Neurosurgical Specialists of El Paso, PLLC
Dr. Helson Pacheco-Serrant
(915) 351-1444

Date:_____/_____/_____ **E-mail**: _____ **Cell Phone**: (_____) _____-_____
(FECHA DE HOY) (CORREO ELECTRONICO) (TELEFONO CELULAR)

Patient's Name: _____ **SS#:** _____-_____-_____
(NOMBRE DEL PACIENTE) (SEGURO SOCIAL)

Address: _____ **Home Phone:** (_____) _____-_____ **DOB:** _____/_____/_____
(DOMICILIO) (TELEFONO DE CASA) (FECHA DE NACIMIENTO)

City, State: _____ **ZIP:** _____ **Gender:** ☐ Female ☐ Male
(CIUDAD Y ESTADO) (CODIGO)

Employer: _____ **Work Phone:** (_____) _____-_____ **Occupation:** _____
(EMPLEADOR) (TELEFONO DE EMPLEADOR) (OCUPACION)

Work Address, City, State: _____
(DOMICILIO DE EMPLEADOR, CIUDAD, Y ESTADO)

WHO REFERRED YOU HERE:
Brochure/Family/YellowPages/Newspaper/Hospital/Doctor: _____
QUIEN LE REFIRIO AQUI:
Folleto/Familia/Pagina Amarillas/Periodico/Hospital/Doctor: _____

Date of Accident or Injury: ____/_____/_____ **Hurt on the Job** ___Yes/Si ___ No **MVA** ___ Yes/Si ___ No
(FECHA DE ACCIDENTE) (FUE LASTIMADO EN EL TRABAJO) (ACCIDENTE DE VEHICULO DE MOTOR)

Emergency Contact Name: _____ **Phone Number:** (_____) _____-_____
(EN CASO DE EMERGENCIA A QUIEN NOTIFICAMOS) (TELEFONO DE CASA/CELULAR)

Emergency Contact Relationship to Patient: _____
(RELACION AL PACIENTE)

PRIMARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**
(INFORMACION DE ASEGURANZA PRIMARIA)

Insurance Company: _____ **Phone Number:** (_____) _____-_____
(COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)

Name of Insured: _____ **Patient Relationship to Insured:** _____
(NOMBRE DE LA PERSONA ASEGURADA) (RELACION AL PACIENTE)

Subscriber ID (Policy #): _____ **Group ID:** _____ **Social Security:** _____/_____/_____
(IDENTIFICACION DE POLIZA) (NUMERO DE GRUPO) (SEGURO SOCIAL)

Effective Date: _____ **Date of Birth** _____/_____/_____ (FECHA DE NACIMIENTO)

SECONDARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**
(INFORMACION DE ASEGURANZA SECUNDARIA)

Insurance Company: _____ **Phone Number:** (_____) _____-_____
(COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)

Name of Insured: _____ **Patient Relationship to Insured:** _____
(NOMBRE DE LA PERSONA ASEGURADA) (RELACION AL PACIENTE)

Subscriber ID (Policy #): _____ **Group ID:** _____ **Social Security:** _____/_____/_____
(IDENTIFICACION DE POLIZA) (NUMERO DE GRUPO) (SEGURO SOCIAL)

Effective Date: _____ **Date of Birth** _____/_____/_____ (FECHA DE NACIMIENTO)

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.
(ESTOY DE ACUERDO EN QUE LA INFORMACION FACILITADO EN ESTE FORMULARIO ES PRECISA Y HASTA LA FECHA A LO MEJOR DE MI CONOCIMIENTO.

Patient Signature _____ Date: _____

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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/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

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1. I authorize **Neurosurgical Specialists of El Paso, PLLC** to file insurance forms on my behalf. I request that payment under Medicare or any other health insurance be made directly to **Neurosurgical Specialists of El Paso, PLLC**. In the event the policy requires payment to the patient, the check must be mailed to the patient in the care of **Neurosurgical Specialists of El Paso, PLLC, 1700 N. Oregon St., Suite 660 El Paso, TX 79902.**

   Yo autorizo a este centro interno del paso a los formularios de seguros de archive en mi nombre. Solicito que el pago en virtud de Medicare o de cualquier otro seguro de salud se haga directamente al centro interno de **Neurosurgical Specialists of El Paso, PLLC.** En el caso de la politica de exigir el pago al paciente, el cheque debe enviarse por correo al paciente en el cuidado de **Neurosurgical Specialists of El Paso, PLLC, 1700 N. Oregon St., Suite 660 El Paso, TX 79902.**

   Signature: _____ Date: _____/_____/_____
   (FIRMA) (FECHA)

2. I hereby authorize **Neurosurgical Specialists of El Paso, PLLC,** to file Medicare or other health insurance forms on my behalf with assignment of benefits as indicated.

   Yo autorizo el centro interno del **Neurosurgical Specialists of El Paso, PLLC,** en el archive de Medicare o de otros formularios de seguros en mi nombre con la asignacion de beneficios, como se indica.

   Signature: _____ Date: _____/_____/_____
   (FIRMA) (FECHA)

3. I hereby authorize **Neurosurgical Specialists of El Paso, PLLC,** to furnish or disclose any information in regard to my illness or treatment to any insurance company, government agency, employer, health professional, or attorneys.

   Yo autorizo **Neurosurgical Specialists of El Paso, PLLC,** para proporcionar o reveler cualquier informacion con respeto a mi enfermedad o tratamiento a cualquier compania de seguros, Agencia gubernamental, empleador, profesionales de la salud, o abogados.

   Signature: _____ Date: _____/_____/_____
   (FIRMA) (FECHA)

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Notice of Form Fee

There will be a $20.00 charge for completion of each disability (or other) forms, which is due at the time the form is brought into the office. Please allow 1 week from the time the form is brought in (and/or the time of the last office visit) for completion of the form so that the insurance clerk has all the necessary information to complete the form.

Thank you,
Management

Aviso De Cobro Para Formas

Habra un cargo de $20.00 para la realizacion de cada forma de discapacidad y de cualquier otra forma, que es debida en el momento en que el formulario se pone en la oficina. Por favor permita una semana desde el momento en que el formulario es traido en (y/o el momento de la ultima visita de oficina) para la realizacion de la forma para que el empleado de seguro tiene toda la informacion necesaria para llenar el formulario.

Gracias,
Administracion

Signature: _____ Date: _____/_____/_____
(FIRMA) (FECHA)

Neurosurgical Specialists of El Paso, PLLC
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Thank you for choosing **Neurosurgical Specialists of El Paso, PLLC.** We shall do our best to provide you with quality and courteous care of your neurological needs.

Gracias por elegir el **Neurosurgical Specialists of El Paso, PLLC.** Haremos nuestro major para proporcionar con calidad y amable atencion de su problema neurological.

Appointment Cancellation Policy

In order to best serve our patients, we respectfully request that appointments be kept as scheduled. Cancellations are accepted in advance of the appointment by telephone. We respectfully request 24 hour advance notice if you need to cancel your appointment.

Poliza de Cancelacion de Cita

Con el fin de servir major a nuestros pacientes, solicitamos respetuosamente que se mantengan las citas como estaba previsto. Las cancelaciones se aceptan antes de la cita por telefono. Respetuosamente solicitamos las 24 horas de antelacion si necesita cancelar su cita.

Medication Refill Policy

A 48 hour notice is needed for refill of medication. If appointments have been missed or cancelled or treatment is not current, medication may not be renewed. Pain medication needs to be filled from your Primary Physician or your Pain Management Physician. Medication will not be renewed when requests are called to the answering service after office hours or on weekends and holidays.

Poliza de Repuesto de Medicamentos

Un aviso de 48 horas es necesaria para el respuesto del medicamento. Si las citas se han perdido o cancelado o tratamiento no es actual, no se podra renovar su medicamento. No se renovara la medicacion cuando se llaman a las solicitudes para el servicio de contestadores despues de horas de oficina o en los fines de semana y dias festivos.

Signature: _____ Date: _____/_____/_____
(FIRMA) (FECHA)

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CONSENT TO TREATMENT

Miguel Ponce, RN, SA-C, RNFA, CNOR (Registered Nurse, Surgical Assistant-Certified, Registered Nurse First Assistant, Certified Nurse Operating Room) working exclusively for Dr. Helson Pacheco-Serrant, as a Registered Nurse First Assistant, has obtained and acquired the necessary educational requirements and skills specific to the expanded role of RNFA clinical practice to function as an assistant in surgery during an operation. Along with first assisting the surgeon, Miguel Ponce's responsibilities include: collaborating with the surgeon and other healthcare professionals for an optimal surgical outcome; evaluating the needs of the patient and of the surgical team throughout the surgical experience; performing follow-up care to evaluate the patient's condition; and participating in discharge planning and postoperative teaching.

AORN official statement on RN First Assistants states: "Preoperative patient management in collaboration with other healthcare providers, including but not limited to:

- Performing preoperative evaluation/focused nursing assessment,
- Communicating/collaborating with other healthcare providers regarding the patient plan of care, and
- Writing preoperative orders according to established protocols,
- Intraoperative surgical first assisting, including but not limited to,
- Using instruments/medical devices, providing exposure,
- Handling and/or cutting tissue,
- Providing hemostasis, and
- Suturing, and
- Postoperative patient management in collaboration with other healthcare providers in the immediate postoperative period and beyond, including but not limited to,
- Writing postoperative orders/operative notes according to established protocols,
- Participating in postoperative rounds, and
- Assisting with discharge planning and identifying appropriate community resources as needed."

First assisting is within the scope of nursing practice of all fifty state boards of nursing. Many major professional organizations recognize the RNFA role including The American College of Surgeons, the Association of Perioperative Registered Nurses, Inc., The National League of Nursing, the American Nurses Association, and the National Association of Orthopedic Nurses.

As a provider of surgical assisting, the registered nurse first assistant may bill independently and/or be reimbursed by insurance companies for services rendered.

I acknowledge that I have been informed that a registered nurse first assistant is not a physician and that I have the right to refuse, at any time, to see the registered nurse first assistant if I so desire. I also understand that Dr. Helson Pacheco-Serrant may assign patient care responsibilities to Miguel Ponce which include: interviewing the surgical patient for a comprehensive health history; performing nursing physical assessments; educating the patient and family; evaluating the needs of the patient and of the surgical team on a continuum throughout the surgical encounter; postoperative patient assessment and evaluation and participating in discharge planning and postoperative teaching, along with any other responsibilities Dr. Helson Pacheco-Serrant may deem necessary within the registered nurse first assistant's scope of practice.

Signature (Patient or Parent/Guardian): _____ Date: _____/_____/_____
(FIRMA) (FECHA)

Neurosurgical Specialists of El Paso, PLLC
General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare 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

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Fecha: _____

Cuestionario médico

Nombre: _____ **Fecha De Nacimiento:** _____ ☐ **M** ☐ **H**

CONDICIÓN PRESENTE: _____

_____

Recomendado por Medico: _____ Médico primario: _____ _____

Manejo del dolor: _____ Cardiólogo: _____

HISTORIA DE LA ENFERMEDAD O CONDICIÓN PRESENTE

¿Estuviste en un accidente de vehículo de motor? **Sí** **No** ¿Herido en el trabajo? **Sí** **No**

Por favor describa el problema, ¿cómo sucedió?

_____

_____

¿Cuál es su nivel de dolor? (1 a 10) _____ **cuánto tiempo han tenido esto?** _____

Que lo hace empeorar? estar de pie acostado caminando inclinarse movimiento otra: _____

Que le ayuda mejorar? Medicamento descansar calor/hielo fisioterapia electro-estimulación otra: _____

¿Tiene problemas de control de su vejiga o intestino? Si No

¿Ha tenido cirugía de espalda o cuello? No Si, fecha_____ Doctor _____

Ha Tenido inyecciones de esteroides? No Si, fecha _____ Doctor _____ lo ayudo **Si** **No**

Ha tenido terapia física? No Si, fecha _____ Doctor _____ lo ayudo **Si** **No**

Ha tenido terapia quiropráctica? No Si, fecha _____ Doctor _____ lo ayudo **Si** **No**

Y	**N**	**Dolor, debilidad o entumecimiento:**
		brazos derecha izquierda
		Espalda
		Pies derecha izquierda
		Manos derecha izquierda
		Caderas
		Piernas derecha izquierda
		Cuello
		Hombro derecho izquierdo

DESCRIBIR SU DOLOR

Constante **viene y va**

Agudo punzante entumecido hormigueo apuñálate ardiente

Presión pulsátil calambres eléctrico penetrante

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HISTORIAL DE TRABAJO

Compañía de Trabajo: _____ Ocupación: _____

Deberes del trabajo: _____

Condiciones - Indique Sí o NO las condiciones que actualmente tiene o ha tenido en el último año

Y	N		Y	N		Y	N		Y	N	
		TRASTORNO DE ESTRÉS POSTRAUMÁTICO			Dependencia de las drogas químicas			Hepatitis - A B C			Enfermedad de la próstata
		Anemia			Diabetes			Osteoporosis			Convulsiones / epilepsia
		Complicaciones de la anestesia			COPD			Hipertensión			Desorden de la tiroides
		Artritis			Fibromialgia			Enfermedad del riñón			Otros: ___
		Asma			Gota			Enfermedad del hígado			Otros: ___
		Depresión			Dolores de cabeza / migrañas			Ansiedad			Otros: ___
		Cáncer ___			Enfermedad cardíaca / marcapasos			Accidente cerebrovascular			Otros: ___

ANTECEDENTES quirúrgicos: Lista de cirugías que ha tenido y qué año	
1.	4.
2.	5.
3.	6.

MEDICAMENTOS: Medicamentos de la lista está actualmente tomando, (incluyendo vitaminas y hierbas)	
1.	5.
2.	6.
3.	7.
4.	8.

ALERGIAS: A los medicamentos o sustancias	
1.	3.
2.	4.

Historia social: Indique la sustancia y Describa cuánto se utiliza.	**Antecedentes familiares: Una lista de cualquier enfermedad que se ejecutan en su familia.**
Cafeína Sí ☐ No ☐ Cuánto:	Madre: viva fallecida enfermedades:
Tabaco Sí ☐ No ☐ Cuánto:	Padre: vivo fallecido enfermedades:
Alcohol Sí ☐ No ☐ Cuánto:	Hermanos: ____ enfermedades: Hermanas: ____ enfermedades:
Casado Solo divorciado separado viudo Con quien vive: _____	Hijos: ____ niños enfermedades: ____ niñas enfermedades

Certifico que la información en este formulario es correcta a lo mejor de mi conocimiento. Que no tengo mi médico o cualquier miembro de este personal responsable de los errores u omisiones que puedo haber hecho en la cumplimentación del presente formulario.

Firma: _____ *Fecha:*_____

*Médico:*_____ *Fecha:*_____