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

THE GREATER HOUSTON
NEUROSURGERY CENTER, P.A.

Dear Patient,

Welcome to The Greater Houston Neurosurgery Center. We have scheduled your appointment in our Woodlands office:

_____	_____	_____
DAY	DATE	TIME

Enclosed you will find a map of our office and several other forms that 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 test 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 card and driver's license.**
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 filed 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. Kevin Moran, and Dr. Michael Knox

The Greater Houston Neurosurgery Center

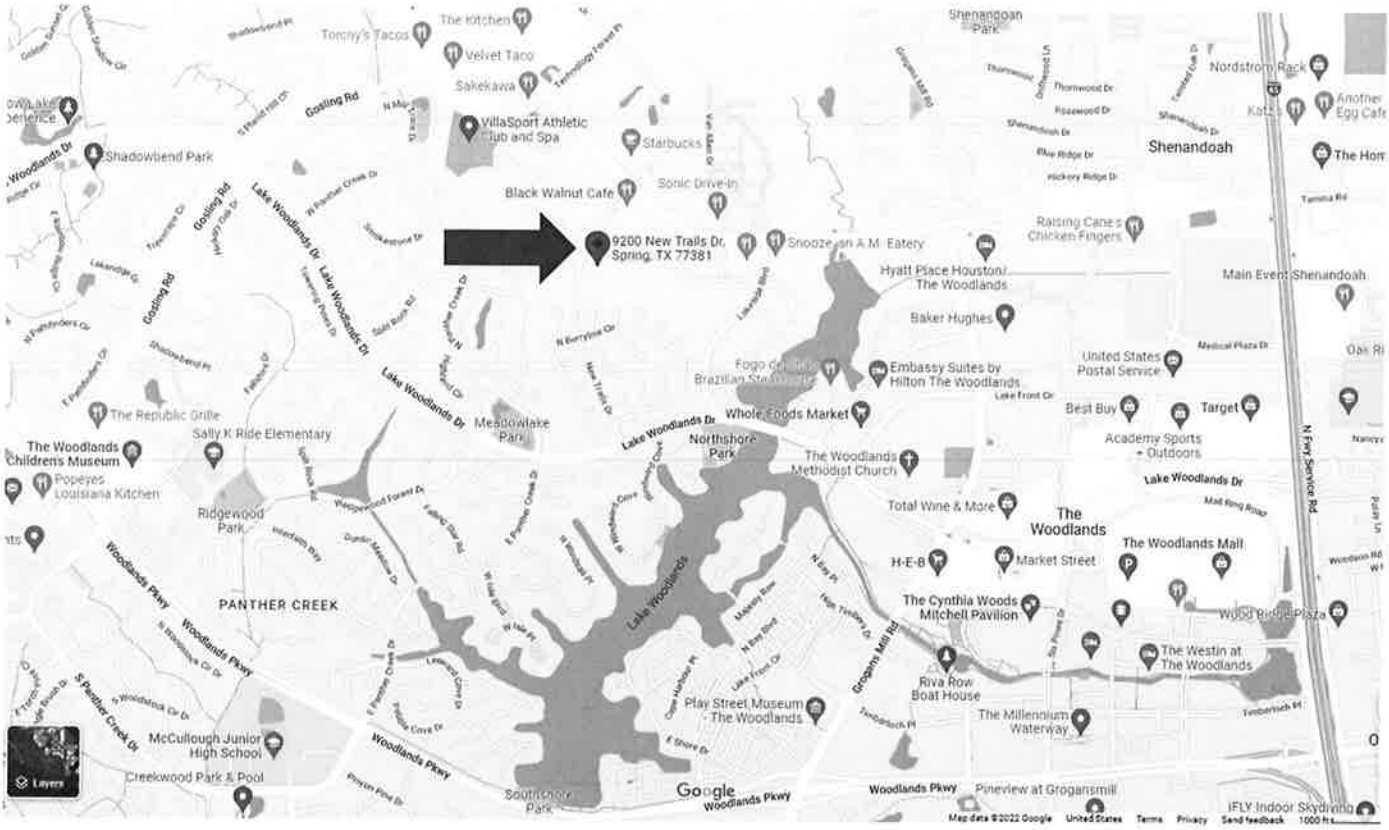
9200 New Trails Dr

Suite 100

The Woodlands, Tx 77381

Phone# 281-364-9509

Fax# 281-364-0984



From I-45 North:

I-45 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 I-45 South:

I-45 North- take the Research Forest exit and turn left, under the highway.
Drive 1.8 miles and turn left onto New Trails Drive (there is a light).
Just beyond the intersection, you will see the parking lot entrance.
The building is on the corner of New Trails Drive and Technology Forest.
We are on the first floor of a brown stucco building.

PATIENT'S PERSONAL MEDICAL HISTORY

LAST NAME: _____ FIRST NAME: _____ MI: _____ AGE: _____ SEX: ☐ M ☐ F

HEIGHT: _____ WEIGHT: _____ Marital Status: SELECT (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: ☐ Y ☐ N
IF YES, WHAT AND HOW MUCH: _____

DO YOU OR HAVE YOU EVER USED ALCOHOLIC BEVERAGES: ☐ Y ☐ N
IF YES, WHAT, WHEN, AND HOW MUCH: _____

DO YOU OR HAVE YOU EVER USED STREET DRUGS: ☐ Y ☐ N
IF YES, WHAT, WHEN, AND HOW MUCH _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐ Y ☐ N
IF YES, PLEASE LIST MEDICATION: _____

LIST ANY CURRENT MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING MILIGRAMS AND FREQUENCY:

_____

_____

LIST ANY SURGERIES WITH DATES:

SURGERY:	DATE:	SURGERY:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT IMMUNIZATIONS/TESTING TO INCLUDE DATE:

PNEUMONIA VACCINE: _____ FLU VACCINE: _____ COLONOSCOPY: _____ MAMMOGRAM: _____ COVID VACCINE: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

(CHECK YOUR ANSWER. IF YES, GIVE DATE OR OCCURRENCE)

STROKE	☐ Y	☐ N	_____	MIGRAINES	☐ Y	☐ N	_____	BLOOD CLOTS	☐ Y	☐ N	_____
ASTHMA	☐ Y	☐ N	_____	TUBERCULOSIS	☐ Y	☐ N	_____	COLITIS	☐ Y	☐ N	_____
BLEEDING TENDENCY	☐ Y	☐ N	_____	THYROID DISEASE	☐ Y	☐ N	_____	BLADDER INFECTION	☐ Y	☐ N	_____
SEIZURES	☐ Y	☐ N	_____	ANXIETY	☐ Y	☐ N	_____	DEPRESSION	☐ Y	☐ N	_____
AIDS AND/ OR HIV	☐ Y	☐ N	_____	DIABETES	☐ Y	☐ N	_____	STOMACH ULCERS	☐ Y	☐ N	_____
KIDNEY DISEASE	☐ Y	☐ N	_____	GLAUCOMA	☐ Y	☐ N	_____	ANEURYSM	☐ Y	☐ N	_____
HIGH BLOOD PRESSURE	☐ Y	☐ N	_____	CHOLESTEROL	☐ Y	☐ N	_____	HIGH FEVER AFTER SURGERY	☐ Y	☐ N	_____
BRAIN TUMOR	☐ Y	☐ N	_____	RHEUMATIC/CONGENITAL HEART	☐ Y	☐ N	_____				
HEPATITIS	☐ Y	☐ N	_____	CANCER/ LEUKEMIA	☐ Y	☐ N	_____				
HEART DISEASE	☐ Y	☐ N	_____								

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

STROKE	☐ Y	☐ N	_____	MIGRAINES	☐ Y	☐ N	_____	BLOOD CLOTS	☐ Y	☐ N	_____
ASTHMA	☐ Y	☐ N	_____	TUBERCULOSIS	☐ Y	☐ N	_____	COLITIS	☐ Y	☐ N	_____
BLEEDING TENDENCY	☐ Y	☐ N	_____	THYROID DISEASE	☐ Y	☐ N	_____	SEIZURES	☐ Y	☐ N	_____
ANXIETY	☐ Y	☐ N	_____	DEPRESSION	☐ Y	☐ N	_____	AIDS AND/OR HIV	☐ Y	☐ N	_____
DIABETES	☐ Y	☐ N	_____	STOMACH ULCERS	☐ Y	☐ N	_____	KIDNEY DISEASE	☐ Y	☐ N	_____
ALZHEIMERS/DEMENTIA	☐ Y	☐ N	_____	ANEURYSM	☐ Y	☐ N	_____	HIGH BLOOD PRESSURE	☐ Y	☐ N	_____
CHOLESTEROL	☐ Y	☐ N	_____	BRAIN TUMOR	☐ Y	☐ N	_____	SUICIDE	☐ Y	☐ N	_____
PROBLEMS/HIGH FEVER AFTER SURGERY	☐ Y	☐ N	_____	RHEUMATIC/CONGENITAL HEART	☐ Y	☐ N	_____				
HEPATITIS	☐ Y	☐ N	_____	CANCER/ LEUKEMIA	☐ Y	☐ N	_____				
HEART DISEASE	☐ Y	☐ N	_____	OTHER?	_____						

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

ASSESSMENT OF BRAIN PATIENT

PATIENT'S NAME: _____ OCCUPATION: _____

IS THE REASON FOR YOUR VISIT A 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: ☐ Y ☐ N

HAVE YOU HAD THIS PROBLEM BEFORE? ☐ Y ☐ N

COMPLAINT:

HEADACHES	☐ Y	☐ N	
VISION	☐ Y	☐ N	
SPEECH	☐ Y	☐ N	
WEAKNESS	☐ Y	☐ N	
NUMBNESS	☐ Y	☐ N	
TINGLING	☐ Y	☐ N	
ARE BLADDER FUNCTIONS NORMAL	☐ Y	☐ N	IF NOT, EXPLAIN: _____
ARE BOWEL FUNCTIONS NORMAL	☐ Y	☐ N	IF NOT, EXPLAIN: _____
ANY CHANGES IN WALKING	☐ Y	☐ N	IF YES, EXPLAIN: _____

HAVE YOU EXPERIENCED RECENT CHANGES IN THINKING? (MEMORY, CONCENTRATION, ATTENTION):

_____

_____

WHAT RECENT TESTING HAVE YOU HAD FOR THE ABOVE SYMPTOMS:

		WHERE:	WHEN:
CT SCAN	☐ Y ☐ N	_____	_____
MRI:	☐ Y ☐ N	_____	_____
MRA/MRV	☐ Y ☐ N	_____	_____
ANGIOGRAM	☐ Y ☐ N	_____	_____
NEUROPSYCHOGY	☐ Y ☐ N	_____	_____

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

B/P: _____ P: _____ R: _____

DESCRIPTION OF ABNORMALITIES:

_____

_____

_____

_____

_____

_____

THE GREATER HOUSTON NEUROSURGERY CENTER, P.A.

TODAY'S DATE: _____

PATIENT INFORMATION

NAME: _____ SEX: ☐ FEMALE ☐ MALE

ADDRESS: _____ DATE OF BIRTH: _____

_____ SS# _____

PREFERRED PHONE# _____ OTHER PHONE# _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME/RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

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

EMPLOYER

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? ☐ Y ☐ N
(PRIMARY CARE PHYSICIAN) **(PLEASE CHECK ONE)**

PLEASE SEND AND ALLOW CORRESPONDENCE TO THE FOLLOWING:

NAME: _____ PHONE: _____
ADDRESS: _____
STREET CITY ZIP

NAME: _____ PHONE: _____
ADDRESS: _____
STREET CITY ZIP

THE GREATER HOUSTON NEUROSURGERY CENTER, PA

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

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

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, TX 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, TX 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 and 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., Robert Borden, P.A., Mary Vollmert, P.A., Dr. Kevin Moran, 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 collections, I agree to pay all cost 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, TX 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, 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 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 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) 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 your 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 you 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 NEUROSURGERY CENTER, P.A.

PATIENT:

_____
Signature

_____
Printed Name

_____
Parent/Legal Guardian of Patient (Print)

_____
Date

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

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____ PATIENT NAME: _____

_____ DATE OF BIRTH:

SOCIAL SECURITY # _____

I, _____ request that you release my medical records to:

The Greater Houston Neurosurgery Center
9200 New Trails Drive Suite 100
The Woodlands, TX 77381
OR
FAX TO 281-364-0984/281-364-7870

(No cover page is necessary if a copy of this release is included.)

Please forward any and all information regarding the examination, treatment, diagnosis and/or prognosis of myself. I understand that this may include information relating to Acquired Immunodeficiency Syndrome (AIDS), infection with HIV (Human Immunodeficiency Virus) and/or treatment of psychiatric conditions, alcohol abuse or drug abuse.

The foregoing authority shall continue in force and effect until revoked by me in writing. A copy of the original hereof shall be as effective as the original.

_____
Patient's Signature

_____
Date

REVIEW OF SYSTEMS

GENERAL

CHILLS	☐ Y ☐ N	FATIGUE	☐ Y ☐ N
FEVER	☐ Y ☐ N	NIGHT SWEATS	☐ Y ☐ N
WEIGHT LOSS	☐ Y ☐ N		

SKIN

RASH	☐ Y ☐ N	LESION	☐ Y ☐ N

HEENT

HEARING CHANGES	☐ Y ☐ N	HEADACHES	☐ Y ☐ N
VOICE CHANGES	☐ Y ☐ N	BLURRED VISION	☐ Y ☐ N
DOUBLE VISION	☐ Y ☐ N		

NECK

NECK PAIN	☐ Y ☐ N	NECK STIFFNESS	☐ Y ☐ N

RESPIRATORY

COUGH	☐ Y ☐ N	DIFFICULTY BREATHING	☐ Y ☐ N
WHEEZING	☐ Y ☐ N		

CARDIOVASCULAR

CHEST PAIN	☐ Y ☐ N	SHORTNESS OF BREATH	☐ Y ☐ N
PALPITATIONS	☐ Y ☐ N	DIFFICULTY BREATHING ON EXERTION	☐ Y ☐ N

GASTROINTESTINAL

NAUSEA	☐ Y ☐ N	ABDOMINAL PAIN	☐ Y ☐ N
VOMITING	☐ Y ☐ N	DIFFICULTY SWALLOWING	☐ Y ☐ N
DIARRHEA	☐ Y ☐ N	CHANGES IN BOWEL HABITS	☐ Y ☐ N
CONSTIPATION	☐ Y ☐ N		

GENITOURINARY

PAINFUL URINATION	☐ Y ☐ N	URGENCY	☐ Y ☐ N
URINARY RETENTION	☐ Y ☐ N	URINARY INCONTINENCE	☐ Y ☐ N

MUSCULOSKELETAL

BACK PAIN	☐ Y ☐ N	BACK STIFFNESS	☐ Y ☐ N
JOINT PAIN	☐ Y ☐ N	JOINT SWELLING	☐ Y ☐ N
LEG WEAKNESS	☐ Y ☐ N	MUSCLE PAIN	☐ Y ☐ N
ARM WEAKNESS	☐ Y ☐ N	MUSCLE WEAKNESS	☐ Y ☐ N

NEUROLOGICAL

DIZZINESS	☐ Y ☐ N	BALANCE ISSUES	☐ Y ☐ N
VERTIGO	☐ Y ☐ N	GAIT ABNORMALITY	☐ Y ☐ N
HEADACHE	☐ Y ☐ N	SEIZURES	☐ Y ☐ N
DECREASED MEMORY	☐ Y ☐ N	NUMBNESS	☐ Y ☐ N
PARESTHESIA(TINGLING/BURNING)	☐ Y ☐ N	TROUBLE WALKING	☐ Y ☐ N
WEAKNESS	☐ Y ☐ N		

PSYCHIATRIC

DISORIENTATION	☐ Y ☐ N	INABILITY TO CONCENTRATE	☐ Y ☐ N
HALLUCINATIONS	☐ Y ☐ N		

HEMATOLOGY

ABNORMAL BLEEDING	☐ Y ☐ N	EASY BRUISING	☐ Y ☐ N

PRINT NAME: _____ DOB: _____ DATE: _____

Medication Contract

I,_____ agree to the following guidelines as part of my treatment for chronic pain with The Greater Houston Neurosurgery Center (GHNC) and the undersigned provider. I understand that medications prescribed may not eliminate my pain but may reduce it and improve my quality of life.

1. I understand that I have the following responsibilities:
    a. I will take medication at the dose and frequency prescribed.
    b. I will not increase or change how I take my medications without the approval of this health care provider.
    c. I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or on weekends.
    Office hours are Monday- Friday 8:00 - 5:00.
    d. I will obtain all refills for medications only at _____ (pharmacy name): _____ (pharmacy address): _____ (pharmacy phone): with full consent for my provider and pharmacist to exchange information in writing or verbally. If it is determined that I am obtaining narcotic medication from sources other than the provider and pharmacy identified herein, I will be discharged from GHNC.

    e. I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications that I am taking.

    f. I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
    h. I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced. I will keep medications only for my own use and will not share them with others. I will keep medications away from children.
    i. I agree to participate in any medical, psychological, or psychiatric assessments recommended by my provider.
    j. I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.

2. I will not use illegal, street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include but are not limited to: 12-step program, securing a sponsor, individual counseling, and inpatient or outpatient treatment.

    a. If in treatment, I will request that a copy of this program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I understand that opioid analgesics could cause chemical dependence. If I suddenly stop or decrease medication, I could have withdrawal smy continuing treatment. symptoms, such as flu-like symptoms, nausea, vomitting, diarrhea, aches, sweats and chills, which may occur within 24-48 hours of the last dose. I understand that opiod withdrawal is quite uncomfortable.

4. I understand that the possible complications of chronic narcotic therapy include:
    a. Chemical dependence (addiction,identified further herein).
    b. Constipation, which could be severe enough to require medical treatment;
    c. Difficulty with urination;
    d. Drowsiness;
    e. Nausea;
    f. Itching;
    g. Slowed respiration;
    h. Reduced sexual function.

5. If I become pregnant, there are known or unknown risks to the unborn child, which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth.

6. I agree and will sign a release if requested to allow GHNC physicians to communicate with my referring physician,primary care physician, and any pharmacists regarding my use of medications.

7. I understand that if I take more medication than prescribed, or if I mix multiple kinds of medication, not prescribed to me a dangerous situation could result, such as coma, organ damage, or even death.

8. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine, saliva or blood is checked to see what drugs I have been taking.

9. I understand that this provider may stop prescribing the medications listed if:
a. I do not show any improvement in pain or my activity has not improved.
b. I develop rapid tolerance or loss of improvement from the treatment.
c. I develop significant side effects from the medication.
d. My behavior is inconsistent with the responsibilities outlined above, which may also result in being prevented from receiving further care from this clinic.

Patient's
Signature: _____ Date: _____

Provider's
Signature: _____ Date: _____