April 11, 2003

Dear Patient,

Patients have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government published regulation designed to protect the privacy of your health information. This "privacy rule" protects the health information that is maintained by physicians, hospitals, other health care providers and health plans. Physicians have two years, until April 14, 2003, to comply with the privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital, or health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you with certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy officer about exercising your rights or how your health information is protected in our office.

The Notice of Private Practices attached to this letter explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any question about our Notice of Privacy Practices. You may contact our Privacy Officer, Kem at 281-469-0339, or discuss any questions you may have with the physician.

Neurosurgery & Spinal Disorders PLLC d.b.a. Texas Spine Center
Shah N. Siddiqi, M.D.
P. O. Box 12267, Spring, TX 77391-2267 **Tel : (281) 469-0339** **Fax: (281)469-0369**

REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Email_____
Patient Last Name_____ First Name_____ Initial_____
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

PROBLEM REPORT ID: 92788
COMPLAINANT: SUPERIOR MEDICAL MANAGEMENT INC

Authorization for the Texas Department of Insurance to Disclose Protected Health Information or Other Confidential Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information or other confidential information.

Covered entities, as that term is defined by Texas Health & Safety Code §181.001, and including TDI, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

NAME OF PATIENT OR INDIVIDUAL (LAST, FIRST, MIDDLE)

OTHER NAMES USED

DATE OF BIRTH (MONTH, DAY, YEAR)

ADDRESS

CITY STATE ZIP CODE

PHONE ALTERNATE PHONE

EMAIL (OPTIONAL)

I authorize the following to disclose the individual's protected health information or other confidential information:

Texas Department of Insurance
333 Guadalupe
Austin, TX 78701

Who can receive and use the health information or other confidential information?

TEXAS SPINE CENTER PLLC
PERSON/ORGANIZATION NAME

ADDRESS

CITY STATE ZIP CODE

PHONE FAX

Reason for disclosure (choose only one option below):

- ☐ Treatment/continuing medical care
- ☐ Insurance
- ☐ Disability determination
- ☐ Other _____
- ☑ Billing or claims
- ☐ Legal purposes
- ☐ Employment

What information can TDI disclose? Complete the following by indicating those items that you want TDI to disclose. A minor patient must sign for the release of some of these items.

- ☑ All health information
- ☐ Email address
- ☐ All other information

Separately sign to indicate which of the following specific information TDI may release:

_____ Mental health records (excluding psychotherapy notes)
_____ Genetic information (including genetic test results)
_____ Drug, alcohol, or substance abuse records
_____ HIV/AIDS test results/treatment
_____ Motor vehicle records

Effective time period. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

X _____
MONTH DAY YEAR

Right to revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization or agency named under "Who can receive and use the health information or other confidential information." I understand that withdrawing my permission will not affect prior actions taken in reliance on this authorization by entities that had permission to access my health information or other confidential information.

Signature authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information or other confidential that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code §181.154(c). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

X _____
SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S LEGALLY AUTHORIZED REPRESENTATIVE DATE

X _____
PRINTED NAME OF LEGALLY AUTHORIZED REPRESENTATIVE (IF APPLICABLE):

If representative, specify relationship to the individual:

- ☐ Parent of minor
- ☐ Guardian
- ☐ other _____

A minor individual must sign to authorize the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, for example, Texas Family Code §32.003).

_____
SIGNATURE OF MINOR INDIVIDUAL DATE

TEXAS SPINE CENTER, Neurosurgery & Spinal Disorders, PLLC

SHAH SIDDIQI, M.D., F.R.C.S. (C). F.A.C.S.

13323 Dotson Rd.
Suite 100
Houston, TX 77070
Tel: (281) 469-0339
Fax: (281) 469-0369

Patient Protection & Advocacy Policy

Affordable Care Act (ACA) Discount Disclosure
You Are Protected From Any Unexpected Costs And Bills

Dear Patient:

1. As your Patient Advocate (PA), we offer the highest care quality and safety possible at the **most affordable cost to you**, no matter if you are covered by an in-network or out-of-network health plan.
2. We offer an **Affordable Care Act Discount (ACA Discount)** under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. **You only pay what you can afford or are willing to pay** for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, based on your medical need. Most people may qualify and **your satisfaction is guaranteed**.
3. Our Affordable Care Act (ACA) Discount is **similar to or even much better than all PPO discounts**, as our **ACA Discount is available from both in-network and out-of-network providers and facilities**.
4. Once you qualify, **you will NOT receive ANY unexpected invoices, bills or collection letters FROM US**, even if your insurance denies your claims.
5. As your Patient Advocate and Authorized Representative, and under the new federal health reform law PPACA (Patient Protection and Affordable Care Act, or ACA), we may appeal all of the claim denials or delays on your behalf, which is strictly in compliance with the new federal health reform law, PPACA.
6. As your Patient Advocate, **your best interest is our best interest**. To ensure that you also get this kind of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, **so you may also receive the best care possible along with the ACA Discounts and Savings.**
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA Discount and ensure that **you are always protected from any unexpected costs and bills** under the new federal health reform law (PPACA).
8. As your Patient Advocate, we want **you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you.**
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we can not speak for or guarantee anything on behalf of other providers we don't know or are not affiliated with regarding their discount or collection policies. You are advised to contact them directly before scheduling your next appointment(s) or medical procedure(s).
10. **If you are willing to be protected from any unexpected costs and bills,** feel free to apply for our Affordable Care Act Discount under our Corporate PPACA Indigency Policy. "*Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount*". Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

Patient Name (print) _____ Signature of Patient _____ Date _____

TEXAS SPINE CENTER, Neurosurgery & Spinal Disorders, PLLC

SHAH SIDDIQI, M.D. , F. R. C. S. (C). F.A.C.S.

13323 Dotson Rd.
Suite 100
Houston, TX 77070
TEL: 281-469-0339
FAX: 281-469-0369

FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS CARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Dishonored checks will be charged back to the patient's account with a service fee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible' for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient, however we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Most health plans or Insurance Polices may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery.
Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and excising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Doctor or Facility with affiliation and remuneration:

Champion Surgical Assistant Staffing, Inc., Orthospine Devices LLC, Spring Monitoring LLC, Cypress Reading LLC, Humble and Pacific Pharmacy, Altus Houston Hospital

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ _____ _____
Signature of Patient or Responsible Party — Patient Name (print) — Date

X _____ _____ _____
Signature of Co-Responsible Party — Your Name (print) — Date

NEUROSURGERY & SPINAL DISORDERS, PLLC
SHAH N. SIDDIQI, M.D., B. CHIR. (CAMB), F.R.C.S. (C)
Office: 281-469-0339 • Fax: 281-469-0369

- 13323 Dotson Rd, Suite 100 Houston, TX 77070
- 9225 Katy Freeway, Suite 404 Houston, TX 77024
- 1327 Lake Pointe Pkwy, Suite 305 Sugar Land, TX 77478
- 3115 College Park Dr, Suite 106 The Woodlands, TX 77384

MEDICAL HISTORY

PATIENT NAME:				DATE:
AGE:	TEMPERATURE:	BLOOD PRESSURE:	PULSE	RESPIRATION:
REFERRING DOCTOR:				
REFERRING DOCTOR ADDRESS:				REFERRING DOCTOR PHONE:

TO THE PATIENT: *This information will be placed in your confidential medical record. It is important to complete each section to the best of your knowledge. If you are uncertain of dates, give approximate dates.*

CHIEF COMPLAINT:

PRESENT ILLNESS (PLEASE DESCRIBE IN DETAIL):

PAST MEDICAL HISTORY Check (✓) any/all problem(s) that you have experienced:

❑ Rheumatic Fever	❑ Knocked Unconscious	❑ Depression	❑ Thyroid
❑ Encephalitis	❑ Paralysis	❑ Polio	❑ Blood Pressure
❑ Meningitis	❑ Diabetes	❑ TB	❑ Memory Loss
❑ Convulsions	❑ Ulcer Disease	❑ Blood Disorder	❑ Eye Problem
❑ Back Pain	❑ Heart Disease	❑ Cancer	
❑ Neck Pain	❑ Lung Disease	❑ Venereal Disease	
❑ Arm Pain	❑ Nervous Breakdown	❑ Urinary	

COMPLETE REVIEW OF SYSTEMS Explain any difficulty or problem that you have had with any system listed below:

Head / Eyes / Ears / Nose / Throat: _____

Chest / Lungs: _____

Heart / Vascular: _____

Abdomen / Intestines / Liver: _____

Urinary System / Genital System: _____

Musculoskeletal (Joints / Muscles): _____

NEUROSURGERY & SPINAL DISORDERS, . PLLC
SHAH N. SIDDIQI, M.D., B. CHIR. (CAMB), F.R.C.S. (C)
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o 13323 Dotson Rd. Suite 100 Houston, TX 77070
o 9226 Katy Freeway, Suite 404 Houston, TX 77024
o 1327 Lake Pointe Pkwy, Suite 305 Sugar Land, TX 77478
o 3116 College Park Dr. Suite 106 The Woodlands, TX 77384

PATIENT INFORMATION SHEET *(PLEASE PRINT)*

Chart Location: | Chart Number:

PATIENT INFORMATION

DATE: | REFERRED BY (PCP): | HAVE WE SEEN ANYONE ELSE IN THE FAMILY? ☐ YES ☐ NO IF YES, NAME:

PATIENT NAME: LAST: FIRST MIDDLE | DATE OF BIRTH: | SEX: ☐ MALE ☐ FEMALE

HOME ADDRESS: | SOCIAL SECURITY NUMBER | MARITAL STATUS:

CITY: | STATE | ZIP CODE | HOME PHONE NUMBER | CELL/PAGER NUMBER

EMPLOYER | OCCUPATION | EMPLOYER PHONE NUMBER:

RESPONSIBLE PARTY NAME: | RELATIONSHIP TO PATIENT: | RESPONSIBLE PARTY SOCIAL SECURITY:

RESPONSIBLE PARTY ADDRESS: | CITY: | STATE: | ZIP CODE:

RESPONSIBLE PARTY EMPLOYER: | RESPONSIBLE PARTY WORK PHONE: | OCCUPATION:

SPOUSE NAME: | SPOUSE SOCIAL SECURITY NUMBER | SPOUSE EMPLOYER | SPOUSE WORK PHONE:

EMERGENCY CONTACT: | RELATIONSHIP TO PATIENT | HOME PHONE NUMBER | WORK PHONE NUMBER:

INSURANCE PRIMARY

INSURANCE COMPANY NAME: | GROUP NUMBER | EMPLOYER OF POLICY HOLDER

POLICY HOLDER NAME: | POLICY HOLDER SS # OR I.D. # | POLICY HOLDER BIRTHDATE: | RELATIONSHIP TO PATIENT:

INSURANCE COMPANY MAILING ADDRESS | CITY: | STATE | ZIP CODE: | INSURANCE CO. PHONE #:

If no secondary insurance circle: **NONE**

INSURANCE SECONDARY

INSURANCE COMPANY NAME: | GROUP NUMBER: | EMPLOYER OF POLICY HOLDER:

POLICY HOLDER NAME: | POLICY HOLDER SS # OR I.D. #: | POLICY HOLDER BIRTHDATE: | RELATIONSHIP TO PATIENT:

INSURANCE COMPANY MAILING ADDRESS: | CITY: | STATE: | ZIP CODE | INSURANCE CO. PHONE #:

I give my consent to Neurosurgery & Spinal Disorders, P.A. to speak to anyone at the above referenced telephone numbers. _____ (INITIALS)

AUTHORIZATION AND CONSENT FOR HEALTH CARE

I hereby authorize the physician, Shah N. Siddiqi, M.D., and affiliated or other providers to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to the physicians of Neurosurgery & Spinal Disorders, or other providers for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Neurosurgical & Spinal Disorders is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatments by my physicians, and my physician's associates, assistants, and other healthcare providers, as may be necessary in my physician's judgement. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made to me as to result or cure. This form has been fully explained to me, and I certify that I understand its contents.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR RESPONSIBLE PARTY | DATE

Update Confirmation (No Changes Necessary)

Patient Name _____ Date_____

List all Hospitalizations:

Date	Diagnosis/Illness	Doctor/Hospital

Past Medical Testing:

Have you had any of the following tests?

EEG (Brian Wave) _____ When and Where _____

CT Scan (Brain) _____ When and Where _____

CT Scan (Spine) _____ When and Where _____

MRI Scan (Brain) _____ When and Where _____

MRI Scan (Spine)_____ When and Where _____

EMG/Nerve Conduction Test _____ When and Where _____

Myelogram _____ When and Where _____

Arteriograms _____ When and Where _____

List all medications your are taking now:

Drug name	Dosage/Frequency	Prescribing Doctor

Patient Name _____ Date _____

List all drug/medication allergies:

Drug Type of reaction

_____

_____

_____

_____

Are you allergic to seafood? _____

Past Family History:

Relative	Living/Dead	Approx. Age	Diseases or Diagnosis
Mother			
Father			
Brothers			
Sisters			

Do any members of your family have hereditary (inherited) diseases:

(Circle one) No Yes

If yes, name of the Disease(s): _____

_____

_____

_____

Social History:

Circle One

Married Widowed Divorced Separated Single Live-In

Occupation _____

(If retired, Last occupation) _____

Do you smoke_____ Do you use any alcohol _____

Do you have any children _____

If so, How many_____ Male_____ Female _____

Neurosurgery & Spinal Disorders, PLLC

Patient Questionnaire
Please Print

1. **Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.**

   _____

   _____

2. **Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.**

   _____

   _____

3. **Please print the address of where you would like your billing statements and/or correspondence from our office sent if other than your home.**

   _____

   _____

4. **Please indicate if you want all your correspondence sent from our office in a sealed envelope marked "CONFIDENTIAL."**

   _____ YES _____ NO

5. **Please print the telephone number, if any, where you want to receive calls about your appointments, labs, and or x-ray results or other health care information if other than your home phone number.**

   (_____) _____-_____

6. **Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?**

   _____ YES _____ NO

7. **If you do not have voicemail, can confidential messages be left at your place of employment?**

   _____ YES _____ NO

PATIENT NAME: _____

SIGNATURE: _____ **DATE:** _____
(Guardian if under 18)

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **NEUROSURGERY & SPINAL DISORDERS,PLLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by, **NEUROSURGERY & SPINAL DISORDERS,PLLC**, describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **NEUROSURGERY & SPINAL DISORDERS, PLLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to **NEUROSURGERY & SPINAL DISORDERS, PLLC**

With this consent, **NEUROSURGERY & SPINAL DISORDERS,PLLC** may call to my home or any other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **NEUROSURGERY & SPINL DISORDERS,PLLC** my mail to my home or any other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **NEUROSURGERY & SPINAL DISORDERS,PLLC**, may email to my home or any other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **NEUROSURGERY & SPINAL DISORDERS, PLLC**, restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **NEUROSURGERY & SPINAL DISORDERS, PLLC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **NEUROURGERY & SPINAL DISORDERS,PLLC** may decline to provide treatment for me.

Signed by:_____

Signature of Patient or Legal Guardian Date Relationship to Patient