



Frank Feigenbaum, M.D., FAANS, FACS

Tarlov Cyst Consultation Check off List

Please use this check off list to ensure all information is complete for your chart.

- ☐ HIPAA Receipt and Authorization
- ☐ Patient History
- ☐ Patient Information
- ☐ MRI Disc/CDs or Films
- ☐ MRI/Radiology report
- ☐ Copy of insurance card(s) front and back

If applicable:

- ☐ Automobile or Liability Claim Information
- ☐ Workers Compensation Claim
- ☐ Medicare Secondary Payer Questionnaire

If you would like to know if your information has arrived, please call our office at 214-351-8450 option 2, on the next prompt 2. If there is additional or missing information needed, we will contact you.

Note: Only complete charts will be forwarded on to Dr. Feigenbaum for review.

Please allow at least 6-10 weeks for a response from the doctor. Thank you.

Mail to:

Tarlov Cyst Center
11970 N Central Expy, Ste 440
Dallas, Texas 75243

Please note: if you are not a surgical candidate, our office will shred your MRI CD unless you provide a prepaid envelope.

Revised July 2020



Frank Feigenbaum, M.D., FAANS, FACS

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**If you have any questions about this Notice please contact the Privacy Officer.
Laura Abshire 214-351-8450 option 5**

Effective Date: September 10, 2013

Revised: June 13, 2019

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.frankfeigenbaum.com**.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.



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We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits,

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investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.



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Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]



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You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.



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Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Laura Abshire

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 10, 2013.



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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: _____	



FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

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):

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

☐ MEDICAL HISTORY NEGATIVE

☐ 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: _____



PATIENT HISTORY

Name	Phone	Birth Date	Age	Sex	Date
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☐ 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 _____

Have you or anyone in your family had a reaction to anesthesia called Malignant Hyperthermia? Yes / No If so, who:

Disease	Father	Mother	Brother	Sister	Other (specify)
Heart Disease					
Diabetes					
Hypertension (high blood pressure)					
High Cholesterol					
Cancer (<i>specify/type</i>)					
Hereditary Defects					
Other					
<input type="checkbox"/> Adopted <input type="checkbox"/> Family history unobtainable <input type="checkbox"/> 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

<u>Constitutional:</u> <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight gain _____ lbs <input type="checkbox"/> Weight loss _____ lbs <input type="checkbox"/> Night sweats	<u>Cardiovascular:</u> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Edema (leg swelling) <input type="checkbox"/> Palpitations (irregular heart beat) <input type="checkbox"/> Paroxysmal nocturnal dyspnea (shortness of breath, coughing at night)	<u>(Gastric continued)</u> <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Black stools
<u>Eye:</u> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Seeing double <input type="checkbox"/> Vision problems <input type="checkbox"/> Eye discharge	<u>Endocrine:</u> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Intolerance to cold <input type="checkbox"/> Intolerance to heat	<u>Urinary:</u> <input type="checkbox"/> Dysuria (pain on urination) <input type="checkbox"/> Hematuria (blood in urine) <input type="checkbox"/> Nocturia (more than 2 urinations during night) <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention
<u>Ear Nose Throat:</u> <input type="checkbox"/> Earache <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sore throat <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Sinus pressure	<u>Respiratory:</u> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up Sputum <input type="checkbox"/> Short of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Home oxygen use (____L) <input type="checkbox"/> Coughing up blood	<u>Female Genital Symptoms:</u> <input type="checkbox"/> Decreased libido <input type="checkbox"/> Heavy periods <input type="checkbox"/> Irregular menses <input type="checkbox"/> No menses > 6 months <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Painful periods <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Private area numbness <input type="checkbox"/> Private area pain
<u>Male Genital Symptoms:</u> <input type="checkbox"/> Erectile disorder <input type="checkbox"/> Penile discharge <input type="checkbox"/> Terminal dripping <input type="checkbox"/> Testicular lump <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Small urine stream <input type="checkbox"/> Private area numbness <input type="checkbox"/> Private area pain	<u>Breast:</u> <input type="checkbox"/> Discharge <input type="checkbox"/> Lump	<u>Psych:</u> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression
<u>Musculoskeletal:</u> <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle aches <input type="checkbox"/> Muscle weakness	<u>Neuro:</u> <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Memory Loss <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Low back pain <input type="checkbox"/> Sacral pain <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Difficulty sitting <input type="checkbox"/> Paralysis	<u>Hematologic /Lymph:</u> <input type="checkbox"/> Anemia <input type="checkbox"/> Excessive bleeding during surgery <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen glands in the neck
<u>Integument:</u> <input type="checkbox"/> Skin rash / Lesions		<u>Immune System:</u> <input type="checkbox"/> Auto-immune disease <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Allergic reaction to medication(s) <input type="checkbox"/> Recurrent infections
<input type="checkbox"/> 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: _____ / _____



FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

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 # _____

Revised December 2020



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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: PtResponse@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,

A handwritten signature in black ink, appearing to be 'F. Feigenbaum', written in a cursive style.

Frank Feigenbaum, M.D.

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: 11970 N Central Expy Ste 460 Dallas, TX 75243		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): <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media, if available (e.g., USB drive, CD/DVD, eDelivery) <input type="checkbox"/> Encrypted Email <input type="checkbox"/> 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: <i>Medical Treatment continuation</i>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical test <input type="checkbox"/> Medication sheets		<input type="checkbox"/> Operative information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Nursing information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER information		<input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-04: <input type="checkbox"/> Other: <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, describe: _____					
May the recipient of the PHI further exchange the information for financial remuneration? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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:	