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 ( )	CELL PHONE 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	CELL PHONE 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:_____

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

Revised May 2014

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

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.

Patient Name: _____ Date of Birth:_____

Smoking Status:

____Current every day smoker ____ packs of cigarettes per day for ____ years.

____Current periodic smoker ____ packs of 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						

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

NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.

Patient Name: _____ Date of Birth:_____

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?_____

_____

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: _____

Patient Signature:_____ Date:_____

MA Signature: _____ Date: _____

Authorization to Release Information to Individuals/Family Members

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

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

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

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

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

_____ _____
Patient Signature Date

Neurosurgical Associates of San Antonio, P.A.

Patient Pharmacy Information

Date: _____

Patient Name:_____ DOB:_____

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

Pharmacy Name:_____

Phone Number: _____

Address/Cross Streets:_____

Pharmacy Name:_____

Phone Number:_____

Address/Cross Streets:_____

Pharmacy Name:_____

Phone Number:_____

Address/Cross Streets:_____

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

Neurosurgical Associates of San Antonio, P. A.

4410 Medical Drive Suite 610
San Antonio, TX 78229

NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP

This is a notice informing you that **Dr. 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: _____

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

Revised 7-29-20

NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Under Federal Privacy Regulations

You have the right to:

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

Complaints

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

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

Our Promise to You

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

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

Contact Information

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

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

Acknowledgement of Review of Notice of Privacy Practices

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

_____ _____

Signature of Patient or Personal Representative Date

_____/_____/_____

Printed Patient Name & DOB

_____

Printed Name of Personal Representative

_____

Description of Personal Representative's Authority