CENTRAL TEXAS BRAIN & SPINE

Registration Form

Name: Social Security #:

Address: City State Zip code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

DOB: / / Age: Marital Status: ☐M ☐S ☐D ☐W

Sex: ☐Male ☐Female Race: ☐ Hispanic ☐Non-Hispanic Us Citizen? ☐Yes ☐No

Email:

Do you want to be registered for our online portal access? ☐Yes ☐No

Person to notify in case of emergency:

Phone: ( ) Relationship:

Who referred you to our practice? Phone: ( )

Address City State: Zip

Who is your family practice doctor? Phone: ( )

Address City State: Zip

Primary Ins: Secondary Ins:

Please give us your insurance card(s) and driver's license so we can make a copy of them

If covered under your spouse's insurance, please provide the following information:

Spouse's Name: D.O.B:

Spouse's Employer:

Social Security #: Is insurance: ☐Primary ☐Secondary ☐Both

U.S. Citizen ☐Yes ☐No If not, which country are you from:

All patients MUST provide some form of identification.
Please read and sign the following statements

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician or supplier for services described in the insurance claim. I understand that my insurance plan(s) MAY NOT COVER THE TOTAL COST OF TREATMENT (DUE TO THE NATURE OF THE INSURANCE PLAN OR THAT SOME TREATMENT(S) MAY BE CONSIDERED MEDICALLY NECESSARY BY THE INSURANCE COMPANY) AND THAT **I AM RESPONSIBLE** FOR **ANY COPAYMENT, DEDUCTIBLE AND OTHER CHARGES NOT COVERED BY MY PRIMARY OR SECONDARY INSURANCE PLAN(S).**

Medicare patients: I understand that I am responsible for the deductible and the copayment applied to my Medicare Insurance coverage.

Signature: Date:

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Medications

Please list any medications, including vitamins and herbal supplements you **currently take**.

Name of Medication (Ex:Plavix)	Dose (Ex: 50mg)	Frequency (Ex: BID, Nightly)

Pharmacy Information

Name:	Address:
Phone Number:	

Allergies

Medications (Ex: Penicillin)	Environmental (Ex: Latex, Food)

Your doctors

Please list any pertinent doctors.(Ex: Dr. Jones Primary Care; Dr. Brown Oncologist)

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Medical History

Please list any **diagnosed major medical problems** below (Ex: high blood pressure, diabetes etc.)

Please list any **previous surgeries** below (Ex: tonsillectomy, craniotomy, etc.)

Surgery	Approximate Date

Please list any **previous hospitalizations** below (Ex: pneumonia, ER visits, etc.)

Please list any pertinent **family medical history** below (Ex: stroke, aneurysm, cancer, etc.)

Description	Relationship to patient

Do you drink alcohol? ☐Yes ☐No If yes, how often?

Do you use tobacco? ☐Yes ☐No If yes, how often?

Do you have a history of tobacco use? If yes, when did you quit?

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Please mark symptoms that apply to you today

	Ophthalmologic		**Gastro Cont…**		**Neuro Cont…**
☐	Dry Eyes	☐	Change in Appetite	☐	Weakness
☐	Irritation	☐	Black/Tarry Stools	☐	Seizures
☐	Vision Changes	☐	Diarrhea	☐	Dizziness
☐	Double Vision	☐	Vomiting Blood	☐	Frequent/Severe Headaches
☐	Eye Pain	☐	Heartburn	☐	Speech Difficulties
	ENT	☐	Constipation	☐	Fainting
☐	Difficulty Hearing	☐	Hepatitis- Type_____	☐	Memory Lapses/Loss
☐	Ear Pain	☐	Difficulty Swallowing		**Psychiatric**
☐	Ringing in Ears	☐	Gallbladder Disease	☐	Depression
☐	Nose Bleed		**Genitourinary**	☐	Anxiety
☐	Nose/Sinus Problems	☐	Urinary Loss of Control		**Endocrine**
☐	Sore Throat	☐	Difficulty Urinating	☐	Fatigue
☐	Dry Mouth	☐	Increased Urinary Frequency	☐	Increased Thirst
☐	Gum Sores	☐	Blood in Urine	☐	Cold Intolerance
☐	Dentures	☐	Kidney Stones	☐	Hot Intolerance
☐	Throat Hoarseness		**Musculoskeletal**	☐	Constant Hunger
	Cardiovascular	☐	Muscle Aches	☐	Diabetes
☐	Chest Pain	☐	Muscle Weakness	☐	Thyroid Disease
☐	Shortness of breath-walking	☐	Joint Pain		**Hematologic**
☐	Shortness of breath-lying	☐	Back Pain	☐	Night Sweats
☐	Palpitations	☐	Numbness in Limbs	☐	Easy Bruising
☐	Known Heart Murmur	☐	Tingling in Limbs	☐	Excessive Bleeding
☐	High Blood Pressure	☐	Difficulty Walking	☐	Swollen Glands
☐	Pacemaker	☐	Muscle Spasms	☐	HIV Positive
☐	History of Heart Disease	☐	Paralysis	☐	Anemia
	Respiratory	☐	Shaking/Tremors	☐	Frequent Infections
☐	Chronic Cough	☐	Limited Motion		**Allergy/Immunology**
☐	Wheezing		**Skin**	☐	Rheumatoid Arthritis
☐	Shortness of Breath	☐	Abnormal Mole	☐	Lupus
☐	Coughing Blood	☐	Rash	☐	Scleroderma
☐	Sleep Apnea	☐	Dry Skin	☐	
☐	Asthma	☐	Growth/Lesions	☐	
☐	Bronchitis/Emphysema	☐	Eczema	☐	**Other:**
☐	Tuberculosis	☐	Shingles	☐	
☐	Pneumonia	☐	Psoriasis	☐	
	Gastrointestinal		**Neurological**	☐	
☐	Abdominal Pain	☐	Loss of Consciousness	☐	
☐	Vomiting			☐	

Financial Policy

This document is to inform you of Central Texas Brain and Spine's (CTBS) financial policy. It is the philosophy of CTBS that all of our patients receive the best possible care and service; therefore, your complete understanding of our financial obligations is an essential part of our philosophy. Please read this document thoroughly, sign and date at the bottom indicating that you understand and agree to comply with these policies.

Payment **FOR ALL SERVICES** by our practice is due in full at the time services are rendered. We reserve the right to charge interest on any accounts deemed past due. Exclusions to this policy include those patients who are a member of a Health Maintenance Organization (HMO).

If you are a member of an insurance company that CTBS participates with, we will file your claims. Co-payment, co-insurance and deductible are due at the time services are provided REGARDLAESS if CTBS is participating *OR* **NOT** participating with your insurance company.

Medicare patients are responsible for their co-insurance, deductible and any items deemed Medically Unnecessary by Medicare. If you have insurance that covers your co-insurance and deductible we will file on your behalf.

Patients will receive a monthly statement itemizing the services rendered, claims submitted on their behalf, payments received and appropriate balances due. All patient balances are payable in full, within fourteen (14) days of date on statement **unless prior arrangements are made** with our billing office.

It is the policy of CTBS that any patient eighteen (18) years of age or older will be financially responsible for all charges incurred. CTBS does not get involved with divorce or separation issues. For any patients under the age of eighteen (18), the parent or guardian who accompanies the minor on the date of their first visit will be held financially responsible for any and all charges incurred.

CTBS accepts Cash, Credit Cards, Checks, Money Orders and Traveler's Checks as payment for services rendered. There is a $25 charge for returned checks. Refunds will be issued on a monthly basis in the form of a check.

CTBS reserves the right to turn any patient over to an attorney and/or a collection agency if it is deemed that the account has been in default of the payment obligations or compliance of these policies and will result in doctor/patient relation termination. A $30 processing fee will be added to your account if this action is taken. CTBS will also terminate doctor/patient relations and any further medical care.

I have read and understand the above financial policy of CTBS. I agree to the terms outlined in the policy and understand that if I do not adhere to CTBS's financial policies, I may be turned over to an attorney and/or a collection agency for payment of debt.

_____ _____

Patient Signature Date

Policies

Due to many changes in the healthcare and our ability to comply with these changes, we have put in place the following policies and procedures. This handout is designed to provide you with concise information about our conditions, expectations and procedures.

Appointments: We make a sincere effort to adhere to our appointment schedule, however, at times an appointment may take longer than planned or an emergency may arise. We appreciate your understanding and patience when this happens. Patients arriving more than 15 minutes late for an appointment will be asked to reschedule. Please be advised that if you cancel your appointment less than 24 hours in advance repeatedly or do not show up for an appointment twice we will ask you to find medical care with another physician. You will be charged the amount of an office visit fee for all no-shows and appointments canceled with less than 24 hours notice.

Letters: If you request a letter or any insurance documents to be generated, on your behalf, there will be a $25 charge. The fee is due at the time of the request. This is not a covered insurance benefit and the patient is responsible for the charge.

Lost information: Should you misplace any items produced by this office there will be a $10 fee for replacing them. This is not a covered insurance benefit and the patient is responsible for the charge.

Prescription Refill Request: Please contact your pharmacy and have them fax us a refill request. Request will be faxed back pending Dr. Patel's approval.

Prescription History: I authorize Central Texas Brain and Spine to access my prescription history through my insurance.

Consent to call: I authorize Central Texas Brain and Spine to call/text my cell phone for various reminders including automated system calls to confirm appointments.

Insurance: Co-pays are due **AT THE TIME OF SERVICE.** Please keep in mind that Dr. Patel is considered a specialist and higher co-pays may apply. It is the patient's responsibility to know if Dr. Patel participates in your plan or not. If we do **NOT** participate with your insurance company, you are considered an Out-of-Network patient and will be responsible for your co-insurance and deductibles. Please contact your insurance company to verify your coverage.

Billing: CTBS follows governmental guidelines for billing our services. Many insurance companies will process charges for ancillary services (labs, x-rays, procedures, etc.) and make the patient responsible for balances above the office co-pay. This could be in the form of deductibles, co-insurance or additional co-pays. We participate with many insurance companies to enable our patients' affordable medical care. Because of this, we are obligated to follow the guidelines that the insurance companies give us on patient balances. If you have specific questions about how your insurance company processed your claim, please call them directly.

_____ _____

Patient Signature Date

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Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices (provided at front desk), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient Signature Date

Disclosure to Families and Loved Ones

Purpose:

This office honors the important role that families, friends and other loved ones play in supporting our patients' healthcare and treatment. At the same time, we are committed to protecting our patients' privacy as well as complying with both state and federal law. Accordingly, disclosure to other people, even family, must remain a decision that rests with the patient. To the extent that is possible we will follow the alternatives addressed in this policy.

Policy:

- This practice will comply with any patient's request for us to share their personal health information with family member(s) and other designated person(s). We will comply with their request as long as: 1) the oral request is noted in the patient's record (ex: "at patient's request will share information with John Doe"), 2) the patient is competent to make this decision, and 3) the patient has not revoked that request. Note that revocations or limitations must also be documented in the patient's record.
- Patients who arrive at this office with others will be asked privately if they would like those persons present while they are being seen and/or treated.
- Patients who are undergoing procedures requiring anesthesia will be asked if they would like information shared with anyone prior to their awakening.
- If the individual cannot express his/her request for sharing information, because of incapacity or an emergency circumstance, our physician(s) will exercise their professional judgment and determine whether the disclosure is in the best interest of the individual. If so, we will disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care.
- Patient family members, neighbors, etc. that come to this office to pick up prescriptions, equipment, directions or other item associated with a patient's care will be permitted to do so if it is reasonable to infer they are involved with our patient's care.
- Notification of appropriate third parties also may occur without a patient's request or approval, to the extent this office is involved with disaster relief services, acting in the role of notifying a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location general condition or death.

_____ _____

Patient Signature Date

Please list the Person(s) we can release information to and relationship to you.