FEIGENBAUM NEUROSURGERY
Specializing in the treatment of spinal meningeal cysts
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.

□ **Patient Information**

□ **Patient History**

□ **Notice of Privacy Practices Acknowledgement/HIPAA Receipt and Authorization**

□ **Patient Practice Agreement**

□ **Patient Code of Conduct**

□ **MRI Disc / CDs or Films**

□ **MRI / Radiology report**

□ **Copy of insurance card(s) front and back**

If you have a Workers Compensation, Automobile, and/or Liability Claim(s), please call our office before sending any records.
If applicable:
□ Worker's Compensation / Liability / Legal / Automotive Release

If you would like to know if your information has arrived, please call our office at 214-351-8450. 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

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PATIENT INFORMATION							
Patient Name: (First)		(MI)	(Last)			Date of Birth:	Date:
Gender: □ Male □ Female	Social Security #:		Address:				Age:
Preferred Contact: □ Home □ Work □ Cell			City:		State:		Zip:
Home Phone:	Work Phone:		Cell Phone:			Can we leave a voicemail: □ Yes □ No	
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner □ Other _____			Race: □ African American □ Non-Hispanic □ Hispanic □ American Indian/Alaskan Native □ Asian/Pacific Islander □ White □ Other _____				
Ethnicity:	Preferred Language:		Email Address: *				
Employer:	Employer Location (City, State):		Work Phone:				

*Email communication is not sent in an encrypted manner, and there is a risk it could be accessed inappropriately. By providing my email, I agree and still elect to receive email communication.

EMERGENCY CONTACT			
Name:	Relationship to Patient:	Address, City, State, Zip:	Preferred Contact: □ Home □ Work □ Cell
Home Phone:	Work Phone:	Cell Phone:	Can we leave a voicemail: □ Yes □ No
Name:	Relationship to Patient:	Address, City, State, Zip:	Preferred Contact: □ Home □ Work □ Cell
Home Phone:	Work Phone:	Cell Phone:	Can we leave a voicemail: □ Yes □ No

REFERRAL INFORMATION			
How did you find us: □ Internet/Website: _____ □ Tarlov Cyst Foundation □ Other: _____	Did you refer yourself: □ Yes □ No	Is your primary care same as your referring doctor? □ Yes □ No	
Referring Physician:	City, State:	Phone:	Fax:
Primary Care Physician:	City, State:	Phone:	Fax:
Have you seen other doctors for this problem: □ Yes □ No		Who:	
Do you have a healthcare directive or power of attorney: □ Yes □ No		If no, would you like more information: □ Yes □ No	

INSURANCE INFORMATION				
Primary Ins:	Policy:		Group:	
Ins Type: □ HMO □ PPO □ Other_____	Primary Card Holder/Policyholder's Name:	Relationship: □ Self □ Spouse □ Child □ Other _____		Social Security:

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AIMIS Spine: Theodorou Potamianou 50 • Kato Polemidia 4155 • Limassol, Cyprus
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Gender: □ Male □ Female	**Date of Birth:**	**Group Employer:**	**Employer Phone:**
Secondary Ins:	**Policy:**	**Group:**	
Ins Type: □ HMO □ PPO □ Other_____	**Policyholder's Name:**	**Relationship:** □ Self □ Spouse □ Child □ Other_____	**Social Security:**
Gender: □ Male □ Female	**Date of Birth:**	**Group Employer:**	**Employer Phone:**
Do you have an open liability case: □ Yes** □ No	**Is this a work-related injury:** □ Yes** □ No	**Is this due to an auto accident:** □ Yes** □ No	

**If yes, contact our office first

Do you have regular Medicare: □ Yes*** □ No	**Do you have a replacement HMO:** □ Yes*** □ No

***If yes, please sign the Medicare Lifetime Certificate section; if there is a secondary to Medicare, sign Medigap Authorization section

MEDICARE SECONDARY PAYER QUESTIONNAIRE (if applicable)		
Is the patient a Veteran: □ Yes □ No	**Did the VA refer the patient to Feigenbaum Neurosurgery for treatment:** □ Yes □ No	
Authorization #:	**Does the patient have a VA "fee basis ID card":** □ Yes □ No	**Do you have a Federal Black Lung Card:** □ Yes □ No
Is the patient covered by an employer's health insurance plan through their own employment or that of a family member (NOT retiree coverage): □ Yes □ No		

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 physicians, and financial and medical information to my emergency contacts. ***I have the right to revoke this authorization at any time; I may inspect or copy the protected health information to be disclosed as described in this document; revocation is not effective in cases where the information has already been disclosed but will be effective going forward; information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____
Patient/Representative Signature Date

_____ _____
Patient Name DOB

MEDICARE LIFETIME CERTIFICATE (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf to FEIGENBAUM NEUROSURGERY, P.A. (FN) 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.

_____ _____ _____
Beneficiary Signature Date Patient Medicare #

MEDIGAP AUTHORIZATION FORM (if applicable)

I hereby authorize payment of my Medigap benefits to FEIGENBAUM NEUROSURGERY, P.A. (FN) 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 Ins Co Policy #

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PATIENT HISTORY

Name:	Date of Birth:	Height:	Weight:	Date:

PAST MEDICAL HISTORY (Check All Present):

☐ No Medial History

Cardiovascular (Heart):

☐ Hypertension (High Blood Pressure)
☐ Coronary Artery / 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
☐ Pacemaker / Defibrillator
☐ Myocardial Infarction:
Last Known _____

Metabolic:

☐ Diabetes:
☐ Type I ☐ Type II
☐ Thyroid Disorder:
☐ Hypothyroid ☐ Hyperthyroid
☐ Hyperlipidemia (High Cholesterol)
☐ Obesity

Connective Tissue Disease:

☐ Marfan's
☐ Ehlers-Danlos Syndrome
☐ Other: _____

Infectious:

☐ HIV / AIDS
☐ Shingles
☐ Methicillin Resistant Staph Aureus (MRSA)

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 (MS)
☐ Peripheral Neuropathy
☐ Hereditary Defects
☐ Spinal Cord Stimulator Implant
☐ Pain Pump

Musculoskeletal:

☐ Rheumatoid Arthritis (RA)
☐ Gout
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis

Renal (Kidney):

☐ Kidney Failure
☐ Removal of Kidney:
☐ Right ☐ Left
☐ Dialysis
☐ Other: _____

Gastrointestinal:

☐ Hepatitis / Liver Disease
☐ Peptic / Gastric Ulcer
☐ GERD (Reflux)
☐ Colon / Rectal: _____
☐ Irritable Bowel Syndrome (IBS)

Cancer:

☐ Breast:
☐ Right ☐ Left Year_____
☐ Colon: _____ Year _____
☐ Lung: _____ Year _____
☐ Prostate: _____ Year _____
☐ Other: _____ Year _____

Respiratory:

☐ COPD / Emphysema
☐ Asthma
☐ Seasonal Allergies
☐ Sleep Apnea:
☐ CPAP ☐ BiPAP
☐ Pulmonary Embolism
☐ Lung Disease: _____

Other:

☐ Chronic Kidney / Renal Disease
☐ Glaucoma
☐ Anemia
☐ Other: _____

PAST SURGICAL HISTORY:

☐ NO PRIOR SURGERIES	Date:	Surgery:	Date:
☐ Tonsillectomy		☐ Shoulder Surgery: ☐ Left ☐ Right	
☐ Appendectomy (Appendix)		☐ Hysterectomy	
☐ Cholecystectomy (Gallbladder)		☐ Heart: ☐ Stents ☐ Ablation ☐ Valve ☐ Bypass	
☐ Breast Augmentation: ☐ Left ☐ Right		☐ Brain Tumor	
☐ Total Hip Arthroplasty: ☐ Left ☐ Right		☐ Brain Aneurysm	
☐ Total Knee Arthroplasty: ☐ Left ☐ Right		☐ Chiari Malformation	
☐ Total Shoulder Arthroplasty: ☐ Left ☐ Right		☐ Brain Shunt(s)	

SURGICAL HISTORY CONTINUED NEXT PAGE

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Name:	Date of Birth:	Date:

PAST SURGICAL HISTORY (Continued):

Surgery:	Level:	Date:	Surgery:	Date:
☐ Tarlov Cyst Treatment ☐ Fibrin Glue ☐ Aspiration ☐ Other: _____	☐ Neck ☐ Mid-Back ☐ Lower Back		☐ Other Surgery:	
☐ Fusion Spine Surgery	☐ Neck ☐ Mid-Back ☐ Lower Back		☐ Other Surgery:	
☐ Discectomy Spine Surgery	☐ Neck ☐ Mid-Back ☐ Lower Back		☐ Other Surgery:	
☐ Pain Stimulator Spine Surgery	☐ Neck ☐ Mid-Back ☐ Lower Back		☐ Other Surgery:	
☐ Pain Pump Spine Surgery	☐ Neck ☐ Mid-Back ☐ Lower Back		☐ Other Surgery:	
☐ Other Spine Surgery	☐ Neck ☐ Mid-Back ☐ Lower Back		☐ 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:

DRUG ALLERGIES AND REACTIONS:

Medication Name:	Reactions (Facial Swelling, Tightened Airway, Hives, Nausea, Vomiting, Upset Stomach, Headache, Etc.):
☐ No Known Drug Allergies (NKDA)	
☐ Latex	
☐ Betadine	
☐ Shellfish	
☐ IV Contrast/Dye	

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Name:	Date of Birth:	Date:

FAMILY MEDICAL HISTORY (Include Deceased Family Members):

☐ Adopted ☐ Family history unobtainable ☐ Family history negative

Disease:	Father:	Mother:	Brother:	Sister:	Other (Specify):
Heart Disease	☐	☐	☐	☐	☐ _____
Diabetes	☐	☐	☐	☐	☐ _____
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐ _____
High Cholesterol	☐	☐	☐	☐	☐ _____
Cancer (Specify/Type): _____	☐	☐	☐	☐	☐ _____
Hereditary Defects	☐	☐	☐	☐	☐ _____
Connective Tissue Disorders: Marfan's Ehlers-Danlos Syndrome Tarlov Cyst(s)	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ _____
Other: _____	☐	☐	☐	☐	☐ _____

Do You Drink Alcohol Excessively: ☐ Yes ☐ No	How Often: ☐ Monthly Or Less ☐ 2-4 Times a Month ☐ 2-3 Times a Week ☐ 4 Or More Times a Week			
Do You Smoke Now: ☐ Yes ☐ No	Packs Per Day:	How Long:	Have You in the Past: ☐ Yes ☐ No	When Did You Quit:
Substance Abuse: ☐ Yes ☐ No	If Yes, Describe:		Have You Been Treated For Substance Abuse: ☐ Yes ☐ No	

Have You Had a Flu Vaccine Within the Past Year: ☐ Yes ☐ No	If No, Reason:
Have You Had a COVID-19 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:
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	

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FALL RISK (65 Years or Older; Using FRAT Pack Assessment Tool):		
Risk Factor:	**Level:**	**Risk Score:**
Recent Falls:	None In Last 12 Months	2
	One Or More Between 3 & 12 Months Ago	4
	One Or More In Last 3 Months	6
	One Or More In Last 3 Months Whilst Inpatient / Resident	8
Medications (Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Anti-Hypertensives, Hypnotics):	Not Taking Any of These	1
	Taking One	2
	Taking Two	3
	Taking More Than Two	4
Psychological (Anxiety, Depression, Decreased Cooperation, Decreased Insight or Judgment Especially Regarding Mobility):	Does Not Appear to Have Any of These	1
	Appears Mildly Affected by One Or More	2
	Appears Moderately Affected by One Or More	3
	Appears Severely Affected by One Or More	4
Cognitive Status:	Intact	1
	Mildly Impaired	2
	Moderately Impaired	3
	Severely Impaired	4
Risk Score: ☐ Low Risk: 5-11 ☐ Medium Risk: 12-15 ☐ High Risk: 16-20		_____/20

PREFERRED PHARMACY:			
Pharmacy Name:	**City/State:**	**Phone:**	**Fax:**

MEDICATIONS YOU ARE TAKING (Include Over the Counter Drugs, Vitamins, Herbals, Etc.):					
Medication Name:	**Dosage:**	**Amount:**	**Frequency:**	**Reason for Taking:**	**Prescribing Physician:**
☐ Not Currently Taking Any Medications					

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Name:	Date of Birth:	Date:

TARLOV ASSESSMENT:

When Did Your Symptoms / Problems Start:
Years Ago
☐ < 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+

Have Your Symptoms Increased:
☐ Yes ☐ No

Was There a Specific Injury:
☐ Yes ☐ No

Was This Accident Related:
☐ Yes ☐ No

Date Of Injury:

Do You Consider This a Work Or Auto Related Injury:
☐ Yes ☐ No

Why:

SYMPTOMS:

Low Back Pain:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Right Calf Pain:
☐ Anterior ☐ Posterior
☐ Medial ☐ Lateral

Right Calf Numbness:
☐ Anterior ☐ Posterior
☐ Medial ☐ Lateral

Cervical Neck Pain:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Sacral Pain:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Left Foot Pain:
☐ Top ☐ Bottom

Right Foot Pain:
☐ Top ☐ Bottom

Cervical Neck Numbness:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Left Foot Numbness:
☐ Top ☐ Bottom

Right Foot Numbness:
☐ Top ☐ Bottom

Buttock Pain:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Perineal:
☐ Pain ☐ Numbness

Rectal:
☐ Pain ☐ Numbness

Occiput (Base of Skull) Pain:
☐ Left ☐ Right

Low Back Numbness:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Pelvic Pain:
☐ Left ☐ Right

Pelvic Numbness:
☐ Left ☐ Right

Left Upper Arm Pain:
☐ Anterior ☐ Posterior ☐ Medial ☐ Lateral

Left Upper Arm Numbness:
☐ Anterior ☐ Posterior ☐ Medial ☐ Lateral

Groin Pain:
☐ Left ☐ Right

Groin Numbness:
☐ Left ☐ Right

Right Upper Arm Pain:
☐ Anterior ☐ Posterior ☐ Medial ☐ Lateral

Sacral Numbness:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Sexual Dysfunction:
☐ PGAD (Persistent Genital Arousal)
☐ Dyspareunia (Painful Sexual Intercourse)
☐ Erectile Dysfunction

Right Upper Arm Numbness:
☐ Anterior ☐ Posterior ☐ Medial ☐ Lateral

Buttock Numbness:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left

Left Lower Arm Pain:
☐ Anterior ☐ Posterior
☐ Medial ☐ Lateral

Bowel Dysfunction:
☐ Constipation ☐ Loss of Sensation
☐ Use of Laxatives ☐ Urgency
☐ Incontinence (Leaking / Unable to Hold)

Left Thigh Pain:
☐ Anterior (Front) ☐ Posterior (Back)
☐ Medial (Inside) ☐ Lateral (Outside)

Left Lower Arm Numbness:
☐ Anterior ☐ Posterior
☐ Medial ☐ Lateral

Urinary Dysfunction:
☐ Frequency
☐ Retention (Unable to Empty Bladder)
☐ Urgency
☐ Have to Self-Catheterize
☐ Valsalva to Void (Push Bear Down to Urinate)
☐ Nocturia (Frequent Urination at Night)
☐ Incontinence (Leaking, Unable to Hold)

Left Thigh Numbness:
☐ Anterior (Front) ☐ Posterior (Back)
☐ Medial (Inside) ☐ Lateral (Outside)

Right Lower Arm Pain:
☐ Anterior ☐ Posterior
☐ Medial ☐ Lateral

Right Thigh Pain:
☐ Anterior (Front) ☐ Posterior (Back)
☐ Medial (Inside) ☐ Lateral (Outside)

Right Lower Arm Numbness:
☐ Anterior ☐ Posterior
☐ Medial ☐ Lateral

Right Thigh Numbness:
☐ Anterior (Front) ☐ Posterior (Back)
☐ Medial (Inside) ☐ Lateral (Outside)

Left Finger Pain:
☐ Thumb ☐ Pointer
☐ Middle ☐ Ring ☐ Pinky

Thoracic Pain:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left
☐ Upper ☐ Middle ☐ Lower

Left Finger Numbness:
☐ Thumb ☐ Pointer
☐ Middle ☐ Ring ☐ Pinky

Left Calf Pain:
☐ Anterior (Front) ☐ Posterior (Back)
☐ Medial (Inside) ☐ Lateral (Outside)

Right Finger Pain:
☐ Thumb ☐ Pointer
☐ Middle ☐ Ring ☐ Pinky

Thoracic Numbness:
☐ Left ☐ Right ☐ Bilateral
☐ Left > Right ☐ Right > Left
☐ Upper ☐ Middle ☐ Lower

Left Calf Numbness:
☐ Anterior (Front) ☐ Posterior (Back)
☐ Medial (Inside) ☐ Lateral (Outside)

Right Finger Numbness:
☐ Thumb ☐ Pointer ☐ Middle ☐ Ring ☐ Pinky

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Name:	Date of Birth:	Date:

TARLOV ASSESSMENT (Continued):

CONSERVATIVE MANAGEMENT:

Therapy:

☐ Physical Therapy:
Sessions
☐ 1-10 ☐ > 10 ☐ > 20 ☐ > 30

☐ Chiropractor:
Sessions
☐ 1-10 ☐ > 10

☐ Message Therapy
☐ Aqua Therapy

☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

Pain Management:

☐ Pain Clinic
Months or Years
☐ 0-3 ☐ 3-6 ☐ 6-12 ☐ 1-2 ☐ > 2

☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

Injections:

☐ Lumbar Epidural
☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

☐ Caudal Block
☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

☐ SI Joint:
☐ Left ☐ Right
☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

☐ Pudendal Block
☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

☐ Diagnostic Nerve Root Block
Level:
_____
☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

☐ Other:
_____

Procedures:

☐ Spinal Cord Stimulator
☐ Prior Meningeal Cyst Treatment
Surgeon:
_____

☐ Lumbar Fusion
☐ Pain Pump

☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

Medications:

☐ Tylenol
☐ Anti-Inflammatory
☐ Norco
☐ Oxycodone
☐ Percocet
☐ Vicodin

☐ Morphine
☐ Fentanyl Patch
☐ Dilaudid – Oral
☐ Other Narcotics
☐ Tramadol

☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

Pain Modulating Medications:

☐ Amitriptyline
☐ Neurontin/Gabapentin
☐ Other:
_____

☐ Pregabalin/Lyrica
☐ Loss of Sensation

☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

***ACTIVITIES*:**

Sitting:

☐ Constantly Squirming
☐ Avoids Activities
☐ Uses Cushion
☐ Unable to Sit for:
Minutes
☐ > 5 ☐ > 10 ☐ > 20 ☐ > 30 ☐ > 30

Other:

☐ Ice Pack
☐ Heat Pack
☐ Behavior Modification
☐ Decreased Activity

☐ TENS Unit
☐ Acupuncture
☐ Yoga

☐ Symptoms Improved
☐ Symptoms Same
☐ Symptoms Worsened

Symptoms Increased By:

☐ Sitting
☐ Standing
☐ Walking

Symptoms Relieved By:

☐ Lying Down
☐ Standing
☐ Sitting

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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.

We are committed to protect the privacy of your personal health information (PHI). If you have any questions about this notice, or complaints regarding our privacy practices, please contact the Privacy Officer Laura Abshire 816-301-4561. You will not be retaliated against for filing a complaint.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. For example, this information can and will be used to:

- **Health Information Exchange: We may make your health information available electronically to other healthcare providers or other 3rd party agencies outside of our facility who are involved in your care. We may conduct, plan, and direct treatment among multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payors.**
- **Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, 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.**

We are required to comply with the terms of this notice currently in effect, although we reserve the right to change the terms of this notice. To the extent that these terms are revised, a copy of the revised notice will be provided to you. Effective date for this notice: September 9, 2021.

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

Subject to certain regulatory limitations (i) you have the right to receive confidential communications from us; (ii) you have the right to inspect and copy your health information; (iii) you have the right to amend your health information that we maintain; and (iv) you have the right to receive an accounting of disclosures of your health information. You have the right to receive a paper copy of this notice upon request. We are obligated to maintain the privacy of your health information, and you have the right to notice of any breach of that information.

_____ _____

Patient/Representative Signature Date

_____ _____

Patient Name DOB

OFFICE USE ONLY		
I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below:		
□ An emergency existed, and a signature was not possible at the time. □ A copy was mailed with a request for a signature by return mail. □ Unable to communicate with patient for following reasons:		□ The individual refused to sign. □ Other:
Reviewed By:	Date:	Signature:

Main Office: 11970 N Central Expressway • Suite 460 • Dallas, Texas 75243
AIMIS Spine: Theodorou Potamianou 50 • Kato Polemidia 4155 • Limassol, Cyprus
P (214) 351-8450 • F (214) 351-8451 • frankfeigenbaum.com

FEIGENBAUM NEUROSURGERY

Specializing in the treatment of spinal meningeal cysts

Frank Feigenbaum, M.D., FAANS, FACS

PATIENT PRACTICE AGREEMENT

Insurance Billing: Insurance is a contract between you and your insurance company. It is your responsibility to know your plan coverage, benefits, eligibility, cost share amounts (deductible, co-payment, co-insurance, etc.) exclusions, limitations, referral, and pre-authorization requirements for specialty services. It is your responsibility to confirm that Feigenbaum Neurosurgery, PA (FN) participates in your plan. If FN participates with your insurance plan, we will file a claim on your behalf and bill you for your portion after insurance processing. FN requires a valid picture ID, all current insurance information, your referral, and an approved pre-authorization to bill your insurance for the visit. **All copays are due at the time of service.** For surgery services, FN will verify your insurance eligibility, benefits, and assist in obtaining prior authorization for surgery and in-patient hospitalization services but **this is not a guarantee of payment.** We can estimate what your insurance company may pay but the final determination of benefits is made by your insurance.

- Payment Responsibility for Non-Covered Services: Limited coverage is common among insurance plans. If non-covered services are known prior to surgery, payment is due before services are rendered.

- Self-pay Accounts: Self-pay accounts include patients with no insurance, or patients with no approved pre-authorization by their insurance. Payment is required prior to the date of service. To determine payment amounts for an office appointment or surgery, please call 214-351-8450.

- 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.

- Outstanding Balance Policy: Billing Statements sent will reflect the amount you owe after insurance processing. Payment in full is expected on receipt of your statement. If no resolution can be made within thirty (30) calendar days, your account may be sent to a collection agency, and you may be discharged from FN. If you have questions regarding any bills, balances or statements regarding services rendered by our group please contact our Billing department at 816-615-2711 or 502-825-1397.

- Surgery Claims: Please allow 30-45 days for claim processing following surgery. It is common to get a letter from your insurance requesting information from FN or denying payment. FN billing department will provide the necessary documentation requested by your insurance. Please contact our billing department for all questions regarding any insurance correspondence you receive in the mail. If necessary, you may be asked to help in the appeal process.

- Other Billing: Questions you have regarding bills from the hospital or other providers will need to be addressed to the name/company listed on the invoice. You may receive statements from the hospital, neuromonitoring company (Neurophysiology Associates, Biotronic, or NuVasive), anesthesia, Radiology, pain management, internal medicine group, and physical therapy, if applicable.

- Medicare: FN accepts Medicare assignment on covered Medicare charges. There is a possibility that some services 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 non-coverage and that you agree to pay in full prior to services being rendered. Medicare 20% coinsurance 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.

- Worker's Compensation, Motor Vehicle Accidents (MVA), Third-Party Liability Insurance: Feigenbaum Neurosurgery does not accept Worker's Compensation, MVA, or any Third-Party Liability Insurance (auto, homeowner, etc.). You are responsible for payment of services rendered. It is the patient's responsibility to seek reimbursement from the third-party insurance.

If you have any questions or need clarification of any of the above policies, please contact our office at 214-351-8450.

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

_____ _____

Patient/Representative Signature Date

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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.

_____ _____

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