

**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 \_\_\_  
Diabetes Yes \_\_\_ No \_\_\_  
Bleeding Problems Yes \_\_\_ No \_\_\_  
Asthma Yes \_\_\_ No \_\_\_  
Pneumonia Yes \_\_\_ No \_\_\_  
Major infections Yes \_\_\_ No \_\_\_  
Body Piercing Yes \_\_\_ No \_\_\_

Blood Thinners Yes \_\_\_ No \_\_\_  
Heart Attack Yes \_\_\_ No \_\_\_  
Phlebitis/Blood Clots Yes \_\_\_ No \_\_\_  
Ulcers Yes \_\_\_ No \_\_\_  
Kidney Problems Yes \_\_\_ No \_\_\_  
Hepatitis 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: \_\_\_\_\_

# Oswestry Index Questionnaire

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two or more statements in any one section relates to you, please mark the box that **most closely** describes your present day situation.

What is your level of pain on an average day using a scale of 0-10 (10 being the worst) \_\_\_\_\_ 

## **SECTION 1 - PAIN INTENSITY**

- My pain is mild to moderate. I do not need pain killers.
- The pain is bad, but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain.

## **SECTION 2 - PERSONAL CARE**

- 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 causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

## **SECTION 4 - WALKING**

- I can walk as far as I wish.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can walk only if I use a cane or crutches.
- I am in bed or in a chair for most of every day.

## **SECTION 5 - SITTING**

- I can sit in any chair for as long as I like.
- I can sit in my favorite chair only, but for as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

## **SECTION 6 - STANDING**

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

## **SECTION 7 - SLEEPING**

- Pain does not prevent me from sleeping well.
- I sleep well but only when taking medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

## **SECTION 8 - SOCIAL LIFE**

- Social life is normal and causes me no extra pain.
- Social life is normal, but increases the degree of pain.
- Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- Pain has restricted my social life, and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

## **SECTION 9 - SEXUAL ACTIVITY**

- Sexual activity is normal and causes no extra pain.
- Sexual activity is normal, but causes some extra pain.
- Sexual activity is nearly normal, but is very painful.
- Sexual activity is severely restricted by pain.
- Sexual activity is nearly absent because of pain.
- Pain prevents any sexual activity at all.

## **SECTION 10 - TRAVELING**

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to necessary journeys under 1/2 hr.
- Pain prevents traveling except to the doctor/hospital

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SCORE \_\_\_\_\_ [50] BENCHMARK -5 = \_\_\_\_\_



# 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.

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 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: \_\_\_\_\_

# 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: [rb@saneuro.com](mailto:rb@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