Date: ____/____/____ (FECHA DE HOY)
E-mail: ______________________ (CORREO ELECTRONICO)
Cell Phone: (____) _____-_______ (TELEFONO CELULAR)

Patient's Name: ______________________ (NOMBRE DEL PACIENTE)
SS#: _______-_______-__________ (SEGURO SOCIAL)

Address: ______________________ (DOMICILIO)
Home Phone: (_____) ______-_________ (TELEFONO DE CASA)
DOB: ____/____/______ (FECHA DE NACIMIENTO)

City, State: ______________________ (CIUDAD Y ESTADO)
ZIP: __________ (CODIGO)
Gender/: Female ☐ Male ☐

Employer: ______________________ (EMPLEADOR)
Work Phone: (_____) _____-________ (TELEFONO DE EMPLEADOR)
Occupation: ______________ (OCUPACION)

Work Address, City, State: ______________________________________
(DOMICILIO DE EMPLEADOR, CIUDAD, Y ESTADO)

WHO REFERRED YOU HERE?
Brochure/Family/YellowPages/Newspaper/Hospital/Doctor: ______________________

QUIEN LE REFIRIO AQUI:
Folleto/Familia/Pagina Amarillas/Periodico/Hospital/Doctor: ______________________

Date of Accident or Injury: ____/____/______ (FECHA DE ACCIDENTE)
hurt on the Job: _________Yes/Si ___ No (FUE LASTIMADO EN EL TRABAJO)
MVA: ___________ Yes/Si ___ No (ACCIDENTE DE VEHICULO DE MOTOR)

Emergency Contact Name: ______________________ (EN CASO DE EMERGENCIA A QUIEN NOTIFICAMOS)
Phone Number: (_____) _____ -_________ (TELEFONO DE CASA/CELULAR)

Emergency Contact Relationship to Patient: ______________________
(RELACION AL PACIENTE)

PRIMARY INSURANCE INFORMATION (INFORMACION DE ASEGURANZA PRIMARIA)
(provide your insurance card to the front desk at check-in)
(proporcionar su tarjeta de seguro a la recepción)

Insurance Company: ______________________ (COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)
Phone Number: (_____) ______-__________ (NUMERO DE TELEPHONO)

Name of Insured: ______________________ (NOMBRE DE LA PERSONA ASEGURADA)
Patient Relationship to Insured: ______________________ (RELACION AL PACIENTE)

Subscriber ID (Policy #): ______________________ (IDENTIFICACION DE POLIZA)
Group ID: ______________ (NUMERO DE GRUPO)
Social Security: ______/_____/_______ (SEGURO SOCIAL)

Effective Date: ______________ (EFFECTIVA)
Date of Birth ______/______/________ (FECHA DE NACIMIENTO)

SECONDARY INSURANCE INFORMATION (INFORMACION DE ASEGURANZA SECUNDARIA)
(provide your insurance card to the front desk at check-in)
(proporcionar su tarjeta de seguro a la recepción)

Insurance Company: ______________________ (COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)
Phone Number: (_____) ______-__________ (Numero De Telefono)

Name of Insured: ______________________ (NOMBRE DE LA PERSONA ASEGURADA)
Patient Relationship to Insured: ______________________ (RELACION AL PACIENTE)

Subscriber ID (Policy #): ______________________ (IDENTIFICACION DE POLIZA)
Group ID: ______________ (NUMERO DE GRUPO)
Social Security: ______/_____/_______ (SEGURO SOCIAL)

Effective Date: ______________ (Effectiva)
Date of Birth ______/______/________ (FECHA DE NACIMIENTO)

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.
(ESTOY DE ACUERDO EN QUE LA INFORMACION FACILITADO EN ESTE FORMULARIO ES PRECISA Y HASTA LA FECHA A LO MEJOR DE MI CONOCIMIENTO.

DR. ALLISON RATHMANN D.O.

Patient Signature ______________________ Date: ______________________

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: ______________________
Date of Birth: ______________________

______ (Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

______ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other affiliated facilities may be made available to subsequent affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

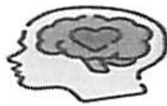
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.



DR. ALLISON RATHMANN D.O.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
I understand that once I have consented to receive communication via text or email, I still have the right to revoke that consent at any time.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

______ (Patient/Representative initials) I **consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is________________________________.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is________________________________.

OR

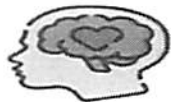
______ (Patient/ Representative Initials) I decline to receive communication via text.
______ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Revocation (I do not consent to use my cell or email any longer)
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

Patient Name: ____

Patient/Patient Representative Signature: ____
Date: ______________________ *Time:* ________________



DR. ALLISON RATHMANN D.O.

1. I authorize **Texas Neurosurgicare** to file insurance forms on my behalf. I request that payment under Medicare or any other health insurance be made directly to **Texas Neurosurgicare.** In the event the policy requires payment to the patient, the check must be mailed to the patient in the care of **Texas Neurosurgicare, 400 West Medical Center Blvd. Ste.245 Webster, TX 77598**

Yo autorizo a este centro interno del paso a los formularios de seguros de archive en mi nombre. Solicito que el pago en virtud de Medicare o de cualquier otro seguro de salud se haga directamente al centro interno de **Texas Neurosurgicare,** En el caso de la política de exigir el pago al paciente, el cheque debe enviarse por correo al paciente en el cuidado de **Texas Neurosurgicare, 400 West Medical Center Blvd. Ste.245 Webster, TX 77598**

Signature: ______________________ Date: ____/____/______
(FIRMA) (FECHA)

2. I hereby authorize **Texas Neurosurgicare,** to file Medicare or other health insurance forms on my behalf with assignment of benefits as indicated.

   Yo autorizo el centro interno del **Texas Neurosurgicare** en el archive de Medicare o de otros formularios de seguros en mi nombre con la asignación de beneficios, como se indica.

   Signature: ______________________ Date: ____/____/______
   (FIRMA) (FECHA)

3. I hereby authorize **Texas Neurosurgicare** to furnish or disclose any information in regard to my illness or treatment to any insurance company, government agency, employer, health professional, or attorneys.

   Yo autorizo **Texas Neurosurgicare** para proporcionar o revelar cualquier información con respeto a mi enfermedad o tratamiento a cualquier compañía de seguros, Agencia gubernamental, empleador, profesionales de la salud, o abogados.

   Signature: ______________________ Date: ____/____/______
   (FIRMA) (FECHA)

4. Self-pay patients paying for surgery with credit or debit cards will have a 4% processing fee.

   Pacientes sin seguranza al pagar su cirugía con tarjeta de credito o débito habrá un cobro de 4% por el proceso.

DR. ALLISON RATHMANN D.O.

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out.

You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

All services for patients who are minors will be billed to the custodial parent or legal guardian. If you have a large balance, a payment plan may be available.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license). If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for knowing your insurance policy, for example:

You will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Texas Neurosurgicare PLLC, and you have not obtained such an authorization or referral; (ii) you received services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Texas Neurosurgicare PLLC are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Texas Neurosurgicare PLLC; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

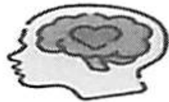
No-shows. Patients who do not show up for their appointment will be considered as a no show and charged a $50.00 fee. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Form fee. There will be a $30.00 charge for completion of each disability, FMLA (or other) forms, which is due at the time the form is brought into the office. Please allow 1 week from the time the form is brought in (and/or the time of the last office visit) for completion of the form.

Thank you for choosing Texas Neurosurgicare PLLC as your healthcare provider!

I confirm that I have read, understand, and agree to the above.

____________________	____________________	________________
Print Name	Signature	Date



DR. ALLISON RATHMANN D.O.

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

DR. ALLISON RATHMANN D.O.

Today's date: ____________

Medical Questionnaire

Patient Name: ______________________ **Date of birth:** ____________ ☐ M ☐ F

Chief complaint: ____

____

Referring doctor: ______________________ Primary care doctor: ______________________

Pain Management: ______________________ Cardiologist: ______________________

HISTORY OF PRESENT ILLNESS/CONDITION

Were you in a motor vehicle accident? **Yes** **No** Were you injured at work? **Yes** **No**

Please describe the problem, how did it happen? ____

____

How bad is it, what is your pain level? (1 to 10) ______ **How long have you had this?** ______

What makes it get worse? standing sitting lying down walking bending movement other: ______

What helps it get better? Pain reliever rest heat/ice physical therapy TENS Unit other: ______

Do you have any problems controlling your bladder or bowel? Yes No

Have you had back or neck surgery? No Yes when____________ by Doctor ____________

Have you had Epidural steroid injections? No Yes when ____________ where ____________ did it help **Y** **N**

Have you had physical therapy? No Yes when ____________ where ____________ did it help **Y** **N**

Have you had chiropractic therapy? No Yes when____________ where ____________ did it help **Y** **N**

DESCRIBE YOUR PAIN

Constant **Comes and goes**

Sharp **stabbing** **numb** **tingling** **dull** **achy** **burning**

Pressing **throbbing** **cramping** **electrical** **shooting**

Y	N	Pain, weakness, or numbness:		
		Arms	RIGHT	LEFT
		Back		
		Feet	RIGHT	LEFT
		Hands	RIGHT	LEFT
		Hips		
		Legs	RIGHT	LEFT
		Neck		
		Shoulder	RIGHT	LEFT

WORK HISTORY

Employer: ______________________ Occupation: ______________________

Duties: ____

DR. ALLISON RATHMANN D.O.

CONDITIONS - Check (✓) YES OR NO the conditions you currently have or have had in the past year

Y	N		Y	N		Y	N		Y	N	
☐	☐	PTSD	☐	☐	Chemical-drug dependency	☐	☐	Hepatitis - A B C	☐	☐	Prostate disease
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐	Seizures / Epilepsy
☐	☐	Anesthesia complications	☐	☐	COPD	☐	☐	Hypertension	☐	☐	Thyroid disorder
☐	☐	Arthritis	☐	☐	Fibromyalgia	☐	☐	Kidney disease	☐	☐	Other: ___________
☐	☐	Asthma	☐	☐	Gout	☐	☐	Liver disease	☐	☐	Other: ___________
☐	☐	Depression	☐	☐	Headaches / Migraines	☐	☐	Anxiety	☐	☐	Other: ___________
☐	☐	Cancer ___________	☐	☐	Heart Disease / pacemaker	☐	☐	Stroke	☐	☐	Other: ___________

PAST SURGICAL HISTORY: List surgeries you have had and what year	
1.	4.
2.	5.
3.	6.

MEDICATION: List medication you are currently taking, (including vitamins and herbs)	
1.	5.
2.	6.
3.	7.
4.	8.

ALLERGIES: To medication or substances	
1.	3.
2.	4.

Social History: Check (✓) the substance you use and Describe how much you use.	Family History: List any illnesses that run in your family.
Caffeine Yes ☐ No ☐ How much:	Mother: alive passed Diseases:
Tobacco Yes ☐ No ☐ How much:	Father: alive passed Diseases:
Alcohol Yes ☐ No ☐ How much:	Siblings: ___ brothers Diseases: ___ sisters Diseases
Married Single Divorced Separated Widow/er Lives with: ______________________	Children: ___ boys Diseases: ___ girls Diseases

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature (firma): ______________________ Date (fecha): ______________________

Physician Signature______________________ Date reviewed______________________