PATIENT'S PERSONAL MEDICAL HISTORY

CONFIDENTIAL RECORD: *The following information is confidential and will be used by your doctor in decisions regarding your care. Please answer all questions to the best of your knowledge.*

Last Name: _____ First Name: _____ MI: _____ DOB: _____ Age ____

Sex: M F Height:_____ Weight:_____ Marital Status: S M W D Race:_____ Language_____

DOES YOUR JOB REQUIRE YOU TO LIFT? _____ IF SO, HOW MUCH?_____ ARE YOU RIGHT OR LEFT HANDED? _____

DO YOU OR HAVE YOU EVER USED TOBACCO PRODUCTS? YES NO
IF YES, WHAT AND HOW MUCH? _____

DO YOU OR HAVE YOU EVER USED ALCOHOLIC BEVERAGES?: YES NO
IF YES, WHAT AND HOW MUCH? _____

DO YOU OR HAVE YOU EVER USED STREET DRUGS? YES NO
IF YES, WHAT, WHEN AND HOW MUCH? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
IF YES, LIST ANY DRUGS WHICH YOU ARE ALLERGIC:
_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDE AMOUNT AND FREQUENCY:
(INCLUDE PRESCRIBED AND NON PRESCRIBED DRUGS)
_____
_____
_____

LIST ANY SURGERIES WITH DATES WHICH YOU HAVE HAD:

SURGERY:	DATE:	SURGERY:	DATE:

LIST ANY SERIOUS ILLNESSES, INJURIES AND/OR ACCIDENTS INCLUDING DATES:

ILLNESS:	DATE:	ILLNESS:	DATE:

DO YOU HAVE OR HAVE YOU EVER HAD: **(CIRCLE YOUR ANSWER. IF YES, GIVE DATE OF OCCURRENCE)**

STROKE	YES	NO	_____	MIGRAINES	YES	NO	_____	BLOOD CLOTS	YES	NO	_____
ASTHMA	YES	NO	_____	TUBERCULOSIS	YES	NO	_____	COLITIS	YES	NO	_____
BLEEDING TENDENCY	YES	NO	_____	THYROID DISEASE	YES	NO	_____	BLADDER INFECTION	YES	NO	_____
SEIZURES	YES	NO	_____	ANXIETY	YES	NO	_____	DEPRESSION	YES	NO	_____
AIDS AND/OR HIV	YES	NO	_____	DIABETES	YES	NO	_____	STOMACH ULCERS	YES	NO	_____
KIDNEY DISEASE	YES	NO	_____	GLAUCOMA	YES	NO	_____	ANEURYSM	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	_____	CHOLESTEROL	YES	NO	_____	HIGH FEVER AFTER SURGERY	YES	NO	_____
RHEUMATIC/CONGENITAL HEART	YES	NO	_____	HEPATITIS	YES	NO	_____ TYPE? _____				
CANCER / LEUKEMIA	YES	NO	_____ TYPE? _____	HEART DISEASE	YES	NO	_____ TYPE? _____				

DO YOU HAVE KNOWLEDGE OF ANY DIRECTLY RELATED PERSON WHO HAS OR HAS HAD ANY OF THE FOLLOWING:
(CIRCLE ANSWER. IF YES, GIVE RELATIONSHIP TO YOU. FOR EXAMPLE: (M) MOTHER, (F) FATHER, (S) SISTER, (B) BROTHER, (MGF/PGF OR MGM/PGM) MATERAL/PATERNAL GRANDFATHER/MOTHER, (MA/PA OR MU/PU) AUNT /UNCLE)

STROKE	YES	NO	_____	MIGRAINES	YES	NO	_____	BLOOD CLOTS	YES	NO	_____
ASTHMA	YES	NO	_____	TUBERCULOSIS	YES	NO	_____	COLITIS	YES	NO	_____
BLEEDING TENDENCY	YES	NO	_____	THYROID DISEASE	YES	NO	_____	SEIZURES	YES	NO	_____
ANXIETY	YES	NO	_____	DEPRESSION	YES	NO	_____	AIDS AND/OR HIV	YES	NO	_____
DIABETES	YES	NO	_____	STOMACH ULCERS	YES	NO	_____	KIDNEY DISEASE	YES	NO	_____
ALZHEIMERS/DEMENTIA	YES	NO	_____	ANEURYSM	YES	NO	_____	HIGH BLOOD PRESSURE	YES	NO	_____
CHOLESTEROL	YES	NO	_____	BACK PROBLEMS	YES	NO	_____	NECK PROBLEMS	YES		_____
PROBLEMS/HIGH FEVER AFTER SURGERY			_____					RHEUMATIC/CONGENITAL HEART	YES	NO	_____
HEPATITIS	YES	NO	_____ TYPE? _____					CANCER / LEUKEMIA	YES	NO	_____ TYPE? _____
HEART DISEASE	YES	NO	_____ TYPE? _____					OTHER?	_____		

TODAY'S DATE: _____ PATIENT'S SIGNATURE: _____

PLEASE CONTINUE ON OTHER SIDE

ASSESSMENT OF LUMBAR PATIENT

PATIENT'S NAME: _____ OCCUPATION: _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN INJURY? IF YES, DATE OF INJURY: _____

WORK RELATED? Y N AUTO ACCIDENT? Y N OTHER? Y N _____

DESCRIBE THE SYMPTOMS YOU ARE EXPERIENCING. _____

_____

_____

WHEN DID THEY START? _____ ARE THEY GETTING WORSE? YES NO

HAVE YOU HAD THIS PROBLEM BEFORE? YES NO

COMPLAINT:

				DOES THE FOLLOWING INCREASE YOUR PAIN?		
BACK PAIN	YES	NO	RIGHT / LEFT	STANDING	YES	NO
HIP PAIN	YES	NO	RIGHT / LEFT	COUGHING	YES	NO
LEG PAIN	YES	NO	RIGHT / LEFT	SNEEZING	YES	NO
PAIN BELOW KNEE	YES	NO	RIGHT / LEFT	WALKING	YES	NO
NUMBNESS/TINGLING	YES	NO	RIGHT / LEFT	SITTING	YES	NO
WEAKNESS	YES	NO	RIGHT / LEFT			

ARE BLADDER FUNCTIONS NORMAL? YES NO IF NOT, EXPLAIN _____

ARE BOWEL FUNCTIONS NORMAL? YES NO IF NOT, EXPLAIN _____

WHAT TREATMENT HAVE YOU HAD FOR THE ABOVE SYMPTOMS:

			DATE:				DATE:
ANTI-INFLAMATORY	YES	NO	_____	PHYSICAL THERAPY	YES	NO	_____
MUSCLE RELAXANTS	YES	NO	_____	STEROID INJECTIONS	YES	NO	_____
PAIN RELIEVER	YES	NO	_____	CHIROPRACTOR	YES	NO	_____

WHAT RECENT TESTING HAVE YOU HAD FOR THE ABOVE SYMPTOMS:

			DATE:	WHERE:
PLAIN X-RAYS	YES	NO	_____	_____
MRI	YES	NO	_____	_____
MYELOGRAM	YES	NO	_____	_____
CT SCAN	YES	NO	_____	_____
EMG/NCS	YES	NO	_____	_____

**********FOR DOCTOR USE ONLY**********

B/P: _____ P: _____ R: _____

	WNL	DESCRIPTION OF ABNORMALITIES
HEENT	:	_____
HEART	:	_____
LUNGS	:	_____
ABDOMEN	:	_____

_____

_____

PLEASE CONTINUE ON OTHER SIDE

THE GREATER HOUSTON NEUROSURGERY CENTER, P. A.
9200 NEW TRAILS DRIVE, SUITE 100
THE WOODLANDS, TX 77381
OFFICE (281) 364-9509
FAX (281) 364-0984

Dear Patient,

Welcome to The Greater Houston Neurosurgery Center. We have scheduled your appointment for our: **WOODLANDS OFFICE** **HUNTSVILLE OFFICE**

_____ _____ at _____
DAY DATE TIME

Enclosed you will find a map to our office and several forms which are needed in order to process your account and to assist us in filing your insurance benefits. Please take the time to review all the documents and fill out all the forms. You will need to bring these completed forms with you. Should you have any questions regarding these forms, please call our office at the above number.

On the day of your appointment, you will need to bring the following with you:

1. **Any reports and original films of testing which have already been performed. (This includes x-rays, MRI's, CT-scans, myelogram, EMG/NCV, or any other tests that you may have had done.) Please bring the printed films AS WELL AS the CD and the radiologist reports. It is extremely important that you bring the images with you in order to properly diagnose your condition. You will not be seen if you do not bring images with you. Should you have trouble getting them before your appointment, please call to reschedule.**
2. **Your insurance cards**
3. **Your referral or authorization number from your PCP**
4. **The name and telephone number of your pharmacy**
5. **The information packet enclosed with the forms filled out prior to your appointment.**
6. **If your insurance requires that you pay a co-pay or percentage of your fees, we will ask for payment at the time of registration.**

Please call our office immediately if you cannot keep your appointment in order that we can reschedule your time and date. **We have a "No Show" policy, which charges you a fee should you not cancel your appointment in advance.**

Please do not hesitate to call our office, should you have any questions. We are happy to assist you.

Thank you,
Dr. Peter Shedden, Dr. William Francis, Dr. Dare Adewumi and Dr. Michael Knox

Greater Houston Neurosurgery Center

9200 New Trails Dr.
Suite 100
The Woodlands, TX 77381

281-364-9509
281-364-0984 fax

From the NORTH:
I45 South – take the Research Forest exit and turn right.
Drive 1.8 miles and turn left onto New Trails (there is a light).
Just beyond the first intersection, you will see the parking lot entrance.
The building is on the corner of New Trails and Technology Forest.
We are on the first floor of a brown stucco building.

From the SOUTH:
I45 North – take the Research Forest exit and turn left, under the highway.
Drive 1.8 miles and turn left onto New Trails (there is a light).
Just beyond the first intersection, you will see the parking lot entrance.
The building is on the corner of New Trails and Technology Forest.
We are on the first floor of a brown stucco building.

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.

TODAY'S DATE: _____

PATIENT INFORMATION

NAME: _____ SEX: ☐ FEMALE ☐ MALE
LAST FIRST INITIAL

ADDRESS: _____ DATE OF BIRTH: _____
STREET

_____ SS#: _____
CITY STATE ZIP

HOME PHONE: _____ OTHER PHONE # _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

EMPLOYER'S NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

WHO REFERRED YOU TO OUR OFFICE:

NAME: _____

ADDRESS: _____
STREET

_____
CITY STATE ZIP

PHONE: _____

PHARMACY NAME:

_____

LOCATION: _____

PHONE: _____

IS THIS YOUR PCP? ☐ YES ☐ NO
(PRIMARY CARE PHYSICIAN) PLEASE CHECK ONE

PLEASE SEND CORRESPONDENCE TO THE FOLLOWING:

PHYSICIAN'S NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHYSICIAN'S NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

FOR WORKER'S COMP USE ONLY

DATE OF INJURY: _____ **W/C CLAIM#** _____

WHO IS YOUR TREATING DR?

_____ PHONE: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

CASE MANAGER'S NAME: _____ PHONE: _____

ADJUSTER'S NAME: _____ PHONE: _____

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.

TODAY'S DATE: _____

INSURANCE INFORMATION

THIS INFORMATION IS NECESSARY IN ORDER TO FILE YOUR INSURANCE ELECTRONICALLY.

PLEASE PROVIDE ALL INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE COMPANY

_____ PHONE#: _____
INSURANCE COMPANY

CLAIMS ADDRESS:

_____
STREET CITY STATE ZIP

SUBSCRIBER ID#: _____ **GROUP #:** _____

INSURED'S NAME: _____ SEX: ☐ FEMALE ☐ MALE
PLEASE CHECK ONE

SS#: _____ **DATE OF BIRTH:** _____

EMPLOYER'S NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY

_____ PHONE#: _____
INSURANCE COMPANY

CLAIMS ADDRESS:

_____
STREET CITY STATE ZIP

SUBSCRIBER ID#: _____ **GROUP #:** _____

INSURED'S NAME: _____ SEX: ☐ FEMALE ☐ MALE
PLEASE CHECK ONE

SS#: _____ **DATE OF BIRTH:** _____

EMPLOYER'S NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

RELATIONSHIP TO PATIENT: _____

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.
9200 NEW TRAILS DRIVE, SUITE 100
THE WOODLANDS, TEXAS 77381
OFFICE (281) 364-9509
FAX (281) 364-0984

PATIENT'S NAME:_____

CONSENT AND AUTHORIZATION FOR TREATMENT

I (We) hereby grant permission to authorize and direct the authorities of The Greater Houston Neurosurgery Center, P.A. to perform such medical procedures on me (him/her) as they deem in their judgment advisable or necessary for the treatment and/or care of (1) any conditions now recognized or contemplated, and (2) any conditions, not now recognized or contemplated, which are revealed or arise during the course of such treatment or care.

I (We) acknowledge that no warranty or guaranty has been made as to the results that may be obtained from such treatment and/or care, that I (we) understand the nature and purpose of the above authorized treatment and that I (we) have fully informed myself (ourselves) of the contents and effects of the above Consent and Authorization and do hereby freely give my (our) consent thereto.

Signature:_____ Date:_____

Signer's Name:_____ _____
Relationship to Patient

Witness' Signature:_____

ACKNOWLEDGEMENT OF NO SHOW AND LATE CANCELLATION POLICY:

The policy for no shows and/or late cancellations is as follows: A fee will be assessed for patient appointments not kept or cancelled at least one day prior to the appointment date. This fee will be due from the patient and is not payable by insurance.

There will be a charge of $100 for all no shows or late cancellations. This will be due and payable by the 15th of the following month or required to be paid prior to scheduling another appointment, whichever comes first.

I (we) understand and agree to this policy.

Signature:_____ Date:_____

Signer's Name:_____ _____
Relationship to Patient

Witness' Signature:_____

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.
9200 NEW TRAILS DRIVE, SUITE 100
THE WOODLANDS, TEXAS 77381
OFFICE (281) 364-9509
FAX (281) 364-0984

PATIENT'S NAME:_____

ASSIGNMENT OF BENEFITS TO THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.

I hereby authorize The Greater Houston Neurosurgery Center, P.A.to bill my insurance carrier or any other payment source and take any and all action necessary to collect such benefits to include, but not limited to appeal. I assign all benefits, rights, appeal rights and authorizations so that Greater Houston Neurosurgery Center, P.A. shall receive payment directly for any benefits otherwise payable to me for all claims for services provided or submitted prior to, or after, the date provided on this form. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefits, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of services provided by Greater Houston Neurosurgery Center, P.A., Peter Shedden, M.D. William Francis, M.D., Dare Adewumi, M.D., Robert Borden, P.A., Mary Vollmert, P.A., Kevin Schumann P.A. and/or Michael Knox PhD.

I understand that I am personally and financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. This assignment and authorization in no way releases me from said responsibility and imposes no obligation on Greater Houston Neurosurgery Center, P.A. to collect money on my behalf. If I receive funds due to GHNC, I shall hold them as a fiduciary trustee and immediately turn them over to GHNC. If I fail to turnover any monies owed to Greater Houston Neurosurgery Center, P.A., then I understand Greater Houston Neurosurgery Center, P.A. has the ability to pursue collections against me. In the event this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees. It is not considered a breach of confidentiality to release information to an attorney or insurance company in order to secure or collect payment.

I have read, understand and agree to all the information above. A photocopy of this agreement may be used as though it were an original.

The Assignment of Benefits shall be effective until revoked by me in writing. Such revocation shall have a prospective effect only.

Signature: _____ Date: _____

Signer's Name: _____ _____
Relationship to Patient

Signature of Primary Insured: _____ _____
Relationship to Patient

Patient Social Security No.: _____

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.
9200 NEW TRAILS DRIVE, SUITE 100
THE WOODLANDS, TEXAS 77381
OFFICE (281) 364-9509
FAX (281) 364-0984

CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

I, _____, Social Security Number _____, date of birth _____, hereby authorize and consent for THE GREATER HOUSTON NEUROSURGERY CENTER, P.A., 9200 New Trails Drive, Suite 100, The Woodlands, Texas 77381 to release any and all medical, and/or psychological reports or records, including, but not limited to, medical notes, physician narratives, office notes, operative notes, discharge summaries, Doctor's orders, Nurse's notes, lab reports, test results, physical therapy progress notes, patient progress reports, diagnosis, post-operative reports, post-operative diagnosis, pathology reports, x-rays, MRI's, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

The release of the matters listed above is being authorized for purposes of obtaining medical treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

This Consent to Disclose Private Healthcare Information may be revoked in writing. However, such revocation shall not be effective on an entity that has taken action in reliance upon this Consent prior to its revocation and/or if this Consent was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further acknowledge that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the privacy regulations.

I further understand that I have the right to review THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.'s privacy notice and to request restrictions.

Signed this ____ day of _____, 20___.

_____
Signature

_____
Printed Name

_____
Date

_____
Signer's Relationship to Patient (if other than Patient)

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

Special Restrictions:

_____
_____
_____
_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients and/or their Legal Guardians:

Healthcare fraud and abuse have been identified as a national problem costing taxpayers literally billions of dollars each year. We want you to know that all of our employees, managers and physicians continually undergo training so that they may understand and comply with government rules and regulations regarding Medicare, Workers Compensation, federal and state healthcare laws and regulations. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine accurate compensation for our services in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper expenditures. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any Medicare, Workers Compensation service or billing errors and/or federal or state law violations.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any billing or service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Sincerely,

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.

Our Compliance Pledge

Our office is fully committed to compliance
with all Medicare, Workers Compensation
and other federal and state laws, rules and regulations.
If you ever have any questions or concerns about your
services or charges, we encourage
you to call and ask for our
compliance officer.

"Committed to Full Compliance"

THE GREATER HOUSTON NEUROSURGERY CENTER, P. A.
9200 New Trails Drive, Suite 100
The Woodlands, Texas 77381

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your healthcare information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your healthcare information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice, at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all healthcare information that we maintain, including healthcare information we create or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this new Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose healthcare information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your healthcare information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your healthcare information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your healthcare information for treatment, payment, or healthcare operations, you may give us written authorization to use your healthcare information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason, except those described in this notice.

To Your Family and Friends: We must disclose your healthcare information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your healthcare information to notify or assist in the notification of (including identifying or location) of a family member, your personal representative, or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only the healthcare information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other forms of healthcare information.

Treatment Alternative: We may use or disclose your healthcare information to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Required by Law: We may use or disclose your healthcare information when we are required to do so by law.

Abuse or Neglect: We may disclose your healthcare information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your healthcare information to military authorities or the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other nation security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected healthcare information of an inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your healthcare information to provide you with appointment reminders (such as voicemail messages, e-mail, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of you healthcare information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your healthcare information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses, such as copiers and staff time. You may also request access by sending us a letter to the address at the end of the Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, disclosed your healthcare information for purposes other than treatment, payment, healthcare operations, and certain activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your healthcare information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your healthcare information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your healthcare information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND/OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If your are concerned that we may have violated your privacy rights, if you disagree with a decision we made about access to your healthcare information, in response to a request you made to amend or restrict the use or disclosure of your healthcare information, or to have us communicate with you by alternative means or at an alternative location, you may complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your healthcare information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Robin Lillegard

Telephone: 281-364-9509 Fax: 281-364-0984

Address: 9200 New Trails Dr., Suite 100, The Woodlands, Texas 77381

ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES OF THE GREATER HOUSTON NEUROSURGEY CENTER.

PATIENT: _____(Signature)

_____(Printed Name)

_____(Parent/Legal Guardian of Patient(Print)

_____(Date)

If you have previously completed this, have there been any changes?

Review of Symptoms

General						
	Chills	YES	NO	Fatigue	YES	NO
	Fever	YES	NO	Night sweats	YES	NO
	Weight loss	YES	NO			
Skin						
	Rash	YES	NO	Lesions	YES	NO
HEENT						
	Hearing changes	YES	NO	Headaches	YES	NO
	Voice changes	YES	NO	Blurred vision	YES	NO
	Double vision	YES	NO			
Neck						
	Neck pain	YES	NO	Neck stiffness	YES	NO
Respiratory						
	Cough	YES	NO	Difficulty breathing	YES	NO
	Wheezing	YES	NO			
Cardiovascular						
	Chest pain	YES	NO	Shortness of breath	YES	NO
	Palpitations	YES	NO	Difficulty breathing on exertion	YES	NO
Gastrointestinal						
	Nausea	YES	NO	Abdominal pain	YES	NO
	Vomiting	YES	NO	Difficulty swallowing	YES	NO
	Diarrhea	YES	NO	Changes in bowel habits	YES	NO
	Constipation	YES	NO			
Genitourinary						
	Painful urination	YES	NO	Urgency	YES	NO
	Urinary retention	YES	NO	Urinary incontinence	YES	NO
Musculoskeletal						
	Back pain	YES	NO	Back stiffness	YES	NO
	Joint pain	YES	NO	Joint swelling	YES	NO
	Leg or arm weakness	YES	NO	Muscle pain	YES	NO
	Muscle weakness	YES	NO			
Neurological						
	Dizziness	YES	NO	Balance issues	YES	NO
	Vertigo	YES	NO	Gait abnormality	YES	NO
	Headache	YES	NO	Seizures	YES	NO
	Decreased memory	YES	NO	Numbness	YES	NO
	Paresthesia (tingling/burning sensation)	YES	NO	Trouble walking	YES	NO
	Weakness	YES	NO			
Psychiatric						
	Disorientation	YES	NO	Inability to concentrate	YES	NO
	Hallucinations	YES	NO			
Hematology						
	Abnormal bleeding	YES	NO	Easy bruising	YES	NO

PRINT NAME: _____ DOB: _____ Date:_____