ADVANCED NEUROSURGERY

Neurosurgery New Patient

Patient Name: _____ **DOB:** _____

Chief Complaint (Reason for visit) :_____

Were you referred to our office? ☐ Yes | ☐ No If yes, by who? _____

Where is the exact location of your pain today? _____

What were you doing when the pain started?_____

When did you first have this pain?_____

Describe your pain ☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Electric ☐ Shooting ☐ Cramping

☐ Throbbing ☐ Crushing ☐ Other_____

Is the pain constant? ☐ Yes | ☐ No How long does the pain last?_____

When is your pain the worst? ☐ Morning ☐ Middle of the Day ☐ Evening ☐ Nighttime

Which of the following worsens your pain? (Check all that apply)

☐ Using your arm or hand ☐ Reaching above your head ☐ Leaning your head forward or backward ☐ Sitting

☐ Coughing/Sneezing/Straining ☐ Lying Down ☐ Standing ☐ Walking ☐ Bending ☐ Twisting

☐ Other_____

Which of the following relieve your pain? (Check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Medication ☐ Heat / Cold ☐ Other_____

Do you have Urinary and/or Bowel problems related to the pain? ☐ Yes | ☐ No

If yes, explain_____

What have you done for the pain? (Check all that apply)

☐ Medications ☐ Acupuncture ☐ Physical Therapy ☐ Chiropractic ☐ Yoga ☐ Injections ☐ Other_____

Preferred Pharmacy: ☐ Advanced Rx ☐ Other_____

Advanced Rx pick up or mail next day available (Shipping and Handling included).

ADVANCED NEUROSURGERY

Neurosurgery New Patient

Patient Name: _____ **DOB:** _____

Type of Imaging	Body Part	Facility Name

Medication History

Name of Medication	Dose	How often do you take it?	What is it for?	Who prescribes it?

Do you have any medication/ drug allergies? Please list: _____

Past Medical History

Have you ever been hospitalized**?** ☐ Yes ☐ No Describe: _____

Indicate whether you have had a medical problem or surgery related to each of the following. Please check the appropriate choice when multiple choices are listed. For surgeries, please indicate the approximate year and describe the problem and type of surgery.

	Medical Diagnoses	Surgery	Year	Describe
Eyes (Cataract, Glaucoma)	☐	☐	_____	_____
Ears, Nose, Sinuses, Tonsils	☐	☐	_____	_____
Endocrine (Thyroid, Parathyroid, Diabetes, Pituitary, Adrenals)	☐	☐	_____	_____
Cardiovascular (Angina, Bypass Surgery, Angioplasty, Stent, Blood Clots, Abnormal Heart Rhythm)	☐	☐	_____	_____
High Blood Pressure	☐	☐	_____	_____
High Cholesterol	☐	☐	_____	_____
Lungs (Asthma, Tuberculosis, Pneumonia, Abnormal Chest X-Ray, Emphysema)	☐	☐	_____	_____
Esophagus or stomach (ulcer, GERD)	☐	☐	_____	_____
Gastrointestinal (growth removed, bowel intestine, appendix)	☐	☐	_____	_____
Liver, Gall Bladder (including Hepatitis)	☐	☐	_____	_____
Hernia	☐	☐	_____	_____

ADVANCED NEUROSURGERY

Neurosurgery New Patient

Patient Name: _____ **DOB:** _____

Kidneys or Bladder	☐	☐	_____	_____
Bones, Joints, or Muscles	☐	☐	_____	_____
Back, Neck, or Spine	☐	☐	_____	_____
Brain (Stroke, TIA, tumor, trauma)	☐	☐	_____	_____
Skin	☐	☐	_____	_____
Breasts	☐	☐	_____	_____
Females: Uterus, Tubes, Ovaries	☐	☐	_____	_____
Males: Prostate, Penis, Testes, Vasectomy	☐	☐	_____	_____

Social History

Any tobacco use? ☐ Yes | ☐ No Packs per day _____ for _____ years.

Any alcohol use? ☐ Yes | ☐ No Drinks per day _____ for _____ years.

Any recreational drug use? ☐ Yes | ☐ No Drugs used_____

Any special diet? ☐ Lactose free ☐ Caffeine Free ☐ Diabetic ☐ Vegetarian ☐ Vegan ☐ Other _____

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widow/ Widower Are you currently working? ☐ Yes | ☐ No

If no: Who took you off work?_____ If yes: What is your occupation?_____

When did you stop working (if applicable)?

Family History

Father: Alive (Age_____) Deceased (Age_____) Unknown Cause of Death:_____

Mother: Alive (Age_____) Deceased (Age_____) Unknown Cause of Death:_____

Illness/Condition	**Family Member**	**Describe**
Cancer	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Stroke/TIA	_____	_____
High Blood Pressure	_____	_____
Additional information	_____	

ADVANCED NEUROSURGERY

Neurosurgery New Patient

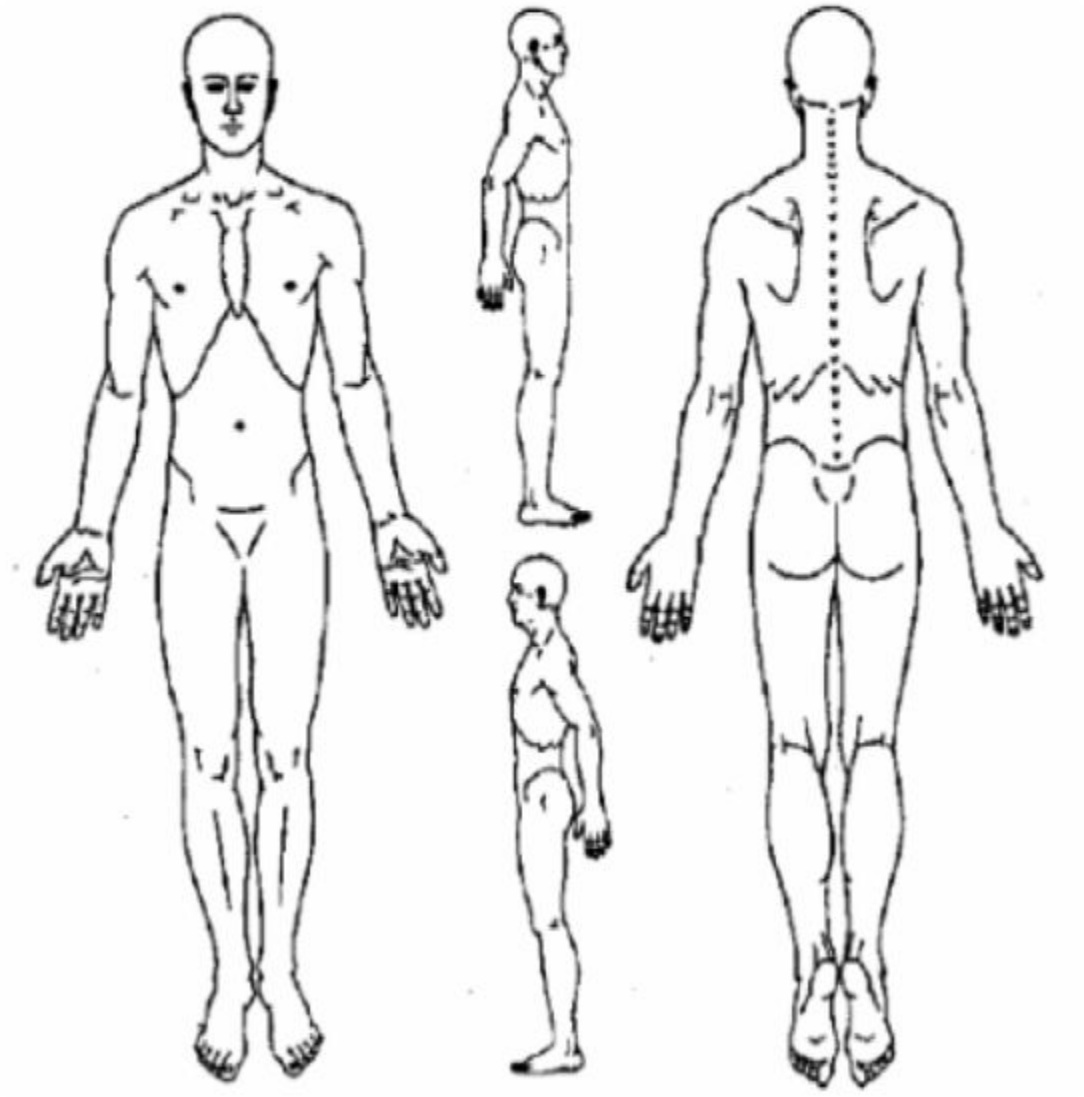
Patient Name: _____ **DOB:** _____

Present Pain Level: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	o o o o o	^ ^ ^ ^ ^	x x x x x	# # # # #
- - - - -	o o o o o	^ ^ ^ ^ ^	x x x x x	# # # # #



Patient Signature:_____**Employee's Initials**:_____**Provider's Initials**:_____

ADVANCED NEUROSURGERY

Quality: Demographics

Patient Name: _____ **DOB:** _____

Language

☐ English ☐ Spanish ☐ Other:_____

Race

☐ American Indian or Alaskan Native
☐ Asian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Black or African American
☐ White or Caucasian
☐ Native Hawaiian
☐ Multi-Racial
☐ Other:_____

Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Marital Status

☐ Married ☐ Single
☐ Widowed ☐ Partner

Portal Email

Please provide email for patient portal access: _____

Consent to Text, Call and leave detailed voice messages

Do you give Advanced Pain Care permission to text you? ☐ Yes ☐ No

Do you give Advanced Pain Care permission to call you? ☐ Yes ☐ No

Consent for communication of medical information via voice message

Do you give Advanced Pain Care permission to leave a detailed voice message on your phone regarding your healthcare? This may include but is not limited to information about upcoming surgical procedures, appointment information, payment information, lab results, and other health-related information. ☐ Yes ☐ No

_____ _____

Patient Signature *Date*

****** OFFICE USE ONLY ******

Staff initial below when completed

Race / Ethnicity / Language updated in Athena _____

Portal Registration: Y or N If no, did they decline and you printed portal URL? Y or N _____

ADVANCED NEUROSURGERY

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

Patient's Name: _____ Date of Birth: _____

Thank you for choosing **Advanced Pain Care and its sub-specialties, affiliated and related entities** your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

A patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee coverage or payment.
2. All charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
6. No show or cancellations without 24-hour notice are subject to a $25.00 charge.
7. Unpaid balances over 90 days may be subject to collection via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release Billing Information and Assignment of Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pain Care and its sub-specialties, affiliated and related entities** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature_____ Date: _____

Relationship to patient if not patient _____ Authorized Witness: _____

Mark Malone MD PA includes Advanced Pain Care and sub-specialties, affiliated and related entities.

ADVANCED NEUROSURGERY

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: *Date of Birth:*

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain PATIENT RIGHTS regarding my protected health information.

I understand that Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for: providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

I authorize Advanced Pain Care , it's sub-specialties, and Advanced Surgical Center to communicate with my **PCP** *(Primary Care Physician)* **: Dr. _____**
Phone #: (_____)_____ _____

_____

Advanced Pain Care it's sub-specialties, and Advanced Surgical Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the ***'Notice of Privacy Practices'*** before signing this agreement. If I ask, Advanced Pain Care , it's sub-specialties, and Advanced Surgical Center will provide me with most current ***'Notice of Privacy Practices'.***

My signature below indicates that I have been given the chance to review such copy of the ***'Notice of Privacy Practices'.*** My signature means that I agree to allow Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke the consent in writing at any time, except to the extent that Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center has taken action relying on

this consent.

_____ _____
Patient Signature ***Date***

_____ _____
Relationship to Patient if signed by another party ***Date***

You may obtain a copy of our ***'Notice of Privacy Practices'*** including any revisions to our ***'Notice of Privacy Practices'*** at any time by contacting: Advanced Pain Care, it's sub-specialties, and Advanced Surgical Center at 2000 S. Mays St, Round Rock Texas 78664 or (512) 244-4272.

****** OFFICE USE ONLY ******

Staff initial below when completed

Consent dates have been updated in Athena _____

ADVANCED NEUROSURGERY

INFORMED CONSENT- NEUROSURGERY

Patient's Name: _____ Date of Birth: _____

PLEASE SIGN THE BOTTOM OF THE FORM SIGNIFYING CONSENT AND UNDERSTANDING

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical, surgical, or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to undergo the recommended medical, surgical, or diagnostic procedure, or take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to undergo the medical, surgical, or diagnostic procedure or take the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

I HAVE BEEN GIVEN THE OPPORTUNITY to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic/surgical procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Neurosurgery, you may be prescribed medication that can be filled at Advanced Rx Pharmacy. The address of the Pharmacy is 2000 South Mays Street Suite 200, Round Rock, TX 78664. You are hereby advised that Advanced Pain Care has an investment interest in the Pharmacy. This information is being provided to help you make an informed decision about your health care. You have the right to choose your pharmacy. You have the option of obtaining the prescription ordered by your physician at Advanced Rx Pharmacy or at any other pharmacy you select. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Rx Pharmacy if you choose to use a different facility.

DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Neurosurgery (Austin Area Patients), you may undergo procedures that will be performed at Advanced Surgical Center. The address of the Surgery Center is 2000 South Mays Street Suite 400, Round Rock, TX 78664. You are hereby advised that Ryan Michaud, MD has an investment interest in the Surgery Center. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Surgical Center if you choose to use a different facility.

DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Pain Care (Killeen Area), you may undergo procedures that will be performed at Advanced Surgical Center. The address of the Surgery Centers are 3400 East Central Tx Expwy Ste 100, Killeen, TX 76543. You are hereby advised that Ryan Michaud, MD has an investment interest in the Surgery Center. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Pain Care or Advanced Surgery Center if you choose to use a different facility.

DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Neurosurgery (Amarillo Area Patients), you may undergo procedures that will be performed at Advanced Surgical Center. The address of the Surgery Center is 1901 Medi Park Drive, Suite 01, Amarillo, TX 79106. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Surgical Center if you choose to use a different facility.

DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Neurosurgery, you may undergo procedures at Advanced Surgical Center that will be performed with Neuromonitoring. You are hereby advised that Mark Malone, MD has an investment interest in Greater Texas Neuromonitoring, LLC. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Neurosurgery or Advanced Surgical Center if you choose to decline Neuromonitoring.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

ADVANCED NEUROSURGERY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

- I authorize Advanced Pain Care and it's sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Check all that apply to the above names:

- ☐ Regarding appointment, time & date
- ☐ Discuss medical care, an issue or concern
- ☐ Discuss Billing Information
- ☐ Discuss Lab Results
- ☐ Pick up Prescriptions
- ☐ Discuss Imaging Results
- ☐ Pick up Forms

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to **Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664**. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected. I understand that Advanced Pain Care will not condition treatment on whether I sign this authorization.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

Patient Signature	Date
Legally Authorized Representative	Relationship to Patient
Witness	Date

ADVANCED NEUROSURGERY

Pharmacy Letter

Patient's Name:_____ Date of Birth: _____

Dear Valued Patients:

Due to new government regulations, it will be much harder to get pain medications approved through your pharmacy starting, January 1, 2019.

Your pharmacist will be required to call your doctor and discuss your prescription(s). In many cases, this could take days. Also, your insurance company will have increased preauthorization requirements that may delay prescriptions.

We strongly urge you to use our pharmacy to avoid this red tape nightmare. Our pharmacists have access to our electronic medical records and can quickly and seamlessly confirm, communicate and obtain authorization for our prescriptions.

There will be no waiting. Your prescriptions will be ready to be picked-up the next day or mailed to your door within 1-2 days. We will have them in stock.

Another regulation is no pharmacy can fill only controlled substances. We ask that for every controlled prescription, you also fill at least one other non-controlled prescription. Your medications can be transferred with a simple call from our pharmacists. We can also fill medications for your family and pets for your convenience.

Your follow-up appointments will be scheduled about two days before running out of medication, giving your doctor and pharmacist time to satisfy all the new requirements.

☐ If you would like Advanced Rx to become your pharmacy, please check the box.

Please sign below stating that you have read and have been informed about the new government mandated rules for prescribers and pharmacists regarding controlled medication refills going into effect January 2019.

Feel free to speak with me, your provider or any staff member should you need more information.

Sincerely,

Mark T. Malone, M.D.

Patient Name: _____ Signature: _____

Date: _____

Advanced Pain Care and Dr. Malone have a vested interest in Advanced Rx Pharmacy.

All patients have a right to receive a copy of their prescription and have it filled wherever they choose.