

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			
Referring Physician	NAME		ADDRESS		CITY	STATE	ZIP	PHONE ()			
Primary Physician	NAME		ADDRESS		CITY	STATE	ZIP	PHONE ()			
Treating Physician	NAME		ADDRESS		CITY	STATE	ZIP	PHONE ()			
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: _____											
ON-THE-JOB INJURY	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 ()		
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				

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

Fever

Check Yes or No

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: _____

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.

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.

1139 E. Sonterra Blvd, Suite 301
San Antonio, TX 78258
210-477-1956

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: _____

revised 12-21-18

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.

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

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