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

Ethinicity ☐ 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 _____ Address _____ Phone _____

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 _____

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 _____

Secondary 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 peform 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

HCA PHYSICIAN SERVICES
AUSTIN BRAIN AND SPINE
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN** (optional)**:**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:		**Recipient's Phone:**
	City:		**State:** **Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Austin Brain & Spine

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. Musculoskeletal
    - ☐ back pain
    - ☐ injury
    - ☐ muscle pain
    - ☐ weakness
    - ☐ neck pain
    - ☐ numbness

Austin Brain & Spine

Central	Georgetown	South	Bastrop	San Marcos	Marble Falls
3000 N IH 35 Suite 600 Austin, Tx 78705	3201 S. Austin Avenue Suite 205 Georgetown, Tx 78626	4101 James Casey St. Suite 340 Austin, Tx 78745	3101 Hwy. 71 East Suite 107 Bastrop, TX 78602	1251 Sadler Drive Suite 2100, Bldg. II San Marcos, TX 78666	102 Max Starcke Dam Rd. Suite 100 Marble Falls, TX 78654

512-306-1323 • 512-306-1142 fax
www.austinbrainandspine.com
Alexa Bodman, M.D.; Calvin Cooper, MD; Craig Kemper, MD, FACS; Hari Tumu, MD

Austin Brain & Spine

Current Medications

	Medicine / Anticoagulants	Strength	Frequency
1			
2			
3			
4			
5			
6			
7			
8			

Past Medical History

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

Allergies Drug / Food / Latex

1 _____

2 _____

3 _____

None Known ☐

Current Height: _____

Current Weight: _____

Austin Brain & Spine

Central
3000 N IH 35
Suite 600
Austin, Tx 78705

Georgetown
3201 S. Austin Avenue
Suite 205
Georgetown, Tx 78626

South
4101 James Casey St.
Suite 340
Austin, Tx 78745

Bastrop
3101 Hwy. 71 East
Suite 107
Bastrop, TX 78602

San Marcos
1251 Sadler Drive
Suite 2100, Bldg. II
San Marcos, TX 78666

Marble Falls
102 Max Starcke Dam Rd.
Suite 100
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Past Surgical History

	Procedure	Doctor	Date
1			
2			
3			
4			

Family History

Condition	Relative	Living / Non-Living
☐ heart disease		☐ / ☐
☐ cancer (location and type)		☐ / ☐
☐ diabetes		☐ / ☐
☐ high blood pressure		☐ / ☐
☐ tuberculosis		☐ / ☐
☐ migraines		☐ / ☐
☐ stroke		☐ / ☐

Imaging

Preferred Imaging Facility? _____

Do you have metal in your body? _____

Do you require sedation? _____

Social History

Occupation _____

Tobacco / Smokeless Tobacco (Circle one)

_____ none

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

_____ currently ____ # of years _____ packs per day

Alcohol _____ drinks per week

Illicit Drug Use _____

Falls

Have you had any falls in the last ☐ 3 months ☐ 12 months?

With injury? ☐ yes ☐ no

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