NEUROSURGICAL
AND SPINE
Consultants, P.A.

WELCOME

YOUR APPOINTMENT WITH DR. DIANA WILSON IS SCHEDULED FOR:

DATE: ________________________ TIME: ____________________

Should you need to cancel, please call the office at: 817 576 6500

Your appointment is scheduled at:

□ Neurosurgical and Spine Consultants, P.A.
Dr. Diana E. Wilson
1001 12th Ave, Suite 171
Fort Worth Texas 76104

Clear Fork Trinity River
Forest Park Blvd
30
377
377
30
Pennsylvania Ave
Inside the Texas Oncology Building
Baylor Surgical Hospital
Plaza Medical Center of FW
NSC
12th Ave
9th Ave
8th Ave
Chisholm Trail Pkwy
W Rosedale St
W Rosedale St

It is very important that you bring your MRI or CT films/CD to your appointment. The physician needs this information to best help you at the time of your visit

□ I have brought my MRI or CT films / CD to my appointment

□ I have my MRI or CT films but forgot to bring them

□ I have requested the following practice to send them to this office

□ ____

If you are relying on the facility or another office to send these directly to our practice we ask that you **call 2 days in advance** of your scheduled appointment to confirm that the office has received them.

TYPE OF VISIT:

□ New Patient □ Returning Patient □ Other

□ I have seen Dr. Wilson before at her other practice

□ I have seen Dr. Wilson but it has been two (or more) years ago

□ I have never seen Dr. Wilson

□ I saw or was consulted on by Dr. Wilson in the ER

Please complete the Welcome Packet to the best of your ability. The following information will help in getting insurance authorizations for recommended tests or procedures.

THANK YOU FOR CHOOSING OUR OFFICE. WE WILL WORK HARD TO HONOR YOUR SCHEDULED APPOINTMENT TIME. SHOULD THERE BE ANY DELAYS DUE TO CIRCUMSTANCES BEYOND OUR CONTROL, WE WILL KEEP YOU UPDATED. WE APOLOGIZE FOR ANY AND ALL INCONVENIENCES SUCH INSTANCES MAY CAUSE.

Demographic Information

NAME First Last MI **DOB:** / / **SOCIAL:**

ADDRESS: STREET CITY STATE ZIP

HOME/MAIN PHONE: **CELL/ALT. PHONE:**

E-MAIL:

Connect with our patient portal for convenient balance statements, payments, visit summaries, and more!

Who referred you to our office? Phone:

Who is your primary care doctor? Phone:

EMERGENCY CONTACT: Phone:

Additional Information

□ **MALE** □ **FEMALE** **MARITAL STATUS:** □ **MARRIED** □ **SINGLE** □ **OTHER** (Explain):

RACE: □ **CAUCASIAN** □ **BLACK** □ **HISPANIC** □ **ASIAN** □ **NATIVE AMERICAN** □ **OTHER**

ETHNICITY: □ **HISPANIC** □ **NON-HISPANIC/NON-LATINO**

LANGUAGES SPOKEN: □ **ENGLISH** □ **SPANISH** □ **OTHER:**

OCCUPATION: **EMPLOYER:**

Insurance Information

PRIMARY INSURANCE:

ID NUMBER: **GROUP NUMBER:**

COPAY: $ / % POLICY HOLDER DOB OF POLICY HOLDER

SECONDARY INSURANCE:

ID NUMBER: **GROUP NUMBER:**

COPAY: $ / % POLICY HOLDER DOB OF POLICY HOLDER

Besides regular mail, I authorize NASC to contact me by the following methods: (please check boxes)

□ **CELL PHONE** □ **TEXT MESSAGING** □ **HOME PHONE** □ **E-MAIL** □ **PATIENT PORTAL**

1. PATIENT/GUARANTOR SIGNATURE: DATE:

Release of Information of Others (HIPAA)

I acknowledge that I have received a copy of "Notice of Privacy Practices". I authorize Neurosurgical and Spine Consultants, P.A. and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

□ **ALL INFORMATION** including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

□ **No one except the patient can obtain information.**

To whom can we release information (please list names):

NAME:____

RELATIONSHIP:____

PHONE:____

NAME:____

RELATIONSHIP:____

PHONE:____

I understand that I have the right to revoke this authorization at any time. I understand that all changes to permissions relating to my account must be done in writing and will not apply to information already released per this authorization.

2.____ ___________________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

Treatment Consent & Authorization

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I hereby authorize Neurosurgical and Spine Consultants, P.A. to furnish to any designated attorney or insurance Company all information necessary to file a health insurance claim form, or to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Neurosurgical and Spine Consultants, P.A.*

I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Neurosurgical and Spine Consultants, P.A. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by Neurosurgical and Spine Consultants, P.A.

The foregoing information is true and correct to the best of my knowledge. I authorize Neurosurgical and Spine Consultants, P.A. to provide medical treatment to me in the office or in the hospital.

3.____ ___________________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

Financial Policy

Neurosurgical and Spine Consultants, P.A. requires payment in full for any amounts that are the patient's responsibility at the time services are rendered. This includes co-pays, co-insurance, and/or deductible amounts. Once your claim is processed by your insurance company, any additional amounts owed will be billed to you. If the patients estimated amount due results in an overpaid claim, then a refund will be processed once all claims are settled and there is no additional amounts owed by the patient.

You are responsible for knowing the specific rules of your insurance carrier. **If your insurance carrier requires a referral, it is your responsibility to work with your primary care physician to obtain this referral prior to your scheduled appointment.** If we do not have your referral number the day prior to your appointment, then you will be contacted to reschedule your appointment. *If you see our physician without a valid referral, then all charges will be the responsibility of the patient.*

Neurosurgical and Spine Consultants, P.A. does not accept Letters of Protection and we do not file claims with automotive insurance companies.

Failure to provide your current insurance information prior to the services rendered may result in denial of your claim. We assist our patients in receiving reimbursement from your insurance company, however please understand that you, the patient, have the final responsibility for your bill.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Neurosurgical and Spine Consultants, P.A.

I have read and understand the Neurosurgical and Spine Consultants Financial Policy. My signature indicates compliance and understanding of this policy.

4.____ ______________________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

Privacy Policy

THIS NOTICE DESCRIBES YOUR HEALTH RECORD/INFORMATION, YOUR HEALTH INFORMATION RIGHTS, AND OUR RESPONSIBILITIES IN REGARDS TO YOUR HEALTH RECORD/INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals you contribute to your care. Understanding what is in you record and how your health information is used helps to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment, and healthcare operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonably copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment if we determine that the subject of the protected health information or record:
    - was not reacted by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment.
    - is not part of your medical or billing records.
    - is not available for inspection as set forth above.
    - is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.

6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment, and healthcare operations as provided above
    - to persons involved in your care or for the notification purposes as provided by law
    - to correctional institutions or law enforcement officials as provided by law
    - for national security or intelligence purposes
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003)
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals).
    - made to patient or their personal representatives.
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained in the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI.**

Further information on how this organization may use and/or disclose your medical information may be requested at any time.

Our Responsibilities

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except for as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

I have read and understand the Neurosurgical and Spine Consultants Privacy Policy. My signature indicates acknowledgement and agreement to this policy.

5.____ _____________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

Reason for Visit

I ____________________________________ am here to see Dr. Wilson to address the following issue:

____

Treatments & Tests

Please look over the following and note those treatments you have used for your present condition and whether or not the treatment has provided relief.

Treatment	Facility/Doctor	# of visits	Helpful?	When?
Physical Therapy				
Hot/Ice packs, Massage, Muscle stimulation, etc.				
Chiropractic Adjustment				
Acupuncture				
Epidural Injection				
TENS Unit				
Pain Medicine *(if narcotics, list the providing doctor)*				
Brace				

Please mark which of the following tests you have undergone for your present condition. Please bring the results and a CD copy of any of the imaging done that you've had **within the last 6 months**.

Test	Date of Test	Location of testing (Body site)
X-Ray		
CAT Scan (CT-Scan)		
MRI		
Myelogram		
EMG (needle test)		
Discogram		
Bone Density		

Problem History

Have you had back or neck problems before? **Yes** **No**

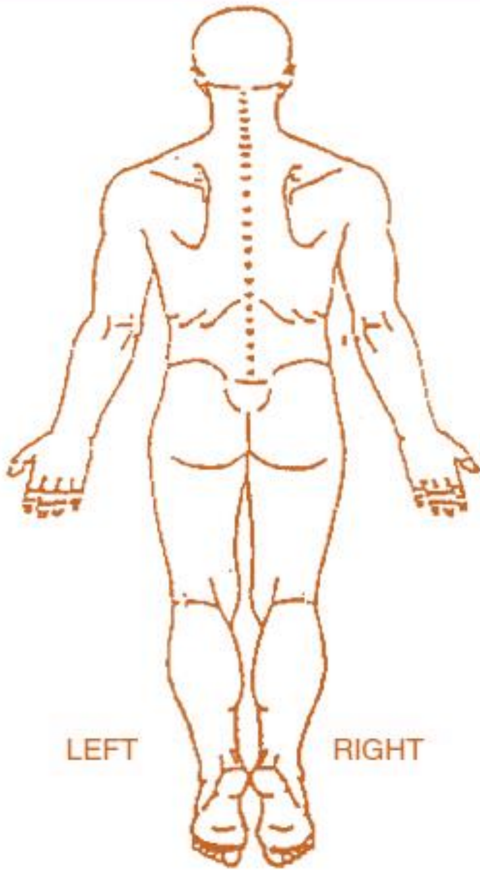
If yes, please describe: ____

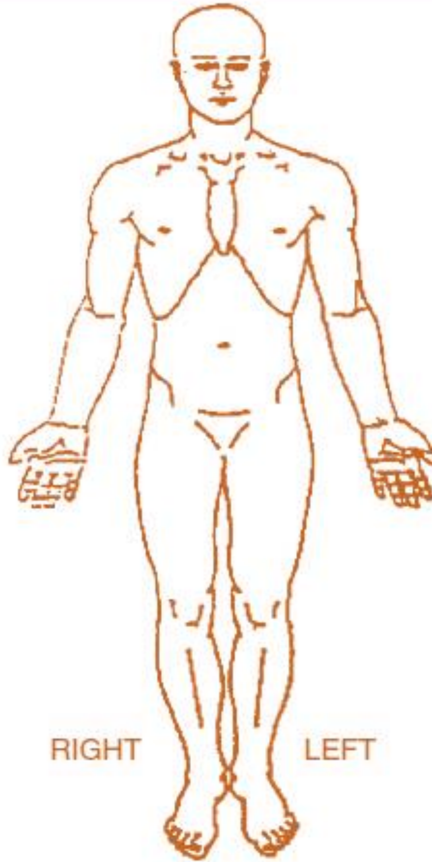
If you've had previous episodes did they cause any of the following? (Please Circle)

Back Pain	Low	Middle	Upper
Neck Pain	Right	Left	Whole Neck
Leg Pain	Right	Left	Both
Arm Pain	Right	Left	Both

Pain & Quality of Life

NUMBNESS	BURNING	ACHING	PINS/NEEDLES	STABBING
:::::::::::::::::::	~~~~~~~	OOOOO	########	////////





Use the appropriate marks on the illustration to describe **where** and **how** you hurt.

Example:
If you're the back aches and your left leg is numb, use the dots ::: on the thigh and the open circles OO on the back to show where.

How would you describe your current pain ratio? (Please check ✓ the appropriate ratio)

BACK PAIN VS. LEG PAIN				NECK PAIN VS. ARM PAIN			
✔	% BACK PAIN	OVER	% LEG PAIN	✔	% NECK PAIN	OVER	% ARM PAIN
	100%		0%		100%		0%
	75%		25%		75%		25%
	50%		50%		50%		50%
	25%		75%		25%		75%
	0%		100%		0%		100%

On a scale of 0 to 10 with 10 being the worst how would you rate your pain?

Today: ____________

Best day: ___________

Worst day: __________

Pain and Quality of Life

Please mark how your pain has affected your ability to perform the following daily activities during the **last four weeks.**

DRESSING (check one box)	SLEEPING (check one box)
☐ I can usually dress myself without pain. ☐ I can dress myself without increasing pain. ☐ I can dress myself but pain increases. ☐ I can dress myself but have significant pain. ☐ I can dress myself but with very severe pain. ☐ I cannot dress myself.	☐ I sleep well. ☐ Pain occasionally interrupts my sleep. ☐ Pain interrupts my sleep half of the time. ☐ Pain often interrupts my sleep. ☐ Pain always interrupts my sleep. ☐ I never sleep well.
LIFTING (check one box)	SOCIAL & RECREATIONAL LIFE (check one box)
☐ I can lift heavy objects without pain. ☐ I can lift heavy objects but it is painful. ☐ Pain prevents me from lifting heavy objects, but I can manage if they are on a table. ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects if they are on a table. ☐ I can only lift light objects. ☐ I cannot lift anything.	☐ My social & recreational life is unchanged. ☐ My social & recreational life is unchanged but increases my pain. ☐ My social & recreational life is unchanged, but severely increases my pain. ☐ Pain has restricted my social & recreational life. ☐ Pain has severely restricted my social and recreational life. ☐ I essentially have no social & recreational life because of pain.
WALKING (check one box)	TRAVELING (check one box)
☐ Pain does not prevent me from walking. ☐ Pain prevents me from walking more than 1 hour. ☐ Pain prevents me from walking more than 30 minutes. ☐ Pain prevents me from walking more than 10 minutes. ☐ I can only walk a few steps at a time. ☐ I am unable to walk.	☐ I can travel anywhere. ☐ I can travel anywhere but it causes pain. ☐ Pain is bad but I can manage travel over 2 hours. ☐ Pain restricts me to trips of less than 1 hour. ☐ Pain restricts me to trips of less than 30 minutes. ☐ Pain prevents me from traveling.
SITTING (check one box)	SEX LIFE (check one box)
☐ I can sit in any chair as long as I like. ☐ I can only sit in a special chair for as long as I like. ☐ Pain prevents me from sitting for more than 1 hour. ☐ Pain prevents me from sitting for more than 30 minutes. ☐ Pain prevents me from sitting more than a few minutes. ☐ Pain prevents me from sitting at all.	☐ My sex life is unchanged. ☐ My sex life is unchanged but occasionally causes some pain. ☐ My sex life is nearly unchanged but is very painful. ☐ My sex life is severely restricted by pain. ☐ My sex life is nearly absent because of pain. ☐ Pain prevents any sex life at all.
STANDING (check one box)	PAIN INTENSITY (check one box)
☐ I can stand as long as I want. ☐ I can stand as long as I want but occasionally will cause some pain. ☐ Pain prevents me from standing for more than 1 hour. ☐ Pain prevents me from standing more than a few minutes. ☐ Pain prevents me from standing at all.	☐ I can tolerate the pain I have without having to use any pain killers. ☐ The pain is bad, but I manage without taking pain killers. ☐ Pain killers provide complete relief from pain. ☐ Pain killers provide moderate relief from pain. ☐ Pain killers provide very little relief from pain. ☐ Pain killers have no effect on the pain, and I do not use them.

Pharmacy Information

Pharmacy:______________________________ Phone:______________________________________

Please try to handle all refill requests at the time of your visit whenever it is possible. It is the patient's responsibility to know when their prescription is about to run out. A good rule of thumb is to always reserve a week's supply in a separate pill box or dispenser.
Please be aware; medication refill requests are addressed during normal business hours (Monday through Thursday 8:30-4:30, Friday 8:30-3:30), have a seven (7) day turnaround time and must be handled through your pharmacy.

I have hereby state my understanding of Neurosurgical and Spine Consultants, P.A. medication policy.

6.____ ___________________________________
SIGNATURE OF PATIENT/GUARDIAN DATE

Medication Allergies

□ **NO KNOWN DRUG ALLERGIES**

□ **NO OTHER ALLERGIES** (latex, contrast or adhesives...)

□ **YES I HAVE KNOWN DRUG ALLERGIES** (Please list name and symptoms)

1.______________________________ ____
DRUG NAME SYMPTOMS

2.______________________________ ____
DRUG NAME SYMPTOMS

□ **YES I HAVE OTHER ALLERGIES TO THINGS LIKE LATEX, CONTRAST OR ADHESIVES** (Please list name and symptoms)

1.______________________________ ____

2.______________________________ ____

Current Medications

List all the medications you are currently taking. (INCLUDING VITAMINS AND OTCS)

Name	Dose	Frequency	Reason Prescribed
1.			
2.			
3.			
4.			
5.			

*You may continue to write on back of this page or provide a current medication list to the front desk.

Review of Systems

Does the patient currently have any of these issues? **PLEASE CIRCLE YES OR NO**									
CONSTITUTIONAL	Fatigue	NO	YES	Fever/Chills	NO	YES	Weight Loss/Gain	NO	YES
NEUROLOGIC	Seizures	NO	YES	Dizziness/Vertigo	NO	YES	Headaches	NO	YES
MUSCULOSKELETAL	Joint Pain	NO	YES	Back/Neck Pain	NO	YES	Morning Stiffness	NO	YES
SKIN	Rash	NO	YES	Ulcers/Lesions	NO	YES			
PULMONARY	Short of Breath	NO	YES	Wheezing	NO	YES	Cough	NO	YES
CARDIOLOGY	Chest Pain	NO	YES	Palpitations	NO	YES	Irregular Heart Beat	NO	YES
	Swelling	NO	YES						
GASTROINTESTINAL	Diarrhea	NO	YES	Nausea/ Vomiting	NO	YES	Abdominal Pain/ Blood in Stool	NO	YES
GENITOURINARY	Frequent Urine	NO	YES	Pain Urinating	NO	YES	Burning with Urination	NO	YES
EYES/EARS/NOSE	Nasal Drainage	NO	YES	Change of Vision	NO	YES	Loss Of Hearing	NO	YES
MOUTH AND THROAT	Sore Throat	NO	YES	Tooth Ache	NO	YES			
HEMATOLOGIC	Easy Bleeding	NO	YES	Easy Bruising	NO	YES			
PSYCHIATRIC	Anxiety	NO	YES	Depression	NO	YES			

If you checked yes to any of the above, are you under treatment for this issue with a physician? Yes No

If so, who is the physician treating you? ____

Family and Social History

□ **RIGHT HANDED** □ **LEFT HANDED** □ **HEIGHT** ____________ □ **WEIGHT** ______________

ALCOHOL INTAKE: (Please circle those that apply to you) **NEVER DRINK** **DRINK OCCASIONALLY** **DRINK DAILY**

What do you drink? **WINE** **BEER** **LIQUOR**

Do any family members with an alcohol history? □ **YES** □ **NO**

SMOKING HISTORY: Do you smoke currently? □ **YES** □ **NO** How long? ________ ________ packs/day

Are you a former smoker? □ **YES** □ **NO** When did you quit? __________

How many years did you smoke? ______ years

BLOOD PRODUCTS: Do you have any objections to receiving blood or blood products? □ **NO** □ **YES**

DRUG USAGE: Do you now or have you ever used drugs? □ **NO** □ **YES**

Please explain: ____

Past Medical and Family Social History

Has the patient or family member ever been diagnosed with any of the following medical conditions?

	Family Members	Patient (self)	If yes to any, please explain.
Heart Disease (CAD)	No Yes	No Yes	
Diabetes	No Yes	No Yes	
Stroke	No Yes	No Yes	
Cancer	No Yes	No Yes	
Coagulation Defects		No Yes	
DVT (Blood Clots) in legs		No Yes	
Anemia		No Yes	
Hepatitis / HIV		No Yes	
High Blood Pressure		No Yes	
Kidney Disease		No Yes	
Lung Disease or Asthma		No Yes	
Sleep Apnea		No Yes	
Stomach Ulcers		No Yes	
Colitis		No Yes	
Rheumatoid /Osteoarthritis		No Yes	
Lupus		No Yes	
Epilepsy or History of Seizures		No Yes	
Depression /Anxiety Disorders		No Yes	

If you checked yes to any of the above for yourself/ the patient, is treatment being provided by a physician?
□ **No** □ **Yes**

If so, who is the physician?

____

Neurosurgical History

If you've had previous neck or back surgery, please fill out the following as best as possible to avoid any issues regarding your care.

Procedure	Date	Surgeon

What were your symptoms prior to your last surgery? ______________________________

____

Did you improve after your last surgery? ______________________________

How long were you better after your surgery? ______________________________

Past Hospitalizations & Surgeries

PRIOR HOSPITALIZATIONS

Please list any hospitalizations you have had:

Hospital: ______________________________ Reason: ____________________ Date: ________

Hospital: ______________________________ Reason: ____________________ Date: ________

Hospital: ______________________________ Reason: ____________________ Date: ________

Hospital: ______________________________ Reason: ____________________ Date: ________

PRIOR SURGERIES

Please list any other surgeries you have had:

Surgery: ______________________ Surgeon: _______________________ Date: ________

Surgery: ______________________ Surgeon: _______________________ Date: ________

Surgery: ______________________ Surgeon: _______________________ Date: ________

Notice of Completion

I, ______________________________________, hereby state that all of the enclosed information is correct and that I have completed this form to the best of by ability and knowledge.

7.____ ____________________________________

SIGNATURE OF PATIENT/GUARDIAN DATE

Staff Only

I have reviewed the listed ROS/PFSH/Screening with the patient and noted the positive/negative findings for this visit.

Staff Member Sign: ______________________________ Date: ______________________________