DR. DAVID MASEL, MD, FAANS, FACS - NEUROSURGEON
13988 Diplomat Drive, Suite 100 C
Farmers Branch, Texas 75234
Phone: 469-833-2927, Fax: 214-888-4450

PATIENT INFORMATION:

Patient Name _____ Date of Birth _____ / _____ / _____ Sex ___

Address _____ City_____ State _____ Zip _____

SSN _____ - _____ - _____ Driver's License # _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Email _____ Home Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____ Phone _____

REFERRAL INFORMATION:

Date of Injury _____ / _____ / _____ Reason for Visit _____

Did a Doctor Refer You? Yes ☐ No ☐ Referring Doctor's Name _____

Primary Care Physician _____ Phone _____ City _____

Worker's Compensation? Employer _____ Insurance _____ Claim # _____

Personal Injury? Attorney _____ Case Manager: _____ Phone _____

PRIMARY INSURANCE:

Name on Card _____ Spouse ☐ Parent ☐ Self ☐

Insurance Company _____ Policy # _____ Member ID _____

SECONDARY INSURANCE

Name on Card _____ Spouse ☐ Parent ☐ Self ☐

Insurance Company _____ Policy # _____ Member ID _____

MEDICARE / MEDICAID: Medicare Number _____ Medicaid Number _____

MEDICARE SUPPLEMENT INSURANCE:

Insurance Name _____ Phone _____

Address _____ City_____ State _____ Zip _____

(CONTINUED FROM PREVIOUS PAGE)

WORKER'S COMPENSATION: It is important that you make our office aware if this is a worker's comp injury prior to your visit. Please have all relevant information available in order to quickly complete your check-in process.

EMPLOYER PAY: If your employer is paying for your visit instead of filing worker's comp, we must have payment up front or a signed contract in hand before your visit. We must be notified of any responsibility changes the employer makes within 80 days of first date of service.

MISSED APPOINTMENT POLICY: In an effort to provide excellent patient care, we will be implementing a missed appointment fee without a cancellation of at least 24 hours in advance. Cancellations must be done over the phone with a staff member in the neurosurgery department. Our direct number is 469-833-2927. Cancellation fee of $25.00 will be applied to your account in the event you fail to notify us 24 hours prior to your appointment time with Dr. David Masel, MD. Illness will be excused with a physician's note explaining your absence.

By signing this, you are acknowledging that all the above information is accurate and correct to the best of your knowledge and that you fully understand the above mentioned.

PATIENT OR GUARDIAN SIGNATURE _____ Date _____ / _____ / _____

SPECIALTY CARE CLINICS – CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

Patient Name _____ Date of Birth _____ / _____ / _____

I authorize the doctor, Dr. David Masel, MD, to examine me (or the patient I am legally responsible for) and to do any x-rays or other diagnostic tests that may be needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Dr. David Masel, MD to release to any insurance company, health plan, or government agency such medical information that may be required to process my claim for payment of this medical bill. I also authorize Dr. David Masel, MD to release appropriate medical information to any doctor, hospital, or other health care facility that has or will participate in my (the patient's) care. I authorize a photocopy, facsimile, or other electronic transmission of the above Assignments, Authorizations, and Releases to be used in place of the original until/unless I send written notice to the contrary to the offices of Dr. David Masel, MD. I further authorize any other doctor, hospital, or health care facility to release to Dr. David Masel, MD office any medical information concerning my (the patient's) illness or injury.

FINANCIAL AGREEMENT: I agree to pay all professional fees charged by Dr. David Masel, MD for my (the patient's) care, irrespective of any insurance benefits to which I may be entitled, except if Dr. David Masel, MD has agreed to accept insurance benefits as full payment for covered services in accordance with federal or state law (e.g. Medicare, Medicaid) or by contract with a prepaid health plan or managed-care plan, and provided such insurance benefits are paid within 60 days of claims submissions, and provided there is no recovery from a third-party negligence lawsuit (see Injuries and Third-Party Negligence, below). Ultimately, it is your responsibility to understand the coverage that you pay for in a monthly premium to your carrier. If an employer or its carrier denies a claim for payment for a work-related injury, or if a prepaid health plan, managed-care health plan, or Medicare, considers certain services ineligible or uncovered services, then you (patient) agree to pay for those services. It is understood that claims for services remaining unpaid 60 days after claims submission shall be presumed ineligible for insurance reimbursement, and you (patient) shall pay for those services. If patient is a minor – the parent/guardian who requests treatment for a child will be responsible for all fees.

INJURIES AND THIRD-PARTY NEGLIGENCE: I understand and agree that if Dr. David Masel, MD has granted discounts from its usual fees for any reason, including its participation in prepaid or managed-care health plans, and if I (the patient) recover(s) any monies as the result of any judgment, award, or settlement of any lawsuit arising from treated injuries or illness, then I shall give a lien to Dr. David Masel, MD against such monetary recovery in the full amount of such discounts.

DELINQUENCY: If my (the patient's) account becomes delinquent, I understand that Dr. David Masel, MD, at its sole discretion, may refer to a collection agency or an attorney as allowed by law.

INSURANCE ASSIGNMENT: I authorize my insurance company or third-party payer to whom a claim for payment has been submitted to pay any eligible benefits directly to Dr. David Masel, MD. I hereby authorize payment to go directly to Specialty Care Clinics for medical benefits payable by insurance company _____ (and/or Medicare) and understand that I am responsible for any charge not covered by the terms of my insurance policy. I hereby assign Dr. David Masel, MD full rights to represent my (the patient's) interests in any complaints of appeals for denial of benefits or reimbursement to the Texas Department of Insurance (State Insurance Commissioner). I hereby authorize said assignee Dr. David Masel, MD to furnish these agencies such information as may be necessary to support such complaints or appeals.

I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid. **I have read, understand, and do hereby agree to the terms of the forgoing Assignments, Authorizations, and Releases. I also certify that the PATIENT INFORMATION I have provided is true and accurate to the best of my knowledge.**

PATIENT OR GUARDIAN SIGNATURE _____ Date _____ / _____ / _____

SPECIALTY CARE CLINICS – HIPAA COMPLIANCE PATIENT CONSENT FORM

Patient Name _____ Date of Birth _____ / _____ / _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protect health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allow for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes ☐ No ☐

May we leave a message on your answering machine at home or on your cell phone? Yes ☐ No ☐

May we discuss your medical condition with any member of your family? Yes ☐ No ☐

If yes, please name the members allowed _____

PATIENT OR GUARDIAN SIGNATURE _____ Date _____ / _____ / _____

Witness Signature _____ Date _____ / _____ / _____

SPECIALTY CARE CLINICS – PRESCRIPTION REFILLS AND PHONE MESSAGES

Patient Name _____ Date of Birth _____ / _____ / _____

PATIENT INSURANCE POLICY:

- It is your responsibility to know your insurance and bring your card with you to all appointments
- Is Dr. David Masel, MD a CONTRACTED PROVIDER of your insurance?
- Do you need PRIOR AUTHORIZATION for procedures?
- Are x-rays and supplies included in your COPAY?
- How much is your COPAY for a specialist?
- Do you have a YEARLY DEDUCTIBLE? If so, has it been met?

PLEASE HELP US HELP YOU. There are hundreds of insurance companies thereby making it almost impossible for our staff to know the specific requirements for each policy. Please call your insurance company prior to your appointment to obtain this needed information.

PROTOCOL FOR PRESCRIPTION REFILLS:

- Please reach out to your pharmacy first for refill requests
- Please allow 48-72 hours on refill requests

In order to be as efficient as possible, these are the policies in effect regarding all prescriptions.

HIPPA EXCEPTIONS (Please check all that apply):

- ☐ OK to have a message left on my answering machine.
- ☐ OK to leave a message with spouse; name of spouse _____
- ☐ OK to leave a message with any adult who answers my phone.
- ☐ OK to leave a message regarding appointments ONLY

I have read and understand the above information regarding MY INSURANACE POLICY, PRESCRIPTION REFILLS, and the HIPAA EXCEPTIONS AUTHORIZATION for leaving messages.

PATIENT OR GUARDIAN SIGNATURE _____ Date _____ / _____ / _____

SPECIALTY CARE CLINICS – MEDICAL RELEASE FORM

I hereby authorize _____ to release to Specialty Care Clinics, Dr. David Masel, MD, information contained in the medical records of:

- Name of Patient _____
- Date of Birth _____ / _____ / _____
- SSN _____ - _____ - _____

SPECIFIC INFORMATION TO BE DISCLOSED:

- ☐ History
- ☐ Physical
- ☐ Therapy Reports
- ☐ Operative Report
- ☐ Radiology Imaging
- ☐ Care Plan
- ☐ Lab Report
- ☐ EMG
- ☐ Office Notes
- ☐ Immunizations
- ☐ Psychological Reports
- ☐ Other _____

I give permission for release of any information in my records, including information relevant to substance abuse, psychiatric mental health services or HIV (positive or negative) unless specifically excluded below.

DO NOT RELEASE INFORMATION RELATED TO:

- ☐ HIV
- ☐ Substance Abuse
- ☐ Psychiatric/Mental Health
- ☐ Other _____

THE ABOVE INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE AND THAT PURPOSE ONLY:

- ☐ Medical
- ☐ Attorney
- ☐ Insurance
- ☐ Other _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it; and that in any event, this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event, or condition as follows. I agree that a photocopy of this authorization may be considered valid:

- ☐ Yes
- ☐ No

THIS INFORMATION IS PRIVILEGED AND CONFIDENTIAL. IT IS INTENDED FOR THE INDIVIDUAL ENTITY DESIGNATED. YOU ARE HEREBY NOTIFIED THAT DISSEMINATION DISTRIBUTION, COPY OR OTHER USE OF THIS INFORMATION BY ANYONE OTHER THAN THE RECIPIENT DESIGNATED ABOVE IS AUTHORIZED AND STRICTLY PROHIBITED.

PATIENT OR GUARDIAN SIGNATURE _____ Date _____ / _____ / _____

SPECIALTY CARE CLINICS – INTAKE

Patient Name _____ Date of Birth _____ / _____ / _____

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____ City_____ State _____ Zip _____

CHIEF COMPLAINT (Check all that apply):

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Other _____
- ☐ Arm Pain
- ☐ Leg Pain

HISTORY OF ILLNESS:

Age _____ Sex _____ Height _____ ft. _____ in. Weight _____ lbs.

Injury? Yes ☐ No ☐ Date of injury _____ / _____ / _____ Work Related Injury? Yes ☐ No ☐

How did the injury occur? _____

_____

_____

_____

How long have you had this problem/pain _____

Has it gotten worse recently? Yes ☐ No ☐ If yes, when did it get worse? _____

Please rate the severity of your pain (10 is the greatest pain):

- Back N/A 1 2 3 4 5 6 7 8 9 10
- Neck N/A 1 2 3 4 5 6 7 8 9 10
- Leg(s) N/A 1 2 3 4 5 6 7 8 9 10 Which leg is worse? Right ☐ Left ☐
- Arm(s) N/A 1 2 3 4 5 6 7 8 9 10 Which arm is worse? Right ☐ Left ☐

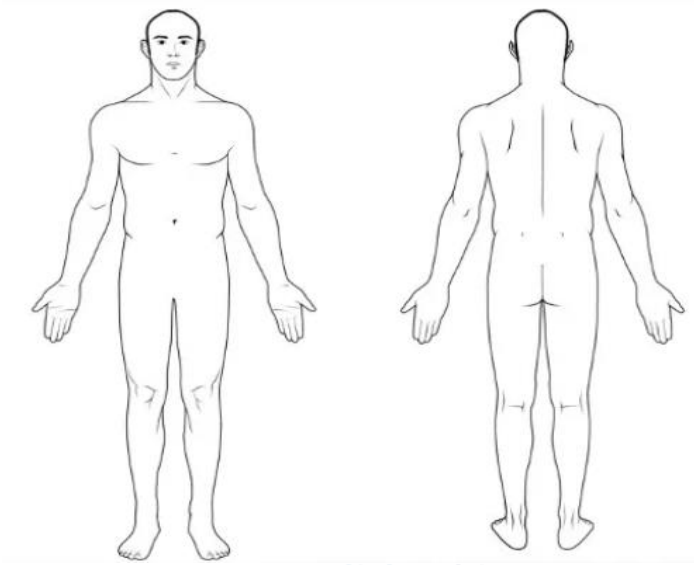
Bowel Problems? Yes ☐ No ☐ How long? _____

Bladder Problems? Yes ☐ No ☐ How long? _____

PLEASE INDICATE THE DISTRIBUTION OF YOUR PAIN/SYMPTOMS ON THE DIAGRAM TO THE RIGHT:

XXXXXXX Pain

0000000 Numbness, Tingling, Pins, Needles



Limitations from the pain:

- Sitting _____ Min. ☐ Hrs. ☐
- Walking _____ Feet
- Standing _____ Min. ☐ Hrs. ☐

Does the pain interfere with sleeping? Yes ☐ No ☐

Does the pain interfere with work or play? Yes ☐ No ☐

What makes the pain better or worse (check all that apply)?

	Better	Worse
• Sitting	☐	☐
• Standing	☐	☐
• Coughing	☐	☐
• Leaning backwards	☐	☐
• Leaning forward	☐	☐
• Other	_____	_____

Which of these tests have you had before and when (check all that apply and include most recent studies)?

- ☐ MRI Date _____ / _____ / _____
- ☐ CT / CT myelogram Date _____ / _____ / _____
- ☐ EMG / NCS Date _____ / _____ / _____
- ☐ Discogram Date _____ / _____ / _____

What have you tried for the pain so far (check all that apply)?

Did it help?

- ☐ Physical therapy Yes ☐ No ☐
  - How long ago? _____
  - Are you satisfied with the effort? Yes ☐ No ☐
- ☐ NSAIDs (e.g. ibuprofen, Naprosyn, meloxicam, Celebrex) Yes ☐ No ☐
- ☐ Oral steroids (e.g. Medrol dose pack, prednisone, methylprednisolone) Yes ☐ No ☐
- ☐ Muscle relaxers (e.g. cyclobenzaprine, methocarbamol, baclofen) Yes ☐ No ☐
- ☐ Membrane stabilizers / nerve pain (e.g. gabapentin, Lyrica) Yes ☐ No ☐
- ☐ Pain meds (e.g. Hydrocodone, Norco, Percocet, Vicodin) Yes ☐ No ☐
  - How much? _____
  - For how long? _____
- ☐ Injections (e.g. epidural steroidal injection, facet, nerve block) Yes ☐ No ☐
  - How much? _____
  - For how long? _____
  - Last injection _____
- ☐ Neck / Back Surgery (include dates): Yes ☐ No ☐
  - How much? _____
  - For how long? _____

PATIENT'S MEDICAL HISTORY:

Medications: Please list all medications you currently take along with its dosing and schedule

Name	*Dose/Schedule*	*Reason for Medication*	*Side Effects*

Please report if you have had or are currently experiencing any of the following:

Heart Disease	Yes ☐ No ☐	Specify _____
Lung Disease	Yes ☐ No ☐	Specify _____
Kidney Disease	Yes ☐ No ☐	Specify _____
Neurologic Disease	Yes ☐ No ☐	Specify _____
Cancer	Yes ☐ No ☐	Specify _____
Liver Disease / Hepatitis	Yes ☐ No ☐	Specify _____
Prostate Disease	Yes ☐ No ☐	Specify _____
Psychiatric / Depression	Yes ☐ No ☐	Specify _____
Stroke	Yes ☐ No ☐	Specify _____

Allergies: Please list any allergies with medications along with reaction type

Name	*Reaction Type*

Past Surgical / Hospitalization History:

Surgery / Hospitalization	*Year*	*Complications*

Have you ever had general anesthesia (i.e. being put to sleep for an operation)? Yes ☐ No ☐

Have you ever had problems with anesthesia? Yes ☐ No ☐ If yes, please describe _____

Are your immunizations up to date? Yes ☐ No ☐ If no, which ones _____

Family History:

Member	*Alive / Deceased*	*Age*	*Health Status / Cause of Death*
Father	A ☐ D ☐		
Mother	A ☐ D ☐		
Sister / Brother	A ☐ D ☐		
Sister / Brother	A ☐ D ☐		
Sister / Brother	A ☐ D ☐		
Sister / Brother	A ☐ D ☐		

Family Member History of

Cardiac disease	Yes ☐ No ☐	Who _____
Stroke	Yes ☐ No ☐	Who _____
Diabetes	Yes ☐ No ☐	Who _____
Neurologic Problems	Yes ☐ No ☐	Who _____
Spine Problems	Yes ☐ No ☐	Who _____

Social History:

Occupation _____ Children? Yes ☐ No ☐ If yes, ages _____

Live alone? Yes ☐ No ☐ If yes, do you have help or family nearby? Yes ☐ No ☐

Smoker? Yes ☐ No ☐ How many packs per day? _____ For how long? _____

Chew tobacco? Yes ☐ No ☐ How much per day? _____ For how long? _____

Quit smoking? < 1 year ☐ 2-4 years ☐ 5-10 years ☐ Other ☐

Drugs (e.g. marijuana, cocaine)? Yes ☐ No ☐ If yes, what? _____

Drink alcohol? Daily ☐ 1-2x/week ☐ 1-2x/month ☐ 1-2x/year ☐ None ☐

Alcohol preference _____

Exercise? Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never ☐

What type of exercise? _____

Review of Systems:

Anemia	Yes ☐ No ☐	High blood pressure	Yes ☐ No ☐
Abdominal pain	Yes ☐ No ☐	Muscle spasms	Yes ☐ No ☐
Balance problems	Yes ☐ No ☐	Nausea	Yes ☐ No ☐
Bleeding problems	Yes ☐ No ☐	Osteoarthritis	Yes ☐ No ☐
Bloody stool	Yes ☐ No ☐	Palpitations	Yes ☐ No ☐
Bloody urine	Yes ☐ No ☐	Rash	Yes ☐ No ☐
Blood clots	Yes ☐ No ☐	Shortness of breath	Yes ☐ No ☐
Chest pain / angina	Yes ☐ No ☐	Speech changes	Yes ☐ No ☐
Constipation	Yes ☐ No ☐	Swelling	Yes ☐ No ☐
Cough	Yes ☐ No ☐	Swollen glands	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Stomach ulcers	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐	Seizures / epilepsy	Yes ☐ No ☐
Fainting	Yes ☐ No ☐	Thyroid disease	Yes ☐ No ☐
Female organs / menstrual	Yes ☐ No ☐	Tremor	Yes ☐ No ☐
Fever	Yes ☐ No ☐	Urine retention	Yes ☐ No ☐
Hearing changes	Yes ☐ No ☐	Vision changes	Yes ☐ No ☐
Heat / cold intolerance	Yes ☐ No ☐	Weight loss	Yes ☐ No ☐
Hair / nail changes	Yes ☐ No ☐		

Other _____

Comments regarding any health issues not covered on this form:

_____

_____

_____

_____

_____

PATIENT OR GUARDIAN SIGNATURE _____ Date _____ / _____ / _____