BRAIN & SPINE INSTITUTE OF SAN ANTONIO

Osama Ahmed, MD, FAANS
Toinette Garza, NP-C / Kimberly Guajardo, NP-C / Ashley Witkowski, PA-C
12709 Toepperwein Rd, Suite 101, Live Oak, TX 78233 • W: 210-625-4733 • F: 210-625-4734 • www.bsiofsa.com

PATIENT INFORMATION : **Provider** (circle)**: Dr. Ahmed / NP Garza / NP Guajardo / PA Witkowski**

□ Dr. □Miss □Mr. □Mrs. □Ms.

Patient Name (Last) _____(First) _____(MI) ____

SSN: _____-____-_____ Date of Birth: MM _____/DD_____/YYYY_____ Sex: □Female □Male □Transgender

Home Address _____ City, State_____ Zip _____

Home Phone_____ Cell No._____ Work Phone_____ Ext. _____

E-mail Address: _____ Preferred Communication: □Text □Email □Phone/Cell

Race: □ American Indian/Alaska Native □Asian □Black/African American □Native Hawaiian □Pacific Islander
□White □Other _____ □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Other: _____

Marital Status: □Married □Single □Divorced □Widowed □Legally Separated □ Declined

Employer Name: _____

Employment Status: □Full-time □Part-time □Not employed □Self-employed □Retired □Active Military

Student Status: □Full-time student □Part-time student □Not a student

Emergency Contact: _____Phone Number: _____

Relationship to Patient: _____ □ Guardian

Primary Care Provider (PCP): _____

How did you hear about us? □ Google □Healthgrades □Other Social Media Platforms _____ □Insurance
□Hospital _____□ Family/Friend: _____ □Referring Provider: _____

Preferred Pharmacy: _____ Do you have a living will? □Yes □No

PRIMARY INSURANCE

Insurance Company: _____ Phone Number: _____
Name of Insured: _____ Patient Relationship to Insured: _____
Insured's Date of Birth: MM_____/DD_____/YYYY_____ Employer:_____
Subscriber ID (Policy Number): _____ Group ID: _____

SECONDARY INSURANCE

Insurance Company: _____ Phone Number: _____
Name of Insured: _____ Patient Relationship to Insured: _____
Insured's Date of Birth: MM_____/DD_____/YYYY_____ Employer:_____
Subscriber ID (Policy Number): _____ Group ID: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.
Patient/Responsible Party Signature _____ Date _____

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At Brain and Spine Institute of San Antonio, our providers strive to provide the most up-to-date neurosurgical treatment options with the utmost care. To provide the best experience, we ask every patient to review the policies below.

Patients new to the office will be asked to arrive 30 minutes prior to their scheduled appointment. The first appointment will require more time to obtain proper medical, family, and social history. It is the patient's responsibility to have pertinent records and/or adequate knowledge of their medical condition/s. Failure to provide pertinent information may delay treatment.

PLEASE INITIAL:

_____ It is the patient's responsibility to provide current insurance information and proper identification. The patient must provide the co-pay/co-insurance prior to the appointment. Failure to do so may prevent assessment from a provider and/or cause a delay in treatment. Any remaining balance after the insurance company is billed is the patient's responsibility.

_____ If multiple issues/conditions need to be discussed, a second appointment may be required at the provider's discretion.

_____ If imaging has been performed prior to the office visit, it is the patient's responsibility to bring the imaging files on a CD. If the imaging center offers to mail it to the office, please decline the request, and bring the CD with you. Our office does not have electronic access to all the imaging centers. A lack of imaging can cause a delay in treatment.

_____ Results will not be discussed over the phone in lieu of an office appointment. Patients are usually scheduled at the time of check-out to go over results of tests ordered at current visit.

_____ For uninsured/self-pay patients, payment for the visit is required prior to seeing a provider.

_____ Cell phones or any recording device usage in the exam room is prohibited. Any device used to record a conversation is prohibited. The provider will not discuss patient care on the phone with anyone other than the patient or approved power of attorney. The provider will not participate in video conferences. Failure to comply by these rules may prevent treatment and/or dismissal from the practice.

_____ Cancellations or appointment time changes must occur 48 hours prior to the scheduled appointment in order not to be considered a "No Show". It is the patient's responsibility to notify the practice within the specified time. If a patient has three (3) violations, the practice reserves the right to terminate the patient from the practice for non-compliance.

_____ A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be rescheduled for a later date.

_____ The patient is allowed one additional guest to his/her appointment. Children 12 years of age and under are prohibited in the exam room.

_____ Our providers do not dispense narcotics for chronic pain. If pain control is required, our providers can send a referral to a pain management physician.

_____ **For non-elective/emergent surgical patients**: Pain medication will be administered by the patient hospitalist for the post-operative period. If prolonged pain control is needed after surgery, establishing care with a pain management physician will be required.

_____ **For elective surgical patients**: Pre-operative instructions and prescriptions will be provided in the office prior to your scheduled surgery.

_____ Our practice does not provide refill for medications. Any prescriptions given will provide adequate coverage between appointments. If an exception must be made, the patient will need to come to the office for a consultation.

_____ FMLA and short-term disability paperwork is reserved for patients treated with surgery by Brain & Spine Institute of San Antonio. Any paperwork completed by our providers will require a pre-payment of $25 per set of forms and may take 7-10 business days to complete. Please do not expect paperwork to be completed on short notice. This paperwork is time-consuming and requires detailed documentation that should not be rushed.

_____ If there is a medical emergency at any time, please call 911. If medical attention is needed during regular business hours, please call the office and every effort will be made to schedule a prompt appointment.

_____ If medical attention is needed due to pain after regular business hours, please go to the nearest urgent care center.

_____ Our providers will not call in prescriptions after hours. Pain medication is reserved for patients who have been treated with surgery. Long-term pain control will require referral to a pain management physician.

_____ _____/_____/_____
(Printed patient name) (Date)

_____
(Patient signature)

_____ _____/_____/_____
(Witness or medical power of attorney) (Date)

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

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

Disclosures to Friends and/or Family Members

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

Name	Relationship	Contact Number

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

Communications about My Healthcare

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

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

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

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

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

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

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

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information

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

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

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

Patient/Representative Signature	Relationship to Patient (self, parent, legal, guardian/representative, etc.)	Date

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Patient Name: _____ Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

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

Third Party Collection. I acknowledge BRAIN AND SPINE INSTITUTE OF SAN ANTONIO may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

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

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

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

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

Patient/patient representative signature : _____ Date :_____

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

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

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New Patient Health History

Name: _____ DOB: _____/_____/_____ HT: _____ WT: _____ Date: _____

Reason for visit: _____

Medical Diagnosis: (Please circle all that apply)

___ Asthma
___ Gastrointestinal
___ Bladder Problems
___ Jaundice
___ Psychiatric Disorder
___ Tuberculosis
___ Liver
___ Diabetes
___ Prostate
___ Skin Disease
___ Joint Disease
___ Stroke
___ Blood Clots
___ Lung Cancer
___ Epilepsy
___ High Blood Pressure
___ Heart Disease
___ Seizures
___ Depression
___ Anxiety
___ Gout
___ Alcoholism
___ Kidney Disease
___ Thyroid

Any Surgical History: (Month/Year)

_____

_____

_____

Family History: (Check if any blood relative has had any of the following)
Indicate which immediate relative **Mother/Father/Brother/Sister ONLY**

___ Diabetes
___ Heart Disease
___ Migraines
___ Alcoholism
___ Cancer
___ Arthritis
___ Osteoporosis
___ Anemia
___ Thyroid Problem
___ High Blood Pressure
___ Mental Illness
___ High Cholesterol
___ Glaucoma
___ Stroke
___ Seizures
___ Allergies
___ Meniere's Disease
___ Asthma
___ Other: _____

Social History:

Do you currently smoke or have previously? Y/N If so, how many cigarettes per day? _____

Do you drink alcohol? Y/ N How often? _____

Do you use illegal drugs? Y/ N If so, what do you use? _____

Do you drink caffeine? Y / N If so, how many cups/cans per week: _____

What is your occupation? _____ If None, circle: Retired / Disabled / Unemployed

Last dates of the following screening(s): A1C: ___/___/___ Mammogram: ___/___/___Colonoscopy: ___/___/___

Last flu vaccine? Date: ___/___/___ Facility: _____

Last pneumovax (pneumonia) vaccine: Date: ___/___/___ Facility: _____

BACK-OFFICE NOTES:

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Name: _____ Today's Date: _____

Circle all that may apply:

Constitutional
Sweats
Weight gain
Weight loss
Fever
Fatigue
Sleep difficulty

Psychiatric
Claustrophobia
Depression
Nervousness
Hallucinations
Paranoia

Ear, Nose, & Throat
Hearing loss
Ringing in the ears
Sinus congestion
Nose bleeds
Sore throat
Swallowing difficulty
Loose teeth

Respiratory
Chronic cough
Sleep apnea
Shortness of breath
Asthma
Wheezing
Sputum production

Cardiovascular
Chest pain
Irregular heartbeat
Swelling in legs/feet

Gastrointestinal
Heartburn
Constipation
Diarrhea
Nausea
Blood in stool
Incontinence

Genitourinary
Incontinence
Painful urination
Urinary frequency
Urgency
Prostate problems
Impotence

Musculoskeletal
Joint pain
Aches
Shoulder pain
Back pain
Neck pain
Muscle spasms

Hematological
Anemia
Bruising
Clotting disorders

Neurological
Dizziness
Loss of Consciousness
Tremor
Word finding difficulty
Stroke
Meningitis
Facial Weakness
Seizures
Spasms
Balance difficulty
Memory loss
Headaches
Double vision
Blurry vision
Vision loss
Numbness/tingling (if so, where)
_____

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Medication Log

Patient Full Name: **DOB:**

Medication Allergies & Reactions:			
CURRENT MEDICATION REGIMEN ***INCLUDING OVER THE COUNTER MEDICATION, VITAMINS & SUPPLEMENTS***			
MEDICATION NAME*	DOSE/SIG/MG	Prescribing Physician	REASON TAKEN
PHARMACY:			PHARMACY PHONE NUMBER:

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Broken Appointment Policy

Our practice is dedicated to quality care and exceptional service. Our medical providers and entire team spend extensive amounts of time preparing for your visit. Broken or missed appointments create multiple scheduling problems for our entire team as well as other scheduled patients. When you have a scheduled appointment with our office, a specific time slot is reserved specifically for you and your medical needs that involves the entire staff. To be respectful of the needs of all our BSISA patients, we have created the following Broken Appointment Policy. We appreciate your understanding.

We request that you give our team a notice of at least **48 hours** in the event that you need to reschedule your appointment. This will allow us time to make every effort possible to accommodate other patients. If you miss an appointment without contacting our office within the required time frame, this is considered a broken appointment. A fee of **$50.00** will be charged to you for that broken appointment. This fee cannot be billed to your insurance company, and you will be held directly responsible for that fee/payment. Payment will be due prior to any additional services rendered including rescheduling the appointment.

If you have any questions regarding this policy, please speak with one of our front office staff members and we will be glad to clarify any questions you may have.

We thank you for your patronage!

I have read and understand the Broken Appointment Policy of Brain and Spine Institute of San Antonio and I agree to be bounded by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____(print name), have received a copy of Brain and Spine Institute of San Antonio's Broken Appointment Policy.

_____ _____

Signature of Patient Date