



Austin Brain & Spine

Patient Information

(Please Print)

Dr. Miss Mr. Mrs. Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address _____

Date of Birth MM ____/DD ____/YYYY _____ Sex F-Female M-Male Transgender

Race American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other _____

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number _____ - _____ - _____ Employer Name _____

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N - Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? Yes No

Emergency Contact Relationship to Patient _____ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Preferred Pharmacy _____

Responsible Party Information

(Information used for patient balance statements)

Responsible Party Another Patient Guarantor Self Check here if information is same as patient

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____/DD ____/YYYY _____

Social Security Number _____ - _____ - _____ Telephone _____

E-Mail Address _____ Sex F-Female M-Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

Primary Insurance Information

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY _____

Primary Insurance Information

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____/DD ____/YYYY _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

Austin Brain and Spine HIPAA Acknowledgement and Consent Form

Patient Name: _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

___ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*

___ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

NOTE: *This revocation only applies to communications from this Practice.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

(Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date _____

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge that, as a courtesy, AUSTIN BRAIN AND SPINE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that AUSTIN BRAIN AND SPINE may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to AUSTIN BRAIN AND SPINE any insurance or other third-party benefits available for health care services provided to me. I understand AUSTIN BRAIN AND SPINE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AUSTIN BRAIN AND SPINE, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to AUSTIN BRAIN AND SPINE by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for AUSTIN BRAIN AND SPINE, or Extended Business Office (EBO) Services and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that AUSTIN BRAIN AND SPINE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or AUSTIN BRAIN AND SPINE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X _____ Date _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below:

Spouse
Parent
Legal Guardian

Guarantor
Healthcare Power of Attorney
Other (please specify)

General 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 understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Printed Name of Witness

Employee Job Title

Signature of Witness

Date



Medical History

History of present illness - Please briefly describe why you are here and how long you have been experiencing your current symptoms:

Review of symptoms (check all that apply) :

1. General

- weight loss
- weight gain
- fever

2. HENNA

- blurry vision
- double vision
- nosebleeds
- hoarseness
- loss of smell
- ringing in ears

3. Pulmonary

- shortness of breath
- coughing blood

4. Cardiovascular

- chest pain
- irregular heartbeat
- ankle swelling

5. Gastrointestinal

- heartburn
- nausea/vomiting
- rectal bleeding
- incontinence

6. Genito-Urinary

- incontinence
- frequent urination
- blood in urine
- painful urination

7. Neuro

- headaches
- seizures
- weakness
- visual changes

8. Endocrine

- cold intolerance
- hair loss
- impotence

9. Integ

- acne
- skin color change
- pruritus

10. Women Only : Last menstrual period _____

- breast discharge

Austin Brain & Spine

801 W. 38th Street, Suite 400
Austin, Tx 78705

4101 James Casey Street, Suite 340
Austin, Tx 78745

512-306-1323
512-306-1142 fax

www.austinbrainandspine.com

Matthew Hummell, MD; Craig Kemper, MD, FACS; Marcella Madera, MD; Daniel Peterson, MD, FACS; Hari Tumu, MD



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Past Medical History

- asthma _____
- heart disease _____
- lung disease _____
- kidney disease _____
- diabetes _____
- bleeding problems _____
- high blood pressure _____
- AIDS/HIV _____
- liver disease _____
- high cholesterol _____
- other (accidents, etc.) _____

Past Surgical History

Procedure	Doctor	Date
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

Family History

Condition	Relative
<input type="checkbox"/> heart disease	_____
<input type="checkbox"/> cancer (location and type)	_____
<input type="checkbox"/> diabetes	_____
<input type="checkbox"/> high blood pressure	_____
<input type="checkbox"/> tuberculosis	_____
<input type="checkbox"/> migraines	_____
<input type="checkbox"/> stroke	_____

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Current Medications

Medicine	Dosage	Frequency
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____

Allergies

- 1 _____
- 2 _____
- 3 _____
- None Known _____

Current Height: _____

Current Weight: _____

Social History

Occupation _____

Tobacco _____ none

_____ previously ___ # of years _____ packs per day _____ date quit

_____ currently ___ # of years _____ packs per day

Alcohol _____ drinks per week

Illicit Drug Use _____

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Name _____ Date _____

Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc). If you feel any of the following symptoms, please indicate where you feel them by placing the appropriate marks on the diagrams. Include all affected areas.

Numbness

11111

Pins and Needles

000000

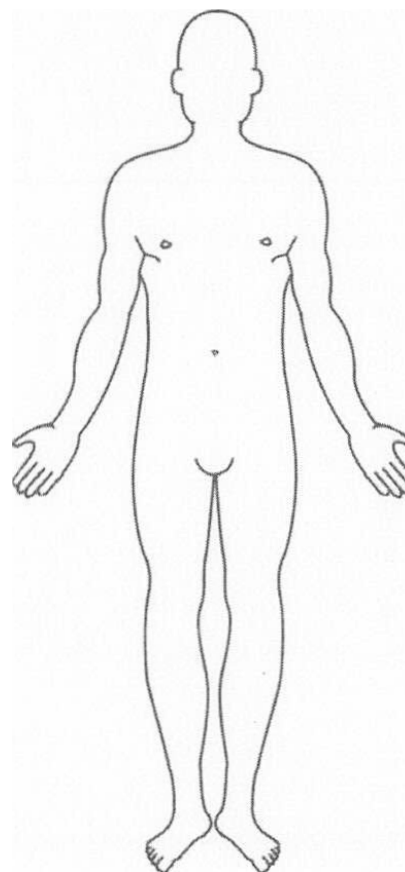
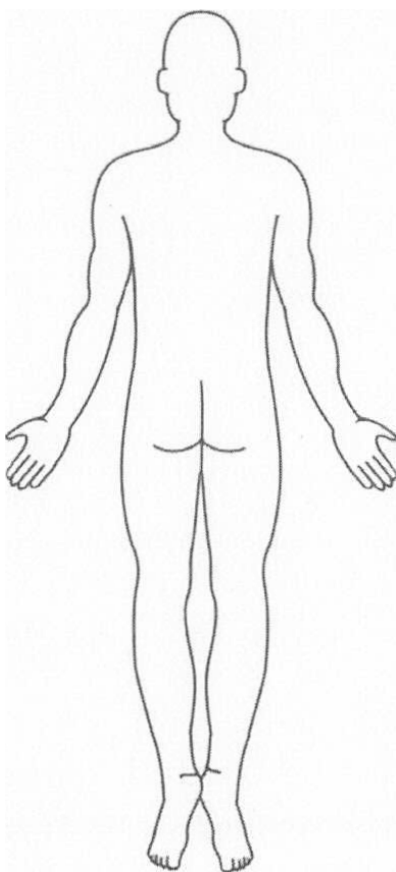
Burning

#####

Stabbing

//////

Ache



1. How bad is your pain now?
2. Please mark with an x on the body form where the pain is worst now.
3. Please circle the appropriate number below representing how bad your pain is now.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

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