Dear Patient,

Thank you for choosing us to help you improve your condition whether it requires surgery or not. Please keep or print this page for your records.

While Dr. Dickerman will be in charge of your specific health and surgical care, they may call on Aimi Dalness PA-C, Shelby Elder DC-RN or MA Julie Williamson to assist with your clinical, pre-operative or postoperative care.

On rare occasion, our providers have emergency patient situations that may affect their existing clinic or surgery schedules. Our office will do everything possible to accommodate any changes in schedules and provide you with options on accommodating these changes.

Our goal is to provide you with the best possible neurosurgical care in the nation and we take pride in our results from the initial visit through the postoperative period. If there are ever any questions, we are available through our office phone number at **(972) 238-0512**, email **(neurotexas@gmail.com)**, text message at **(785) 428-0924** or 24-hour emergency line by requesting the answering service be paged through our office phone number. At any point in time, you feel your care is less than our best, please request to have your message sent to or request to speak with Julie Williamson directly.

There's a reason we see patients from around the world, it's our team approach. Should you need to contact us, please save this page for your records with our contact options.

Thank you for your choice in choosing us for your care.

NEW PATIENT DEMOGRAPHICS

Patient's Name:_____D.O.B.:___/___/_____
Address:_____ City:_____ State:_____ Zip:_____
Cell#:_____ Home#:_____ SSN:_____-_____-_____
Email Address:_____
Emergency Contact:_____Phone#:_____

PRIMARY INSURANCE

Insurance Company Name:_____Phone#:_____

Address for Claims:_____

Member ID _____ Group Number _____

Policy Holder Name:_____ SSN:_____-_____-_____D.O.B.:___/___/___

SECONDARY INSURANCE

Insurance Company Name:_____Phone#:_____

Address for Claims:_____

Member ID _____ Group Number _____

Policy Holder Name:_____ SSN:_____-_____-_____D.O.B.:___/___/___

Do you have Medicaid, Molina or Marketplace in any capacity? _____

WORKERS COMPENSATION

A worker's compensation appointment must be disclosed a the time of scheduling and must remain within its compensatory limitations. Please complete only if relevant to appointment.

Date of Injury: ___/___/_____ Claim#:_____
Work Comp Insurance Co.:_____ Adjustor's #:_____
Claims Address:_____
Phone#:_____Fax#:_____
Employer at Time of Injury:_____ Supervisors Name:_____
Employer:_____Phone#:_____

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage. The afore mentioned patient requests that payment of authorized Medicare/other insurance company benefits be made on my behalf to one of the following physicians that treated my condition: Rob D. Dickerman, D.O., Ph.D., Aimi Dalness PA-C or Shelby Elder DC. For any services furnished me by that party who accepts assignment regulations pertaining to Medicare/other insurance company benefits apply. I authorize any holder of medical or other information about me, be release to the social security administration, healthcare financing administration, Intermediaries, any other insurance company or carrier of any information needed for this, or a related Medicare/other insurance company claim. I understand my signature requests that

payments be made and authorizes release of medical information necessary to pay the claim if item 9 of hcfa-1500 is completed, my signature releasing of the information to the insurer or agency shows in Medicare/other insurance company assigned cases, physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge and the patient is responsible only for deductible coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/other insurance company.

Financial Policy for the Office of NeuroTexas

Thank you for choosing us as one of your healthcare providers; we are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we request you read and sign. All patients are required to complete this information prior to seeing the physician. Copayment is due at time of service. We accept Cash, Checks, HSA, Visa, Mastercard, Discover and American Express.

Regarding Insurance:

We may accept assignment of insurance benefits after your visit. However, we do require your copayment to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We will file your private insurance as a courtesy for all patient procedures. We cannot bill your insurance company unless you bring all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

In the event your insurance company has not paid the balance in 45 days, it will be automatically transferred and billed directly to you.

We are Medicare providers and contracted with several HMO's and PPO's. We do file insurance for those carriers; however, you will be responsible for your deductible and coinsurance. Please give your insurance card(s) to the receptionist so we may copy the card and a picture ID so as to help us file the claim.

All debts that exhausted insurance collection and that are greater than 120 days will be turned over to a collection agency unless arrangements with this office have been made.
Thank you for understanding our financial policy. Please let our staff know if you have any questions or if we can help you understand your insurance carrier's paperwork.

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

Please request a list of our practices and practitioner's financial disclosure interests form at the front desk if you would like one provided to you.

I have read and understand the financial policy for this office and agree to adhere to this policy.

_____ _____ _____

Printed Name Patient Signature Date

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, NeuroTexas, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I have been provided with a notice of privacy practice that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices prior to implementation will mail a copy of any revised notice to the address I have provided upon request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations to insurance providers, referring practices, internal staff, hospital staff, ordering facilities.

This consent is given freely with the understanding that:

1. I have the right to revoke this consent, in writing, except where disclosure has already been made in reliance on my prior consent.
2. Any and all records, whether written, oral and in electronic format will not be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
3. A photocopy or fax of this consent is as valid as this original.

I have read & understand the policy for this office & agree to adhere to it.

_____ _____ _____

Printed Name Patient Signature Date

Any non-medical person whom you would like your personal health information released to?

Name: _____ Relation: _____Contact: _____

Name: _____ Relation: _____Contact: _____

Patient Consent for Use of Email Communication

To better serve our patients, this office has established an email address for added forms of communication. For routine matters that do not require immediate response, please feel free to contact us at neurotexas@gmail.com. Please remember however, that this form of communication and communication to individual office staff email is not appropriate for use in an emergency. The turnaround time for routine patient communications is 48 hours.

When sending messages via email or text, please put the subject of your message, name and date of birth so we can return the message more efficiently with an appropriate response.

We may use multiple non-encrypted platforms to communicate with you or your approved care team relating to diagnosis and treatment with this given permission. This office is dedicated to keeping your medical record information secure with our best efforts. All email servers, EMR and cell phone use have password access protection security.

I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are subject to the use of these written communication platforms. This is release that you indicate that you are accepting and acknowledge non-password protected correspondence with our staff and clinical team.

I understand and agree to the above email and text message policy. By signing below, I agree that we may send medical related correspondence to me via text or email unless explicitly stated in which I will only receive communication and medical care through the use of The Athena One Patient Portal

I have read & understand the policy for this office & agree to adhere to it.

_____	_____	_____
Printed Name	Patient Signature	Date

******PLEASE NOTE FMLA AND SHORT-TERM DISABILITY PAPERWORK WILL ONLY BE COMPLETED FOR SURGICAL PATIENTS. THIS PAPERWORK WILL REQUIRE 5-7 BUSINESS DAYS UPON RECEIPT FOR COMPLETION. WE CANNOT COMPLETE LONG TERM DISABILITY PAPERWORK. THE IS A $40 FEE ASSOCIATED WITH THE COMPLETION OF APPROVED PAPERWORK******

I have read & understand the policy for this office & agree to adhere to it.

_____ _____ _____

Printed Name Patient Signature Date

Patient Agreement for Controlled Substance Medication

To ensure these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled substance medication. If the prescription or medication is lost, misplaced, stolen, or I use it up sooner than prescribed, I understand that it will not be replaced. _____ **Initial**
2. My pain medication may need to stay with my current pain management provider or physician that is regularly prescribing as NeuroTexas does not provide any long-term pain medication. This may inhibit me from getting medication during my NeuroTexas visit. _____ **Initial**
3. I agree to use one and only one pharmacy per DEA guidelines.
4. I understand that if I violate any of the above condition or refuse to take any necessary drug test at my physician's request, my controlled substance prescription and treatment by NeuroTexas, may be ended immediately. _____ **Initial**

If the violation involves obtaining controlled substances from another individual as described above, I may also be reported to my primary care physician, local medical facilities, and other authorities.

I have been informed by my physician the risks with the use of controlled substances.

_____ _____ _____

Printed Name Patient Signature Date

**Narcotic effects, including normal physiologic effect of tolerance (need for more medicine to achieve pain relief), dependence (withdrawal will occur if I stop the medicine abruptly), and addiction (abnormal physiological dependence), which is rare in patients with pain. Withdrawal can be a consequence of overuse, and oftentimes can be unpleasant (e.g. nausea, vomiting, diarrhea, sweating, rapid pulse, etc.) Controlled substance medications (narcotics) can be very useful but have high potential for misuse and abuse and are closely controlled by the local, state, and federal governments. Used properly, they are very effective pain medications. However, if used excessively they can cause adverse effects such as vomiting, constipation, lethargy, liver, and kidney failure, or even death.

Cancellations, Missed Appointments or No-Show Policy

A cancellation, missed appointment or no show with Dr. Dickerman with less than 24 hours' notice can result in a non-refundable fee of $75 that will be applied to your account. A cancellation missed appointment or no show with Dr. Elder or Aimi with less than 24 hours' notice can result in a non-refundable fee of $50 that will be applied to your account.
Cancelling an injection with less than 24 hours' notice can result in a non-refundable $150 fee that will be applied to your account.

Please check with our staff to ensure that your best contact number is on file with us so that you may receive automated call and text reminders for your appointments.

Consent for Non-Physician Care

This facility has on staff physician assistants, registered nurses, medical assistants, and designated health professionals to assist in the delivery of medical care specially trained br Dr. Rob Dickerman. These team members are not medical doctors. They may have graduate education, certified training, specialty training, and state training. All are under the supervision of Dr. Rob Dickerman specifically for every patient care case and need. These medical care personnel can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at in office procedures, surgery or injections
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals
- Providing wound care
- Administering injections when approved by physician

I have read the above, and hereby consent to the services from a designated health care professional or NeuroTexas under the supervision of Dr. Rob Dickerman for my health care needs. I understand that at any time I can refuse and request to see the physician directly.

_____	_____	_____
Printed Name	Patient Signature	Date

*Referring Source:_____
*Primary Care Physician:_____
*Pharmacy Name & Phone#:_____

Today's Date:____/____/_____

Patient Name:_____

Date Of Birth: _____/_____/_____ Age:_____

Circle One: Female Male Height:_____ Weight:_____

#1 Complaint and what do you want to happen as a result of this visit?

_____
_____
_____

Are you currently involved in a legal case regarding your back pain? Yes No
Is your pain associated with a Motor Vehicle Accident? Yes No
Is your pain associated with an AT WORK injury? Yes No If yes, when was date of incident. _____

Factors of Complaint

How & when did your problem begin? (Please mark each answer that applies to your back/neck pain):

____ I do not know how it began
____ I have had it a long time (about ____ years)
____ Injury (Date Of Injury) _____ / _____ / _____
____ It comes and goes
____ On the Job Injury
Explain how the injury happened: _____

Do you have any allergies?

_____

Medications

List ALL medication that you are taking, including prescriptions, over the counter, and herbals.

Medication Name	Reason Taken	Prescribing Doctor
_____	_____	_____
_____	_____	_____

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please indicate if you had any of the following tests performed. (circle answer)

X-Rays: No Yes **MRI**: No Yes **Nerve Test:** No Yes

Myelogram: No Yes **Discogram:** No Yes **CT**: No Yes

Other Providers

Pain Management _____
Neurologist _____
Cardiologist _____

Family Medical History

Please check this line if you do not know past family medical history. _____
My mother is alive & is _____ years old. She is in good health _____ She suffers with _____ My mother is deceased at the age of _____ due to _____.
My father is alive & is _____ years old. He is in good health _____ He suffers with _____ My father is deceased at the age of _____ due to _____.
I have _____ living brothers / sisters
I have _____ deceased brothers / sisters
Cause(s): _____
Members of my family (parents, siblings, grandparents, aunts/uncles) suffer with the following.

_____ _____
_____ _____
_____ _____
_____ _____

Social History

What is the highest grade or level of education completed? _____

Are you currently in school: _____ Are you currently employed: _____

What is your occupation: _____ Who is your employer: _____

Are there any occupational health risks where you work: _____

Are you able to care for yourself: Yes No

Do you have difficulty seeing: Yes No

Do you have serious difficulty hearing: Yes No

Do you have difficulty doing errands alone: Yes No

Do you have difficulty concentrating or making decisions: Yes No

Do you have difficulty walking or climbing stairs: Yes No

Do you have difficulty dressing or bathing: Yes No

Are you able to walk without restrictions Yes No

How far can you walk without pain? _____ Blocks / Miles

Do you have transportation difficulties Yes No

Do you or have you ever smoked tobacco: Yes No

Active Smoker _____ Packs per day Former Smoker: Quit _____

Do you use any other forms of tobacco or nicotine: Yes No

What is your level of alcohol consumption: Never Occasional Daily

How many times per week do you consume alcohol: _____ times per week

Do you use any illicit or recreational drugs: Yes No

Have you traveled abroad within the past Month: Yes No

Gender Identity and LGBTQ Identity

I Gender Identify as:	Male	Female	Other	Non-Disclosed
Assigned sex at birth:	Male	Female		
Pronouns:	he/him	she/her	they/them	
First name used:	_____			
Sexual orientation:	Straight	Homosexual	Non-Disclosed	

Marital Status: Married Single Separated Widow/Widowed Divorced

Previous Surgical History

Have you had spine surgery? _____ IF YES, complete the following:

Type of surgery: (Most recent)_____

When:_____ Surgeon:_____

Did it help your pain? Yes No

Please list **ANY** additional Surgeries

_____ Implants? YES NO

_____ Implants? YES NO

_____ Implants? YES NO

_____ Implants? YES NO

Past / Current Medical History

*Circle all the conditions below that you currently have or have had previously:

AIDS/HIV	Hepatitis	Anemia	High Blood Pressure
Aneurysm	Angina	Anxiety	Hyperlipidemia
Hypertension	Depression	Hypogonadism	Hyperthyroidism
Arthritis	Asthma	Kidney Disease	Liver Disease
MRSA	Brain Tumor	Bleeding Disorder	Menstrual Problems
Cancer	Meningitis	Cerebral Palsy	Multiple Sclerosis
Neck injury	Cirrhosis	Chronic Bronchitis	Colon Problems
Neuropathy	Diabetes	Neuro Problems	Obesity
Osteoporosis	PTSD	Duodenal Problems	Emphysema
Parkinson's	Epilepsy	Sexual Difficulty	Head Injury
Thyroid Disorder	Headaches	Tuberculosis	Heart Attack
Heart Murmur	Varicose Veins	Vitamin D Deficiency	

Other(s) _____

Pain Scale

Do you have any chronic problems we should be aware of? _____

_____

Write in the number 0-10 to indicate each area of pain. 0 – No Pain 10 – Most Severe Pain.

Pain in Lower Back _____ Pain in Neck _____

Pain in Middle Back _____ Pain in Head _____

Pain in Arms _____ Right Arm Left Arm Both Arms

Pain in Legs _____ Right Leg Left Leg Both Legs

Bladder control:	No problem	Cannot empty bladder	Loss of control
Bowel control:	No problem	Constipation	Loss of control

Do you have weakness in?	Arms	Hands	Legs	Feet	None
Do you have numbness in?	Arms	Hands	Legs	Feet	None
Do you have tingling in?	Arms	Hands	Legs	Feet	None

Is your pain worse at night?	YES	NO
Does your pain awaken you from sleep?	YES	NO
Does coughing affect your pain?	YES	NO
Do your legs tire/hurt if you walk too far?	YES	NO
Does resting your legs relieve the pain?	YES	NO
Does bending forward relieve the pain?	YES	NO

Circle if **ANY** of the below **HELP** your pain.

Sitting	Standing	Walking	Lying Down	Heat
Cold	Massage	Physical Activity	Rising from Chair	

Alternative Treatments

We need to know if you received any of the below treatments for your CURRENT pain.

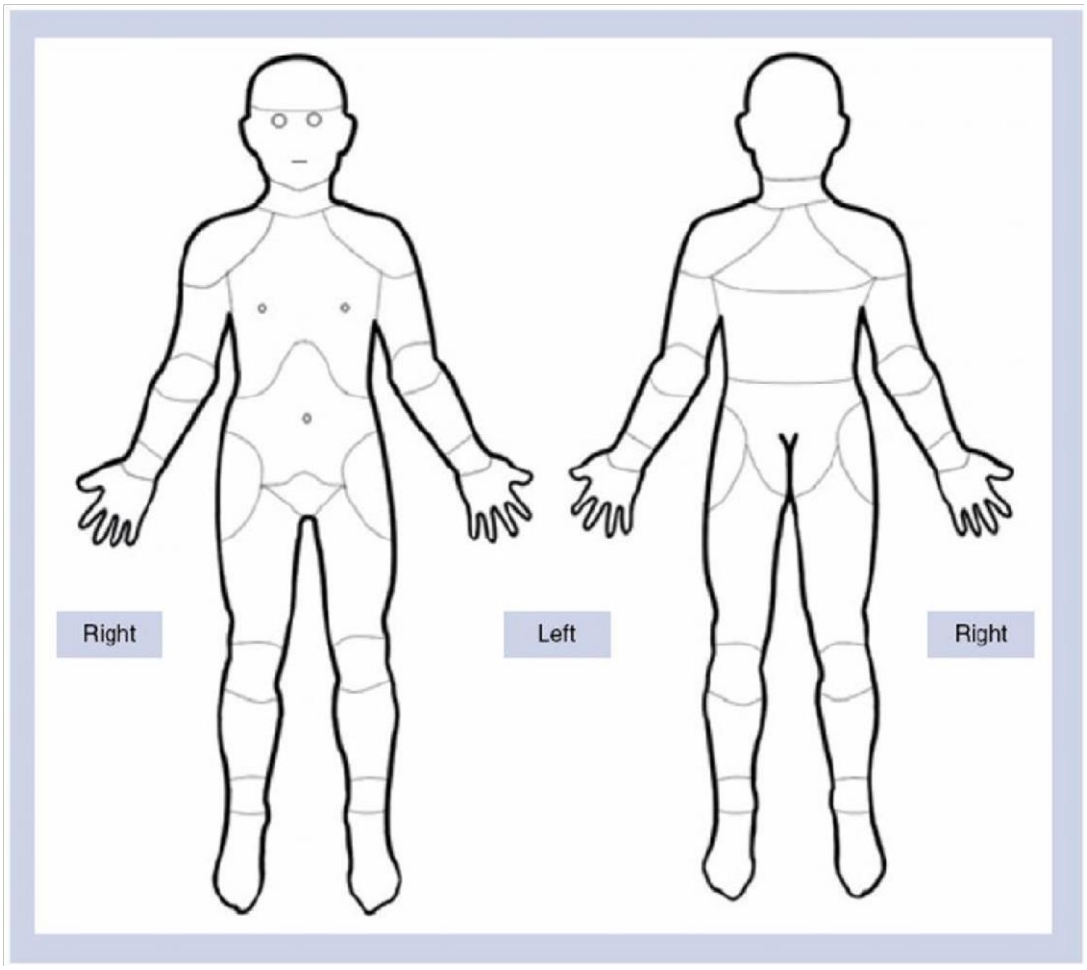
Physical Therapy	Chiropractic Care	Spinal Injections
Steroid Injections	Prescription Medication	OTC Medication
Psychological Consultation	Ice / Heat	Other_____

At home remedies attempted _____

PAIN DIAGRAM

Please Mark the area of injury or discomfort on the chart below, using the appropriate symbols.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - -	o o o o o o o o	^ ^ ^ ^ ^ ^	x x x x x x	/ / / / / / / /
- - - - - - - -	o o o o o o o o	^ ^ ^ ^ ^ ^	x x x x x x	/ / / / / / / /



Patient Name: _____ Today's Date: ____/____/_____

New Allergies: _____ Date of Birth: ____/____/_____

Height: _____ Weight: _____ (lbs) Age: _____