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:______________________

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

NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.
Jordan J. Jude, M.D.
MEDICAL QUESTIONNAIRE

Today's Date:________________

Patient Name:____Date of Birth:________________

Occupation:____Dominant Hand:__________

Family Physician:________________________________Referring Physician:________________________

Pain Specialist:_________________________________Cardiologist: ______________________________

Any other Specialists?____

____

Reason for today's visit?____

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

____

____

____

List any medical conditions that you may have: ____

____

____

List drug allergies and reaction;____

____

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

____

____

____

____

Have you ever smoked? ______________________

Do you currently smoke? _________ Specific Amount ________________How often? ____________

What do you smoke?_________________________How long have you smoked?______________________

Do you use alcoholic beverages? ______________ Specific Amount ________ How often?_____________

Please select type of alcohol: ____Beer ____Wine ____Mixed Drinks ____Liquor

NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.

Patient Name: ____

Family Member	Alive	Deceased	Medical Problem/Condition
Mother			
Father			
Grandmother (mom)			
Grandmother (dad)			
Grandfather(mom)			
Grandfather(dad)			
Sister			
Brother			

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

Neck Pain	0__	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Rt Arm Pain	0__	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Lt Arm Pain	0__	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Low Back Pain	0__	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Rt Leg Pain	0__	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__
Lt Leg Pain	0__	1__	2__	3__	4__	5__	6__	7__	8__	9__	10__

Do you have any numbness or tingling?_____Yes ___No

Location of numbness/tingling:_____Left Leg/foot_____Right Leg/foot_____Left Arm/hand_____Right Arm/hand

Do you have any weakness?_____Yes ___No

Location of weakness:_____Left Leg/foot_____Right Leg/foot_____Left Arm/hand_____Right Arm/hand

What activity, if any makes your symptoms:

Better:____

____

Worse:____

____

Other physicians you have seen for this problem?______________________________

____

NEUROSURGICAL ASSOCIATES OF SAN ANTONIO, P.A.

Patient Name:____ Date of Birth:_______________

Any complaints of:

Vision changes?	NO____	YES____
Recent fevers of 101.0 or greater?	NO____	YES____
Have you been diagnosed with sleep apnea/obstruction?	NO____	YES____
Shortness of breath while walking?	NO____	YES____
Chest pain or pressure?	NO____	YES____
Abdominal pain?	NO____	YES____
Headaches?	NO____	YES____
Easy bleeding or bruising?	NO____	YES____
Recent rashes on your skin?	NO____	YES____
Loss of bladder function?	NO____	YES____

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

MEDICATION	Please indicate if you have taken	Did the medicine help?	Does it still help?	When or How long did you take the medication?
Acetaminophen (Tylenol)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Acetaminophen with Hydrocodone (Vicodin)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Oxycodone (OxyContin)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Oxycodone (with Acetaminophen)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Hydrocodonewith Acetaminophen (Norco)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Ultram (Tramadol)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
OTHER ANTI-INFLAMMATORIES:				
Aspirin	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Naproxen (Aleve)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Ibuprofen (Motrin)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Celecoxib (Celebrex)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Meloxicam (Mobic)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Methylprednisolone (Medrol Dose Pak)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Hydrocortisone (Solu-Cortef)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
MUSCLE RELAXERS:				
Cyclobenzaprine (Flexeril)	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Skelaxin	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Soma	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	
Other:	__ Yes __No	___Yes ___No ___N/A	___Yes ___No ___N/A	

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?

Treatment		Length of treatment	Did it help?
Physical Therapy	___ Yes____No		___ Yes____No
Traction	___ Yes____No		___ Yes____No
Injections	___ Yes____No		___ Yes____No

Do you routinely exercise ?_____Yes ____No

Have you had to modify your lifestyle (activity) due to problem?_____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

Is this problem the result of an accident/injury?_______Yes _______No

1. Check one:_________On-the job ________ Auto _________Other

   If other, please state:____

Date of Injury:____

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.

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 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

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. Jordan J Jude** has one or more financial relationships with the following medical device development, manufacturing, and/or distributing companies:

Alliance Spine
Encompass
Alamo City Spine, LLC
Physicians Surgical Network Affiliates

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   7-29-20

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1139 E. Sonterra Blvd., Suite 301
San Antonio, Texas 78258-4347
(210) 477-1956
Fax (210) 477-1965