- Request communication of your health information by alternative means or at alternative locations
- Receive an accounting of disclosures made of your health information.

Complaints

If you are concerned that your privacy rights have been violated, you may contact NASA's Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us.

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

NASA is required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect. Additionally, NASA is required to notify you of certain unauthorized access, acquisition or use of your medical information. NASA is committed to complying with all applicable laws and regulations pertaining to your medical information.

NASA may change its policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Contact Information

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Rosa Tealer Privacy Officer
4410 Medical Drive, Suite 610
San Antonio, TX 78229
Phone: 210-614-2453
Fax: 210-477-5792
Email: rlb@saneuro.com

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

_____/_____/_____

Printed Patient Name & DOB

_____

Printed Name of Personal Representative

_____

Description of Personal Representative's Authority