FORT WORTH BRAIN & SPINE INSTITUTE, LLP

1900 Mistletoe Blvd, Ste 200
Fort Worth, TX 76104
(817) 878-5333
(817) 878-5334 Fax
www.FWBSI.com

Patient Registration Sheet (Please Print)

Date: _____

Name (as listed on driver's license if applicable): _____
Last First MI

Mailing Address: _____
Street Address City State Zip

Date of Birth: _____ Sex: ____ Age: ____ Marital Status: M S W D O SSN: _____

Race: _____ Language: _____ Ethnicity: ☐ Hispanic/Latin ☐ Non-Hispanic/Latin

Home Phone Number: _____ Cell Phone Number: _____ Preferred Phone: ☐ Home ☐ Cell

Email Address (for access to patient portal & appt reminders): _____

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Student Employer: _____

Work Phone Number: _____ Employer Address: _____

Spouse: _____ Phone Number: _____

Who can we contact in case of emergency or if we need to change an appointment and are unable to reach you?

Name: _____ Relationship: _____ Phone Number: _____

Address: _____

Is today's visit related to a Worker's Compensation claim or motor vehicle accident? ☐ Yes ☐ No Initials: _____

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adjuster: _____

Phone Number: _____Claim Number: _____ Date of Injury: _____

Address: _____
Street Address City State Zip

ACCIDENT INFORMATION

Was this the result of an accident? ☐ Yes ☐ No Where did it occur: ☐ At Work ☐ Auto Accident ☐ Other (specify)_____

Date of Accident: _____ Have you reported this injury to your employer? ☐ Yes ☐ No

Briefly describe accident: _____

Do you have any attorney? _____ Attorney Name: _____

Phone Number: _____ Address: _____

RESPONSIBLE PARTY & BILLING INFORMATION (Patient is responsible unless a minor child or guardian)

Patient Relationship to Responsible Party: ☐ Child ☐ Other (please specify) _____

Name (as listed on driver's license if applicable): _____
Last First MI

Mailing Address: _____
Street Address City State Zip

Date of Birth: _____ Sex: ____ Age: ____ Marital Status: M S W D O SSN: _____

Home Phone Number: _____ Cell Phone Number: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Student Employer: _____

Work Phone Number: _____ Employer Address: _____

INSURANCE INFORMATION (Fill out completely, as shown on insurance card)

Primary Insurance Company: _____ ID Number: _____ Group Number: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

SSN: _____ Policy Holder Employer (If Applicable): _____

Secondary Insurance Company: _____ ID Number: _____ Group Number: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

SSN: _____ Policy Holder Employer (If Applicable): _____

Check all that apply: ☐ I have a Medicare Advantage Plan ☐ I have a Medi-Gap Policy ☐ My Group Policy is Self-Insured

☐ I have an HRA (Health Reimbursement Account) ☐ I have a Mini-Med Policy ☐ My Group Policy is Fully-Insured

My HRA is administered by:_____

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Name: _____ DOB: _____ Age: _____ Male or Female

Race: _____ Height: _____ Weight: _____ Handedness R L

WE NEED COMPLETE NAME AND ADDRESS OF YOUR TREATING PHYSICIAN AND THE REFERRING PHYSICIAN IN ORDER TO FORWARD OUR REPORT TO THEM.

Medical Doctor or Primary Care Physician	Referring Physician
Name: _____ MD/DO	Name: _____ MD/DO
Street: _____	Street: _____
City/State: _____	City/State: _____
Phone # ( ) -	Phone # ( ) -

Do you have an active DNR agreement? (Do not resuscitate wishes for your family) **YES** **NO**

What brings you here today? What is your most important complaint? _____

_____

_____

When did this start? _____

Have you previously seen a neurosurgeon for this issue? _____

If yes: Who was the physician? _____

When did you see them? _____

What was the outcome? _____

Are you seeking a second opinion? _____

Back/Neck

Do you have Back pain? ___ Neck pain? ___ How long? _____
Do you have Leg pain? ___ R L B Arm pain? ___ R L B;
How long? _____
Do you have Hip pain? ___ R L B How long? _____
Do you have Bowel or Urinary Incontinence? ___;
How long? _____
Are you Improving? ___ or Worsening? ___ or Same? ___
On a **PAIN SCALE** of 1-10 (1 being slight pain and 10 being severe pain) what number would you consider yourself?

1 2 3 4 5 6 7 8 9 10

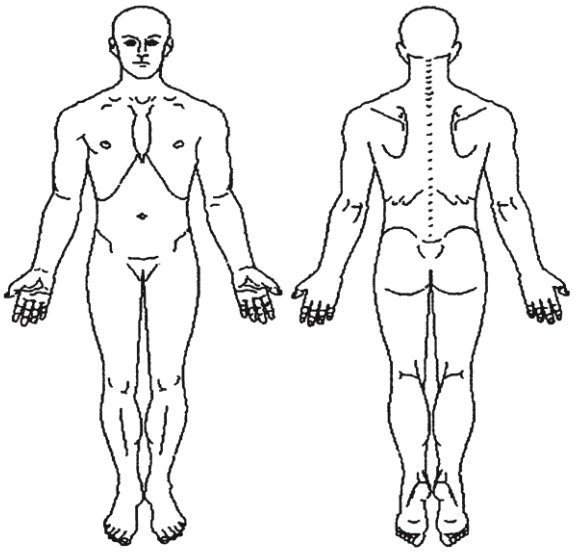
1. Do you have numbness ___ tingling ___ or burning ___;
   Arms: R L B Legs: R L B
2. Do you experience any weakness? ___;
   Arms: R L B Legs: R L B

Head

1. Where is your pain: Front Back Left Side Right Side Eyes
2. How long does the pain last? _____
3. How often does it occur? _____
4. Do you have problems with: vision, hearing, fainting, dizziness, nausea, vomiting, loss of balance, LOC, stroke, TIAs or seizures? _____
   _____

Please place the appropriate letter as noted above in the areas of the body where you experience pain, burning, tingling and/or numbness on the drawing.

X = Pain B = Burning T = Tingling W = Weakness



Patient Name: _____ Patient DOB: _____

1. What seems to aggravate your symptoms? **Sitting, Standing, Lying down, Walking**
2. How far are you able to walk? _____

NEURLOGICAL HISTORY

Have you ever had:

1. Previous neck surgery? Yes ___ No ___ If yes, when, where, and doctor name: _____
_____
2. Previous back surgery? Yes ___ No ___ If yes, when, where, and doctor name: _____
_____
3. Previous head surgery? Yes ___ No ___ If yes, when, where, and doctor name: _____
_____

What treatment have you had for your back/neck problems? Indicate your response to the treatment:

Treatment	No Relief	Some Relief	Good Relief
Bed Rest			
Physical Therapy			
Traction			
TENS Unit			
Spinal or Muscle Injections			
Chiropractic Treatment			
Soft Collar			
Lumbar Corset or Brace			
Application of Heat or Ice			
Medication			
Other:			

Have you had any TESTS for your back/neck problems? (Please check those that apply)

Test	Facility	Date
CT Scan		
Myelogram		
MRI		
X-ray		
Discogram		
EMG or NCV		
Bone Scan		
Other:		

PAST MEDICAL HISTORY

Medical History: Please list all illnesses: (Examples: High blood pressure, diabetes, cancer, heart, lung, liver, or kidney problems)

_____

_____

Prior **SURGERIES** and dates:_____

_____

Hospitalizations (dates): _____

_____

LIST ALL ALLERGIES TO MEDICATIONS: _____

_____

HAVE YOU HAD AN ALLERGIC REACTION TO FOOD, SEAFOOD, OR IODINE?_____

Pharmacy Name: _____

Location: _____

Phone #: _____

Please circle if you are taking any of the following:
Echinacea, Garlic, Ginger, Ginko Biloba, Ginseng, St. John's Wort, Metabolife, Kava Kava, Feverfew, Ephedra

List **ALL MEDICATIONS** being taken now, including over-the-counter medications. Please attach list if necessary.

Medication Name	Dose and Frequency	Ordering Doctor

Patient Name: _____ Patient DOB: _____

FAMILY HISTORY

	Age	Living or Deceased	Health Problems or Cause of Death
Mother		Living or Deceased	
Father		Living or Deceased	
Brother(s)		Living or Deceased	
Sister(s)		Living or Deceased	
Children		Living or Deceased	

Please circle any disease that "runs in the family": Tuberculosis, Diabetes, Cancer, Heart Disease, Kidney Disease, Mental Disease, Stroke.

SOCIAL HISTORY

Marital Status? Single Married Divorced Widowed
Tobacco use? ___ How much? _____ How often? _____ For how long? _____
Alcohol use? ____ How much? _____ How often? _____ For how long? _____
Caffeine? _____ How much? _____ How often? _____ For how long? _____
Drug use? Yes ___ No ___
What type of work do you do? _____
If retired, what type of work did you do? _____
How long have you worked at your present job? _____

REVIEW OF SYSTEMS: (PAST AND PRESENT)

Circle/Indicate if you have had:

HEENT: Failing vision, blurring of vision, watering of eyes, itching of eyes, trouble with sinus, frequent colds, nose bleeds, false teeth, bleeding gums, hoarseness, headaches, dizziness, previous head injury, stroke.

RESPIRATORY SYSTEM: Asthma, Emphysema, Bronchitis, COPD

CARDIOVASCULAR SYSTEM: Angina, chest pain, blocked arteries, palpitations, heart attack, high blood pressure, heart failure, irregular heartbeat, pacemaker, defibrillator.

GASTROINTESTINAL SYSTEM: Ulcer, change in bowel habits, bloody stools, jaundice.

GENITOURINARY: Blood in urine, albumin in urine, trouble getting your stream of water started, surgery on your prostate gland, venereal or sexually transmitted disease, impotence/sexual dysfunction, urinary incontinence, bowel or bladder problems.

OBSTETRICAL HISTORY: How many pregnancies? _____ Miscarriages? _____ Abortions? _____ Full- term deliveries? _____
How many children? _____ Ages of children living and deceased: _____

BREASTS: Breast cancer, discharge from your nipples, soreness, lumps, biopsies.

MUSCULOSKELETAL: Rheumatoid arthritis, gout, osteoarthritis, osteoporosis, other _____.

ENDOCRINE: Diabetes, thyroid disease.

PSYCHIATRIC: Depression, Schizophrenia, Manic-depressive disorder, Bipolar disorder, Learning disorder.

HEMATOLOGICAL/ONC: Cancer, Anemia, Sickle cell disease, Neoplasms, other _____

Patient Signature: _____ Date: _____

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OFFICE POLICIES

APPOINTMENT DETAILS: For initial office visits, all items listed below must be received by our office prior to being seen. Patients should arrive at least 30 minutes before their appointment time in order to complete the registration process.

- All new patient paperwork
- Insurance card(s)
- Driver license or government issued photo ID
- CD's of all imaging & the accompanying reports. The appointment may be rescheduled if we do not have them.
- EMG & other tests related to diagnosis

For follow-up office visits, all items listed below must be received by our office prior to being seen. Patients should arrive at least 10 minutes before their appointment time to complete the check-in process. If X-rays are being done in office prior to being seen, the patient should arrive at least 30 minutes before their appointment time.

- Insurance card(s)
- Driver license or government issued photo ID
- CD's of any new imaging or testing with the reports

Due to physicians' patient load, arrival more than 10 minutes late for your appointment, may result in being rescheduled.

APPOINTMENT RESCHEDULING AND CANCELLATIONS: Please notify our office as soon as possible in the event an appointment needs to be rescheduled or cancelled. Failure to notify our office of the cancellation at least 24 hours prior to your appointment, may result in a missed appointment fee. Our office hours are 8:00 am to 5:00 pm, Monday through Friday.

PHYSICIAN EMERGENCY SURGERY SCHEDULE CHANGES: Please be aware that our physicians are on-call surgeons for some of the busiest hospitals in the area. Should a physician be called away for an emergency surgery, he/she may run late seeing patients. Occasionally, an emergency may necessitate cancelling office appointments on short notice. These types of emergencies could also affect your scheduled surgery date/time. Every effort will be made to contact you in the event this does occur. Please be sure all contact information remains current so our office can contact you in a timely manner.

WORKERS' COMPENSATION: It is the patient's responsibility to notify their Workers' Compensation case manager of any change in appointment date and/or time. If a case manager accompanies you to the appointment, there is a $250 charge he/she must pay at the time of check-in for a team conference.

FINANCIAL RESPONSIBILITY: All co-pays, co-insurance, and/or deductibles are due at the time of service. If the patient does not have health insurance or if their health insurance plan is not one with which our physicians participate, full payment for services is due at the time of service. Please note that additional services provided in the office, such as but not limited to x-rays, reprogramming, and injections are not included in the office visit charge. Post-operative visits are included in the insurance carrier's global period from surgery; however, x-rays are not. MEDICARE PATIENTS ONLY: Unless the patient has supplemental or secondary insurance coverage, you are responsible for your twenty percent co-insurance at the time of your visit. If your visit is the result of an injury due to a Motor Vehicle Accident which led to a liability claim, your office visit here and any surgery will be on a cash only basis. Any surgery must be paid in full prior to the day of surgery. We do not accept letters of protection from attorneys. **There is a $25 fee for any returned checks due to insufficient funds**.

NETWORK PARTICIPATION AND REFERRALS: Our office will make every effort to verify your insurance prior to your visit, but it is ultimately the patient's responsibility to ensure we are participating in the plan prior to your appointment. If your insurance requires a referral to see our physicians, please check with your primary care physician to see that a referral has been completed. If the referral is not received in the office prior to your appointment, the appointment may have to be rescheduled.

DISABILITY/FMLA & OTHER FORMS: We will gladly complete forms for disability/FMLA/ or other requests. There is a $35 fee per form each time it is completed and is payable at the time of request. Please allow 7-10 business days for completion.

PRESCRIPTION REFILLS: Requests for prescription refills must be called in at least 24 hours in advance. No refills will be called in over the weekend or holidays. Refill requests submitted on Friday may be called into the pharmacy on Monday. Refills are given under the direction of the physician who reserves the right to refuse a refill at any time.

By signing this document, I understand the above policies.

_____ _____ _____

Patient Signature Date of Birth Date

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Assignment of Benefits

I, the undersigned, have third-party insurance coverage and assign directly to Fort Worth Brain and Spine Institute, LLP, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Fort Worth Brain and Spine Institute, LLP to release all information necessary to secure the payment of benefits. I authorize the use of the below signature on all my insurance submissions.

Medicare Authorization (Only applicable to Medicare-enrolled Patients)

If covered by Medicare, I request the payment of authorized Medicare benefits be made to or on my behalf to Fort Worth Brain and Spine Institute, LLP, for any services furnished me by one of their physicians. I authorize any holder of information about me to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Fort Worth Brain and Spine Institute, LLP'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 upon request.

Consent for Treatment

The undersigned patient ("Patient"), or legally-authorized representative of the Patient, desires a physical evaluation and/or treatment at Fort Worth Brain and Spine Institute, LLP. The undersigned voluntarily consents to such care which may include, but is not limited to, routine diagnostic procedures, physical examinations, including but not limited to x-rays, blood draws, laboratory tests, administration of medication and to medical or surgical treatment by physicians and staff members of Fort Worth Brain and Spine Institute, LLP, as well as any other health care providers who may be called upon to consult or assist in the Patient's care as judged necessary by Patient's treating physicians. The undersigned acknowledges that the practice of medicine is not an exact science and further acknowledges that no guaranties have been made as to the results of Patient's examination or treatment at Fort Worth Brain and Spine Institute, LLP. The undersigned acknowledges that treatment at Fort Worth Brain and Spine Institute, LLP is intended to address specific episodic illnesses or injury and is not intended to substitute for comprehensive care in lieu of a primary care physician or other specialized physician. In order to provide the best chance for successful treatment, the undersigned accepts responsibility to follow the advice of the Patient's treating physician including compliance with medications, discharge instructions and follow up with all needed physicians. The undersigned agrees that Patient shall return to the clinic or seek care in an emergency department of a hospital if Patient's condition substantially changes. The undersigned further agrees to hold harmless the physician and staff of Fort Worth Brain and Spine Institute, LLP should the undersigned fail to comply with the above conditions. Patients at Fort Worth Brain and Spine Institute, LLP will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above criteria, Fort Worth Brain and Spine Institute, LLP reserves the right to refuse care to any individual for any reason at the discretion of the physician on duty.

_____ _____

Patient Name (Please Print)

Signature of Patient or Patient's Legally Authorized Representative*
(*Representative signature required if patient unable to consent)

Date: _____

Patient Date of Birth: _____

Representative's Relationship to Patient: _____

Patient is unable to consent because: _____ Witness: _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND CONSENT TO TELEPHONE-ELECTRONIC COMMUNICATION

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 the 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. 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.

Patient Name (Please Print) | Date of Birth | Social Security Number

Email Address | Phone Number

THE FOLLOWING PERSON(S) ARE ABLE TO RECEIVE AND ACCESS ANY OF MY PRIVATE HEALTH INFORMATION (PHI):

Name	Email/Phone	Relation to Patient

REASON FOR DISCLOSURE

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

PERSON WHO HOLDS MEDICAL POWER OF ATTORNEY (If applicable): _____

TELEPHONE COMMUNICATIONS ARE LIMITED TO: ☐ Home ☐ Work ☐ Cell ☐ Other_____
MAY WE LEAVE A MESSAGE: ☐ YES ☐ NO
MAY WE LEAVE A CALLBACK NUMBER: ☐ YES ☐ NO
MAY WE LEAVE AN APPOINTMENT REMINDER: ☐ YES ☐ NO
MAY WE CONTACT YOU VIA EMAIL: ☐ YES ☐ NO

WHAT INFORMATION CAN BE DISCOLOSED? 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
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports

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.

By signing below, I acknowledge that there are risks associated with electronic e-mail communication, including some level of risk that the information in an e-mail could be read by a third party. I acknowledge and agree that Fort Worth Brain & Spine Institute, LLP will not be liable for loss of information due to technical failures on my end. I acknowledge that the use of e-mail may pose certain limitations and may not be appropriate in certain situations. For example, I acknowledge that the nature of electronic communication may cause delays in response. Further, I acknowledge that e-mail communication may be an insufficient mode for me to receive certain health care services. I agree to schedule an appointment if I have further questions about my health care.

I acknowledge and agree that completion of this document does not establish a patient-physician relationship and that this form is meant only for existing patients of Fort Worth Brain & Spine Institute, LLP. By signing below, I consent to communication via e-mail and confirm my preference to use e-mail over other available means of communication.

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**

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

Dear Patient:

The Physicians at Fort Worth Brain & Spine Institute, LLP are ***independent, private practice*** physicians. This means our Physicians are ***not employed*** by any corporate or outside health care entity. And ***this means*** we work for ***YOU***, not for a hospital, an administrator, or any other corporate or outside health care entity.

In order to assure the highest quality and efficient delivery of your health care, the Physicians of Fort Worth Brain & Spine Institute, LLP may maintain financial interests in other health care facilities and providers. Our commitment to providing the highest quality care for our patients is paramount. Having financial interests in certain health care facilities and/or providers enables your Physician to have additional control on the quality of care provided to you as opposed to having little control or input with corporate health care entities. A simple example would be having an imaging study done in a specific fashion tailored to the patient's individual condition, rather than having to accept a "cookie-cutter" study that is done the same way for every patient, regardless of the condition being investigated.

Decisions regarding your care are always based on your best individual medical treatment plan developed by you and your Physician. Patients of Fort Worth Brain & Spine Institute, LLP always have the option of utilizing alternate health care facilities or providers, and at times, this may actually be dictated by their individual health insurance plan. Regardless, your Physician and you will develop the best treatment regimen available for your specific condition, using evidence-based "best practices." Please feel free to discuss your options or any questions you may have with your Physician or our staff during your visit. We welcome any questions regarding this aspect of your patient care.

The following list includes the facilities and providers for which our Physicians maintain any form of ownership interest. As a Patient of Fort Worth Brain & Spine Institute, LLP, you may receive care or services from any of these facilities or providers. Your Physician may receive some form of financial benefit related to the care or services rendered by these facilities and providers, depending on the legal ownership structure of each individual facility or entity.

- *Methodist Southlake Hospital, Southlake, TX 76092*
- *Baylor Surgical Hospital, Fort Worth, TX 76110*
- *Parkway Surgical Hospital, Fort Worth, TX 76177*
- *Page Medical, Grapevine, TX 76051*
- *Vaquero Medical, Grapevine, TX 76051*
- *Polestar Medical Solutions, Southlake, TX 76092*
- *Trinity IOM, Fort Worth, TX 76104*
- *117 Surgical Assistants, Fort Worth, TX 76104*
- *Squire Surgical Services, Southlake, TX 76092*
- *Fort Worth Ranch Assist, Fort Worth, TX 76109*
- *Myeuverse IOM, Fort Worth, TX 76102*
- *FW CSN Monitoring, Fort Worth, TX 76102*
- *Lone Star Monitoring, Irving, TX 75063*
- *Lone Star Neurosurgical Assistants, Westlake, TX 76262*
- *Select Pain Procedure Center, Fort Worth, TX 76102*
- *Brain Assist, Keller, TX 76248*
- *IONM, Keller, TX 76248*

Patient Acknowledgement

I acknowledge that my attending Physician(s) has disclosed to me, at the time of initial contact and at the time of referral (A) his/her affiliation if any, with the facilities or providers for whom, I, the patient am being referred, and (B) that he/she may receive financial benefit related the care rendered by the facility or provider based on the individual legal ownership structure of the facility or provider. I understand that I, the Patient, have the right to choose the providers of my health care services.

Please sign below to acknowledge the receipt of this disclosure and to indicate that you do not have any objections to using the facilities or providers listed above.

Patient Signature: _____ Date of Birth: _____ Date: _____

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Notice of Non-participating Providers

Patient Name: _____Date of Birth: _____

All Fort Worth Brain & Spine Institute, LLP **Surgical Assistants** are out-of-network with the majority of our participating insurance company networks.

If you are recommended and scheduled for surgery, our RCM department will contact you by phone or email to notify you of the charge amounts that will be billed to your insurance company for the out-of-network surgical assistant, prior to surgery.

Our RCM department will also send a Good Faith Estimate with charge amounts prior to surgery for your review and signature. To proceed to have surgery with our physicians, a Good Faith Estimate must be signed by the patient prior to surgery.

Fort Worth Brain & Spine Institute, LLP agrees to accept the payment processed, normally against your out-of-network benefits, and will collect the patient responsibility due according to the explanation of benefits.

By signing below, you are acknowledging and accepting Fort Worth Brain & Spine Institute, LLP's Notice of Non-participating Providers policy and procedures.

Print Name: _____ Date: _____

Signature: _____