Mathew T. Alexander, M.D.

Melissa Y.Macias, M.D.,PhD

Raymond Perez, PA-C

FIRST:	MI:	LAST:
ADDRESS:	CITY:	STATE ZIP:
HOME:	CELL:	WORK:
SS#:	DOB:	FEMALE OR MALE
MARTIAL STATUS:	RACE:	ETHNICITY:
DOMINANT HAND: RIGHT OR LEFT	PRIMARY INSURANCE:	SECONDARY INSURANCE:

PRIMARY CARE PHYSICIAN:	PHARMACY:
PATIENT EMPLOYER:	PATIENT OCCUPATION:
ADDRESS:	CITY/STATE/ZIP
EMAIL:	

EMERGENCY CONTACT:	RELATIONSHIP:	PHONE:

RESPONSIBLE PARTY (IF OTHER THAN THE PATIENT)

FIRST:	MI:	LAST:
ADDRESS:	CITY:	STATE/ZIP:
HOME:	WORK:	SS#:
EMPLOYER:	ADDRESS:	CITY:
STATE:	ZIP CODE:	DATE OF BIRTH:

I AUTHORIZE ANY HOLDER OR MEDICAL OR THEIR INFORMATION ABOUT ME TO BE RELEASED TO MY INSURANCE COMPANY OR MEDIGAP AND OR ANY OTHER CARRIER; THE INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN A PLACE OF THE ORIGIANL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OT TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICAL ASSIGNMENT OF BENEFITS APPLY.

SIGNATURE:_____ DATE: _____

1227 Third Street
Corpus Christi, TX 78404

www.southtexasbrainandspine.com

Office: (361) 883-4323
Fax: (361) 883-4324

Mathew T. Alexander, M.D. Melissa Y.Macias, M.D.

Raymond Perez, P.A- C

FINANCIAL AND HEALTH POLICY

The following is a statement of our financial policy that we require you to read and sign prior to receiving treatment.

INSURANCE:

We will bill your insurance company **(Primary or Secondary as a courtesy to you.)**We will complete necessary forms to help expedite insurance carrier payment. However the **Patient** is responsible for all fees that are not covered by the insurance plan. Any dispute about overage needs to be settled between you and your Insurance Company.

OUTSTANDING BALANCES:

The patient will receive a monthly statement until the amount is paid in full. You are not required to pay the insurance pending balance amount; we send the invoices to keep you informed about your account. After the insurance has paid, you are required to pay the balance in full, unless other arrangements have been made in advance with our Patient Account Representative. If after 90 days you have not attempted to contact our office regarding your account or to make payment arrangements, your account will be turned over to collection agency.

NSF CHECKS:

In the event of a returned check regardless of the cause, there will be a charge of $30.00 you will have TEN DAYS to come in and pay the amount of the returned check, plus a $30.00 fee. If you not comply your account will be turned over to the Nueces County Attorney's Office.

OVER PAYMENTS:

In the event of an overpayment you or your insurance company will be reimbursed by the 30th of the following month. We process refunds on the 30th of each month.

RELEASED OF MEDICAL INFORMATION:

I have reviewed the above financial policy and give my permission to South Texas Brain & Spine Center to disclose any information to my Health Insurance.

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices
(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Print Patient's Name: _____ DOB: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

☐ Health information may not be released.

☐ Health information may be released to: _____

_____

(FAMILY MEMBERS, SPOUSE, ETC.)

Internal Use Only

If patient / patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date): _____

By (Employee's name and title): _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PAIN MANAGEMENT: _____
CARDIOLOGIST: _____
PHYSICAL THERAPY: _____
PSYCHIATRIST: _____
OTHER: _____

PATIENT'S NAME: _____ DOB: _____
ADDRESS: _____ SOCIAL SECURITY: _____

I, _____, hereby authorize facilities listed above to furnish copies of my medical records to:

South Texas Brain & Spine Center
1227 Third Street
Corpus Christi, Texas 78404
Phone: (361)883-4323 Fax: (361)883-4324

Patient's Signature: _____ Date: _____

Mathew T. Alexander, M.D. Melissa Y.Macias, M.D.,PhD

Raymond Perez, P.A-C

DATE:_____

NAME:_____
DOB: _____
TREATED DATE: _____

Before me, the undersigned authority, on this day personally appeared _____ **known to be the person whose name is subscribed to the foregoing instrument in the capacity there in stated, who being first dully sworn, stated upon his/her oath that the condition I am being treated for is NOT A WORK RELATED/MVA INJURY.**

By signing this form, I am assuming all financial responsibility by all charges incurred by South Texas Brain and Spine.

Patient signature: _____

SWORN TO AND SUBSCRIBED before me this _____ **day of** _____**,20**_____

_____

NOTARY PUBLIC

My commission Expires: 08/16/2023

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AUTHORIZATION UNDER 45 CFR § 164.508 TO RELEASE

PROTECTED HEALTH INFORMATION. (HIPPA AUTHORIZATION)

Patient Name: _____ **Patient Date of Birth:** _____

Statement of Intent: This authorization is being signed to allow **South Texas Brain and Spine Center** to verify my current employment status in order to confirm my health insurance coverage. **South Texas Brain and Spine Center** may not condition my treatment on my signing of this Authorization. However, pursuant to 45 CFR § 164.502(a)(1)(iv), **South Texas Brain and Spine Center** is hereby permitted to disclose protected health information pursuant to and in compliance with this valid authorization under § 164.508.

I, (***THE SUBSCRIBER OF HEALTH INSURANCE***) _____, hereby authorize **South Texas Brain and Spine Cente**r to disclose to my Employer the fact that I am seeking medical and health care treatment by and through **South Texas Brain and Spine Center**. This disclosure will be made for the purpose of verifying my employment status for insurance purposes.

Subscriber of Insurance Employer is:

Company Name: _____

Company Address: _____

Company/Supervisor Phone No: _____

Office Use Only-Spoke to: _____

_____

Termination: This authorization shall terminate on the first to occur of: (1) the completion of my treatment by or through **South Texas Brain and Spine Center,** or (2) upon my written revocation actually received by **South Texas Brain and Spine Center.** Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity except to the extent that the covered entity has taken action in reliance on it.

Re-disclosure: By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by my Employer, and the information once disclosed will no longer be protected by the rules created in HIPPA. My Employer shall not require **South Texas Brain and Spine Center** provide indemnification or agree to perform any act in order for my Employer to comply with this authorization.

Valid Document: A copy or facsimile of this original authorization shall be accepted as though it were an original document.

My Waiver and Release: I hereby release my Employer, acting in reliance on this authorization, from any liability that may accrue from releasing my protected medical information and for any actions taken by **South Texas Brain and Spine Center.**

Signature of Subscriber of Insurance: _____ **Date:** _____

Subscriber of Insurance DOB: _____ **Subscriber of Insurance SS:** _____

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MEDICAL HISTORY QUESTIONNAIRE

PHARMACY: _____

NAME: _____ DOB: _____

DO YOU HAVE OR HAVE HAD (PLEASE CIRLE ALL THAT APPLY)

ASTHMA	YES	NO	KIDNEY DISEASE	YES	NO
SLEEP APNEA	YES	NO	LIVER DISEASE	YES	NO
COPD/EMPHYSEMA	YES	NO	GOUT	YES	NO
BLOOD CLOTS	YES	NO	HIV	YES	NO
ARRHYTHMIA	YES	NO	BI-POLAR	YES	NO
CORONARY ARTERY DISEASE	YES	NO	DEPRESSION	YES	NO
HIGH CHOLESTEROL	YES	NO	ANIEXTY	YES	NO
HIGH/LOW THYROID	YES	NO	ARTHRITIS	YES	NO
HYPERTENSION (HIGH BLOOD PRESSURE)	YES	NO	GALLSTONES	YES	NO
DIABETES (INSULIN/NON-INSULIN)	YES	NO	MYOCARDIAL INFARCTION (HEART ATTACK)	YES	NO
STROKE	YES	NO	GERD (REFLUX/HEARTBURN)	YES	NO
ANEURYSM	YES	NO	HEPATITIS (CIRCLE) A B C	YES	NO
CANCER TYPE:	YES	NO	HEART MURMUR	YES	NO
EATING DISORDER	YES	NO	LEARNING DISORDER	YES	NO
OTHER:			OTHER:		

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY)

FAMILY MEMBER	OBESITY	DIABETES	HIGH BLOOD PRESSURE	SLEEP APNEA	HIGH CHOLESTEROL	HEART ATTACK	CANCER	OTHER
MOTHER								
FATHER								
GRANDMOTHER								
GRANDFATHER								
SIBLINGS								

SIGNATURE: _____ DATE: _____

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PATIENT NAME: _____ DOB: _____ DATE: _____

ALLERGIES (PLEASE LIST THE FOLLOWING OR ATTACH LIST)

DRUG/FOOD	TYPE OF REACTION

MEDICATIONS

MEDICATION: NAME,DOSE & FREQUENCY	WHY (EX: DIABETES)

PREVIOUS SURGERIES

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General Information

PRINT NAME: _____ DOB: _____ SEX: _____

REFERRING PHYSICIAN: _____ PHONE: _____

HAVE YOU HAD PHYSICAL THERAPY: YES OR NO WHERE? _____

HAVE YOU SEEN A PAIN MANAGEMENT: YES OR NO NAME: _____

HAVE YOU SEEN A PSYCHIATRIST: YES OR NO NAME: _____

HAVE YOU SEEN A CARDIOLOGIST: YES OR NO NAME: _____

ARE YOU ABLE TO CARE FOR SELF: YES OR NO WHO CARES FOR YOU: _____

SOCIAL HISTORY

CHILDREN: _____ GRANDCHILDREN: _____ HOBBIES: _____

TOBACCO USE (PLEASE CIRCLE): NEVER FORMER OCCASIONAL EVERYDAY CHEWING TOBACCO

AMOUNT/FREQUENCY: _____ YRS OF USE: _____ DATE QUIT: _____

ALCOHOL USE (PLEASE CIRCLE): NONE OCCASIONAL MODERATE HEAVY IN THE PAST

AMOUNTY/FREQUENCY: _____ YRS OF USE: _____ DATE QUIT: _____

DO YOU USE DRUGS FOR RECREATIONAL PURPOSES? YES NO PAST ONLY

(PLEASE CIRCLE ALL THAT APPLY): AMPHETAMINES COCAINE MARIJUANA HEROIN INHALANTS LSD

AMOUNT/FREQUENCY: _____ YRS OF USE: _____ DATE QUIT: _____

IS THIS A WORK RELATED INJURY? YES OR NO

SIGNATURE: _____ **DATE:** _____

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Name: _____

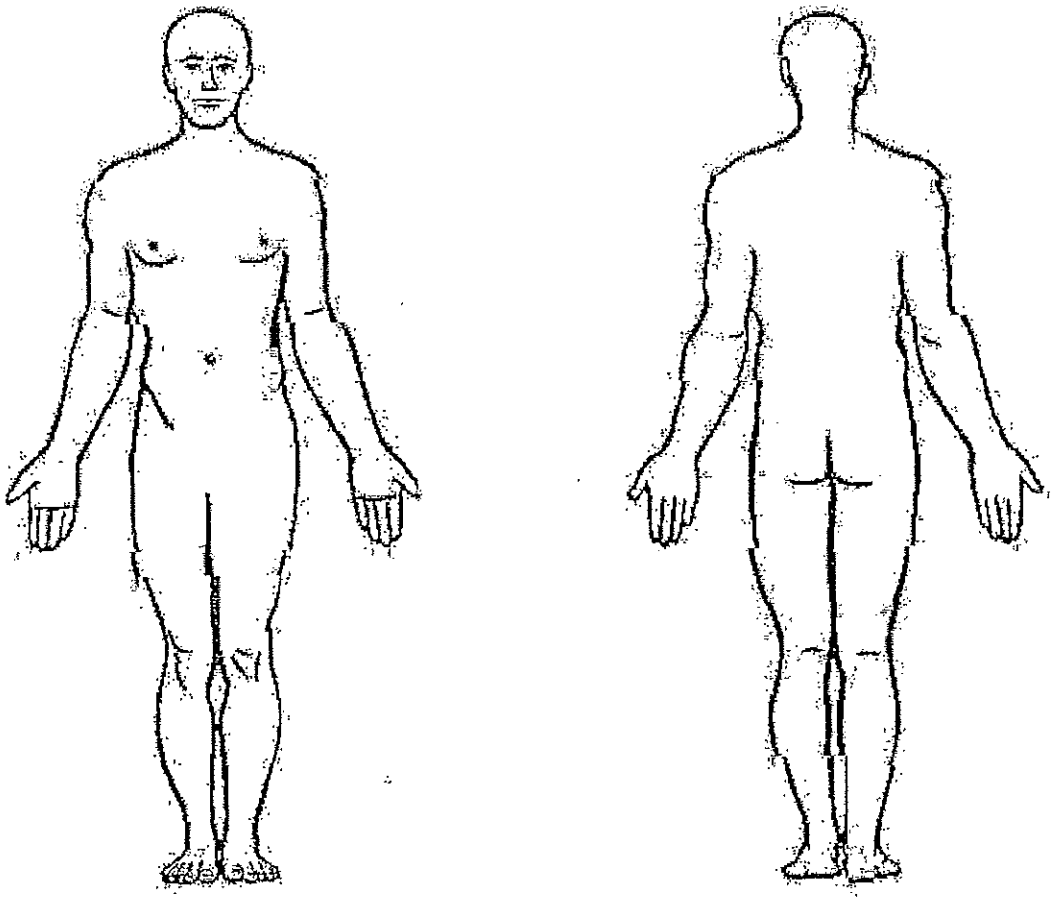
Hand Preference

Please Circle Your Hand Preference	Right	Left	Ambidextrous

Pain Diagram

Please indicate the location of the pain on the chart below using the following symbols:

Numbness _____ Burning XXXX Pins and Needles //// Aching ||||



How did you first hear about South Texas Brain & Spine Center?

Internet / Website	
Mass Media (i.e. magazine, newspaper, radio)	
Family Member	
Friend or Colleague	
Referring physician	
Other (please describe): _____	

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YOUR CURRENT SYMPTOMS

(CIRCLE ALL THAT APPLY)

PRINT NAME: _____ DOB: _____ DATE: _____

EYES:
CONTACTS GLASSES BLURRED VISION DOUBLE VISION

EARS/ NOSE/ THROAT:
DEAFNESS RINGING
SWALLOWING HOARSNESS

CARDIOVASCULAR:
CHEST PAIN/PRESSURE EDEMA
SKIP BEATS RAPID BEATS

RESPIRATORY:
COUGH COUGH W/BLOOD
WHEEZING/ASTHMA SHORTNESS OF BREATH

GASTROINTESTINAL:
HEPATITIS CONSTIPATION FECAL INCONTINENCE
DIARRHEA BLOODY STOOL

GENITOURINARY/NEPHROLOGY:
URINARY FREQUENCY BURNING URINARY INCONTINENCE
SCROTAL SWELLING BLEEDING

MUSCULOSKELETAL:
STIFFNESS SWELLING MUSCLE WEAKNESS JOINT/PAIN ARTHRITIS
BACKPAIN LEG PAIN ARM PAIN SHOULDER PAIN
CANE/WALKER CARPAL TUNNEL OSTEOPOROSIS PAIN

DERMATOLOGIC:
BRUISING LESIONS BIRTH MARKS

NEUROLOGIC:
HEADACHES DIZZINESS MEMORY LOSS MENTAL STATUS CHANGES
NUMBNESS PARESTHESIA SEIZURE SPASMS/SPASTICITY
WEAKNESS SPEECH DIFFICULTIES

PSYCHIATRIC:
DEPRESSION INSOMNIA FATIGUABILITY SUICIDALITY
ANXIETY

ENDOCRINE:
WEIGHT GAIN WEIGHT LOSS

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Patient Comfort Assessment Guide

Name:_____ Date:_____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One occasional continuous

What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime

Approximate date the pain started? _____**(month/year)**

Was there any trauma involved? Yes or No If yes, explain_____

Where does the pain radiate to? _____Legs R or L _____Abdomen _____Arms R or L

Do you have good control of your bladder/bowels? _____

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its least in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain on average in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain right now.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain better? __ Medications __Physical Therapy __ Injections __ OTC __Tens unit __Heat __ Ice __Other

8. What makes your pain worse? __ Walking __ Standing __ Sitting __ Laying __ Bending

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week <u>pain has interfered</u> with your:

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Patient Signature:_____Date:_____