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

1626 W. Baker Rd
Baytown, TX 77521
Tel: (713) 795-5300
Fax: (713) 795-0030

Patient Name: _____

Your appointment will be on _____ at _____

COMPLAINT: _____

CLINIC OFFICE ADDRESS

1626 W. Baker Rd. Baytown Texas 77521

(2nd Floor)

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, your appointment will be rescheduled.

THERE WILL BE AN APPOINTMENT NO SHOW FEE OF $25 THAT MUST BE PAID PRIOR TO RESCHEDULING.

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
1626 W. Baker Rd.
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 HIS PHYSICIAN ASSISTANT, ROBERT J. WILLIAMS, 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 only 90 days following surgery. There will be a service fee of $35 for the initial short-term disability and FMLA forms and a $15 charge for any additional forms throughout your time off work. Once payment is received, we will fax the completed forms back to the appropriate entity.

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.
- FULL PAYMENT IS DUE AT TIME OF SERVICE
- 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 of whether or not your insurance will pay for your total balance of your claims. 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 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.

At this time, Dr. MacDougall participates in Aetna, Blue Cross/Blue Shield, Cigna, Meritain Health, MHealth, United Healthcare, Humana, 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 is 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.

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