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 May 2020

Main Office: 11970 N Central Expressway • Suite 460 • Dallas, Texas 75243
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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

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:

- <u>If required by law:</u> 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.
- <u>Public health activities:</u> 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.
- <u>Health oversight agencies:</u> 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:_____

Revised May 2020

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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

Self-pay Accounts

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, at 214-351-8450 ext. 1. _____ 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

Revised May 2020

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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: _____
- ☐ 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:** _____
- **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** _____
- **Have you had a flu vaccine within the past year?** ☐ Yes ☐ No If No, Reason _____
- **If 65 years or older of age, have you ever had a pneumonia vaccination?** ☐ Yes ☐ No ☐ N/A
  If No, Reason _____

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FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

PATIENT HISTORY

Name _____ Phone _____ Birth Date _____ Age ___ Sex ___ Date _____

- **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
-
- **If 50-75 years of age, have you had a complete colonoscopy in the past 10 years?** ☐ Yes ☐ No ☐ N/A

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

<table>
<tr>
<td>Constitutional:
☐ Chills
☐ Fatigue
☐ Fever
☐ Weight gain _____lbs
☐ Weight loss _____lbs
☐ Night sweats</td>
<td>Cardiovascular:
☐ Chest Pain
☐ Edema (leg swelling)
☐ Palpitations (irregular heart beat)
☐ Paroxysmal nocturnal dyspnea (shortness of breath, coughing at night)</td>
<td>(Gastric continued)
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Rectal bleeding
☐ Black stools</td>
</tr>
<tr>
<td>Eye:
☐ Blurry vision
☐ Seeing double
☐ Vision problems
☐ Eye discharge</td>
<td>Endocrine:
☐ Excessive thirst
☐ Intolerance to cold
☐ Intolerance to heat</td>
<td rowspan="2">Urinary:
☐ Dysuria (pain on urination)
☐ Hematuria (blood in urine)
☐ Nocturia (more than 2 urinations during night)
☐ Urinary frequency
☐ Urinary incontinence
☐ Urinary retention</td>
</tr>
<tr>
<td rowspan="2">Ear Nose Throat:
☐ Earache
☐ Hoarseness
☐ Loss of Hearing
☐ Nasal Congestion
☐ Ringing in Ears
☐ Sinus Pain
☐ Sore throat
☐ Ear discharge
☐ Nasal discharge
☐ Sinus pressure</td>
<td>Respiratory:
☐ Cough
☐ Coughing up Sputum
☐ Short of breath
☐ Wheezing
☐ Home oxygen use (___L)
☐ Coughing up blood</td>
</tr>
<tr>
<td>Gastric:
☐ Abdominal pain
☐ Constipation
☐ Decreased appetite
☐ Diarrhea
☐ Difficulty swallowing</td>
<td>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</td>
</tr>
<tr>
<td>Male Genital Symptoms:
☐ Erectile disorder
☐ Penile discharge
☐ Terminal drippling
☐ Testicular lump
☐ Urinary hesitancy
☐ Small urine stream
☐ Private area numbness</td>
<td>Breast:
☐ Discharge
☐ Lump</td>
<td>Psych:
☐ Anxiety
☐ Depression</td>
</tr>
<tr>
<td>☐ Private area pain</td>
<td rowspan="3">Neuro:
☐ Headache
☐ Dizziness
☐ Fainting
☐ Memory Loss
☐ Numbness / Tingling
☐ Claustrophobia
☐ Sleep disturbances
☐ Low back pain
☐ Sacral pain
☐ Difficulty walking
☐ Difficulty sitting
☐ Paralysis</td>
<td>Hematologic /Lymph:
☐ Anemia
☐ Excessive bleeding during surgery
☐ Easy bruising
☐ Swollen glands in the neck</td>
</tr>
<tr>
<td>Musculoskeletal:
☐ Joint pain
☐ Joint swelling
☐ Muscle aches
☐ Muscle weakness</td>
<td>Immune System:
☐ Auto-immune disease
☐ Seasonal allergies
☐ Allergic reaction to medication(s)
☐ Recurrent infections</td>
</tr>
<tr>
<td>Integument:
☐ Skin rash / Lesions</td>
<td></td>
</tr>
<tr>
<td colspan="3">☐ REVIEW OF SYSTEMS NEGATIVE</td>
</tr>
</table>

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FEIGENBAUM NEUROSURGERY

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PATIENT HISTORY

Name _____ Phone _____ Birth Date _____ Age ___ Sex ___ Date _____

If 65 years or older: Fall Risk (using FRAT Pack Assessment Tool)

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS	None in last 12 months One or more between 3 & 12 months ago One or more in last 3 months One or more in last 3 months whilst inpatient/resident	2 4 6 8
MEDICATIONS (Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Anti-hypertensives, hypnotics)	Not taking any of these Taking one Taking two Taking more than two	1 2 3 4
PSYCHOLOGICAL (Anxiety, Depression, Decreased Cooperation, Decreased Insight or Judgment esp. re: mobility)	Does not appear to have any of these Appears mildly affected by one or more Appears moderately affected by one or more Appears severely affected by one or more	1 2 3 4
COGNITIVE STATUS	Intact Mildly impaired Moderately impaired Severely impaired	1 2 3 4
RISK SCORE (Low Risk: 5-11 Medium Risk: 12-15 High Risk: 16-20)		**_____/20**

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:** _____

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PATIENT HISTORY

Name _____ Phone _____ Birth Date _____ Age ___ Sex ___ Date _____

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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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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MEDICARE SECONDARY PAYER QUESTIONNAIRE

(To be completed for all Medicare patients)

NAME_____

DOB_____

(If any answer to questions 1a through 4 is yes, the corresponding section of "Other Insurance" form must be filled out completely)

	YES	NO
1. Is the patient a Veteran?	____	____
a. Did the VA refer you here for treatment?	____	____
b. Does the patient have a VA "fee basis ID card"?	____	____
2. Do you have a Federal Black Lung Card?	____	____
3. Is this medical condition due to an accident of any kind?	____	____

If yes, was it: Work Related_____ Auto_____

Injured in own home_____ Other_____

Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (NOT retiree coverage) ____ ____

SIGNATURE_____

DATE_____

Revised May 2020

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FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

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,

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: 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): ☐ **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:**