Seton Brain & Spine Institute

Dear New Patient,

Welcome to Seton Brain & Spine Institute! We are very pleased you selected us for your medical care. Enclosed are forms for you to fill out *prior* to your appointment. This will assist our office staff in making sure we have all the information necessary to provide you with quality care and treatment. Please bring your forms with you to your appointment so we may review your medical history prior to your visit. This allows our staff to have your chart prepared in advance in order to prevent delays in seeing your provider. If you have been referred by another provider or hospital for your condition, please request copies of your medical records prior to your appointment. You may bring your records with you, or they may be faxed to our office at **512-324-8301**. If you had imaging completed at any other location than a ***Seton Facility*** or ***Austin Radiological Association (ARA)***, please request a CD of your images and bring with you to your appointment.

Included in the "Get Started Packet" are the following forms:

- New Patient Registration Form
- Patient History
- Family History
- Patient Record Disclosure
- Seton Patient Rights and Responsibilities (for your review)

If you have any questions or problems filling out the forms, we will be pleased to assist you. Once again, welcome to our practice. We look forward to providing you with quality care.

Thank you,

Seton Brain & Spine Institute

Seton Brain & Spine Institute

REGISTRATION FORM (PLEASE PRINT)

Please Complete Entire form Thank you.

Today's Date:					
PATIENT INFORMATION					
Patient's last name:	**First:**	**Middle:**	Age:	❑ Male ❑ Female	**Date of Birth:** / /
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed		Right _____ or Left _____ Handed?			
Street address:		Social Security no.:			Home phone no: ( )
City	State		ZIP Code		Cell no: ( )
Employer:	Title:				Email:
Work Phone: ( )					
INSURANCE INFORMATION					
Name of Primary insurance:	**Subscriber's name:**	**Birth date:** / /	**Subscriber's SS no:**	**Policy no:**	**Group no:**
Type: ( ) HMO ( ) POS ( ) Choice ( ) PPO/EPO	**Phone no:**		Employer:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of Secondary insurance (if any):	Subscriber's name:	Subscriber DOB:	Subscriber SS# :	Policy no:	
Policy no:	Group no:	Type:	Relation:	Employer:	
EMERGENCY CONTACT					
Last name:	First:	Middle:	Phone no: ( )		
Email:		Relationship to Patient:			
APPOINTMENT INFORMANTION					
Referred by:	Phone No: ( )		**Reason for Visit:**		

Please bring your insurance card to the front desk when you return these forms.

Seton Brain & Spine Institute

PATIENT RECORD OF DISCLOSURE

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protect health information. (PHI)

Patient/ Parent Signature _____Date_____

Print Name_____ DOB_____

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of, disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and Disclosure for TPO may be permitted without prior consent in an emergency.

The following names listed are those that I give Seton Family of Doctors, the authorization to give health information:

Name	Relationship

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices (Version Effective 3/03)

Signature of Patient/ Legal Guardian _____Date_____

(To be completed if patient refuses to sign acknowledgment)

Name of person providing notice _____Date_____

Patient Name_____**Date**_____

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will only be used by your doctor in decisions regarding your care.

HISTORY OF PRESENT ILLNESS

1. What brings you in to see us today?

_____

2. When did this problem begin?

_____

Please check any of the following treatments you have had:

Treatments	Dates	Comments
Surgeries		
Radiation		
Chemotherapy		

PAST MEDICAL HISTORY please list any medical problems you have been diagnosed with:

1._____ 2._____ 3._____

4._____ 5._____ 6. _____

PAST SURGICAL HISTORY and Complications (bleeding, infections, blood clots, pneumonia etc.)
Surgery/ Date/ Complication

1._____ 2._____ 3._____

4._____ 5._____ 6. _____

MEDICATIONS YOU'RE CURRENTLY TAKING: *(If you have a list, please ask Front Desk Personnel to make a copy)*
Medication/Dose/ Frequency

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

ALLERGIES:

_____

Patient Name_____**Date**_____

FAMILY HISTORY
Please circle the diagnosis and list which family member had the following conditions.

Medical Diagnosis	Relationship	Medical Diagnosis	Relationship
Diabetes		Kidney Disease	
Heart Attacks		Cancer	
High Blood Pressure		Aneurysms	
Stroke		Mental Retardation	
High Cholesterol		Other:	

SOCIAL HISTORY
Do you use tobacco? Yes ___ No ___ How many packs per week? ___
Do you drink alcohol? Yes ___ No ___ How many drinks per week? ___
Illicit or Illegal Drug Use? _____
Children? Yes _____ No_____ Number _____
What is your Occupation?_____

REVIEW OF SYSTEMS:
Do you currently experience any of the following symptoms? ***(Circle all that apply)***

Constitutional
Unintentional Weight Loss
Fevers
Fatigue
Night sweats
Insomnia
Feeling faint
Easy/ excessive bruising

Eyes
Glasses/Contacts
Visual Changes
Cataracts
Glaucoma
Double Vision
Painful eyesight with light

Ears/Nose/Mouth/Throat
Sinus problems
Hearing loss
Ringing or Buzzing
Difficulty swallowing
Hoarseness
Nose Bleeds

Cardiovascular
Irregular Heartbeats
Chest Pains
Shortness of Breath
Murmurs

Respiratory
Shortness of Breath
Persistent Cough
Increased or Bloody Mucous
Wheezing

Musculoskeletal
Painful aching joints
Swollen joints
Stiff joints
Muscle spasms

Gastrointestinal
Nausea
Vomiting
Diarrhea
Constipation
Loss of appetite
Change in Stool
Loss of Control of Stool
Abdominal Pain

Genitourinary
Loss of Bladder Control
Urgency
Frequency
Hesitancy to start flow
Start and stopping of flow
Burning or painful urination
Increased need for urination
Blood in urine

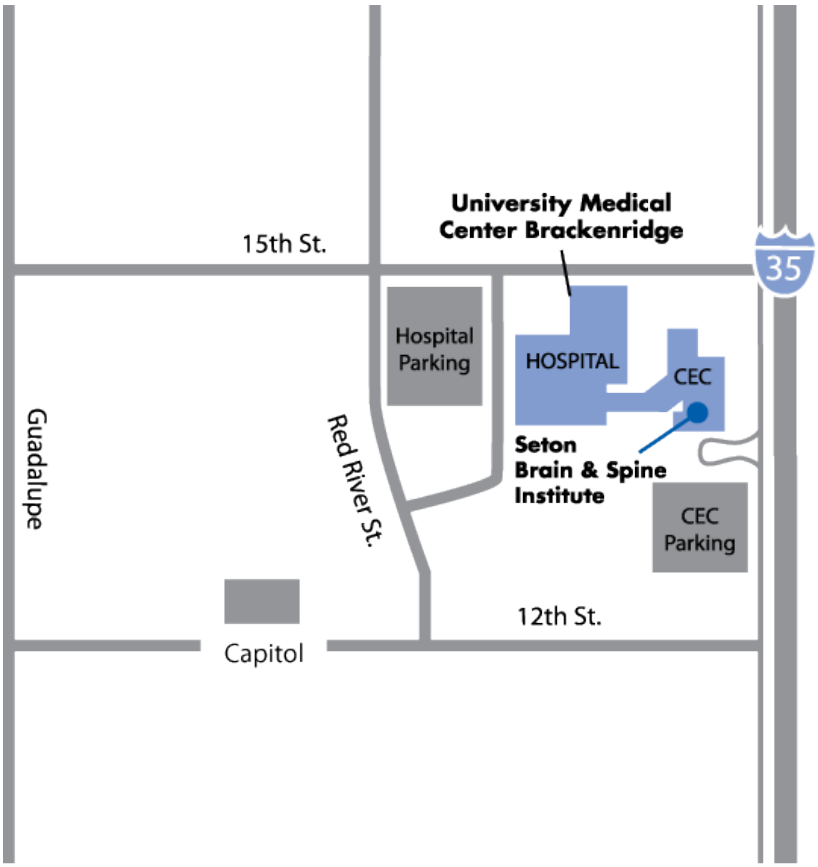
Endocrine
Swollen glands or lymph nodes
Heat or cold intolerance
Excessive thirst

Neurologic
Memory loss
Weakness
Numbness
Thinking trouble
Speech trouble
Headaches

Seton Brain & Spine Institute

Seton Brain & Spine Institute – Central

1400 N IH-35, Suite 300 - Austin, TX 78701
Phone: 512-324-8300 – Fax: 512-324-8301



Directions to the Central Office

PLEASE NOTE THAT WE ARE LOCATED IN THE CLINICAL EDUCATION CENTER BUILDING, NOT THE MEDICAL CENTER.

From South Austin:

- Take IH-35 north and exit 235A toward 15th St/MLK
- Merge onto the IH-35 Frontage Road
- Take U-Turn before traffic light at 15th St (under bridge)
- Entrance to the CEC Building will be on your right
- Please park in the CEC Parking Garage

** We are almost parallel to the ramp back onto IH-35 South

From North Austin:

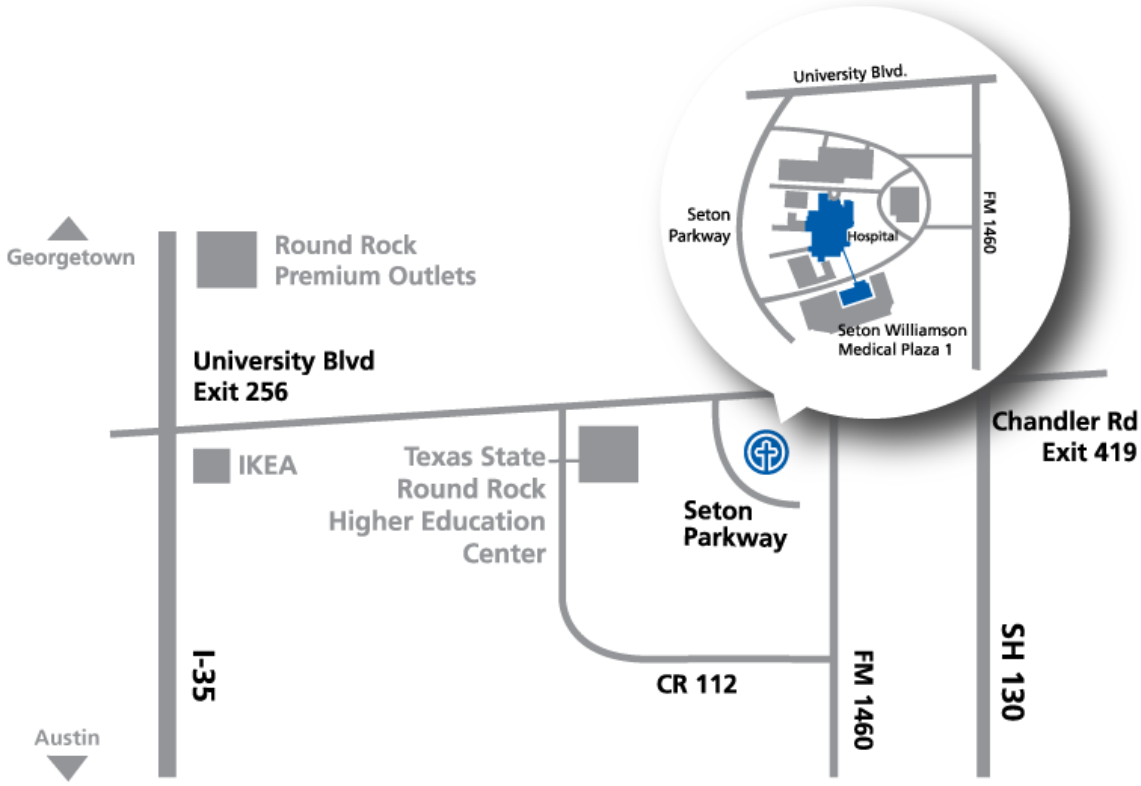
- Take IH-35 south to exit 235A toward 15th St
- Merge onto the IH-35 Frontage Rd
- Continue straight thru the light at 15th St (DO NOT turn onto 15th St)
- Turn right into the CEC Building Entrance (1/2 block after light)
- Please park in the CEC Parking Garage

WE WILL GLADLY VALIDATE YOUR PARKING TICKET. PLEASE USE ELEVATORS AND COME TO THE 3RD FLOOR. WE ARE THE FIRST SUITE WHEN EXITING THE ELEVATORS, SUITE 300.

Seton Brain & Spine Institute

Seton Brain & Spine Institute – Round Rock

301 Seton Pkwy, Suite 402 - Round Rock, TX 78665
Phone (Local Practice): 512-324-4816 – Phone (Scheduling): 512-324-8300



Directions to the Round Rock Office

PLEASE NOTE THAT WE ARE LOCATED IN THE MEDICAL PLAZA I BUILDING, NOT THE MEDICAL CENTER.

From Austin:

- Take IH-35 north and exit 256 toward FM 1431/Cedar Park
- Merge onto the IH-35 Frontage Road
- Take right onto University Blvd
- Turn right onto Seton Blvd
- Please park at the Medical Plaza I building to the right of the hospital

From Georgetown:

- Take IH-35 south to exit 256 toward Texas 26 Spur/Southeast Inner Loop
- Turn right on FM 1460 S
- Stay straight on FM 1460 past University Blvd.
- Seton Medical Center Williamson will be on the right
- Please park at the Medical Plaza I building to the left of the hospital

PLEASE USE ELEVATORS AND COME TO THE 4TH FLOOR. WE ARE IN SUITE 402 TO THE RIGHT.

Seton Brain & Spine Institute

Consent to Treat and Health Care Agreement

(Physician Enterprise Clinic Form)

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee. I understand that Seton Brain & Spine Institute includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to the Seton Brain & Spine Institute until revoked by me in writing.

2. Consent to Release Information

I acknowledge that Seton Brain & Spine Institute may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Seton Brain & Spine Institute.

I acknowledge and consent to allow Seton Brain & Spine Institute to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Seton Brain & Spine Institute all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Seton Brain & Spine Institute are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary

for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Seton Brain & Spine Institute on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Seton Brain & Spine Institute or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of Privacy Practice

I acknowledge receipt of the "Notice of Privacy Practices" from Seton Brain & Spine Institute.

_____ _____
Patient Printed Name Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date