PATIENT'S PERSONAL MEDICAL HISTORY FOR NEUROPSYCHOLOGICAL EVALUATION

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: _____ AGE: _____ Sex: M F

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

Highest level of school completed: _____ Referred by: _____

PRIMARY COMPLAINT / DESCRIBE THE SYMPTOMS YOU ARE EXPERIENCING. _____

_____

_____

ONSET OF SYMPTOMS: _____ **EVENT ASSOCIATED WITH ONSET? YES NO IF YES, PLEASE DESCRIBE**

_____

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 _____

ARE YOU CURRENTLY INVOLVED IN ANY LEGAL ISSUES? Y N IF YES, DESCRIBE: _____

SYMPTOM COURSE? CONSISTENT IMPROVED WORSENED

ATTENTION/CONCENTRATION DIFFICULTIES? YES NO WORD FINDING DIFFICULTIES? YES NO
TROUBLE WITH COMPLEX TASKS? YES NO MEMORY DIFFICULTIES? YES NO

ARE YOU CURRENTLY DRIVING? YES NO
IF YES, HAVE YOU HAD ANY RECENT TICKETS? YES NO RECENT ACCIDENTS? YES NO

DO YOU MANAGE YOUR OWN MEDICATIONS? YES NO WITH ASSISTANCE? YES NO

DO YOU MANAGE YOUR OWN FINANCES? YES NO WITH ASSISTANCE? YES NO

WHAT IS YOUR CURRRENT LIVING SITUATION (HOME, APARTMENT, ASSISTED LIVING, etc.)? _____

WHAT IS YOUR EMPLOYMENT STATUS? _____

CURRENT OR MOST RECENT EMPLOYER? _____ **POSITION?** _____
NUMBER OF YEARS? _____

DESCRIBE YOUR CURRENT MOOD: _____

_____

DO YOU HAVE A HISTORY OF PSYCHIATRIC ILLNESS? YES NO

IF YES, Treatment History? Medication Therapy Hospitalization

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? YES NO

IF YES, WHAT TYPE OF TREATMENT DID YOU HAVE? _____

LIST SUBSTANCES _____

CURRENT USE? _____ **ALCOHOL USE? YES NO (IF YES AMOUNT AND FREQUENCY)** _____

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:**
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE CONTINUE ON OTHER SIDE

ASSESSMENT OF BRAIN PATIENT

PATIENT'S NAME: _____

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	_____
BRAIN TUMOR	YES	NO	_____	RHEUMATIC/CONGENITAL HEART	YES	NO	_____				
HEPATITIS	YES	NO	_____ TYPE? _____		CANCER / LEUKEMIA	YES	NO	_____ TYPE? _____			
HEART DISEASE	YES	NO	_____ TYPE? _____								

CURRENT COMPLAINTS:

HEADACHES	YES	NO	VISION	YES	NO
SPEECH	YES	NO	WEAKNESS	YES	NO
NUMBNESS	YES	NO	TINGLING	YES	NO

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

ANY CHANGES IN WALKING? YES NO IF YES, EXPLAIN _____

WHAT RECENT TESTING HAVE YOU HAD FOR THE ABOVE SYMPTOMS:

			DATE:	WHERE:
CT SCAN	YES	NO	_____	_____
MRI	YES	NO	_____	_____
MRA/MRV	YES	NO	_____	_____
ANGIOGRAM	YES	NO	_____	_____
NEUROPSYCHOLOGY	YES	NO	_____	_____

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	_____	BRAIN TUMOR	YES	NO	_____	SUICIDE	YES	NO	_____
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? _____						

Do you authorize us to release the results of your evaluation to any family, friends or caretakers? YES NO

If yes, whom? _____

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

PLEASE CONTINUE ON OTHER SIDE

THE GREATER HOUSTON
NEUROSURGERY CENTER, P.A.

PETER M. SHEDDEN, MSc., M.D., FRCS(C), FACS
BOARD CERTIFIED NEUROSURGEON

MICHAEL R. KNOX, PH.D.
CLINICAL NEUROPSYCHOLOGIST

WILLIAM R. FRANCIS, JR., M.D., M.B.A.
ORTHOPEDIC SPINE SPECIALIST

Dear Patient,

Welcome to the Greater Houston Neurosurgery Center. We have scheduled your appointment with Michael Knox, Ph.D. Your appointment is on:

_____ _____ at _____
DAY DATE TIME

Enclosed you will find a map to our office and several other forms that need to be completed for your appointment, process your account and assist us in filing your insurance benefits. Please take the time to review and complete all documents.

Your appointment will be approximately 3 - 4 hours long. Please being your glasses, hearing aids or any other type of aid you may need to assist you with your testing. Also, Dr. Knox would like a family member to be present for the first 30 minutes of the appointment for a group consultation.

Please be advised that we have a "NO SHOW" policy which charges you a fee should you not cancel your appointment 24 hours in advance.

Feel free to contact our office should you have any questions. We are happy to assist you!

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

PREFERRED PHONE #: _____ OTHER PHONE # _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME/RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

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

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 $250 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)