

Brain & Spine Center of Texas, L.L.P.
Dallas Minimally Invasive Spine

Walter X. Loyola, MD, FAANS, FACS

E. Rita Seo, PA-C

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (First, M.I., Last) _____

Date of Birth _____ Social Security # _____ Male / Female

Race _____ Ethnicity (Latino / Non Latino) Language Preference _____

Address _____

Preferred Phone Number _____ Driver's License # _____ Marital Status: S M W D

Employer _____ Phone _____

Referring Physician _____

How did you hear about us? _____

Primary Insurance Information

Insurance Company _____ Phone Number _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Secondary Insurance Information

Insurance Company _____ Phone Number _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

I hereby assign, transfer, and set over to Walter X. Loyola, M.D., P.A. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

Brain & Spine Center of Texas, L.L.P. Dallas Minimally Invasive Spine

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E. Rita Seo, PA-C

Name: _____ Date: _____
 DOB: _____

What is your reason for this office visit? _____
 Date of Injury and/or onset: _____

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.), Please indicate which sensations you feel by referring to the key below.

- Right Handed
- Left Handed

KEY

///// Stabbing

XXXX Burning

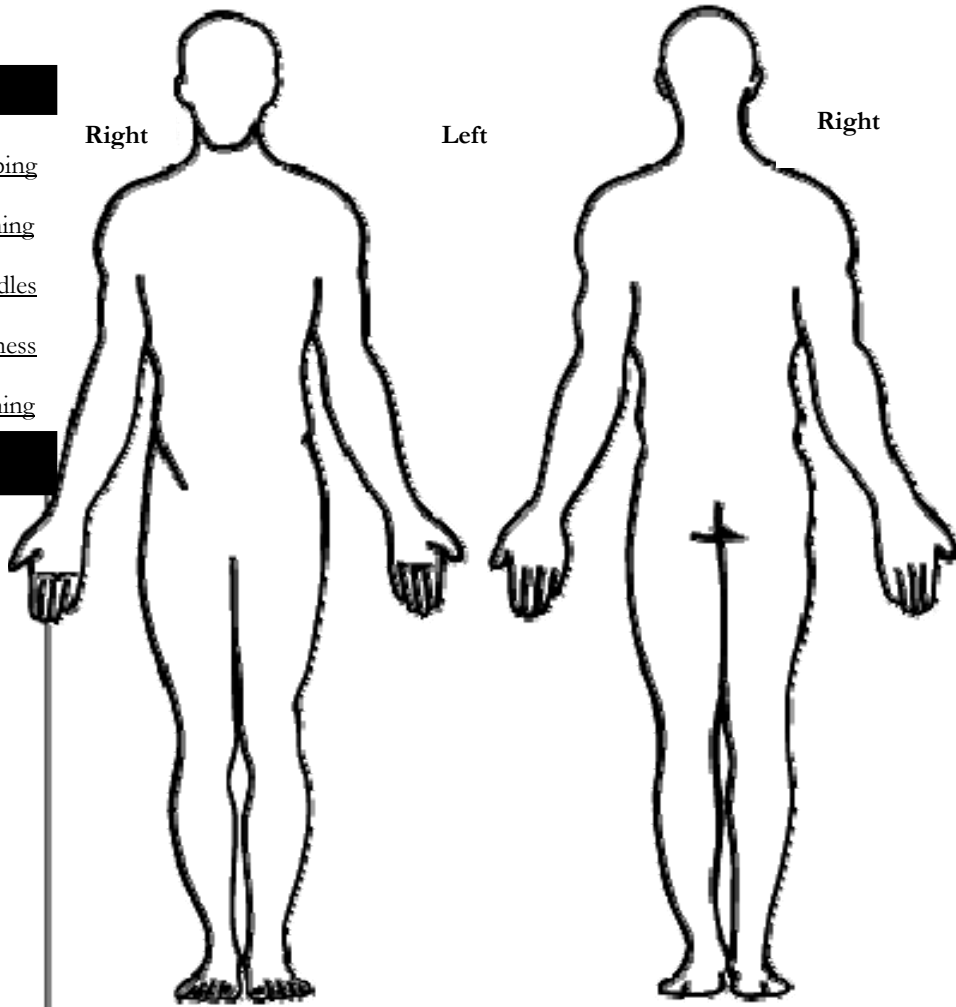
0000 Pins & Needles

==== Numbness

++++ Aching

PAIN LEVEL

- 0 No Pain
- 1 Mild pain, you are aware of it but it doesn't bother you
- 2 Moderate pain that you can tolerate without medication
- 3 Moderate pain that requires medication to tolerate
- 4-5 More severe pain; you begin to feel antisocial
- 6 Severe pain
- 7-9 Intensely severe pain
- 10 Most severe pain



Circle Your Current Pain Level
 0 1 2 3 4 5 6 7 8 9 10

Occupation: _____

Are you currently working?: Yes No

If Student, Full-Time / Part-Time

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Name: _____ Date: _____
DOB: _____

Please list all medications you are currently taking: Complete list entered through patient portal

NAME	DOSE	FREQUENCY	PRESCRIBING M.D.

**MEDICATION PRESCRIPTION AND REFILL POLICY FOR
WALTER X. LOYOLA, M.D., F.A.C.S.**

As a reminder to our patients, this is a surgical practice. It is not our policy to prescribe pain medications on a long term basis. Pain medications are prescribed in the immediate postoperative period.

You must only receive pain medication from one physician.

Requests and/or refills for medications will be accepted only from your pharmacy during our regular office hours from 8:30 A.M.-5:00 P.M. Monday-Thursday and 8:30A.M.-3:00P.M. Friday. If your request is received after 2:00 P.M., it will be processed the following business day.

Absolutely no refills will be authorized on Saturday or Sunday.

I have read and understand the above policy.

Patient Signature & Date

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E. Rita Seo, PA-C

Name: _____ Date: _____
DOB: _____

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept cash, check, Visa, MasterCard, and Discover, We will charge 6% annual interest rate on all accounts with balances older than 30 days.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment and/or deductible at the time of service. This office has the policy to collect this co-payment and/or deductible when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all service provided in the hospital Walter X. Loyola, M.D. and E. Rita Seo, PA-C. Any balance due is your responsibility and is due upon receipt of a statement for our office.
- You may request an estimate of the cost for the proposed services before the procedure is performed.
- If we receive a check of non-sufficient funds there is a \$40.00 fee.

Minor Patients

For all services rendered to minor patients, we will look to the adult and/or guardian with custody accompanying the patient for payment.

Notice of Financial Interests

You are informed by this Notice that Walter X. Loyola, M.D. holds a financial interest in Texas Health Center for Diagnostics & Surgery of Flower Mound, Methodist McKinney Hospital, and other facilities. You have the option, at your discretion, to use an alternate health care facility and/or inquire if the facility you are being sent to has any financial interest with Walter X. Loyola, M.D.

By my signature, I agree to comply with the Financial Policy, Consent to Treat Policy, Authorization to Release Information, Assignment of Benefits, Patient Record of Disclosures, and Notice to Patients of Financial Interests.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient

Signature of the Patient or Responsible Party if a Minor

Date

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Name: _____ Date: _____
DOB: _____

Disclosure Authorization

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home

Please indicate how you would like to be contacted and receive information from this office.

Home Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Work Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Mobile Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Written Communication:

- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number: _____
- O.K. to email to this address: _____

If you desire for us to contact another individual you must complete a different form prior to any contact being made with the other individual.

Signature

Date

Printed Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and 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 requested by the individual. Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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Name: _____ Date: _____

DOB: _____

Pharmacy Name: _____

Address: _____

Phone: _____

Fax: _____

NO SHOW AND CANCELLATION POLICY

Patients who do not keep their appointments or provide 24 hour notice of cancellation will be subject to a charge of \$25.00. This fee will be applied after the second missed appointment or second failure to provide 24 hour notice of cancellation within a 12 month period. This is not a billable charge to any insurance company and is the responsibility of the patient.

If a patient misses or cancels 3 times, we reserve the right to dismiss that patient from the care of Walter X. Loyola, M.D.

Printed Name of the Patient

Signature of the Patient or Responsible Party if a Minor

Date

NOTICE OF PRIVACY PRACTICES

Effective Date: December 02, 2002

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact:

Walter X. Loyola, M.D., P.A. at 972-312-0607

WHO WILL FOLLOW THIS NOTICE?

- Walter X. Loyola, M.D., P.A.
- Walter X. Loyola, M.D., P.A. providers
- All Walter X. Loyola, M.D., P.A. employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Walter X. Loyola, M.D., P.A., a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as “medical information”). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

Walter X. Loyola, M.D., P.A. shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;

- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Walter X. Loyola, M.D., P.A. will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run Walter X. Loyola, M.D., P.A. in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Walter X. Loyola, M.D., P.A. may provide a written or telephone reminder that your next appointment with Walter X. Loyola, M.D., P.A. is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of

procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
 - To prevent or control disease, injury, or disability;
 - To report reactions to medications or problems with products;
 - To notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
 - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order or subpoena; or
 - If Walter X. Loyola, M.D., P.A. determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (*e.g.*, to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for Walter X. Loyola, M.D., P.A. If you request a copy of the information, Walter X. Loyola, M.D., P.A. may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.

Walter X. Loyola, M.D., P.A. may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Walter X. Loyola, M.D., P.A. will review your request and denial. The person conducting the review will not be the person who denied your request. Walter X. Loyola, M.D., P.A. will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Walter X. Loyola, M.D., P.A. to amend the information. You have the right to request an amendment for as long as the information is kept by Walter X. Loyola, M.D., P.A.
- To request an amendment, your request must be made in writing and submitted to Walter X. Loyola, M.D., P.A. . In addition, you must provide a reason that supports your request.

Walter X. Loyola, M.D., P.A. may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Walter X. Loyola, M.D., P.A. may deny your request if you ask us to amend information that:

- Was not created by Walter X. Loyola, M.D., P.A. , unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by Walter X. Loyola, M.D., P.A. ;
 - Is not part of the information which you would be permitted to inspect and copy; or
 - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

To request this list you must submit your request in writing to *Ivette Loyola –Privacy Officer*. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Walter X. Loyola, M.D., P.A. will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Walter X. Loyola, M.D., P.A. uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Walter X. Loyola, M.D., P.A. discloses about you to someone who is involved in your care or the payment for your care.

Walter X. Loyola, M.D., P.A. is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Walter X. Loyola, M.D., P.A. has been paid out of pocket in full. Should Walter X. Loyola, M.D., P.A. agree to your request, Walter X. Loyola, M.D., P.A. will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions you must make your request in writing to Walter X. Loyola, M.D., P.A. . In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Walter X. Loyola, M.D., P.A. 's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that Walter X. Loyola, M.D., P.A. communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Walter X. Loyola, M.D., P.A. contact you only at work or by mail.

To request that Walter X. Loyola, M.D., P.A. communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Walter X. Loyola, M.D., P.A. will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer .

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Walter X. Loyola, M.D., P.A. or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Walter X. Loyola, M.D., P.A. , contact the Privacy Officer at Walter X. Loyola, M.D., P.A. . Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

*Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202*

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

**PATIENT AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

I understand Walter X. Loyola, M.D., P.A. is authorized by me to use or disclose my protected health information ("PHI") for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

I specifically authorize Walter X. Loyola, M.D., P.A. or its designated employee(s) to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization if I do so in accordance with the steps set forth below.

Description of the information to be used or disclosed (*check all that apply*):

My entire record

Note: This requires an explanation of why it is necessary to disclose the entire record.

My demographic information (*check all that apply*):

- | | | | |
|-------------------------------|----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Name | <input type="checkbox"/> Address | <input type="checkbox"/> State/Zip Code only | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Age | <input type="checkbox"/> Gender | <input type="checkbox"/> Race | <input type="checkbox"/> Other _____ |

Medical Data/Information related to:

- Specific condition(s) _____
- Specific professional service(s) _____
- Specific medication(s) _____
- Other _____

Other _____

Please disclose the above information to:

Name _____ Phone Number _____

Address _____

I do do not authorize this information to be faxed. If yes, fax number _____

Name(s) or class of person(s) to whom Walter X. Loyola, M.D., P.A. may disclose my PHI

Purpose(s) for the disclosure of the information:

Note: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure."

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. For the revocation of this authorization to be effective, Walter X. Loyola, M.D., P.A. must receive the revocation in writing and the revocation must include:

- My name and address
- The effective date of this authorization and the recipients of the PHI according to this authorization
- My desire to revoke this authorization
- The date of the revocation, and
- My signature.

Walter X. Loyola, M.D., P.A. will accept written revocations of this authorization via:

- Certified U.S. mail
- Facsimile at this number: 972-312-0805

All revocations must be sent to *Ivette Loyola* and are not effective until received by him or her.

This authorization shall expire on last day patient was under physician care or _____. After this date, Walter X. Loyola, M.D., P.A. can no longer use or disclose my PHI for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient Name _____

Patient Signature _____ Date _____

Name of Representative _____

Relationship to Patient _____

FOR OFFICE USE ONLY

- Authorization added to the patient's record on _____.
- Authorization verified by _____ on _____.
- Patient has been provided with a copy of the signed authorization.