Texas Center for Neurosciences PLLC - Remi Nader, MD

PO BOX 271463, Houston, TX 77277 Tel: 832-932-9300 or 409-833-2225 Fax: 1-855-790-3974 www.TexasNeuroscience.net

REGISTRATION

Patient Last Name_____First Name_____ Initial_____
Date_____ Home Phone_____ Work Phone_____ Email_____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security #_____ Driver's License #_____
Insured Name_____How and where did you learn about this clinic?_____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City _____ State _____ Zip_____Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____Phone_____ Occupation_____ City_____ State _____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birth Date:_____

Height: _____ Weight: _____

Reason for Office Visit (briefly explain):_____
_____
_____
_____
_____

☐ Injury/Date of Injury _____

☐ Illness/Date Illness Began_____

☐ Symptoms/Date symptoms began _____

☐ Second Opinion/IME _____

1. Pain is:

☐ in the neck ☐in the shoulder ☐in the arm/hand

☐in the back ☐in the hip ☐in the leg/foot

☐ other_____

2. How long has pain been present?_____

3. Pain occurs with the following frequency:

☐ occasionally ☐ on and off ☐ all the time

☐ throughout the day ☐at night ☐no difference

4. Each episode of pain usually lasts: _____

☐seconds ☐minutes ☐hours ☐days ☐weeks

5. Are you: Right Handed_____ Left Handed _____
Use both Equally_____

6. Pain feels like:

☐a dull aching ☐sharp ☐stabbing ☐burning ☐cramping

Pain location: ☐middle of low back

☐ to Left or Right (circle) ☐across buttock / back

7. Intensity of pain (scale of 1-10: 1 –2 –3 –4 –5 –6 –7 – 8 – 9 – 10)

☐no pain (0) ☐ mild pain (1-2) ☐moderate pain (3-4)

☐severe pain (5-6) ☐very severe pain (7-8)

☐worst possible pain (9-10)

8. Pain in the neck compared with arm is:

☐ worse in the neck ☐same ☐less in the neck
Pain in the back compared with leg is :

☐ worse in the back ☐ same ☐less in the back

9. Mark the body position and /or activities that make pain better or worse:

a. Sitting ☐ better ☐worse

b. Standing☐better ☐worse

c. Walking☐better ☐worse

d. Laying Down ☐better ☐ worse

e. At night, pain is ☐ better ☐worse

f. Coughing, Sneezing ☐better☐worse

g. Straining only ☐better ☐worse

h. Movement ☐ better ☐ worse

i. During the day pain is ☐better ☐worse

j. No difference ☐better ☐worse

10. Any urinary or fecal incontinence? ☐NO ☐YES

11. Do you have foot drop or paralysis? ☐NO ☐YES

12. Previous tests done: Where/ when ?

☐MRI_____

☐CT Scan_____

☐Myelogram_____ ☐EMG/NCV_____

☐Discogram_____ ☐Bone Scan_____

13. Treatment done so far:

☐bed rest ☐pain pills ☐muscle relaxants ☐anti-inflammatory non-steroidals ☐ TENS unit ☐chiropractic

☐physical thereapy ☐epidural blocks

☐Other injections (trigger point) ☐Back/ neck brace

☐decompression of nerve ☐removal of disc

☐spinal fusion

14. Previous treatments have been:

☐unsuccessful ☐partially successful ☐very successful

15. Is current condition:

related to an accident ? ☐ yes ☐no

Covered under Workmen's Compensation? ☐ yes ☐no

related to an injury on the job? ☐yes ☐no

Under litigation? ☐yes ☐no

If yes, Name of
Attorney_____
Phone#_____
Date of injury or accident_____

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birth Date:_____

PAST HOSPITALIZATION / SURGICAL HISTORY:
Check any previous SPINAL surgeries and indicate the date(s) when they occurred: □ No spinal surgeries
□ Thoracic _____
□ Lumbar _____
□ Cervical _____
Check all OTHER surgeries: □ NONE □ appendectomy
□ cardiac surgery □ tonsil / adenoidectomy
□ wisdom teeth removal □ gall bladder surgery
□ other orthopedic surgery □ thyroid surgery
□ breast surgery □ hernia repair □ Cesarean section
□ Other _____

PERSONAL MEDICAL HISTORY
Do you have a history of medical problems/surgery for:
Vision Problems: □ cataracts □ blurred vision □ glasses □ surgery □ other: _____
Hearing Problems: □ hearing loss □ hearing aid □ vertigo □ ringing in ears □ surgery □ other: _____
Skin Problems: □ rash □ hives □ lesions □ discoloration □ other: _____
Cardiovascular: □ heart attack □ heart failure □ angina / chest pain □ mitral valve prolapse □ irregular heartbeats □ shortness of breath □ other: _____
Circulation/Blood flow: □ varicose veins □ leg swelling □ peripheral vascular disease □ blood clots □ high blood pressure □ low blood pressure □ other: _____
Respiratory: □ asthma □ bronchitis □ emphysema □ pneumonia □ COPD □ tuberculosis □ oxygen tank □ other: _____
Bowels/Intestines: □ cramps □ irritation □ Irritable Bowel Syndrome □ other: _____
Kidneys: □ dialysis □ renal failure □ renal insufficiency □ kidney disease □ other: _____
Uterus/Prostate: □ BPH benign prostate enlargement □ weak urine stream □ prostate disease □ cancer □ fibroids □ other: _____
Mental problems: □ depression □ anxiety □ psychosis □ other: _____
Brain: □ seizure □ stroke □ tumor □ cyst □ hydrocephalus □ aneurysm □ headache □ migraines □ dizziness/fainting □ other: _____
Infections: □ hepatitis □ HIV / AIDS □ staph □ venereal disease □ herpes □ other: _____

Other personal medical problems:
_____
_____
_____
_____

ALLERGIES:
List all medications you are allergic to and the reaction you have:_____
_____
_____

MEDICATIONS:
List all medication you are now taking & what they are for:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS (Check items that applies to you):
Musculoskeletal / Joints: □ Muscular disease □ Arthritis □ Degenerative
Neurological: □ Headaches □ Migraines □ Seizures □ Strokes
Endocrine: □ Diabetes □ Thyroid □ Hypoglycemia
Bleeding Disorders: □ Anemia □ Clots □ Other bleeding problems: _____
Urinary: □ Blood in urine □ Frequent urination □ Trouble starting urination □ Trouble stopping urination □ Pain with urination
Gastrointestinal: □ Stomach ulcers □ Reflux / GERD □ Gallbladder problems □ Pancreatitis □ Colitis □ Blood in stool □ Hiatal hernia □ Liver disease □ Constipation □ Loss of bowel control □ Jaundice
Cancer: □ Lung □ Breast / Colon / Intestinal □ Stomach □ Prostate □ Skin □ Kidney □ Bone □ Other _____

Women only: Are you on the Pill? □ No □ Yes
Are you pregnant now? □ No □ Yes Due date: _____
How long ago was your last complete physical?
_____ yrs _____months □ Endometriosis
Where there any abnormal findings? □ No □ Yes, describe:
_____

LIFESTYLE
Do you smoke NOW? □ No □ Yes: Packs per day: _____ for _____ years
Did you smoke in the Past? □ No □ Yes: Packs per day: _____ for _____ years
Do you drink alcoholic beverages? □ No □ Yes: Drinks per week: _____ for _____ years
Do you have a history of drug abuse? □ No □ Yes: Please describe: _____
_____

SOCIAL HISTORY:
Patient's Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated
# of children: _____ Hobbies: _____
Spouse Occupation: _____

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Patient Name:_____ Date:_____ Birthdate:_____

FAMILY HISTORY:
Please check any of the problems immediate family have had and indicate the family member:
□ Diabetes □ High Blood Pressure □ Heart Disease
□ Neck Pain □ Back pain □ Low Blood Pressure
□ Kidney disease □ Depression/mental problems
□ Alzheimers/Memory loss □ Vascular Disease
□ Stroke/brain tumor/aneurysm
□ Lung problems □ Parkinson's □ Multiple Sclerosis
□ Cancer:_____
OTHER_____

Is there any reason you cannot receive blood or blood product: ☐ no ☐ yes: _____

OCCUPATIONAL HISTORY:
Occupation: _____
Employer: _____
When did this employer hire you? _____
Presently Working? □ Yes □ No
How long off work? _____

Does your job require you to perform the following activities:
□ Lift _____ pounds □ Sit □ Use a computer

□ Lift over head □ Bend □ Drive a truck or forklift

□ Reach over head □ Stand

If you are married, does your spouse work?
□ YES □ NO
If no, how long has he/she been off work? _____

ADDITIONAL PATIENT INFORMATION:
(Provide additional explanation of any response on this form in the space below)

I certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

X _____ _____ _____
Signature of Patient or Personal Representative Date Verified by Physician/Nurse/ Medical assistant

DISCLOSURES & ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Texas Center for Neurosciences' (TCN) 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.

Medical Release of Information:

I hereby authorize Texas Center for Neurosciences, to release any Medical Information (from my medical and other records) required to process my claim, to any insurance or third party payor, any other person or entity financially responsible for my care/ treatment, any representative of local, state or federal agencies in accordance with the law, for the purpose of conducting a medical audit, utilization reviews, quality assurance reviews, or to any referring physician or skilled/health care facility.

X_____ _____ _____
Signature of Patient or Personal Representative Date Name (& Description of Personal Representative Authority if applicable)

AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION/ CONSENT TO PUBLICATION/PHOTOGRAPHY

I authorize TCN and/or Dr. Remi Nader, M.D. to take photographs or videos of myself/ my surgery or the below named patient or to use information contained in my medical record such as history and physical, progress notes, consultations, operative reports, laboratory and pathology reports, radiological images and reports, other hospital and clinic documents for the purpose of medical publication and studies. I understand that ***ALL IDENTIFYING INFORMATION WILL BE REMOVED*** if used for that purpose. I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply for information that has already been released. I understand that this authorization is voluntary and I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I fully and completely release TCN and Dr. Remi Nader from any claims or liabilities arising from the use of this information. I also understand that the information gathered will be the property of TCN/ Dr. Remi Nader. I understand that disclosure of this information carries with it the potential of unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

X_____ _____
Signature of Patient or Personal Representative Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW TEXAS CENTER FOR NEUROSCIENCES (TCN) MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with TCN This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

TCN is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 409-833-2225

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability - This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations - We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating deindentified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required By Law - We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings - We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement - We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity - Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

For Workers' Compensation - Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

When an Inmate - We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.