NEUROSURGICAL ASSOCIATION OF HOUSTON
David J. MacDougall, DO, FACOS, PA
Robert J. Williams, PA-C

4201 Garth Rd.
Plaza 1, Suite 205
Baytown, TX 77521
Tel: (713) 795-5300
Fax: (713) 795-0030

Patient Name: _____

Your appointment will be on _____ at _____

COMPLAINT: _____

CLINIC OFFICE ADDRESS

4201 Garth Road, Plaza One, Suite #205 Baytown Texas 77521
(CORNER OF GARTH AND BAKER, BAYTOWN, TX)

We REQUIRE that you bring all your diagnostic imaging CDs to this appointment for the above complaint. Examples of these would be MRI scan, Myelogram, CAT scan, EMG nerve test, or plain x-rays as well as all printed radiologist reports.

If you come to this appointment without your CD AND your new patient packet filled out entirely, you appointment will be rescheduled.

We accept Aetna, Assurant, Blue Cross Blue Shield, Cigna, Humana, Meritain Health, MHealth, United Healthcare, Medicare, and most PPO Medicare Advantage plans. **We accept PPO plans only**. We **DO** however accept Healthspring and AARP Medicare Complete

Insurance copays are expected at time of visit.
We accept cash, debit, or credit cards ONLY. Personal checks are no longer accepted.

Please complete the enclosed forms and bring them with you for your appointment.

Dr. MacDougall does not prescribe pain medications. Pain medication is only prescribed by Dr. MacDougal post-operatively. For any pain medication requests, you will need to contact your referring/treating physician.

If you are unable to make this appointment, please call our office within 24 hours of your scheduled appointment.

Thank you,
Neurosurgical Association of Houston

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PATIENT REGISTRATION
CLINIC ADDRESS
4201 Garth Road Plaza One Suite 205
Baytown, Texas 77521

DATE: _____ Have you or your spouse ever been in the military _____

Cell #_____ Home #_____ Work # _____ Email_____

Patient Last Name _____First Name_____ Initial_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured Name _____How and where did you learn about this clinic? _____
Last Name First Name Initial

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To: ☐ Illness ☐ Employment ☐ Auto ☐ Other

Race:_____ Language Spoken:_____ Hispanic or Hispanic Origin:_____ Refuse to answer_____

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City_____ State_____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate _____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address _____Phone_____ Occupation_____ City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____

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Patient Registration Page 2

MEDICAL AND LEGAL

INFORMATION

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury where someone else might be legally liable for? ☐ **Yes** ☐ **No** **Your Initials:** _____

If you answered yes, please notify the front desk.

Are you Pregnant ☐ Yes ☐ No Do you have a Pacemaker ☐ Yes ☐ No

Family Physician _____ Phone # _____

Person to contact in case of emergency _____

Phone # _____ Relationship _____

Cell # _____

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment of Benefits and Designation of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian/Patient Date

COMMENTS: _____

_____

_____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Neurosurgical Association of Houston to furnish any consulting physician or insurance company and its representative, any information or copies of all hospital, medical records, consultations, and prescriptions related to my illness. A copy of this authorization shall be effective and valid.

INITIALS: _____

AUTHORIZATION TO LEAVE MESSAGE

I authorize the staff of Neurosurgical Association of Houston to leave necessary messages at my home phone, cell phone, or place of employment.

INITIALS: _____

AUTHORIZATION TO SPEAK WITH SOMEONE ON MY BEHALF

I authorize Neurosurgical Association of Houston to speak with _____

Relationship_____ Phone# _____ regarding my healthcare from this office.

INITIALS: _____

GENERAL CONSENT FOR TREATMENT

BY SIGNING THIS CONSENT BELOW, I AM NOT CONSENTING FOR SURGERY TO BE PERFORMED DURING MY OFFICE VISIT. ANY SURGICAL PROCEDURE WILL REQUIRE A LENGHTY CONSENT FORM TO BE OBTAINED BY DR. MACDOUGALL OR ONE OF HIS PHYSICIAN ASSISTANTS, ROBERT J. WILLIAMS, PA-C OR LEE ANN CONRAD, PA-C

I, knowing that I am suffering from a condition requiring diagnostic medical treatment, do hereby voluntarily consent to such treatment, examination and care and to such medical or other services under the specific instructions of David J. MacDougall, DO, FACOS, PA, and his assistants or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the result or outcome of treatment or examinations by David J. MacDougall, DO, FACOS, PA or his designees.

PATIENT SIGNATURE: _____ **DATE:** _____

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INFORMATION REGARDING COMPLETION OF EMPLOYER, DISABILITY, OR FMLA FORMS

This office does not complete insurance disability or other financial forms unless you have had surgery by Dr. MacDougall. If you are not an operative patient, you will need to have these forms completed by your family physician. Once surgery is performed we will be more than happy to complete your short term disability forms or financial forms for a period of 90 days only following surgery. Any forms required after the 90 day post op period will be accessed a charge of $50.00 per page (front and back $100).

PATIENT SIGNATURE: _____ **DATE:** _____

NOTICE REGARDING EXPERT/LEGAL TESTIMONY INVOLVING AUTO ACCIDENTS OR OTHER LITIGATION CASES

DUE TO THE OVERWHELMING REQUESTS FOR DR. MACDOUGALL TO TESTIFY IN LITIGATION (LAWSUITE) CASES, IT HAS BECOME NECESSARY TO INFORM OUR CURRENT AND FUTURE PATIENTS THAT DR. MACDOUGALL DOES NOT PROVIDE THIS SERVICE AS IT TAKES AWAY FROM HIS PRACTICE AND TREATING HIS PATIENTS. DR. MACDOUGALL DOES NOT WRITE LETTERS FOR PATIENTS OR ATTORNEYS STATING THAT AN INJURY IS OR IS NOT A DIRECT RESULT OF AN AUTO ACCIDENT OR ANY OTHER ACCIDENT. THE PRACTIONERS IN THIS PRACTICE DO NOT MEET WITH ATTORNEYS NOR DO THEY PROVIDE FUTURE MEDICAL COSTS INVOLVING AUTO ACCIDENTS OR OTHER ACCIDENTS FOR LITIGATION CASES. NEUROSURGICAL ASSOCIATION OF HOUSTON DOES NOT ACCEPT LETTERS OF PROTECTION OR FILE PERSONAL INJURY PROTECTION INSURANCE. PLEASE SIGN BELOW TO INDICATE YOUR UNDERSTANDING OF OUR LITIGATION POLICY. THERE ARE NO EXCEPTIONS TO THIS POLICY.

PATIENT SIGNATURE: _____ **DATE:** _____

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ALL PATIENTS – WORKMAN'S COMP. DISCLAIMER

Dr. MacDougall does not accept workman's comp insurance. If you have an ongoing workman's comp claim for your spine we will not be able to see you in our office. A patient cannot choose to use his/her private insurance to cover a workman's comp claim once a claim has been started. This is considered insurance fraud and it is against the law.

I, _____, know and understand that I will be responsible for refunding any private insurance money paid to Neurosurgical Association of Houston and its providers (MacDougall, Williams or Staley) or this office for services performed on an unreported workman's comp injury. If at any time, I decide that I want to file this as a workman's comp injury after services are performed, or it was determined that I had services performed for a workman's comp injury, I will be responsible for reimbursing my private insurance carrier any money paid to Neurosurgical Association of Houston and its providers for services rendered for my claim(s). If at any time my private insurance company recoups or takes back money paid to these providers, I will be 100% financially responsible for any outstanding balances not paid or recouped from my private insurance carrier. Once it has been determined that I have or had a workman's comp injury, I know and understand that I will need to seek care from a workman's comp provider.

PATIENT SIGNATURE: _____ **DATE:** _____

OUT OF NETWORK REFERRALS

This office will try to refer you to a facility or provider that is in network with your insurance company. The occasion may arise that you are referred to an out of network provider or facility for services that are required for diagnostic testing or for inpatient care.

PATIENT SIGNATURE: _____ **DATE:** _____

Name: _____ Height: _____

Date: _____ Weight: _____

Present History

What is the main reason for your visit today? : _____

_____

When and how did your problem start? : _____

_____

Describe the location of your symptoms and/ or pain: _____

_____

Describe your symptoms: ___ burning ___ numbness ___ stabbing ___ pins ___ ache ___ tingling

___weakness or other_____

Please indicate the severity of your pain on a scale from 1 to 10 ("10" being most severe, "0" if no pain)

At Worst

0___1___2___3___4___5___6___7___8___9___10

At Best

0___1___2___3___4___5___6___7___8___9___10

What makes your symptoms/pain worse? : _____

_____

What helps to relieve your symptoms (e.g. ice, heat, sitting, standing)? : _____

_____

Have you tried any of the following treatments?

__Physical Therapy ..... duration_____ __ Traction.....duration _____

__ Chiropractor..... duration _____

__Anti-inflammatories....name/duration _____

__Muscle relaxants.....name/duration_____

__Pain medications.....name/duration _____

__Injections....Please list_____

Please list any X-rays, CT Scans, MRI's, Nerve studies, or other tests related to your condition that you have had: _____

Medications

****MAKE CERTAIN TO LIST BLOOD THINNERS (i.e. aspirin) AND ALL OVER THE COUNTER MEDICATIONS AND VITIMINS****

NAME	STRENGTH	FREQUENCY	REASON

Name: _____

Date: _____

Drug Allergies

Drug name/Reaction

1. _____
2. _____
3. _____
4. _____

Past Medical History

Please check all that apply to you or your family, now or in the past:

Patient / Family Member (Specify who)

_____	_____	High Blood Pressure	_____	_____	Bleeding Disorder
_____	_____	Diabetes	_____	_____	Hepatitis
_____	_____	Heart Disease	_____	_____	Kidney Disease
_____	_____	Anemia	_____	_____	TB (Tuberculosis)
_____	_____	Asthma	_____	_____	Sleep Apnea
_____	_____	Emphysema/COPD	_____	_____	Stomach ulcers
_____	_____	Thyroid problems	_____	_____	Cancer _____
_____	_____	Arthritis	_____	_____	Seizures
_____	_____	Stroke	_____	_____	Migraines
_____	_____	Depression/Anxiety	_____	_____	Other _____

Past Surgical History

Please list ALL surgeries:

Date	Surgery	Doctor/Location
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____

Any complications with Anesthesia? ____ Yes ____ No Complication _____

Past Hospitalizations

Date	Reason	Doctor/Location
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____
_____/	_____/	_____

Social History

Work Status: _____ Employed _____ Unemployed _____Retired

Occupation: _____

Are you currently able to work? : _____ Yes _____ No

If not working, is it due to this problem? : _____ Yes _____ No When did you last work?: _____

_____Work related injury? Date: _____ Is this a worker's compensation case? _____Yes _____ No

_____ Motor Vehicle Accident? Date: _____ Is this a personal injury case? _____ Yes _____ No

Are you on Disability? _____ Yes _____ No

Do you use tobacco? _____Currently _____ Previously How long? _____ Quit Date: _____

(Check all that apply) ___Cigarettes ___Cigars ___ Chew ___ Amount _____

Do you consume alcoholic beverages? __Yes __ No Amount_____ Frequency _____

Do you now or have you ever abused prescription drugs or other illegal drugs? _____Yes _____ No

Describe: _____

Do you drink coffee or drinks with caffeine? _____ Yes _____ No Amount _____

Name: _____

Date: _____

Please circle any CURRENT symptoms that you are experiencing:

Constitutional

Fever, unexplained weight loss or weight gain in the last 12 months

Allergy/Immune

Colds, runny nose, nasal/ seasonal allergies

Ophthalmology

Double vision, loss of vision, visual changes

ENT/ Respiratory

Change in voice, difficulty swallowing, chronic cough, hearing loss

Endocrinology

Urinating frequently, diabetes, sexual dysfunction

Cardiology

Chest pain, shortness of breath, irregular heart beat

Gastroenterology

Abdominal pain, constipation, diarrhea, nausea, vomiting

Hematology

Easy bruising

Musculoskeletal

Joint pain, leg cramps

Neurology

Headache, Seizures, fainting spells, numbness

PLEASE LIST ALL OF YOUR CURRENT DOCTORS

PHYSICIAN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

Physician's Specialty: _____

PHYSICIAN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

Physician's Specialty: _____

PHYSICIAN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Fax number: _____

Physician's Specialty: _____

Pharmacy

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone number: _____ **Fax number:** _____

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FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE
- WE ACCEPT CASH, DEBIT CARDS, AND ALL MAJOR CREDIT CARDS (CHECKS NOT ACCEPTED)
- WE ACCEPT ALL HEALTH SAVINGS ACCOUNT (HSA) PAYMENT.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Affordable Care Act (ACA) Discount

We may offer Affordable Care Act (ACA) Discounts to uninsured (Cash-Pay) and under-insured patients. We may also waive your cost-sharing amounts, deductibles, co-insurance and co-pay based on the individual medical needs and ability to pay, on a case-by-case, non-routine, unadvertised basis for under-insured patients, and after determining in good faith that you are in financial need or after reasonable collection efforts failed. Unless expressly prohibited by any specific terms of the health plan, we are fully in compliance with the terms of health plan, applicable federal and state laws under our Corporate Indigency Policy.

Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage. Our patient advocate collection efforts are proactive with indigency determination and subsequent claim submissions and/or appeals. Any patient balance billing is only consequential to administrative and/or judicial appeal outcomes and subject to proactive patient indigency agreement.

You may apply for financial indigency ACA Discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to

every patient, however we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, Dr. MacDougall participates in Aetna, Assurant Health, Blue Cross/Blue Shield, Cigna, Meritain Health, MHealth, United Healthcare, and others not listed. He doesn't participate in any HMO policies. Please contact our office if your insurance company is not listed above to verify if we are in your insurance network.

At this time Robert J. Williams, PA-C and Lee Ann Conrad, PA-C are out of network for all insurance plans.

Dr. MacDougall participates in Medicare Part B, as well as most PPO Medicare Advantage plans. Most health plans or Insurance Polices may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain pre-certification if applicable for all services as a courtesy to you before your surgery.

Please understand that all insurance verification is not a guarantee of insurance payment.

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 and 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.

Doctor or Facility with affiliation and remuneration: **1. Altus Baytown Hospital**
2. Altus Accountable Care Organization

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff at our office is ready to help you at all time.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ _____ _____

Patient or Responsible Party Signature | Patient Name (print) | Date

X _____ _____ _____

Co-Responsible Party Signature | Your Name (print) | Date

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Patient Protection & Advocacy Policy
Affordable Care Act (ACA) Discount Disclosure
You Are Protected From Any Unexpected Costs And Bills

Dear Patient:

1. As your Patient Advocate (PA), we offer the highest care quality and safety possible at the **most affordable cost to you**, no matter if you are covered by an in-network or out-of-network health plan.
2. We offer an **Affordable Care Act Discount (ACA Discount)** under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. **You only pay what you can afford or are willing to pay** for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, based on your medical need. Most people may qualify and **your satisfaction is guaranteed**.
3. Our Affordable Care Act (ACA) Discount is **similar to or even much better than all PPO discounts**, as our **ACA Discount is available from both in-network and out-of-network providers and facilities**.
4. Once you qualify, **you will NOT receive ANY unexpected invoices, bills or collection letters FROM US**, even if your insurance denies your claims.
5. As your Patient Advocate and Authorized Representative, and under the new federal health reform law PPACA (Patient Protection and Affordable Care Act, or ACA), we may appeal all of the claim denials or delays on your behalf, which is strictly in compliance with the new federal health reform law, PPACA.
6. As your Patient Advocate, **your best interest is our best interest**. To ensure that you also get this kind of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, **so you may also receive the best care possible along with the ACA Discounts and Savings**.
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA Discount and ensure that **you are always protected from any unexpected costs and bills** under the new federal health reform law (PPACA).
8. As your Patient Advocate, we want **you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you.**
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we can not speak for or guarantee anything on behalf of other providers we don't know or are not affiliated with regarding their discount or collection policies. You are advised to contact them directly before scheduling your next appointment(s) or medical procedure(s).
10. **If you are willing to be protected from any unexpected costs and bills,** feel free to apply for our Affordable Care Act Discount under our Corporate PPACA Indigency Policy. "*Once indigence is determined, **collection is no longer undertaken** with regard to the patient for the forgiven amount*". Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

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

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Neurosurgical Association of Houston Compliance Alert, 2013(A)(a)
PPACA Patient Advocacy for Freedom of Choice
Disclosure and Compliance with Texas Occupations Code - Section 102.006

Dear Provider of Patient Advocacy:

In compliance with new health care reform laws, PPACA, and all applicable federal and Texas laws, and as a long-standing patient advocacy practice for patient freedom of choice of healthcare providers solely based on the healthcare quality, safety, provider's reputation and patient satisfaction, we are excited to share with you on our 2013 compliance and advocacy updates.

According to the latest DOL Report in Dec 2012, about **76%** of all insured private industry workers participated in PPO plans that "Allow non-emergency services **outside Network**". In order to advocate for patient PPACA rights for freedom of choice of providers, Neurosurgical Association of Houston adopted the following new policies:
(http://stats.bls.gov/ncs/ebs/detailedprovisions/2012/ownership/private/table02a.pdf)

Effective June 1, 2013, every healthcare provider shall voluntarily submit documents demonstrating your full and proper disclosures in compliance with all applicable federal and state laws, especially Texas Occupations Code - Section 102.006, as well as your managed-care network requirements, when scheduling for an appointment with the Neurosurgical Association of Houston office.

Effective July 1, 2013, every healthcare provider must submit documents demonstrating your full and proper disclosures in compliance with federal and state laws, especially Texas Occupations Code - Section 102.006, as well as your managed-care network requirements, when scheduling for an appointment with all Neurosurgical Association of Houston entities or facilities.

You may fax or email the documents to the Neurosurgical Association of Houston office 24 hours in advance of scheduling patient appointment, or any time for urgent care cases.

It is important that every provider must comply with both *public policies* in applicable federal and state laws and in *private agreement* with managed-care networks in advocating patient rights for freedom of choice. The documents submitted shall include **specific Network Disclosure Forms**, if any, under your PPO participating agreement, and **any forms of your choice demonstrating full and proper compliance with all applicable federal and state laws**.

It is also important to understand that Texas State law mandates for full and proper disclosures for any and all permissible self-referrals, regardless of in-network or out-of-network referrals, for both Medicare or non-Medicare patients, in addition to Medicare Stark Prohibitions and Anti-kickback Statutes.

Under the Section 102.006 of Texas Occupations Code, an attending physician or healthcare provider must disclose to every patient at the time of initial contact and at the time of referral with respect to the choice of a doctor 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 patient's request and exercising patient's rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage in compliance with all applicable federal and state laws. << http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.102.htm>>

As you are well aware that Neurosurgical Association of Houston has been fully dedicated to the patient advocacy for the quality care and patient choice through compliance, we have always shared with you on our compliance initiatives in protecting your practice and your own financial safety in the course of advocating patient rights.

We'll keep you updated on our forthcoming compliance and patient advocacy meetings and training programs. If you have any questions regarding this compliance alert, please do not hesitate to contact Mindy Melendez.

Respectively,
Mindy Melendez
PPACA Compliance Specialist
Neurosurgical Association of Houston Compliance Liaison