Methodist
MOODY BRAIN AND SPINE INSTITUTE

PATIENT INFORMATION
(Please Print)

Is this a Worker's Comp Injury? Yes or No (Please Circle One)

NAME: _____ **DATE OF BIRTH:** _____

(First) (Initial) (Last)

ADDRESS: _____

CITY_____**STATE:**_____**ZIP CODE:** _____**COUNTY:** _____

(Please circle one) SEX: (Legally) *Male* or *Female* **Marital Status**: *Single Married Divorced Widowed*

ETHNICITY*: Hispanic/Latino, Non-Hispanic or Latino,* Caucasian, Black/African American, Asian*, Other:*_____

PRIMARY LANGUAGE: English, Spanish, Other: _____ **SS#** _____

EMAIL ADDRESS: _____

CELL # _____ **HOME PHONE#** _____

POLICY HOLDER NAME: _____ **DOB:** _____ **RELATION TO POLICY HOLDER:** _____

EMERGENCY CONTACT NAME: _____ **RELATION:** _____

PHONE: _____

EMPLOYER NAME: _____ **PHONE #** _____

REFERRING DOCTOR: _____ **PHONE #** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE #** _____

CARDIOLOGIST: _____ **PHONE #** _____

Do you have any metal in your body? *Including stents, Pacemaker/ Defibrillator, Bullets, Stimulators, Any joint replacements, or other metal implants, including dental implants* (Please List ALL)

_____

_____

_____

What tests or studies have you had recently for the reason we are seeing you for today? (In the last 6-12 Months)

NONE X-RAY MRI CT EMG/NCV or EMG/NCS INJECTIONS PHYSICAL THERAPY

(PLEASE CIRCLE ALL THAT APPLY AND INDICATE BELOW WHERE THEY WERE PERFORMED)

_____

_____

_____

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GENERAL PATIENT CONSENT FOR CARE FORM

General Consent to Care:
I, the undersigned*, for myself or another person for whom I have authority to sign*, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Methodist Medical Group on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant) and other health care providers of the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Methodist Medical Group is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations at Methodist Medical Group facilities.

Telemedicine:
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmissions of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

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

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 full effective until it is revoked in writing. You have the right at any time to discontinue services.

_____

Signed Consent

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Methodist Medical Group. Any care deemed medically necessary may be provided with or without my presence:

Child: _____ Date of birth _____

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

[ ] *Patient under 18 years of age*

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Date

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Welcome Information

Thank you for choosing our practice to take care of your health care needs! We know that you have a choice in selecting your medical care and we strive to provide you with the best service possible. Here are a few of our office policies.

Registration: All patients must complete a patient information form before seeing their provider once a year.

Medication refills: Non-narcotic prescription refills should be called into your pharmacy or our office at least ***5 business days*** before the last pill taken to allow adequate time for approval. Please have your pharmacy fax your request to **214-948-9990.** Allow 24 hours for all requests to be processed. Refills will only be handled during normal business hours Monday through Friday**. Narcotic prescriptions CANNOT be refilled through your pharmacy, you MUST call our office and speak with your respective Medical Assistant at least 3 business days before running out**, and our staff will have to add you to the schedule for either in person or a telephone call. Our providers are not always available, as they are in surgery.

FMLA/ Disability Paperwork: We will complete forms for patients' who have undergone surgery by our physicians only. Please allow **7-10 business days** to complete paperwork. **Medical forms CANNOT be completed on the same day that forms are presented to the office.** Non-Surgical patients may request their medical records and refer to their primary care physician for completion of forms. Only short-term disability will be granted. **No long-term disability** forms will be completed by our providers.

Medical records: All medical record requests are processed by Health Mark and **take approximately 7 business days to process**. All medical requests must be in writing. Please contact our health information staff member for all requests at 214-948-2076 Ext. 110. Fax 214-948-9990.

Appointments/ No Show: We request a 24-Hour notice for appointment cancellations. Patients with (3) missed appointments and/or no shows annually will result in dismissal from the practice. If you no show to your appointment you will be charged $25. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled visit.

Authorizations for Surgery: *Please allow your health plan up to **15 business days** to process routine surgery authorizations for medical review.*

Surgery Deposits: A surgery deposit may be required prior to each surgery performed, depending on your insurance. Our office representative will contact you, to discuss your insurance benefits, estimates, and your amount of down payment prior to surgery***. Please refer to the Financial Policy for further details***.

After hours: Our phones message will direct patient calls to our answering service for urgent needs after hours. The answering machine service will notify the physician on call. Please understand you may not be able to speak directly with your personal physician. It is possible to receive a phone call from the Advanced Practice Provider in most cases. ***Please note the physician on call will NOT authorize medication refills or prescribe narcotics or new medication. If you feel you have a life threatening emergency, please contact 911 or go to the nearest emergency facility.***

Behavior: Physical and verbal abuse towards the office staff will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate discharge from the practice. All Methodist policies regarding masks are required to be followed.

Feedback: You may receive a patient satisfaction survey from Press-Ganey via text or email. Please take the time to complete and let us know how we are doing. Your opinion matters to us.

Notice of Privacy Acknowledgement: Methodist Moody Brain and Spine Institute's Notice of Privacy provides information about how Methodist Moody Brain and Spine Institute may use and disclose protected health information. You may have the right to review the Notice before signing this acknowledgement. A copy of the current notice is posted in the waiting room. This notice contains the effective date and is provided in our Notice, the terms of our Notice may change. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice. You may have the right to revoke this consent, in writing, except where we have already made disclosures prior to the revoking of consent. Your signature also represents acknowledgement of receipt of the MBSI Privacy Notice, Financial Policy and Patient Rights and Responsibilities Notice. This Privacy acknowledgement does NOT give us consent to release records to anyone to whom is mentioned above. A signed medical release authorization form must be completed prior to us releasing records on your behalf.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

_____ _____

Printed Patient Name Date

_____

Signature of Patient

ADVANCED PRACTICE PROVIDERS
(PHYSICIAN ASSISTANT AND ADVANCED PRACTICE NURSE INFORMATION)

At Methodist Moody Brain and Spine Institute, each Neurosurgeon is accompanied by a Nurse Practitioner or Physician Assistant. Both professions are also called Advanced Practice Providers. Our Advanced Practice Providers are highly qualified to carry out your plan of care. You may be in contact with our Advanced Practice Providers for your first appointment, Post- Surgery appointments, and if the Physician is called away to a surgery due to a hospital trauma.

An Advanced Practice Provider is not a doctor. They are graduates of a certified training program and are licensed by the Texas State Board. Under the supervision of a Physician, Advanced Practiced Providers' can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant Physician presence of the supervising Physician, but rather overseeing the activities of the APP and of accepting responsibility for the medical services provided.

An Advanced Practice Provider may provide such medical services that are within his/her education, training and experience. These services may include, but are not limited to:

- Assisting our Neurosurgeons in surgery.
- Collaborating with the Neurosurgeons and other health providers about patient care.
- Counseling and educating patients on health behaviors, self-care skills and treatment options
- Diagnosing and treating acute illnesses, infections and injuries
- Diagnosing, treating and monitoring chronic conditions
- Obtaining medical histories and conducting physical examinations
- Ordering, performing and interpreting diagnostic studies (E.g., Lab tests, x-rays, MRIs, CT Scans)
- Prescribing medications
- Prescribing physical therapy and other rehabilitation treatments

PLEASE SEE A COMPLETE LIST OF OUR DOCTORS AND THEIR ADVANCED PRACTICE PROVIDERS BELOW:

- Dr. Randall B. Graham- Kylie Vogel, PA-C
- Dr. Stephen L. Katzen- Laci Childers, APRN, FNP-C
- Dr. Richard B. Meyrat- Sarah Breanne Smith, RN-FNP-C & Rachel Mayer, PA-C
- Dr. Bartley D. Mitchell- Whitney McClung, RN, FNP-BC
- Dr. Michael C. Oh- Linda Rodriguez-Gilmore, ARPN, FNP-BC
- Dr. Nimesh H. Patel – Stacey Castellanos, RN, FNP-C
- Dr. Lauren A. Sand- Claire Carpenter, APRN, FNP-C
- Jason Brown, ACNPC-AG (hospital based)
- Irene Stanley, PA-C (hospital based)

Please feel free to visit our website at www.methodistbrainandspine.com to view the biographies of our Advanced Practice Providers.

Advanced Practice Provider: Here at Methodist Moody Brain And Spine Institute, we take strong consideration about your wait time and the convenience of our patients. Each neurosurgeon is accompanied by their own advanced Practitioner(s) to also see patients in clinic and surgery. Our APP's are highly qualified to carry out your plan of care**. You may see the APP for initial visits, post-surgery appointments, and if the physician is called away to surgery due to a hospital trauma. If you do not wish to see the Advanced Practice Practitioner, please notify our front desk representative. Your appointment will be rescheduled to the next available appointment to see the Physician.**

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AUTHORIZATION TO RELEASE INFORMATION/PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure emails results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

I authorize Methodist Moody Brain And Spine Institute (MBSI) to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party for purpose of obtaining payment on account of MBSI, (2) The disability insurance company to expedite my claim (3) any other person(s) or entities financially responsible for the patient's care or treatment, and (4) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable disease such as Acquired Immune Deficiency Syndrome (AIDS). I also authorize the release of information and/ or review of patient's records for purpose of conducting medical audits, utilization reviews, or quality assurance reviews.
I hereby give my permission for the release of medical and/or financial information regarding appointment and questions about my condition and treatment to the following person(s):

Name: _____ Relation: _____ Phone #:_____

Check one: ◯ Financial and Medical Information ◯ Financial Information Only ◯ Medical Information Only

Name: _____ Relation: _____ Phone #:_____

Check one: ◯ Financial and Medical Information ◯ Financial Information Only ◯ Medical Information Only

Name: _____ Relation: _____ Phone #:_____

Check one: ◯ *Financial and Medical Information* ◯ *Financial Information Only* ◯ *Medical Information Only*

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (*please check all that apply*): ___email address ___phone ___text message ___secure patient portal to be used in the manner described above.

Preferred Email Address _____Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.
In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/or ability to review all email received at your work address.

___**(***initial)* I decline to give MMG consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be required to schedule a follow up appointment with the doctor to review my test results and it could take up to 10 business days to receive your results in the mail.
Consent and Agreement I have carefully reviewed this document and agree to full comply with the guidelines defined herein for the communication of my health information.

Do you have an Advance Directive? Yes Or No **Living Will?** Yes Or No
Consent and Agreement: *I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.*

_____ _____
Printed Patient Name Date

_____
Signature of Patient or Guardian

This authorization will expire 1 year from date of signature.

ASSIGNMENT OF BENEFITS

1. **Assignment of Benefits**:
   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 at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

   IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID FOR PRIOR TO EACH VISIT.

   If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.

   I understand that I am responsible for providing METHODIST MOODY BRAIN AND SPINE INSTITUTE all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

   I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to METHODIST MOODY BRAIN AND SPINE INSTITUTE. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

2. **Medicare / Medicaid Assignment of Benefits**: *(Do not complete unless you receive Medicare/Medicaid Healthcare benefits)*

a. I certify that the information given by me in applying for payment under the Title XVII of the social security act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any given information needed for filing a Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

Initial_____

b. I understand that Medicaid recipients are responsible for payment of any medical care or services received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

Initial_____

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN *(RELATIONSHIP IF NOT PATIENT)* **DATE**

_____(*Witness*)

Methodist
MOODY BRAIN AND SPINE INSTITUTE

FINANCIAL POLICY & PROCEDURES

Thank you for choosing us to serve your medical needs. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established a financial policy, for which you should be able to receive all of the benefits offered to you by your health plan; allowing our physicians the opportunity to concentrate on caring for your medical needs. The following is a list of guidelines we ask that you read and follow, which are necessary to facilitate your care.

Identity: We ask that you present your Insurance card and picture identification at each visit. It is a requirement that we correctly identify all patients in our medical record. Failure to present your picture ID may result in cancellation of your appointment.

Insurance: Insurance card(s) and picture ID must be available for each visit. If you have a change of address, telephone numbers, employer, insurance plans or coverage, please notify the receptionist. We file claims as a courtesy to our patients and are only responsible for filling claims to contracted insurance companies and their member. Any dispute for unpaid charges from the insurance company will be billed to the member.

Further Information:

- If you have a HMO or other managed care policy, you must obtain a referral from your PCP as Instructed by your health plan. Due to HMO Regulations and restrictions, we may have to cancel or reschedule your appointment until a referral is obtained. Depending on your particular plan, please verify the number of visits permitted. You will be responsible for any visit not authorized.
- We will collect all applicable co-pays, co- insurance, and deductibles at the time of service.
- In most cases, surgery prior authorization is required by the insurance. Please allow your health plan at least 15 days to prior approve all routine surgery requests for medical review and payment.
- Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy, as we cannot guarantee payment of claims.

Charges: Copays and balances are expected at the time of service. After 90 days, outstanding balances will be referred to a collection process. Billed charges not covered by insurance are patient's responsibility. Delays in insurance processes occur when insurance information is not provided in a timely manner. Such delays may result in insurance not covering care. Whenever insurance denies payment for a service, it is your responsibility to cover the charges, even while you may choose to review your benefits with your insurance plan. In all cases, our office provides an estimate of your financial responsibility. We will credit any overpayment in a timely manner. If you have a responsibility greater than what was originally collected, our office will send you a statement for the additional portion. Payment is due upon receipt.

Self-pay: Payment is expected at the time of service. However treatment decisions are based solely on the patient's medical needs. MBSI will not deny critical care to anyone due to their inability to pay or lack of insurance. Patients who have financial constraints should speak to our Financial Counselor.

Surgery deposits: In all cases, our office provides and collects an estimate of your financial responsibility prior to each surgery performed. Our office representative will contact you to discuss your insurance benefits, estimates and your amount of down payment prior to your surgery. Surgery may be rescheduled or cancelled, if the surgery deposit is not received in our office. We will credit any overpayment in a timely manner

Third Party Liability Carriers: Our practice does not take part in third party liability cases; nor do we file claims to third party liability carriers such as auto insurance. We will recommend before using your private insurance, to contact the third party carrier to verify the company is willing to reimburse you of any out of pocket expenses that will occur. We will collect all applicable copays, coinsurance, and deductibles according to your health plan at the time of service. You may request an itemized receipt to provide to your third party carrier to show proof of payment. Should your health plan deny or request a refund of payments made, all charges will be your responsibility.

Worker's compensation: Our practice does not take part in workers compensation claims. If you have sustained an injury on the job and have a worker's comp claim, Texas Worker's Commission bylaws prohibit us to accept your private insurance nor can we accept payments for your office visit. (Texas Labor Code 413.042)

NFS / Closed Accounts: There will be a $35.00 Charge added for returned checks.

FMLA / Disability Paperwork: **We will complete forms for patients that have undergone surgery by our physicians only**.

Payment Arrangements: Arrangements can be made in the event unforeseen circumstances occur and your payment obligations cannot be met at the time of service. You may contact our Financial representative to make arrangements for payment.

My signature below represents that I have ready and full understanding of the Financial Policy of the Methodist Moody Brain and Spine Institute. I may also request a copy of the signed policy for my own record.

_____ _____

Printed Patient Name Date

_____

Signature of Patient or Guardian

Methodist
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PATIENT NAME _____
DATE OF BIRTH _____

PHARMACY NAME_____
ADDRESS_____
PHARMACY #_____

Office Use only:

BP: P: WT: HT:

PATIENT HISTORY (PLEASE CIRCLE ALL THAT APPLY):

ALCOHOLISM	DEPRESSION/ANXIETY	HIGH CHOLESTEROL	MIGRAINE	STROKE
ANEMIA	DIABETES	HIV/AIDS	OSTEOPORSIS	THYROID DISEASE
ARTHRITIS	GOUT	GLAUCOMA	HYPERTENSION	RHEUMATOID DISEASE
TUBERCULOSIS	ASTHMA	HEART DISEASE	KIDNEY DISEASE	SEIZURES
ULCERS	CANCER	HEPATITIS	MENTAL ILLNESS	CLAUSTROPHOBIA
OTHER:				

HAND: Right Handed or Left Handed (**Please Circle)**

MEDICATIONS: NONE (List below all including prescriptions, over the counter, vitamins and herbal supplements)

MEDICATION	DOSAGE	FREQUENCY	REASON
IF MORE ROOM IS NEEDED PLEASE WRITE ON THE BACK OF THIS PAGE			

MEDICATION ALLERGIES: NONE

NAME OF MEDICATION	REACTION (CIRCLE ALL THAT APPLY)				
ANESTHETIC	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
PENICILLIN	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
IODINE	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
SULFA	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
CODEINE	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
LATEX	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
TAPE	RASH	NAUSEA/VOMITING	DIARRHEA	WHEEZING	OTHER:
OTHER:					

SURGICAL HISTORY: Please list ALL surgeries you have EVER had and the year they were performed

_____
_____
_____

Social History: Occupation**:** _____ **Work Status**: *Full Part-Time Retired Disabled*

Alcohol_____Drinks per week Recreational Drugs: _____

Tobacco: Smoking: _____Cigs/Day #Years: _____ Years Quit: _____
Chewing: _____Cans/Day #Years: _____ Years Quit: _____
E-Cig or Vaping: _____/ Day #Years: _____ Years Quit: _____

Family History: (If any relative had suffered any of the following, mark and indicate which relative)
F- Father M-Mother B-Brother S-Sister SN-Son D-Daughter MGP-Maternal Grandparent PGP-Paternal Grandparent

Arthritis F M B S SN D MGP PGP Grandmother/father	Gastritis F M B S SN D MGP PGP Grandmother/father	Liver Disease F M B S SN D MGP PGP Grandmother/father
Diabetes F M B S SN D MGP PGP Grandmother/father	Heart Disease F M B S SN D MGP PGP Grandmother/father	Rheumatoid Disease F M B S SN D MGP PGP Grandmother/father
Asthma F M B S SN D MGP PGP Grandmother/father	Aneurysm F M B S SN D MGP PGP Grandmother/father	Seizures F M B S SN D MGP PGP Grandmother/father
Bleeding Tendency F M B S SN D MGP PGP Grandmother/father	HIV/AIDS F M B S SN D MGP PGP Grandmother/father	Stroke F M B S SN D MGP PGP Grandmother/father
Cancer F M B S SN D MGP PGP Grandmother/father	Hypertension F M B S SN D MGP PGP Grandmother/father	Hereditary Defects F M B S SN D MGP PGP Grandmother/father