FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

Dear Patient,

For your appointment BEFOREHAND you need to:

- Go on Patient Portal to create an account to fill out demographic information. You will receive an invite via email.
- Complete Patient History sheet – see attachment. Return to our office via fax 214-351-8451 ONE WEEK PRIOR TO YOUR APPOINTMENT. Noncompliance means appointment will be rescheduled.
- Sign, hand write name, and date the Notice of Privacy Practices Acknowledgment – see attachment. Return to our office via fax 214-351-8451 ONE WEEK PRIOR TO YOUR APPOINTMENT.
- Read, initial each paragraph, sign, hand write name, and date the Patient Practice Agreement – see attachment. Return to our office via fax 214-351-8451 ONE WEEK PRIOR TO YOUR APPOINTMENT.
- If you are filing with Worker's Comp or Auto, please fill out attached form – see attachment.
- If you are a Medicare patient, please fill out form Medicare Secondary Payer Questionnaire – see attachment.

Things to Bring to Your Appointment:

- Bring MRI CD AND report
- Current Insurance card(s)
- Photo ID

Revised June 2019

Main Office: 7777 Forest Lane • Suite C-520 • Dallas, Texas 75230
AIMIS Spine: Theodorou Potamianou 50, Kato Polemidia 4155, Limassol, Cyprus
P (214) 351-8450 • F (214) 366-3713 • frankfeigenbaum.com

PLEASE ATTACH FRONT AND BACK COPY OF YOUR INSURANCE CARD/CARDS.

It is very important that we receive a copy BEFORE your appointment.

Thank you.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.
- Authorization to release medication history to SureScripts for prescribing purposes (allows communication with pharmacy).

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient (or Custodian) Name & DOB:_____ Date:_____

Patient Address:_____

Signature:_____ Relation to Patient:_____

In accordance with *Feigenbaum Neurosurgery Privacy Practices,* I hereby authorize Feigenbaum Neurosurgery to communicate with my spouse, children, and/or parents regarding my care and I authorize representatives of FN to communicate with me via home answering machine, voice mail (work phone or cell phone), and/or E-mail unless I check this box:

☐ I hereby authorize Feigenbaum Neurosurgery to communicate with the following people:

Name	Relationship
_____	_____
_____	_____

These authorizations will remain in effect until you send us written notice of your desire to revoke the authorizations.

Signature:_____ Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ **Prepared By:** _____ **Signature:** _____

Reason:

- _____ **An emergency existed and a signature was not possible at the time.**
- _____ **The individual refused to sign.**
- _____ **A copy was mailed with a request for a signature by return mail.**
- _____ **Unable to communicate with patient for following reason:**_____
- _____ **Other:**_____

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Date_____

PATIENT INFORMATION

Name (last) (first) (middle) Social Security #

Date of Birth Age Gender Marital Status

Address City, State Zip Home Phone Cell Phone

Employer Employers Address (city, state, zip) Work Phone

E-Mail Address Spouse/Parent/Significant Other Contact Phone

Referring Physician City, State Phone Primary Care Physician Phone

EMERGENCY CONTACT

Name Relationship to Patient Contact Phone Address, City, State, Zip

Name Relationship to Patient Contact Phone Address, City, State, Zip

INSURANCE INFORMATION

Primary Insurance Company Policyholder/Relationship/Date of Birth Policy # Group #/Name

Secondary Insurance Company Policyholder/Relationship/Date of Birth Policy # Group #/Name

DO YOU HAVE REGULAR MEDICARE? Yes____ No____ DO YOU HAVE A REPLACEMENT HMO? Yes____ No____

IS THIS A WORK RELATED INJURY? Yes_____ No_____ (*If yes, please complete workers compensation form in addition*)

IS THIS DUE TO AN AUTO ACCIDENT? Yes_____ No _____(*If yes, please complete auto information form in addition*)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits directly to FEIGENBAUM NEUROSURGERY, P.A. I consent to the release of medical information to my insurance company and to my referring physician.

_____

Signature Date

MEDICARE LIFETIME CERTIFICATE

I request that payment of authorized Medicare benefits be made on my behalf to FEIGENBAUM NEUROSURGERY, P.A. for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Beneficiary Patient Medicare # Date

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to FEIGENBAUM NEUROSURGERY, P.A. for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative

Beneficiary signature _____ Date _____

MEDIGAP Insurance Company _____ Policy # _____

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Patient Name: _____ Patient DOB: _____ Date: _____

Patient – Practice Agreement

Insurance Billing

Insurance is a contract between you and your insurance company. Our group accepts most major insurance plans. Prior to your initial visit, please contact your insurance carrier to confirm that our physician participates in your plan. It is your responsibility to notify us when making your appointment if you need a referral or pre-authorization for the visit with Dr. Feigenbaum. Typically this is applicable for HMO policies. This referral is submitted to the insurance company from the Primary Care Physician's (PCP) office. Please make sure you have obtained any required referrals in advance of your visit. If your insurance plan requires a referral and we do not have one, we will try to notify you prior to the visit. If we are unable to obtain a referral while you wait, you will be given the option to pay for the visit out of pocket or to reschedule for a later date. Please understand that if we have not been advised in advance of your program's requirements and we provide a service that is outside your program, YOU WILL BE RESPONSIBLE FOR THE APPROPRIATE FEES. These are your insurance company's regulations and unless you follow them carefully, the insurance company may decline all or part of your claim. If our physician does not participate with your insurance plan, and you do not have any out-of-network benefits, you will be considered self-pay and will be responsible for payment of all charges at the time of your visit. _____ Patient's initials

All COPAYS ARE DUE AT THE TIME OF SERVICE. If you have a high deductible which has not been met you will be asked to make a partial payment at the time of service. _____Patient's initials

This office will verify and bill the patient's insurance when appropriate. Your insurance company will more than likely require prior authorization (precertification) prior to any in-patient procedures performed by our physician. Our Office Manager will assist in obtaining prior authorization for in-patient services. However, as stated by your insurance company, "this is not a guarantee of payment". We may estimate what your insurance company may pay, but the final determination of your eligibility and benefits is made by them. You are responsible to know your eligibility, insurance coverage and benefits. _____ Patient's initials

If our physician participates with your insurance plan, we will file a claim on your behalf. We will bill you for your portion once the claim has been processed. To file your insurance, we must have a valid picture ID, current insurance coverage(s), and current patient address and phone numbers. It is your responsibility to inform us which insurance is primary and which is secondary. Notify us immediately of any change of insurance, if you fail to do so, it could result in the entire bill becoming your responsibility. Please bring your insurance card to every visit. Patient's initials

<u>Self-pay Accounts</u>

Self-pay accounts are patients without insurance coverage, patients with incorrect insurance information, or patients without an insurance card on file with us. Self-pay patients will be required to make payment at time of service. To determine payment

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Patient Name: Patient DOB: Date:

amounts for: an office appointment, please 214-351-8450 option 2; surgery, please contact (214-351-8450 option 5). _____ Patient's initials

Medicare

Our physician accepts Medicare assignment on covered Medicare charges. Medicare 20% coinsurance amount will be billed after we receive payment from Medicare. Payment of the annual deductible and any non-covered charges is expected at the time of service unless you have secondary insurance accepted by the group. Not all secondary insurance will pay for non-covered charges. There is a possibility that some services and durable medical equipment are not covered by Medicare. When services fall under that category, you will be asked to sign an advanced beneficiary notice (ABN) indicating that you acknowledge this possibility and that you agree to pay in full prior to services being rendered. _____ Patient's initials

Worker's Compensation Insurance and Automobile Accidents

Validated worker's compensation services are billed either to the employer or the employer's carrier, depending on company policy. In the absence of validation by the employer of a work-related injury, the patient will be held responsible for payment for services rendered. Should the employer or carrier subsequently deny a validated worker's compensation service, such charges will be the financial responsibility of the patient. For the first visit for a work-related injury, you must bring a letter authorizing services with the date of injury, and complete our Worker's Compensation form (you will need to provide insurance carrier information, claim number, and adjustor's name and phone number). For treatment for an automobile accident, you most likely will have to pay for your services at the time of your visit as most insurance carriers will not pay medical bills until your case has settled. If you have a denial letter from your automobile carrier we can bill your medical insurance. Automobile insurance will usually not prior authorize any services. _____ Patient's initials

Payment Responsibility For Non-Covered Services

Limited coverage is common among insurance plans. We will request payment for any non-covered services once claims have been processed. If known prior, payment is due at the time of service. Once the surgery claim has been processed, and if the service has been denied, please contact our billing office for further instruction. We may need your assistance in appealing the claim, as well as assistance from the employer who provides the insurance policy. _____ Patient's initials

Returned Checks

The charge for a returned check is $25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Patient's initials

Outstanding Balance Policy

Payment in full is expected on receipt of your billing statement. Monthly payment plans are available; please contact our billing company. Statements sent will reflect the amount you owe after your insurance has processed your claim. If no resolution

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Patient Name: Patient DOB: Date:

can be made within thirty (30) calendar days, the account will be sent to the collection agency and discharge from the practice may be initiated. Patient's initials

Surgery Claims

Please allow time for the processing of your claim by your insurance company following surgery. It is fairly common to get a letter from your insurance company either requesting information from our office or denying payment. Our billing office has a system in place for providing the necessary documentation needed by your insurance company for processing the claim. Please contact our billing office regarding all questions regarding claims, denials of services, or any insurance correspondence you receive in the mail. You may be instructed to help in the appeal process by contacting your insurance company, providing more documentation for the claim, and/or contacting the employer who provides the insurance policy. _____ Patient's initials

Any questions that you have regarding bills from other providers or from the hospital will need to be addressed to the name/company listed on the invoice. _____ Patient's initials

You will receive a bill from: our office, the hospital, the neuromonitoring company (Neurophysiology Associates, Biotronic, or NuVasive), anesthesia, x-ray use during the operation, radiologist reading of the x-ray, pain management, internal medicine group, and physical therapy, if applicable. Patient's initials

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please contact our Office Manager at 214-351-8450 option 5. If you have questions regarding any bills, balances or statements regarding services rendered by our group, please contact our Billing office, Pulse Systems at 800-444-0882 ext. 1542. Patient's initials

By signing this, I acknowledge I have read the above information and understand and agree to all the terms listed.

_____ _____

Patient Signature Today's Date

_____ _____

Patient Name DOB

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Patient Code of Conduct

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Feigenbaum Neurosurgery, P.A., expects *visitors, patients, and accompanying family members* to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited:

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects
- Climbing on furniture or toys*
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing gestures
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email , or other forms of written, verbal, or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, both not limited to, race, language or sexuality

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.
*Adults are expected to supervise children in their care.

_____ _____
Patient Signature Today's Date

_____ _____
Patient Name DOB

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PATIENT HISTORY

Name_____Phone_____Birth Date_____Age____Sex____Date_____

Who requested that you see our physician? _____ Phone_____

How did you find us: ☐ Internet, name of website/search engine: _____ ☐ Tarlov Cyst Foundation

Did you refer yourself? ☐ Yes ☐ No ☐ Other explain: _____

Family Physician or Internist: _____ Phone_____

What is your major problem or complaint? _____

When did your problem start? _____ Was there a specific injury? _____ Date of Injury _____

DO YOU CONSIDER THIS A WORK OR AUTO RELATED INJURY? _____ Why? _____

Have you seen other doctors for this problem? _____ Who? _____

PAST MEDICAL HISTORY (check all present): ☐ MEDICAL HISTORY NEGATIVE

Cardiovascular (heart):
☐ Hypertension (high blood pressure)
☐ Coronary artery disease / Heart disease
☐ Deep Vessel Thrombosis (DVT/blood clots/congenital clotting factor deficiency)
☐ Atrial fibrillation / Irregular heart rhythm–type_____
☐ Heart valve problems
☐ Cardiac stents
☐ Congestive heart failure
☐ Peripheral vascular disease
☐ Pace maker / Defibrillator
☐ Myocardial Infarction: last known_____

Respiratory:
☐ COPD/emphysema
☐ Asthma
☐ Seasonal allergies
☐ Sleep apnea / CPAP/BiPAP
☐ Pulmonary embolism
☐ Lung disease: _____

Gastrointestinal:
☐ Hepatitis / Liver disease
☐ Peptic/gastric ulcer
☐ GERD (reflux)
☐ Colon/Rectal: _____
☐ Irritable Bowel Syndrome

Metabolic:
☐ Diabetes: Type I / Type II
☐ Thyroid disorder: Hypothyroid / Hyperthyroid
☐ Hyperlipidemia (high cholesterol)
☐ Obesity

Musculoskeletal:
☐ Rheumatoid arthritis
☐ Gout
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis

Cancer:
Indicate type, treatment, year
☐ Breast: Right/ Left _____
☐ Colon _____
☐ Lung _____
☐ Prostate _____
☐ Other: _____

Connective Tissue Disease:
☐ Marfan's
☐ Ehlers-Danlos syndrome
☐ Other: _____

Renal (kidney):
☐ Kidney failure
☐ Removal of kidney Right / Left
☐ Dialysis
☐ Other: _____

Neurologic / Psychiatric:
☐ Stroke: last known_____, last recommended change_____
☐ Seizures: last seizure_____
☐ Trauma
☐ Head injury
☐ Anxiety disorder
☐ Bi-polar disorder
☐ Depression
☐ Dementia
☐ Migraine headaches
☐ Multiple Sclerosis
☐ Peripheral neuropathy
☐ Parkinson's disease
☐ Hereditary defects
☐ Spinal cord stimulator implant

Infectious:
☐ HIV / AIDS
☐ Shingles
☐ Methicillin resistant staph aureus (MRSA)

Other:
☐ Chronic kidney/renal disease
☐ Glaucoma
☐ Anemia
☐ Other: _____

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PATIENT HISTORY

Name_____Phone_____Birth Date_____Age____Sex____Date_____

PAST SURGICAL HISTORY: *INCLUDE DATE(S)*

☐ NO PRIOR SURGERIES ☐ Tonsillectomy _____ ☐ Appendectomy (appendix) _____ ☐ Cholecystectomy (gallbladder) _____ ☐ Vasectomy _____ ☐ Tubal ligation _____ ☐ C-Section _____ ☐ D&C _____ ☐ Hysterectomy_____ ☐ Heart _____ ☐ Stents ☐ Ablation ☐ Spine surgery If yes, which level? ☐ Neck ☐ Mid-back ☐ Lower back Neck_____ Mid-back_____ Lower_____	☐ Other surgery:_____ ☐ Other surgery:_____ ☐ Other surgery:_____ **Do you have 'restrictive extremity'?** Yes / No **If yes, which limb? _____** **Do you have metal in your body?** Yes / No **If yes, is it MRI compatible (titanium)?** Yes / No **Have you had any problems with anesthesia with previous surgeries?** Yes / No **If so, explain:** _____ **Have you or anyone in your family had a reaction to anesthesia called Malignant Hyperthermia?** Yes / No **If so, who:** _____

DISEASES THAT RUN IN THE FAMILY/FAMILY MEDICAL HISTORY: (include deceased family members):

Disease	Father	Mother	Brother	Sister	Other (specify)
Heart Disease					
Diabetes					
Hypertension (high blood pressure)					
High Cholesterol					
Cancer (*specify/type*)					
Hereditary Defects					
Other					
☐ **Adopted**	☐ **Family history unobtainable**		☐ **Family history negative**		

- **Do you drink alcohol excessively? _____ Do you use drugs? _____ Have you been treated for substance abuse? _____**
- **Do you smoke now? _____ Packs per day? _____ How long? _____ Have you in the past? _____ When did you quit? _____**
- **Race:** ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ Other Race ☐ White ☐ Decline to specify
- **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to specify
- **Preferred Language: _____**
- **Have you had a flu vaccine within the past year?** ☐ Yes ☐ No If No, Reason_____
- **Women, ages 21-64, have you received one or more pap tests to screen for cervical cancer?** ☐ Yes ☐ No ☐ N/A
- **Women, ages 40-69, have you had a mammogram in the past 2 years?** ☐ Yes ☐ No ☐ Mastectomy ☐ N/A

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PATIENT HISTORY

Name_____Phone_____Birth Date_____Age____Sex____Date_____

- **If 50-75 years of age, have you had a complete colonoscopy in the past 10 years?** ☐ Yes ☐ No ☐ N/A
- **Marital Status** _____ **Number of children** _____ **Do you have a healthcare directive or power of attorney?** ☐ Yes ☐ No **If No, would you like more information?** ☐ Yes ☐ No
- **Occupation** _____ **Height** _____ **Weight** _____

REVIEW OF SYSTEMS (check all present): **ALL OTHER SYSTEMS NEGATIVE**

Constitutional:
☐ Chills
☐ Fatigue
☐ Fever
☐ Weight gain _____lbs
☐ Weight loss _____lbs
☐ Night sweats

Eye:
☐ Blurry vision
☐ Seeing double
☐ Vision problems
☐ Eye discharge

Ear Nose Throat:
☐ Earache
☐ Hoarseness
☐ Loss of Hearing
☐ Nasal Congestion
☐ Ringing in Ears
☐ Sinus Pain
☐ Sore throat
☐ Ear discharge
☐ Nasal discharge
☐ Sinus pressure

Cardiovascular:
☐ Chest Pain
☐ Edema (leg swelling)
☐ Palpitations (irregular heart beat)
☐ Paroxysmal nocturnal dyspnea (shortness of breath, coughing at night)

Endocrine:
☐ Excessive thirst
☐ Intolerance to cold
☐ Intolerance to heat

Respiratory:
☐ Cough
☐ Coughing up Sputum
☐ Short of breath
☐ Wheezing
☐ Home oxygen use (___L)
☐ Coughing up blood

Gastric:
☐ Abdominal pain
☐ Constipation
☐ Decreased appetite
☐ Diarrhea
☐ Difficulty swallowing

(Gastric continued)
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Rectal bleeding
☐ Black stools

Urinary:
☐ Dysuria (pain on urination)
☐ Hematuria (blood in urine)
☐ Nocturia (more than 2 urinations during night)
☐ Urinary frequency
☐ Urinary incontinence
☐ Urinary retention

Female Genital Symptoms:
☐ Decreased libido
☐ Heavy periods
☐ Irregular menses
☐ No menses > 6 months
☐ Painful intercourse
☐ Painful periods
☐ Vaginal discharge
☐ Private area numbness
☐ Private area pain

Male Genital Symptoms:
☐ Erectile disorder
☐ Penile discharge
☐ Terminal drippling
☐ Testicular lump
☐ Urinary hesitancy
☐ Small urine stream
☐ Private area numbness
☐ Private area pain

Musculoskeletal:
☐ Joint pain
☐ Joint swelling
☐ Muscle aches
☐ Muscle weakness

Integument:
☐ Skin rash / Lesions

Breast:
☐ Discharge
☐ Lump

Neuro:
☐ Headache
☐ Dizziness
☐ Fainting
☐ Memory Loss
☐ Numbness / Tingling
☐ Claustrophobia
☐ Sleep disturbances
☐ Low back pain
☐ Sacral pain
☐ Difficulty walking
☐ Difficulty sitting
☐ Paralysis

Psych:
☐ Anxiety
☐ Depression

Hematologic /Lymph:
☐ Anemia
☐ Excessive bleeding during surgery
☐ Easy bruising
☐ Swollen glands in the neck

Immune System:
☐ Auto-immune disease
☐ Seasonal allergies
☐ Allergic reaction to medication(s)
☐ Recurrent infections

☐ REVIEW OF SYSTEMS NEGATIVE

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PATIENT HISTORY

Name_____Phone_____Birth Date_____Age____Sex____Date_____

MEDICATIONS YOU ARE TAKING (include dose, prescription, over the counter drugs, vitamins, herbals, etc.): ☐ Not currently taking any medications

Medication Name	Dosage / Amount / Frequency	Reason for Taking	Prescribing Doctor

Preferred Pharmacy: _____ **Phone:** _____

DRUG ALLERGIES AND REACTIONS: ☐ **No Known Drug Allergies**

Medication Name	True Allergy (facial swelling, airway tightening, hives)	Adverse Reaction (nausea, vomiting, upset stomach, headache)	Date

Allergy to: ____ Latex ____Betadine ____Shellfish ____ IV Contrast/Dye **Reaction:** _____

For Office Use Only:	
Pulse:_____	BP:_____/_____

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December 4, 2019

To All of our Feigenbaum Neurosurgery patients:

In the next few months Feigenbaum Neurosurgery (FN) will begin referring subsequent surgical patient evaluations to the Tarlov Cyst Center (TCC) located at the new Medical City Dallas – Spine & Heart Hospital Complex. New patient surgical consults, post-surgical outpatient patient care evaluations and in-patient care will be in one convenient campus location.

If you anticipate requiring further care in an outpatient setting related to your Tarlov/meningeal cyst (e.g., clinical evaluations, medication management, follow-up consults, etc.) we can more quickly facilitate care if you agree to transition your FN medical record information to the Medical City Dallas Tarlov Cyst Center electronic medical records system.

The transition of patient medical records requires existing FN patients to complete and sign a Release of Information form. The Transfer of Information is strictly voluntary.

If you choose to allow FN to transition your medical record to the TCC, please take a moment to fill out the attached Release of Information form. Upon reviewing the form, please ensure to complete the highlighted sections and sign and date at the bottom.

You may scan and email the completed form to the FN inbox – appointment@frankfeigenbaum.com

We also accept faxing of the completed form to (214) 366-3713.

We want to thank you in advance for your allowing FN to previously provide your care and look forward to serving your healthcare needs in the new Tarlov Cyst Center.

Sincerely,

Frank Feigenbaum, M.D.

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Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**

Provider's Name: Feigenbaum Neurosurgery	**Recipient's Name:** Medical City Dallas – Tarlov Cyst Center		
Provider's Address: 7777 Forest Lane C-520 Dallas, TX 75230	**Address 1:** 11970 North Central Expressway		
	Address 2: *Suite 440*	**Recipient's Phone:**	
	City: *Dallas*	**State:** Texas	**Zip:** 75243

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD, eDelivery)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: ***Medical Treatment continuation***

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)
If this authorization is for disclosure of genetic information, please describe: _____

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☒ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☒ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☒ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**