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

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.

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.
Colin T. Son, M.D.
Medical Questionnaire

Today's Date _____

Patient Name _____ Age _____ Date of Birth _____

Occupation _____ Weight _____ Height _____ Dominant Hand _____

Primary Care Physician _____

Referring Physician: _____

Reason for today's visit _____

List any known drug allergies and reactions _____

List any other allergies and reactions? _____

List all medications you take regularly:

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

List any medical conditions that you may have: _____

_____

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

_____

_____

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

Do you smoke? Yes _____ No _____ If yes, how much? _____

Do you use alcoholic beverages? Yes _____ No _____ If yes, how much? _____

Family History

Family Member	Alive	Deceased	Age	Medical Conditions	Status or Cause of Death
Father					
Mother					
Grandfather (dad)					
Grandmother (dad)					
Grandmother (mom)					
Grandfather (mom)					
Sister/Brother					
Sister/Brother					
Sister/Brother					

Which of the following treatments have you done for your problem?

Treatment	Yes	No	When? For how Long?	Did it help?	Facility/Dr?
Bed Rest					
Medications					
Physical Therapy					
Traction					
TENS Unit					
Injections					

Other physicians you have seen for this problem? _____

_____

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
Other Anti-Inflammatories			
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

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? _____

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

Pharmacy Name _____

Phone Number _____

Address _____

City _____ State _____ Zip Code _____

Review of Systems
Are you currently, or have you had, problems with:

General	Check Yes or No	
Fever	Yes___	No___
Weight Loss	Yes___	No___
Excessive Fatigue	Yes___	No___
Other:_____		

Eyes		
Changes in Vision	Yes___	No___
Other:_____		

Ears, Nose, Throat, & Mouth		
Hearing Loss	Yes___	No___
Ringing in Ears ____ Left ____ Right ____ Both	Yes___	No___
Other:_____		

Neurologic		
Headaches	Yes___	No___
Fainting or Near Fainting	Yes___	No___
Seizures	Yes___	No___
Difficulty with Speech	Yes___	No___
Arm or Leg Weakness	Yes___	No___
Face Weakness	Yes___	No___
Balance Difficulty	Yes___	No___
Other:_____		

Psychiatric		
Depression	Yes___	No___
Anxiety	Yes___	No___
Other:_____		

Cardiac		
Chest Pain	Yes___	No___
Irregular Heartbeat	Yes___	No___
Other:_____		

Respiratory		
Shortness of Breath	Yes___	No___
Cough	Yes___	No___
Blood in sputum	Yes___	No___
Other:_____		

Gastrointestinal		
Nausea or Vomiting	Yes___	No___
Abdominal Pain	Yes___	No___
Diarrhea	Yes___	No___
Blood in Stool	Yes___	No___
Other:_____		

Genitourinary

Painful Urination	Yes___	No___
Difficulty starting Urination	Yes___	No___
Frequent Urination	Yes___	No___

Other:_____

Musculoskeletal

Joint Pain	Yes___	No___
Stiff Joints	Yes___	No___

Other:_____

Integumentary

Rash	Yes___	No___

Other:_____

Endocrine

Intolerance to Heat/Cold	Yes___	No___
Excessive Thirst	Yes___	No___

Other:_____

Hematologic

Easy Bruising	Yes___	No___
Excessive Bleeding	Yes___	No___
Swollen Lymph Nodes	Yes___	No___

Other:_____

Allergic/Immunologic

New Allergies	Yes___	No___

Other:_____

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 explain:_____

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_____

   Complete Address_____

   Patient Signature_____ Date_____

Patient Signature_____Date _____

MA 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. Colin R. Son** 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

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