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

Neurosurgical Associates of San Antonio, P.A.
Donald P. Atkins, M.D.
Medical Questionnaire

Today's Date _____

Patient Name _____ Date of Birth _____ Age:_____

Occupation _____ Weight _____ Height _____ Dominant Hand ___Right ___Left

Primary Care Physician: _____ Referring Physician:_____

Pain Management Physician: _____

Reason for today's visit _____

List any known drug allergies and reactions _____

Any other known allergies:_____

List all medications you take regularly:

☐ Currently takes no medications

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

For Office Use Only:

Diagnosis _____

RTC ___ 3 Weeks ___ 1 Month ___ 6 Weeks ___ 3 Months ___ 6 Months ___ PRN
___ After SO Completed ___ Other _____

Services Ordered: 1. _____

2. _____

3. _____

4. _____

Immunization History:

Have you had an influenza (flu) vaccine? ___ No ____ Yes If yes, when? _____

Have you had a Pneumococcal (pneumonia) vaccine? ___ No ____ Yes If yes, when? _____

Social History:

Smoking Status: _____ Does not smoke _____ Current Smoker

Do you drink alcoholic beverages? Yes ___ No ____ If yes, how much? _____

Please indicate below if you have any medical conditions (check all that apply):

___ High Blood Pressure ___ Heart Disease ___Asthma ___ COPD ___ Ulcers ___Gastric Reflux

___ Cancer ___ Bleeding Disorder ___ Epilepsy ___ Stroke ___ Diabetes ___ Kidney Failure ___ Liver Disease

Other _____

Surgical/Hospitalization History:

Spine Surgeries you have had in the past, including dates:_____

_____

Other operations/hospitalizations you have had in the past, including dates:_____

_____

_____

Please indicate any of the following symptoms that you may be recently experiencing:

___ Fever
___ Vision Change
___ Sleep Apnea
___ Chest Pain
___ Dyspnea (shortness of breath walking)
___ Abdominal (stomach) Pain
___ Urinary Incontinence
___ Myalgia (generalized aches)
___ Headache
___ Easy Bleeding or Bruising

Please provide the name and contact information of your preferred pharmacy.

Pharmacy Name _____

Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Conservative Care Treatment

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

Medication	When-How long did you take the medication?	Did the medicine help?	Does it still help?
Acetaminophen (Tylenol)		Yes No	Yes No
Acetaminophen with Hydrocodone (Vicodin)		Yes No	Yes No
Oxycodone (OxyContin)		Yes No	Yes No
Oxycodone (Oxycodone with Acetaminophen (Percocet)		Yes No	Yes No
Hydrocodone with Acetaminophen (Norco)		Yes No	Yes No
Ultram (Tramadol)		Yes No	Yes No
Other Anti-Inflammatories			
Aspirin		Yes No	Yes No
Naproxen (Aleve)		Yes No	Yes No
Ibuprofen (Motrin)		Yes No	Yes No
Celecoxib (Celebrex)		Yes No	Yes No
Meloxicam (Mobic)		Yes No	Yes No
Methylprednisolone (Medrol Dose Pak)		Yes No	Yes No
Hydrocortisone (Solu-Cortef)		Yes No	Yes No
Muscle Relaxers			
Cycloobenzaprine (Flexeril)		Yes No	Yes No
Skelaxin		Yes No	Yes No
Soma		Yes No	Yes No
Other:		Yes No	Yes No

Treatment	Yes	No	When? For how Long?	Did it help?	Facility/Dr?
Bed Rest					
Physical Therapy					
Traction					
TENS Unit					
Injections (If yes, how many)					

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? _____

1. Where is your pain or symptom located? _____
2. When did the problem begin? _____
3. What started it (if anything)? _____
4. What makes the problem (pain):

   Better: _____

   Worse: _____
5. Other physicians seen for this problem _____
6. Which hurts more? ___ back ***or*** ___ neck ___buttock/leg ***or*** ___shoulder/arm ___ neither
7. How did it begin? ___suddenly ____ gradually
8. Have you missed any work since your symptoms began? ___ Yes ___ No

   If yes, how long were you out? _____

   Are you working now? ___ Yes ___ No

Please describe your present symptoms, *using a scale of 0-10*, with 10 being the worst.

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

Is this condition the result of an accident or injury? ___ Yes (continue below) ___ No (skip to next page)

1. If yes, check one: ___ On the Job Injury ___ Auto Accident ___ Other
2. Date of Injury: _____
3. Briefly describe what happened and where: _____

   _____

   _____
4. Is there an attorney involved in your case? ___ Yes ___ No

   If yes, please provide your attorney's contact information:

   Full Name of Attorney _____Phone Number _____

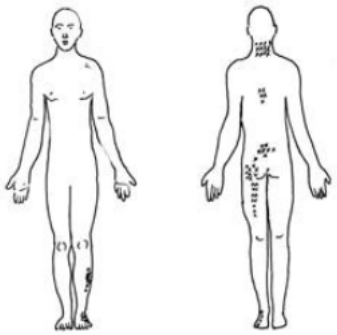
   Complete Address _____

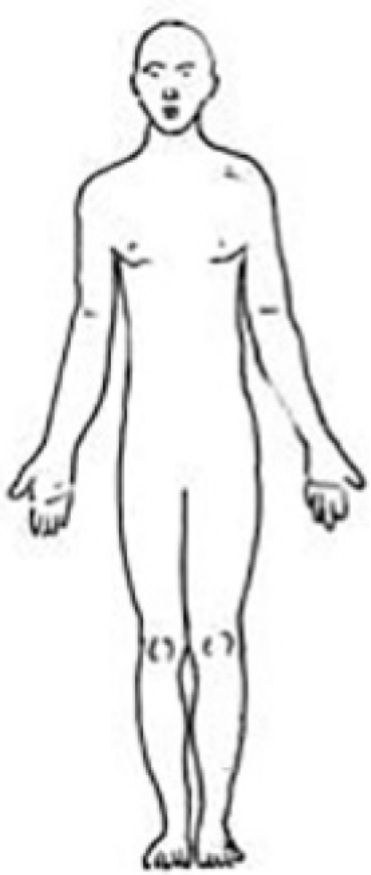
   I hereby authorize you to release to my attorney any information including the diagnosis and records of any treatment or examination rendered to me.

   Patient Signature _____ Date _____

Complete the picture below by making small X's for areas that are painful and small O's for areas that are numb or tingly on your body, be as precise as possible.

Example:





Right Left

Left Right

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.

SECTION 1 - Pain Intensity

___I have no pain at the moment.
___The pain is very mild at the moment.
___The pain is moderate at the moment.
___The pain is fairly severe at the moment.
___The pain is very severe at the moment.
___The pain is the worst imaginable at the

SECTION 2 -Personal Care (Washing, Dressing, etc.)

___I can look after myself normally without causing extra pain.
___I can look after myself normally, but it causes extra pain.
___It is painful to look after myself and I am slow and careful.
___I need some help, but manage most of my personal care.
___I need help every day in most aspects of self care.
___I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

___I can lift heavy weights without extra pain.
___I can lift heavy weights, but it gives extra pain.
___Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
___Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
___I can lift very light weights.
___I cannot lift or carry anything at all.

SECTION 4 - Reading

___I can read as much as I want to with no pain in my neck.
___I can read as much as I want to with slight pain in my neck.
___I can read as much as I want to with moderate pain in my neck.
___I cannot read as much as I want because of moderate pain in my neck.
___I cannot read as much as I want because of severe pain in my neck.
___I cannot read at all.

SECTION 5 - Headaches

___I have no headaches at all.
___I have slight headaches which come infrequently.
___I have moderate headaches which come infrequently.
___I have moderate headaches which come frequently.
___I have severe headaches which come frequently.
___I have headaches almost all the time.

SECTION 6 - Concentration

___I can concentrate fully when I want to with no difficulty.
___I can concentrate fully when I want to with slight difficulty.
___I have a fair degree of difficulty in concentrating when I want to.
___I have a lot of difficulty in concentrating when I want to.
___I have a great deal of difficulty in concentrating when I want to.
___I cannot concentrate at all.

SECTION 7 - Work

___I can do as much work as I want to.
___I can only do my usual work, but no more.
___I can do most of my usual work, but no more.
___I cannot do my usual work.
___I can hardly do any work at all.
___I cannot do any work at all.

SECTION 8 - Driving

___I can drive my car without any neck pain.
___I can drive my car as long as I want with slight pain in my neck.
___I can drive my car as long as I want with moderate pain in my neck.
___I cannot drive my car as long as I want because of moderate pain in my neck.
___I can hardly drive at all because of severe pain in my neck.
___I cannot drive my car at all.

SECTION 9 - Sleeping

___I have no trouble sleeping.
___My sleep is slightly disturbed (less than 1 hour sleepless).
___My sleep is mildly disturbed (1-2 hours sleepless).
___My sleep is moderately disturbed (2-3 hours sleepless).
___My sleep is greatly disturbed (3-5 hours sleepless).
___My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

___I am able to engage in all of my recreational activities with no neck pain at all.
___I am able to engage in all of my recreational activities with some pain in my neck.
___I am able to engage in most, but not all of my recreational activities because of pain in my neck.
___I am able to engage in a few of my recreational activities because of pain in my neck.
___I can hardly do any recreational activities because of pain in my neck.
___I cannot do any recreational activities at all.

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.

1139 E. Sonterra Blvd #301
San Antonio, TX 78258

NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP

This is a notice informing you that **Dr. Donald P. Atkins** has one or more financial relationships with the following medical device development, manufacturing, and/or distributing companies:

Epiom
Globus Medical
Stone Oak Surgery Center
Comfort Surgery Center

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 _____

revised 1-30-19

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

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** _____

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

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