TEXAS BRAIN AND SPINE
REGISTRATION FORM

Today's Date_____/_____/_____ Ludwig Orozco, MD Board Certified Neurosurgeon

PATIENT INFORMATION

Patient's
Last Name_____ First_____ Middle_____ Marital Status_____

Pharmacy Name_____ Pharmacy Phone_____

DOB_____/_____/_____(mm/dd/yyyy) Age_____ Sex ☐ Male ☐ Female

Address_____

Social Security #_____ Home Phone_____ Cell Phone_____

Occupation:_____ Employer_____ Phone_____

Primary Care Physician_____ Phone_____

Referring Physician_____ Phone_____

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance_____ Policy #_____ Co Pay $_____

Subscriber's Name_____ SSN_____ DOB_____ Group #_____

Patient's Relationship to Subscriber_____

Secondary Insurance_____ Policy #_____ Group #_____

Subscriber's Name_____ Patient's Relationship to Subscriber_____

IN CASE OF EMERGENCY

Name of Friend or Relative (not living at same address)_____

Relationship to Patient_____ Home Phone_____ Cell Phone_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NSNP 1, PLLC d/b/a Texas Brain and Spine or the insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

TEXAS BRAIN AND SPINE

Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	**Date:**
_____	_____
Printed Name of Patient or Personal Representative	**Relationship to Patient**
_____	_____

TEXAS BRAIN AND SPINE

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed NSNP 1, PLLC d/b/a Texas Brain and Spine, 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.

_____
Patient Name

_____
Relationship to Patient

_____
Date

Disclosure of Information

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guardian. If you would like to add additional contacts (other than the patient or legal guardian) that Texas Brain and Spine is allowed to disclose this type of information to, please complete.

_____ _____
Name (Please Print) Relationship to Patient

_____ _____
Name (Please Print) Relationship to Patient

_____ _____
Name (Please Print) Relationship to Patient

TEXAS BRAIN AND SPINE

Texas Brain and Spine physicians fully support an electronic patient care experience through implementation of a common electronic health record platform. TXbas is pleased to offer EHR as a convenience to communicate electronically with you under the conditions and terms outlined below.

Use of Electronic Communication from TXbas to the Patient

☐ **Yes,** I want TXbas to communicate my information with me through a secure system that is designed to keep my information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you would like to use to receive secure messages.

_____

E-mail Address (Please Print)

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

☐ **No,** I do not want TXbas to use electronic communication as a way to communicate my information to me.

Confidentiality and Privacy

- **If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.**
- **TXbas will not share your e-mail address with anyone unauthorized to view your medical record.**

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from TXbas. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent or Legal Guardian Date

TEXAS BRAIN AND SPINE

Patient Name: _____

Please list ALL your current medications, including strength and how often you take them:

Medication	Strength	Number of Times a Day
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	

Do you have any allergies to medications? ____Yes_____No

Please List:_____

_____

_____

Have you suffered from any of the following medical conditions? If you answered Yes, please explain.

Headaches	Yes	No	
Blurred Vision	Yes	No	
Neck pain	Yes	No	
Asthma	Yes	No	
Emphysema	Yes	No	
Tuberculosis	Yes	No	
High Blood Pressure	Yes	No	
Heart Attack	Yes	No	
Circulatory problems	Yes	No	
Swelling of extremities	Yes	No	
Incontinence	Yes	No	
Kidney problems	Yes	No	
Back pain	Yes	No	
Painful Joints	Yes	No	
Seizures	Yes	No	
Stroke	Yes	No	
Dizziness	Yes	No	
Constipation	Yes	No	
Weakness in extremities	Yes	No	
Diabetes mellitus	Yes	No	
Thyroid problems	Yes	No	
Cancer	Yes	No	
Rheumatoid arthritis	Yes	No	
Sexual dysfunction	Yes	No	
Blood clots	Yes	No	

TEXAS BRAIN AND SPINE

New Patient Questionnaire

List radiology studies you have had:

MRI of _____ Date: _____

CT of _____ Date: _____

X-ray of _____ Date: _____

Patient Name: _____

Age: _____ Date of birth: _____

What is the reason for your visit:

_____

_____

What are your current symptoms (i.e. pain, numbness, etc…)?

_____

_____

Is this visit due to a work related injury? _____ Yes _____ No If yes, please explain _____

_____

_____

How long have you had these symptoms? _____ Days _____ Weeks _____ Years

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

Check all treatments you have had for your current condition to this point:

- ☐ Physical Therapy DATE _____
- ☐ Occupational Therapy DATE _____
- ☐ Acupuncture DATE _____
- ☐ Nerve Root Blocks DATE _____
- Ablations DATE _____
- ☐ Epidural Steroid Injections DATE _____
- ☐ Chiropractic Manipulation DATE _____
- ☐ Electromyography (EMG) DATE _____
- ☐ Pilates DATE _____
- ☐ Yoga DATE _____

Please list ALL surgeries you have had in your lifetime:

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Please list ALL medical diagnoses and conditions:

_____

_____

_____

_____

_____

_____

TEXAS BRAIN AND SPINE

Patient Name: _____

Pain Drawing

1. **How bad is your pain now?**

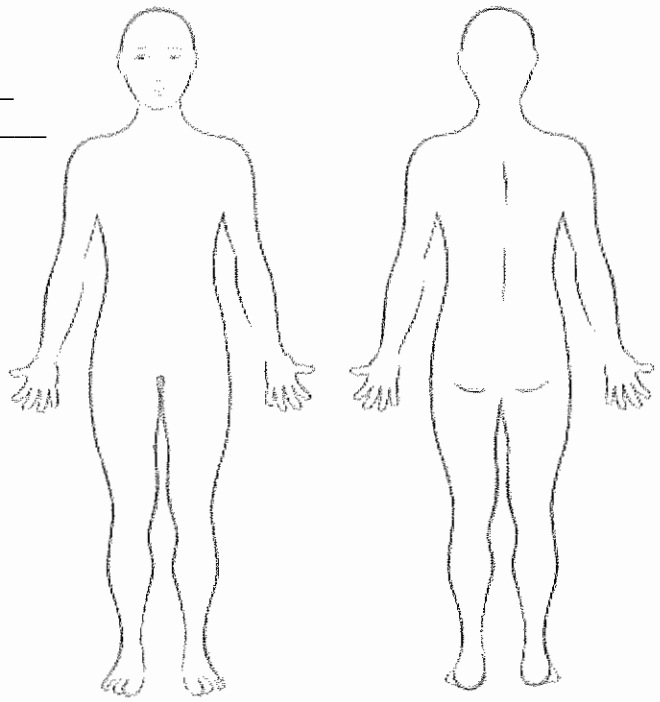
I___I___I___I___I___I___I___I___I___I___I

1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

2. **Mark the areas on your body using the appropriate symbols to the left to describe your symptoms.**

Ht(in)____
Wt(lbs)_____



Type of pain / Symbol

Ache <<<<<<<<<	Burning xxxxxxxx
Pins/Needles ■■■■	Numbness OOOOO
	Radiating pain /////////

3. Where is your pain?

Neck Pain ____%	Back Pain ____%
Arm Pain ____%	Leg Pain ____%
Total 100%	Total 100%

4. What is the duration of pain?

____ Continuous ____ Positional

____ Intermittent (On/Off) ____ Unable to rate

Social History

What is your occupation? _____ Retired/Disabled

What is your marital status? ____ Single ____ Married ____ Divorced ____ Widowed

Who lives with you at home? _____

Do you smoke? ____ Yes ____ No Do you use illicit drugs? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No If yes, how frequent? _____

Family History

Family	Are they deceased?	Cause of death? And/Or Medical History
Father		
Mother		
Sibling		
Sibling		
Sibling		

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, Mastercard, Discover, American Express and Care Credit.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment/coinsurance at the time of service. This office's policy is to collect this copayment/coinsurance when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and submit the claim for you on an assigned basis. You will be responsible for your portion and also any payments your insurance may deny.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

- We will charge a $30.00 fee for any checks written that are not honored by your bank.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

FMLA AND SHORT-TERM DISABILITY POLICY

Dear Patient,

Please note the following is our policy on FMLA Paperwork:

- We only complete short- term disability forms.
- We do not complete long term, or social security disability paperwork. For this you will need to return to your primary care physician to approve that.
- The start date of your leave will be the actual date of your surgery, not before.
- You will be allowed 6 weeks from the date of surgery as a continuous leave. Intermittent leave will be addressed after your post-op visit.
- We do not complete short term disability forms if you are not scheduled for surgery.
- If surgery is cancelled then you will be returned to work. If your surgery is rescheduled then we will complete new forms with the new surgery date.
- This takes a minimum of 7-10 business days to be completed by the provider.
- Only 1 family member requiring FMLA paperwork for your post-op care, will be limited to 2 weeks.

You may have correspondence faxed to 469-626-1335 Attn: Brittney

Forms will be faxed to employer and or insurance upon completion.

Notice to Patients:
As of January 1, 2o2o Texas Brain and Spine will be charging a fee for the completion of forms you ask us to complete on your behalf. We receive many requests for completion of these forms. This requires extra work, time and financial resources in excess of what is normally needed to complete the medical record. Payment of $3o.oo is required prior to completion of the form(s). Thank you.

TEXAS BRAIN AND SPINE

Name:_____DOB:_____

Nurse Practitioner & Physician Assistant Consent

Here at, Texas Brain and Spine, we strive to offer you high quality medical care and give strong consideration to your wait time. We employ Advanced Practice Registered Nurses, also known as Nurse Practitioners and/or Physician Assistants to assist us in carrying out your plan of care. Nurse Practitioners and Physician Assistants have received advanced education and training in the provision of health care. They are graduates of a certified training program and licensed by the Texas State Medical Board. They can diagnose and treat as well as provide health maintenance care. If you are seen by one of these providers, your doctor will review your care with them as part of your treatment plan. "Supervision" does not require the constant physical presence of the supervising physician, but rather, observing the activities of accepting responsibility for the medical services provided.

I have read the above and understand that in this practice a team approach is used with my unique needs presented and reviewed by one or more physicians in the development of my plan of care. I also understand that from time to time I may be seen by any or all of the providers in this practice, including the physicians, Nurse Practitioners and Physician Assistant.

I hereby consent to the services of a Nurse Practitioner or Physician Assistant for my healthcare needs. I understand that I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician. I understand that this may require my appointment to be rescheduled.

X_____

Patient's or Authorized Representative's Signature Today's Date

Disclosure of Physician Interest & Ownership

To better serve you, Dr. Ludwig Orozco has ownership or financial interests in various other health care providers and/or facilities. Today's medical business climate is very complicated, and physicians have little negotiation power with insurance companies. Our physician is committed to providing high quality health care services to our patients and may refer you to one of these providers and/or facilities to receive health care items or services that he has determined you need. Ownership interest in these often provides a voice in administrative, clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service. During a physician/patient relationship you may be referred to a provider/facility or service. I am providing this information to help you make an informed decision about your health care. However, you have the right to choose your health care provider and you have the option to use a health care provider/facility/service other than the provider/facility/service to which you might be referred you. You will not be treated any differently if you choose to obtain health care from a provider/facility/service other than the provider/facility/service in which Texas Brain and Spine Providers have an ownership or financial interest. If you require assistance, we will be happy to provide information about alternative providers/facilities/services. A list of these facilities/providers is available upon request.

If you have questions, please do not hesitate to ask. We welcome you as a patient & we value our relationship with you. By signing below, you acknowledge that you have read and understood this Disclosure, and that you are aware of the Physician ownership or financial interest.

X_____

Patient's or Authorized Representative's Signature Today's Date