NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC
10201 Gateway Boulevard West, #200 El Paso, Texas 79925
Office (915) 633-1914 Fax (915) 633-1611

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_____-_____-_____Phone number: _____

Address:_____

City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State:_____ZIP: _____

Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to 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 recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative _____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

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Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC any insurance or other third-party benefits available for health care services provided to me. I understand NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse
Parent
Legal Guardian
Guarantor
Healthcare Power of Attorney
Other (please specify) _____

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Notice of Privacy Practice/clinics

_____ (**Patient/Representative initials**) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

☐ I CONSENT ☐ I DO NOT CONSENT

To photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

☐ I CONSENT ☐ I DO NOT CONSENT

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

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Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of Patient/Guardian _____ Date: ___/___/___

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.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

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

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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 note these forms are only filled out for patients who are undergoing surgery. 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 receptionist has all the necessary information to complete the form.

Thank you.

Aviso de Cobro Para Formas

Habrá un cargo de $ 20.00 por completar cada uno de los formularios de discapacidad (u otros), que se deben pagar en el momento en que se lleve el formulario a la oficina. Tenga en cuenta que estos formularios solo se completan para pacientes que se someten a cirugía. Permita que transcurra una semana desde el momento en que se presenta el formulario (y / o la hora de la última visita al consultorio) para completar el formulario, de modo que la recepcionista tenga toda la información necesaria para completar el formulario.

Gracias.

Signature: _____ Date: _____/_____/_____
(Firma)

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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 a Neurosurgical Specialists of El Paso, PLLC. Haremos todo lo posible para brindarle calidad y atención amable a sus necesidades neurológicas.

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.

Política de cancelación de citas

Con el fin de servir mejor a nuestros pacientes, respetuosamente solicitamos que la cita se cumpla según lo programado. Las cancelaciones se aceptan antes de la cita por teléfono. Solicitamos respetuosamente un aviso con 24 horas de anticipación 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 phyisican or your pain management physician. Medication requests will not be taken after hours or on weekends.

Política de reposición de medicamentos

Se necesita un aviso de 48 horas para rellenar el medicamento. Si las citas se han perdido o cancelado, o el tratamiento no es actual, los medicamentos no pueden ser renovados. La medicación para el dolor debe ser llenada por su médico de cabecera o por su médico de control del dolor. Las solicitudes de medicamentos no se tomarán fuera del horario habitual o los fines de semana.

Signature: _____ Date: _____/_____/_____
(Firma)

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Today's Date: _____

Medical Questionnaire

Patient Name: _____ **Date of Birth**: _____ □ Male □ Female

Chief Complaint: _____

_____

Referring Doctor: _____ **Primary Care Doctor**: _____

Pain Management: _____ **Cardiologist**: _____

WORK HISTORY:

Employer: _____ Occupation: _____

Duties: _____

HISTORY OF PRESENT ILLNESS/CONDITION: _____

Were you in a motor vehicle accident? □ Yes □ No Were you injured at work? □ Yes □ No

If injured at work, when was date of injury? _____

Adjuster Name/Number: _____

Please describe the problem, how did it happen? _____

_____

What is your pain level from scale 1 to 10 with 10 being the worst pain possible? _____

How long have you had this pain? _____

What makes pain worse? Standing Sitting Lying Down Walking Bending Movement Other: _____

Do you have any problems controlling your bowel or bladder? □ Yes □ No

Have you had back or neck surgery? □ Yes □ No When: _____ By Dr: _____

Have you had epidural injections? □ Yes □ No When: _____ Where: _____

Have you had physical therapy? □ Yes □ No When: _____ Where: _____

Have you had chiropractic therapy? □ Yes □ No When: _____ Where: _____

DESCRIBE YOUR PAIN: Constant Comes and goes Sharp Stabbing Numb Tingling
Dull Achy Burning Pressing Throbbing Cramping Electrical Shooting

Please Check Yes or No if you experience pain, weakness, or numbness

Yes	No				Yes	No			
		Arms	Right	Left			Hips		
		Back					Legs	Right	Left
		Feet	Right	Left			Neck		
		Hands	Right	Left			Shoulder	Right	Left

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CONDITIONS: Check Yes or No to the conditions you currently have or have had in the past year

Yes	No		Yes	No	
		PTSD			Hepatitis A B C
		Anemia			Osteoporosis
		Anesthesia Complications			Hypertension
		Arthritis			Kidney Disease
		Asthma			Liver Disease
		Depression			Anxiety
		Cancer: _____			Stroke
		Chemical drug dependency			Prostate Disease
		Diabetes			Seizures/Epilepsy
		COPD			Thyroid Disorder
		Fibromyalgia			Other _____
		Gout			Other _____
		Headaches/Migraines			Other _____
		Heart Disease/Pacemaker			Other: _____

PAST SURGICAL HISTORY: List any surgeries you have had and in what year	
1.	4.
2.	**5.**
3	6.

MEDICATION: List any medications you are currently taking (including vitamins and herbs)	
1.	6.
2.	7.
3.	8.
4	9.
5.	10.

ALLERGIES: List any allergies to medications or substances	
1.	3
2.	4.

SOCIAL HISTORY: Check Yes or No to substance and list how much

Caffeine: ◯ Yes ◯ No How much: _____
Tobacco: ◯ Yes ◯ No How much: _____
Alcohol: ◯ Yes ◯ No How much: _____

FAMILY HISTORY: List any illnesses that run in your family

Mother: Alive Passed Diseases: _____
Father: Alive Passed Diseases: _____
Siblings: _____ Brothers Diseases: _____
Siblings: _____ Sisters Diseases: _____
Children: _____ Boys Diseases: _____
_____ Girls Diseases: _____

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Signature (Firma): _____ Date: _____