KEEP ON TOP

HSNC Houston Spine & Neurosurgery Center, P.A.

18333 Egret Bay Blvd., Suite 200
Houston, TX 77058
(281) 333-1300 Office
(281) 333-1303 Fax
(281) 333-1239 Insurance

Richard M. Westmark, M.D.
Neurosurgery – Board Certified
American Board of Neurosurgery

Jeremy C. Wang, M.D.
Neurosurgery – Board Certified
American Board of Neurosurgery

Gerardo Moreno, P.A.-C
Irene Mata, P.A.-C

Patient Name **Date of Birth**

	All Medication Prescription/Non-Prescription	Milligram/strength	Dosage	Route (p.o., etc)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Patient Signature Date Provider Signature Date

Patient Signature Date Provider Signature Date

Patient Signature Date Provider Signature Date

Patient Signature Date Provider Signature Date

Patient Signature Date Provider Signature Date

HOUSTON SPINE & NEUROSURGERY CENTER, P.A.

Name: _____ DOB: _____ Date: _____

I. Chief Complaint (Why are you here?)

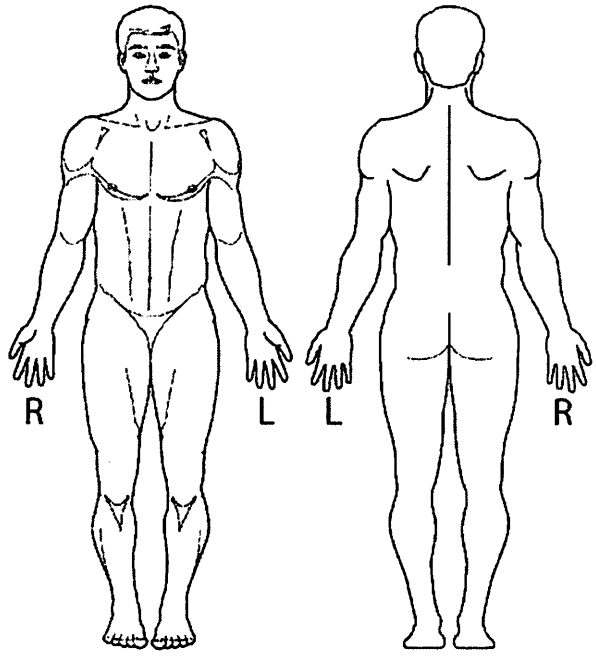
_____

_____

_____

Referred by_____

On the diagram below, **mark** the painful areas with an **X**.



II. History of Present Illness

When did the symptoms/pain start?

_____

_____

Check the word(s) which describes your pain:

☐ Burning ☐ Sharp ☐ Pins & Needles

☐ Sensitivity ☐ Aching ☐ Electrical

☐ Other:_____

When does your pain occur?

☐ Constantly ☐ Occasionally

☐ With Stress ☐ At the same time daily

☐ When I move a certain way (circle all that apply):
bend forward / bend backward / bend to the side (left / right) / turn head (left / right) / twist torso / raise arms above head / lift or carry a load

Other:_____

Do you have:

Numbness (location):_____Tingling (location):_____

Weakness (location):_____Unsteady Gait:_____

Difficulty with Bladder/Bowel Control: (describe)_____

How long/far can you:

Stand:_____ Walk:_____ Sit:_____

Do you use any of the following: (circle) cane / walker / wheelchair / brace / collar

Are the symptoms improved or relieved by: (circle all that apply) sitting / lying down / bending forward

Other:_____

Have you missed work due to symptoms? (circle) yes / no **If yes, dates:**_____

What treatments have you tried already?

Medications: _____

Physical Therapy (dates)_____Chiropractor (dates)_____

Pain Injection/Procedure (dates)_____

Other (dates):_____

Are you involved in litigation related to your symptoms? (circle) yes / no

Patient Initial_____

HOUSTON SPINE & NEUROSURGERY CENTER, P.A.

Name: _____ DOB: _____ Date: _____

Do you need help with activities of daily living? (circle) yes / no
Explain: _____

Global Pain Scale

Pain Scale: (circle one number for each item)

My **CURRENT** pain is…	None – **0 1 2 3 4 5 6 7 8 9 10** – Extreme
During the **past week,** the **BEST** my pain has been is…	None – **0 1 2 3 4 5 6 7 8 9 10** – Extreme
During the **past week,** the **WORST** my pain has been is...	None – **0 1 2 3 4 5 6 7 8 9 10** – Extreme
During the **past week,** my **AVERAGE** pain has been...	None – **0 1 2 3 4 5 6 7 8 9 10** – Extreme

Your Feelings: During the past week I have felt… (circle one number for each item)

…afraid	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…depressed	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…tired	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…anxious	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…stressed	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree

Your Clinical Outcomes: During the past week… (circle one number for each item)

…I had trouble sleeping	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…I had trouble feeling comfortable	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…I was less independent	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…I was unable to work (or perform normal tasks)	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…I needed to take more medication	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree

Your Activities: During the past week, I was **NOT** able to… (circle one number for each item)

…go to the store	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…do chores in my home	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…enjoy my friends and family	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…exercise (including walking)	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree
…participate in my favorite hobbies	Strongly Disagree - **1 2 3 4 5 6 7 8 9 10** - Strongly Agree

Patient Initial_____

HOUSTON SPINE & NEUROSURGERY CENTER, P.A

(PLEASE FILL OUT FORM FULLY)

PATIENT'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ RIGHT OR LEFT HANDED: _____

WEIGHT: _____ HEIGHT: _____

Is this a work related issue? NO YES **Is this injury related to a Motor Vehicle Accident? NO YES**

MEDICAL CONDITIONS: (I.E. DIABETES, HEART DISEASE): _____

_____

_____

_____

PRIOR SURGERY (LIST DATE & TYPE): _____

_____

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

ALLERGIES (DRUG & REACTION): _____

_____

SOCIAL HISTORY:

SMOKING: NO: _____ YES: _____ PACKS PER DAY, FOR _____ YEARS

ALCOHOL: NO: _____ YES: _____

OCCUPATION: _____

FAMILY HISTORY (LIST APPROX. AGE OR AGE AT TIME OF DEATH, BE SURE TO LIST ANY MAJOR MEDICAL CONDITONS AS WELL):

FATHER: _____

MOTHER: _____

OTHER RELATIVES WITH MEDICAL CONDITIONS: _____

_____

REVIEW OF SYSTEMS (PLEASE CHECK YES OR NO):

CONDITIONS:	YES	NO
FEVER		
CHILLS		
NIGHTSWEATS		
SHORTNESS OF BREATH		
CHEST PAIN		
UNEXPLAINED WEIGHT LOSS		

CONDITIONS:	YES	NO
UNEXPLAINED WEIGHT GAIN		
UNUSUAL BLEEDING		
CHANGES IN SKIN LESION(S)		
ENLARGED LYMPHNODES		
EXCESSIVE THIRST		
HISTORY OF DRUG USE/ABUSE		

OFFICE USE ONLY:

☐ REVIEWED, DATE: _____ CHANGES: _____

☐ REVIEWED, DATE: _____ CHANGES: _____

☐ REVIEWED, DATE: _____ CHANGES: _____

HOUSTON SPINE & NEUROSURGERY CENTER, P.A

Patient Information

Name: (First) _____ (MI) _____ (Last)_____

Date of Birth _____ Age _____ Sex: M or F Marital Status: S M D W

Mailing Address: _____

(City, State, Zip) _____

Home #: _____Work #: _____Cell #: _____

Driver License #: _____ Social Security #: _____

Employer: _____Employer Phone #: _____

Pharmacy Name: _____Pharmacy Phone #: _____

Referring Physician: _____Referring Physician Phone # _____

Primary Care Physician: _____ PCP Phone # _____

Emergency Contact (Not Living With Patient): _____

Emergency Contact Phone #: _____ Relationship to Patient: _____

Primary Policy Holder Information (Insurance)

Name: _____ Relationship to Patient: _____

Address: (Street)_____

(City, State, Zip) _____

Phone #: _____ Work #: _____ Cell #: _____

Social Security #: _____Driver License #: _____ DOB: _____

Employer: _____ Employer's Address: _____

Assignment and Release

I hereby assign, transfer, and set over to Houston Spine & Neurosurgery Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. I understand that I am financially responsible for all payments at the time of service and for charges whether or not that are covered by insurance.

Patient's Signature: _____ Date: _____

HSNC Houston Spine & Neurosurgery Center, P.A.

18333 Egret Bay Blvd., Suite 200
Houston, TX 77058
(281) 333-1300 Office
(281) 333-1303 Fax
(281) 333-1239 Insurance

Richard M. Westmark, M.D., F.A.A.N.S.
Neurosurgery – Board Certified
American Board of Neurosurgery

Jeremy C. Wang, M.D., F.A.A.N.S.
Neurosurgery – Board Certified
American Board of Neurosurgery

Gerardo Moreno, PA-C

Irene Mata, P.A.-C

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. **I am responsible for the controlled substance medications prescribed to me.** If my prescription is lost, misplaced or stolen or if I "run out early," **I understand that it will not be replaced.**

2. **Refills** of controlled substance medications:

   a. **Will be made only during regular office hours** Monday through Friday, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends, or during holidays. **No refills by phone.**

   b. **Will not be made** if I "run out early," or "lose a prescription," or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

   c. **Will not be made** as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least twenty-four (24) hours ahead if I need assistance with a refill. **Must be refilled in person in office.**

3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.

4. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.

5. I understand that **if I violate any of the above conditions,** my prescription for controlled substance medications may be terminated **immediately**. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

6. I understand that the **main treatment goal is to reduce pain and improve any ability to function and/or work.** In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

7. I understand that the **long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined** and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.

8. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

Pharmacy Name: _____

Pharmacy Phone: _____

I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect and there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I must do so slowly while under medical supervision or I may have withdrawal symptoms.

I have read this contract and I fully understand the consequences of violating this agreement.

Date _____ Patient Signature _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Cancellation Policy

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care. To cancel your appointment, please call 281-333-1300.

Appointments not cancelled within 24 hours of a scheduled visit or no shows will be responsible for a $25 fee. This fee will be collected over the phone prior to rescheduling.

Non-insured (cash-pay) patients will be responsible for the full cost of their visit at the time of scheduling.

_____
Signature of Patient

_____
Date

HOUSTON SPINE & NEUROSURGERY CENTER
18333 EGRET BAY BLVD. STE 200
HOUSTON, TX 77058
PHONE: 281-333-1300

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
FAX: _____

I HEREBY AUTHORIZE YOU TO RELEASE MEDICAL RECORDS ON

** PATIENT NAME: _____

** DATE OF BIRTH: _____

PLEASE MAIL RECORDS TO:

HSNC
18333 EGRET BAY BLVD
STE 200
HOUSTON, TX 77058

PLEASE FAX RECORDS TO:

FAX #: 281-333-1303

INFORMATION NEEDED:

_____ ALL RECORDS
_____ OPERATIVE REPORTS
_____ LAB REPORTS TYPE: _____ DATE: _____
_____ IMAGING REPORTS TYPE: _____ DATE: _____

** PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

***

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

* ☐ **All health information**

- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

* **SIGNATURE X**_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Houston Spine & Neurosurgery Center, P.A.

18333 Egret Bay Blvd., Suite 200
Houston, TX 77058
Tel: (281) 333-1300
Fax: (281) 333-1303

Disclosure and Authorization Form for Patient Referral to Other Non-Participating Physician(s) or Facility

Patient Name:_____ Physician Name: Dr. Jeremy Wang
Diagnosis: _____ Referred To: _____
Patient Insurance:_____

In order to better serve you with the highest care quality and safety at most affordable costs, sometimes it is necessary and important to have other provider(s) or entities join our team to complete or continue your medical procedures or treatment in order to ensure the speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other provider(s) or entities and obtain your informed authorization before our referral and scheduling for your next treatment procedure(s).

While no provider or entity could be participating in every managed care network, such as the one your health plan has contracted with, these other provider(s) or entities may or may not be in your health plan's network. This form is used to inform you of our verification that the above names provider(s) or entities are non-participating provider(s) or entities with your health plan.

We have verified your insurance coverage for non-participating provider(s) or entities and the recommended treatment / procedure(s) and obtain pre-certification if applicable for all services as a courtesy to you.

Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan.

If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider, please call the member services number on your Insurance Identification Card.

Compliance & Disclosure under Texas Occupations Code - Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Facility with affiliation and remuneration: Gulf Coast Imaging, Houston Physicians Hospital, Premier Neurologics, Houston Brain and Spine, Rocket Neuromonitoring, Choice Spine and Innovasis.

I certify that I will be informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity. I certify that my attending physician(s) will make referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize referrals to non-participating and out-of-network provider(s) or entities as named above.

_____ _____ _____
Patient Name (print) Signature of Patient Date

HSNC Houston Spine & Neurosurgery Center, P.A.

18333 Egret Bay Blvd., Suite 200
Houston, TX 77058
(281) 333-1300 Office
(281) 333-1303 Fax
(281) 333-1239 Insurance

Jeremy C. Wang, M.D.
Neurosurgery – Board Certified
American Board of Neurosurgery

Irene Mata, P.A.-C

Please be aware that Dr. Wang has direct or indirect ownership interests in various healthcare enterprises including Houston Physicians Hospital, Gulf Coast Imaging, Houston Brain and Spine, Rocket Neuromonitoring, and Premier Neurologics.

Dr. Wang is also a consultant for Choice Spine and Innovasis.

Dr. Wang believes these interests allow him greater influence over the care his patients receive. If you have any questions or concerns, please feel free to discuss them with Dr. Wang or the office manager, Angela Bales.

Patient _____ **Date** _____

HSNC Houston Spine & Neurosurgery Center, P.A.

18333 Egret Bay Blvd., Suite 200
Houston, TX 77058
(281) 333-1300 Office
(281) 333-1303 Fax
(281) 333-1239 Insurance

Richard M.Westmark, M.D.
Neurosurgery – Board Certified
American Board of Neurosurgery

Jeremy C. Wang, M.D.
Neurosurgery – Board Certified
American Board of Neurosurgery

Gerardo Moreno, P.A.-C
Irene Mata, P.A.-C

Physician Assistant
Consent for Treatment

This facility has on staff physician assistants to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant 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.

A physician assistant may provide such medical services that are within his/her education, training, and experience. 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 surgery
- Offering counseling and education
- Writing prescriptions
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant or request to see the physician.

Name:_____ Date:_____

Signature:_____

HSNC Houston Spine & Neurosurgery Center, P.A.

18333 Egret Bay Blvd., Suite 200
Houston, TX 77058
(281) 333-1300 Office
(281) 333-1303 Fax
(281) 333-1239 Insurance

Richard M.Westmark, M.D.
Neurosurgery - Board Certified
American Board of Neurosurgery

Jeremy C. Wang, M.D.
Neurosurgery - Board Certified
American Board of Neurosurgery

Gerardo Moreno, P.A.-C
Irene Mata, P.A.-C

Houston Spine & Neurosurgery Center, P.A. is required by law and regulations to protect the privacy of your medical information. Our office may contact you to provide appointment reminders, schedule diagnostic testing, therapy, or surgery.

In the event that you are unavailable, may we:

Speak with a relative at your home? If YES, please list their names.

Leave a message on your voicemail?

If you do not wish for Houston Spine & Neurosurgery Center, P.A. to speak with anyone other than yourself regarding your health care, please state below.

If available, may we access your computerized medical records?

May we contact you by email? What is your email address?

Patient's Name (please print) _____

Patient's Signature_____Date_____