# 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 _____

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Name: _____ Date: _____
DOB: _____

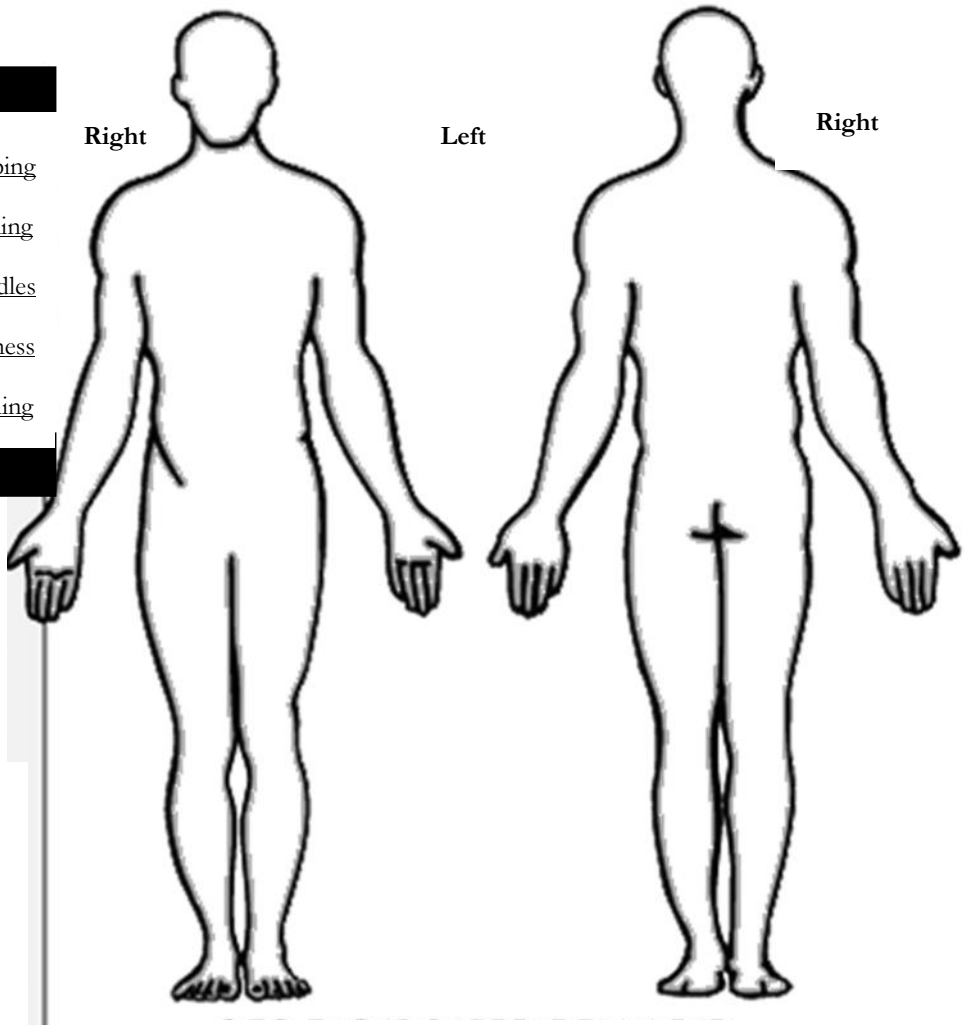
**What is your reason for this office visit?** _____
**Date of Injury and/or onset:** _____

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 |
| X X X X | Burning |
| 0 0 0 0 | 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: □ No medications are being taken

| NAME | DOSE | FREQUENCY | PRESCRIBING M.D. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**DRUG ALLERGIES:** □ No known drug allergies

_____

_____

## 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. Dr. Walter X. Loyola does not refill prescriptions that contain Hydrocodone. In order to prescribe or refill pain medications for you, our practice will perform routine Medication Monitoring Test.

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.-12:00P.M. Friday. If your request is received after 12:00 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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Walter X. Loyola, MD, FAANS, FACS E. Rita Seo, PA-C

Name: _____ Date: _____
DOB: _____

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 you 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.

**Surgery Assistant, Surgery Monitoring Billing**
I authorize PlanoNeuroMonitoring as my designated representative to submit and communicate as necessary in order to bill or/appeal on my behalf for services provided by PlanoNeuroMonitoring to the insurance company

**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.

**Medical Records & Forms Fees**
When medical records are requested, we use an outside medical service (AMRAS) for copying records. Please note that there will be a copy charge by this company. There is a $25.00 fee for each form completion.

**Notice of Financial Interests**

You are informed by this notice that Walter X. Loyola, M.D. holds financial interest in Texas Health Center for Diagnostics & Surgery of Flower Mound, Methodist McKinney Hospital, SurgCenter of Plano, LLC. 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 (address will be connected to your patient portal to allow access to secure messaging and patient record) to _____

Emergency and alternative contacts:

Person(s) _____ Relationship _____ Telephone: _____

Person(s) _____ Relationship _____ Telephone: _____

Person(s) _____ Relationship _____ Telephone: _____

_____ _____
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**