

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.**  
**Please thoroughly complete this form before turning in. Thank you!**

<b>PLEASE PRINT</b>		DOCTOR YOU ARE SEEING TODAY				DATE					
<b>PATIENT INFO</b>	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 ( )			
<b>SPOUSE INFO OR INSURED</b>	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			
<b>Referring Physician</b>	NAME		ADDRESS		CITY	STATE	ZIP	PHONE ( )			
<b>Primary Physician</b>	NAME		ADDRESS		CITY	STATE	ZIP	PHONE ( )			
<b>Treating Physician</b>	NAME		ADDRESS		CITY	STATE	ZIP	PHONE ( )			
<b>Primary Insurance</b>	INSURANCE COMPANY				POLICY #		GROUP #				
	INSURED'S NAME			INSURED'S DOB MO ____ DAY ____ YEAR ____		NETWORK					
<b>Secondary Insurance</b>	INSURANCE COMPANY				POLICY #		GROUP #				
	INSURED'S NAME			INSURED'S DOB MO ____ DAY ____ YEAR ____		NETWORK					
<b>EMERGENCY CONTACT AT DIFFERENT ADDRESS</b>	NAME		ADDRESS		CITY	STATE	ZIP	PHONE	RELATIONSHIP		
<b>PREFERRED METHOD OF CONTACT</b>	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										
<b>I hereby give permission for Neurosurgical Associates to leave message(s) on my voicemail concerning my appointment information at the following phone number:</b> _____											
<b>ON-THE-JOB INJURY</b>	EMPLOYER AT TIME OF INJURY			DATE OF INJURY		WORKERS COMPENSATION INSURANCE COMPANY			NETWORK		
	NAME				NAME						
	ADDRESS				ADDRESS						
	CITY				CITY						
	STATE				ZIP		STATE				ZIP
CLAIM FILED YES__NO__			CLAIM #		ADJUSTOR NAME			ADJUSTOR PHONE ( )			
<b>ACCIDENT RELATED</b>	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 ( )			
<b>ASSIGNMENT OF BENEFITS</b>	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.										
<b>SIGN HERE</b>							Date				

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.**  
**Robert G. Johnson, M.D.**  
**MEDICAL QUESTIONNAIRE**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Dominant Hand: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Please describe complaint that brings you to the doctor today: \_\_\_\_\_

\_\_\_\_\_

List all operations/hospitalizations you have had in the past, including dates: \_\_\_\_\_

\_\_\_\_\_

Have you ever had problems with anesthesia? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, what? \_\_\_\_\_

\_\_\_\_\_

List any medical conditions that you may have: \_\_\_\_\_

\_\_\_\_\_

List known allergies and reaction: \_\_\_\_\_

\_\_\_\_\_

List medications and doses you currently take: (If you brought a list please hand it to the receptionist)

\_\_\_\_\_

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

\_\_\_\_\_

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 ___ | Blood Thinners        | Yes ___ No ___ |
| Diabetes            | Yes ___ No ___ | Heart Attack          | Yes ___ No ___ |
| Bleeding Problems   | Yes ___ No ___ | Phlebitis/Blood Clots | Yes ___ No ___ |
| Asthma              | Yes ___ No ___ | Ulcers                | Yes ___ No ___ |
| Pneumonia           | Yes ___ No ___ | Kidney Problems       | Yes ___ No ___ |
| Major infections    | Yes ___ No ___ | Hepatitis             | Yes ___ No ___ |
| Body Piercing       | Yes ___ No ___ | Liver Problems        | Yes ___ No ___ |

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.**  
**Robert G. Johnson, M.D.**

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 \_\_\_\_\_ No If yes, how much? \_\_\_\_\_

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

Have you ever had any previous back or neck problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.**  
**Robert G. Johnson, M.D.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please describe present symptoms, using a scale of 0-10 (10 being the worst):

	Pain	Numbness	Weakness
Neck	_____	_____	_____
Right Arm	_____	_____	_____
Left Arm	_____	_____	_____
Low Back	_____	_____	_____
Right Leg	_____	_____	_____
Left Leg	_____	_____	_____

What activity, if any makes your symptoms:

Better: \_\_\_\_\_

Worse: \_\_\_\_\_

Have you missed work since your symptoms began? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how long were you out? \_\_\_\_\_

Are you working now? \_\_\_\_\_ Yes \_\_\_\_\_ No

Which of the following have you done to treat your problem and for how long?

Bedrest: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical Therapy: \_\_\_\_\_

Traction: \_\_\_\_\_

TENS Unit: \_\_\_\_\_

Injections: \_\_\_\_\_

Other physicians you have seen for this problem? \_\_\_\_\_

\_\_\_\_\_

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.**  
**Robert G. Johnson, M.D.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please identify and/or list any medications taken to treat the reason for this physician's visit.

MEDICATION	When- How long did you take the medication?	Did the medicine help?	Does it still help?
Acetaminophen (Tylenol)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Acetaminophen with Hydrocodone ( Vicodin)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Oxycodone (OxyContin)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Oxycodone (Oxycodone with Acetaminophen (Percocet)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Hydrocodone with Acetaminophen (Norco)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Ultram (Tramadol)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
<b>OTHER ANTI-INFLAMMATORIES:</b>			
Aspirin		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Naproxen (Aleve)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Ibuprofen (Motrin)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Celecoxib (Celebrex)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Meloxicam (Mobic)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Methylprednisolone (Medrol Dose Pak)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Hydrocortisone (Solu-Cortef)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
<b>MUSCLE RELAXERS:</b>			
Cyclobenzaprine (Flexeril)		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Skelaxin		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Soma		Yes ___ No ___ N/A	Yes ___ No ___ N/A
Other:		Yes ___ No ___ N/A	Yes ___ No ___ N/A
		Yes ___ No ___ N/A	Yes ___ No ___ N/A
		Yes ___ No ___ N/A	Yes ___ No ___ N/A
		Yes ___ No ___ N/A	Yes ___ No ___ N/A

Do you exercise daily? \_\_\_ Yes \_\_\_ No

Have you had to modify your activity lifestyle? \_\_\_ Yes \_\_\_ No

If yes, please provide examples. \_\_\_\_\_  
 \_\_\_\_\_

Has weight control been discussed as contributing factor ? \_\_\_ Yes \_\_\_ No

If yes, have you lost weight ? \_\_\_ Yes \_\_\_ No

Physical Therapy? \_\_\_ Yes \_\_\_ No If yes, for how long ? \_\_\_\_\_

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.**  
**Robert G. Johnson, M.D.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is this problem the result of an accident/injury? \_\_\_\_\_ Yes      \_\_\_\_\_ No (if NO, skip this box)

1. Check one: \_\_\_\_\_ On-the job      \_\_\_\_\_ Auto      \_\_\_\_\_ Other

If other, please state: \_\_\_\_\_

2. Date of Injury: \_\_\_\_\_

3. Briefly describe what happened and where: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Is there an attorney involved in your case? \_\_\_\_\_ Yes      \_\_\_\_\_ No      If yes,

Full Name of Attorney: \_\_\_\_\_

Complete 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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration</i></p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p><i>SECTION 2 - Personal Care (Washing, Dressing, etc.)</i></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help, but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self care.</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Work</i></p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can only do my usual work, but no more.</p> <p><input type="checkbox"/> I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Driving</i></p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 - Headaches</i></p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p><i>SECTION 10 - Recreation</i></p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in a few of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I cannot do any recreational activities at all.</p>

**COMMENTS:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **SCORE:** \_\_\_\_\_

**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. Robert G. Johnson** has one or more financial relationships with the following medical device development, manufacturing, and/or distributing companies:

### **Celling Biosciences, LLC**

He may, directly or indirectly, receive compensation for services you receive that may involve use of any of the products developed, manufactured, or distributed by these 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 Central Office**  
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 future 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.

# NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A

## NOTICE OF PRIVACY PRACTICES

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.

# NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A

## NOTICE OF PRIVACY PRACTICES

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](mailto:rlb@saneuro.com)

**NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A**

**NOTICE OF PRIVACY PRACTICES**

**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