MINIMALLY INVASIVE SPINE SURGERY
AUSTIN NEUROSURGICAL INSTITUTE

**Name:** ___________________________ **Date of Birth:** ______________ **Age:** _______**SS#** _______________________

**Referring Physician:** _________________________________________________________________________________

**Referring Physician Address:** __________________________________________________________________________

**Reason for visit:**

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Date of injury/onset of symptoms:**

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Medical History:** (Examples - high blood pressure, diabetes, high cholesterol, etc.)

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Surgical History:** (list all previous surgeries)

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Medications:** (list all medications taken regularly, please attach a separate list if necessary)

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Allergies:** (list all medication allergies):

______________________________________________________________________________________________________

______________________________________________________________________________________________________

**Family Medical History**: (include family members illness and their relationship to you)

______________________________________________________________________________________________________

Do you currently smoke/and or use tobacco products? Y N How often? ___________________________ How many years? ______

Have you ever smoked and/or used tobacco products in the past? Y N How often? _________________ How many years? ______

Do you use illicit drugs? Y N If yes, how much/often?_____________________ How many years? ___________

Do you drink alcohol? Y N If yes, how much/often?_____________________ How many years? ___________

Marital Status: Married Divorced Widowed Never Married

Do you have children? Y N If yes, list ages: ________________________________________________________________

Are you employed? Y N If yes, what is your occupation? ____________________________________________________

**Worker's Comp:**

- Is this a work related injury? Y N
- Is there an attorney or third party payer involved? Y N

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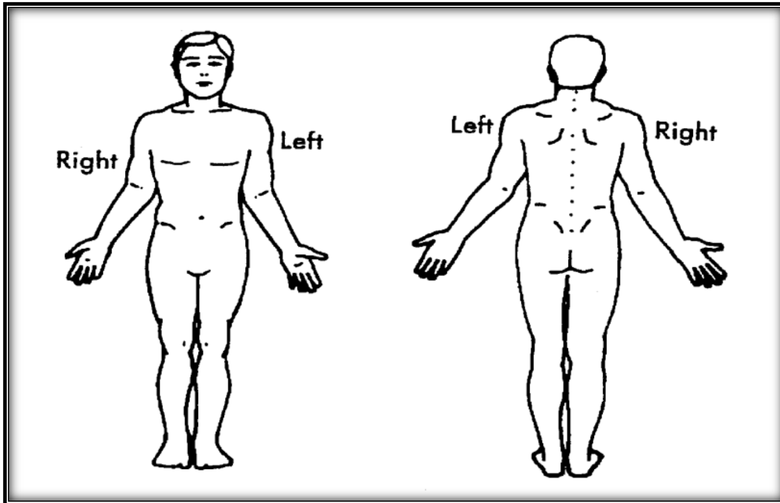
## Brief Medical History Form

If applicable, please indicate where symptoms occur using the symbols:




XXX = Pain
000 = Numbness
+++ = Tingling

### Other Health Complaints (please check all that apply):

- ☐ Night Sweats
- ☐ Weight Change
- ☐ Fever
- ☐ Chills
- ☐ Seizures
- ☐ Paralysis
- ☐ Tingling
- ☐ Sore Throat
- ☐ Runny Nose
- ☐ Swollen glands in neck
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Urinary Loss of Control
- ☐ Urinary Frequency or Irregularity
- ☐ Urinary Urgency
- ☐ Painful Urination
- ☐ Excessive Thirst
- ☐ Joint Swelling
- ☐ Joint Stiffness/Pain
- ☐ Bruising
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances

### Other symptoms not listed above:

________________________________________

________________________________________

________________________________________

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## PATIENT INFORMATION

| Today's date: | Preferred Method of contact for appointment reminders? TEXT / PHONE / EMAIL |
|---|---|

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Ms. | Email: |
|---|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Marital Status: | Employer: | Occupation: | Employer Address: |
|---|---|---|---|

| **Patient's Mailing Address**: | City/State/Zip: | Home Phone: ( ) -<br>Mobile Phone: ( ) - |
|---|---|---|

| Primary Care Provider: | Referring Provider:<br>Phone: | DL#:<br>State: | SSN: |
|---|---|---|---|

| Person Financially Responsible for Account? SELF / OTHER | *If Other*: Name: Relation to Patient? | SSN: Phone: |
|---|---|---|

| Other family members seen here: | Mother's Maiden Name: |
|---|---|

## INSURANCE INFORMATION

(Please Provide all Insurance cards at time of visit)

Is this patient covered by insurance? ❑ Yes ❑ No

| Please indicate ***primary*** insurance | | Effective Date: |
|---|---|---|

| Subscriber's name: | Subscriber's S.S. no./ID #: | Birth date: / / | HMO / PPO | Patient's relationship to subscriber:<br>SELF / SPOUSE / CHILD / OTHER |
|---|---|---|---|---|

| Please indicate ***secondary*** insurance | | Effective Date: |
|---|---|---|

| Subscriber's name: | Subscriber's S.S no./ ID #.: | Birth date: / / | HMO / PPO | Patient's relationship to subscriber:<br>SELF / SPOUSE / CHILD / OTHER |
|---|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

## PHARMACY INFORMATION

| Preferred Pharmacy Name: | Address: | City/St/Zip | Phone: |
|---|---|---|---|

## RELEASE OF INFORMATION

| **Optional:** Please list the name of family members, including spouse, parents, or friends you authorize us to discuss your personal health information with: | 1.<br>2. |
|---|---|

For data purposes only, please check one of the following:

***RACE:*** ❑ Asian ❑ Black or African American ❑ Hispanic ❑White ❑ Native Hawaiian ❑ Other ❑ I choose not to report

***ETHNICITY:*** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to report

***PRIMARY LANGUAGE:*** ❑ English ❑ Spanish ❑ Other:

My signature below confirms that the information listed in my medical and financial file today is accurate and true to the best of my knowledge. I also confirm that my insurance listed is effective for today's services. I understand that it is my responsibility to update the office with any changes in my information.

_______________________________________ ________________________

**Patient/ Legal Guardian Signature** (if child is under 18 years old) **Date**

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# Financial Policy

Thank you for choosing Austin Neurosurgical Institute as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following explains our Financial Policy, which we ask you to read, sign, and return prior to treatment.

- All patients should provide accurate and complete personal information prior to being seen by the doctor.
- All personal balances, both current and prior, are due at the time of service.
- We accept cash, check or MasterCard/VISA, American Express and Discover credit cards.

**Insurance:** We participate in limited insurance plans at the current time. All patients enrolled in non-participating plans are given itemized statements by the attending Physician to assist in expediting the processing of insurance claims. The amount you are reimbursed will be determined by your insurance company in accordance with your policy. Office visit statements will be provided which you can submit to your insurance company for potential reimbursement. We try our best to make sure that all insurance claims submitted for our charges are correctly paid by your insurance company. However, if for any reason the patient's insurance company does not cover charges for Dr. Loftus or his surgical assistant, including charges for procedures and/or durable medical equipment provided; the patient will be responsible for the remaining balance in full. We recommend that you do check with your insurance(s) that all physicians and procedures are covered under your personalized plan.

**Surgical Procedures:** Our office is responsible for obtaining authorization prior to your surgical procedures. If for any reason, it is not approved, we will make the patient aware as soon as possible. If the patient has not met their deductible or out of pocket expenses for the insurances calendar year, our office will estimate the patient's responsibility before the procedure. This surgery amount is due in full before any services are performed.

**Surgery Reschedule/Cancellations:**

1. If you need to cancel or reschedule your surgery, you must notify the office no later than 5 business days prior to your surgery.
2. If you do not give the required notice, there will be a **$150 fee billed directly to the patient's account**. (Your insurance is not responsible for this fee.)

**Copays and Payments:**

- Any office visit copay and/or co-insurance is due prior to services rendered.
- **Missed Appointments:** Unless canceled 24 hours in advance, there is a $30 fee for a missed appointment. This fee is not covered by insurance and is the patient's responsibility.
- **Past Due Accounts:** Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account. This fee is not covered by insurance and is the patient's responsibility. There is a 30% fee added to any balance that is sent to a collection agency.
- **Credit Card Payments:** Austin Neurosurgical Institute has authorization to charge my credit card for a balance or payment in the event that I call to make arrangements. The office will not charge any amount unless authorized by the patient.
- **Returned Checks:** There is a $25.00 fee for a returned check.

**Additional Paperwork:** There is a **$25.00 form fee** for the request of medical records and/or documentation completed by the providers.

**Please initial:** _________________

**Private Insurance:** I, the undersigned authorize payment of medical benefits to Thomas S. Loftus, M.D., P.A. DBA: Austin Neurosurgical Institute for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

**Medicare:** I request that payment of authorized Medicare benefits be made on the behalf of, Thomas S. Loftus, M.D., P.A. DBA: Austin Neurosurgical Institute for any services furnished to me by the physician. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

I have read and acknowledged the Financial Policy at Austin Neurosurgical Institute.

| ______________________________ | ______________________________ | ____________________ |
|---|---|---|
| **Patient/ Legal Guardian Signature** | **Print Patient Name** | **Date** |

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# Policies, Notices, and Disclosures

**Notice of Privacy Practices**
Austin Neurosurgical Institute's Notice of Privacy Practices explain how our office may use and disclosure your protected health information (PHI), your rights, and our obligations to disclosure your medical information for treatment in care, payment, and healthcare operations. Austin Neurosurgical Institute will use and disclose your protected health information to provide your medical care, receive payment for services, and to conduct its business.

________ Initial

**Medication, Opioid, and Refill Policy**
Pain medications will only be prescribed in a patient's post-operative period. Use of pain medications after a patient's post-operative period will need to be managed by either the patient's primary care physician or pain management specialist.

By signing this, I acknowledge that there is an addiction risk associated with usage of opioids. By signing this, I also acknowledge that issues regarding drug management, diversion, and the use of other substances exist when being prescribed opioids by a provider.

Medication and refills prescribed by our office are only accepted from a pharmacy during regular business hours, Monday-Friday from 7:30 am to 4:30 pm. Patients requesting a refill will need to call their pharmacy first and the pharmacy will request the refill from our office. If your request is received after 2:00 pm Monday-Thursday or after 12:00 pm on Friday, it will be processed the next business day. Refills are not authorized on Saturdays or Sundays.

________ Initial

**Authorization Policy**
As a courtesy, we try to remind patients when authorization is required prior to a scheduled appointment. It is the patient's responsibility to ensure an authorization is obtained and current during their time of care**.** Patients who do not obtain an authorization prior to their appointment will need to reschedule their appointment. As a specialty office, we are unable to obtain authorizations on a patient's behalf. Therefore, the patient will need to initiate authorization through their primary care physician.

________ Initial

**Disclosure of Physician Ownership**
Thomas S. Loftus, M.D. is the owner of Austin Neurosurgical Institute and has ownership and/or investment interests in:

- Northwest Hills Surgical Hospital
- Cedar Park Surgery Center
- Legent Surgery Center/EHI Surgery Center
- Capitol Neurodiagnostics, PLLC

Services provided by these facilities may be out of network, and as a result you may receive an out of network bill. However, you have the right to choose the provider of your healthcare services. Therefore, you have the option to use the healthcare facility of your choice. You will not be treated differently by Thomas S. Loftus, M.D. or Austin Neurosurgical Institute if you choose to have services performed at a different facility.

I have read and acknowledged the **Notice of Privacy Practices, Medication and Refill Policy, Authorization Policy, and Disclosure of Physician Ownership** at Austin Neurosurgical Institute.

________ Initial

______________________________
Patient/Legal Guardian Signature

______________________________ ______________________________
Print Patient Name Date

# Authorization to Release Healthcare Information

**Fax: 512-836-0902** **Phone: 512-836-0900**

Patient Name:_________________________________ Date of Birth: _________________________

Previous Name: _______________________________ Social Security #:______________________

☐ **I authorize Austin Neurosurgical Institute** to release my medical records and/or health Information to ________________________________________________________.

☐ **I request and authorize** _________________________________________ to release my medical records and/or health information to: Austin Neurosurgical Institute, 2200 Park Bend Dr. Bldg. 2, Ste. 202 Austin, Texas 78758.

☐ **All health information.**

☐ **Other: _____________________________________________________________________.**

Patient Signature:_____________________________________ Date: ______________________

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# Third Party or Workers' Compensation

At Austin Neurosurgical Institute, our number one priority is providing the patient with the best care possible. In order to do so, we need to ensure that we have all of the correct information for the patient. Austin Neurosurgical Institute **does not accept workers' compensation** or **any third party payers (**auto, home, accident, lawyers, etc.). This may affect whether your healthcare insurance (including Medicare) is primary or secondary.
To help prevent delay in care, please provide us with the most accurate information.

**Check the box/boxes that apply** to you and complete the requested information:

☐ **No, I do not have a workers' compensation or third party claim.** Please note: If for any reason your insurance does not cover your services due to a third party payer, the patient will be responsible for all charges.

☐ **Yes, I have an open workers' compensation claim.**
☐ **Yes, I have an open third party claim.**
☐ **Yes, I have an open Letter of Protection claim.**

Date of injury:____________________ Claim #: ____________________________________
Carrier Name:____________________ Employer at time of injury:______________________
Brief description of injury: ____________________________________________________________

Contact information for workers' compensation or third party claim:______________________________
__________________________________________________________________________________

☐ **I have a closed workers' compensation or third party claim.**
Date of injury:________________ Date closed:_______________
Claim #: ____________________ Phone:____________________
Contact information for person/company handling claim: ______________________________________
__________________________________________________________________________________
Was a medical release provided? _________________________________________________
Brief description of injury: ____________________________________________________________
__________________________________________________________________________________

I have read and acknowledged the Third Party and Workers' Compensation Form at Austin Neurosurgical Institute.

Print Patient Name: ___________________________________

Patient/Legal Guardian Signature:________________________ Date:____________________