



Nasa Spine Institute

Patient Information Form

Patient's Name: _____
FIRST MIDDLE LAST

INSURANCE INFORMATION

We will need your current insurance card and your driver's license/form of identification.

Are you being seen due to an Accident or Injury? Yes No Is Yes, Date of Accident/Injury: _____

Type of Accident: Work Related Auto Other _____

Primary Insurance/ Workers' Compensation Information Insurance

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SS#: _____ Insured's Employer Name: _____

Policy/Claim #: _____ Group #: _____

Adjuster/Contact Name: _____ Phone #: (_____) _____

Secondary Insurance or Attorney Information

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Insured's DOB: _____

Insured's SS#: _____ Insured's Employer Name: _____

Policy/Claim #: _____ Group #: _____

Adjuster/Contact Name: _____ Phone #: (_____) _____

*All professional services rendered are charged to the patient. **The patient is responsible for all fees, regardless of insurance coverage.** In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to Kim J Garges, MD & R. Eric Santos, MD.*

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

The undersigned guarantees payment in full. Guarantor understands all patients including those with Medicare or other insurance, are personally responsible for the balance after the insurance company has made payment. I hereby assign and direct you to pay any surgical or medical benefits under claims submitted directly to Kim J Garges, MD & R. Eric Santos, MD I also authorize the release of any medical records or information requested by the insurance companies in connection with the above assignments. I understand that my doctor has no obligation to my attorney to furnish consult, narrative reports, or depositions. I also understand that under no circumstances, will my doctor appear as a witness in court on my behalf.

Signature of patient or responsible party: _____ Date: _____

Nasa Spine Institute Representative: _____ Date: _____

For internal use only: Patient present with ID and/or insurance card(s) Yes No

If no, reason card(s) are not presented _____



Nasa Spine Institute
Kim J Garges, MD
R. Eric Santos, MD

DISCLOSURE OF INFORMATION

I, _____, give permission for this office to leave detailed messages on the answering service/voicemail messaging at:

My home (please initial) _____ My cellular phone (please initial) _____

DISCLOSURE OF INFORMATION TO PATIENT’S COMPANION(S)

The physicians at Nasa Spine Institute are committed to complying with HIPAA regulations. Therefore, we require our patients to sign authorization stating that companion(s) (family members, friends, etc.) accompanying them to their appointment are approved to hear discussion regarding the patients health information.

TO BE COMPLETED BY THE PATIENT:

I authorize the following individuals to be involved in the discussion of my medical health information and relieve Nasa Spine Institute of any responsibility for harmful neglect (release of medical health information) by my authorized companion(s):

Relationship	Name
_____	_____
_____	_____
_____	_____

Patient Name: _____

Patient Signature: _____ **Date:** _____



Nasa Spine Institute
Kim J Garges, MD
R. Eric Santos, MD

Practice Pharmacy Information

Patient Name: _____

Parent/Guardian Name: _____

Date of Birth: _____

Phone Number: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Allergies: _____

This information will be used for submission of electronic prescriptions to your listed pharmacy.



Nasa Spine Institute
Kim J Garges, MD
R. Eric Santos, MD
333 N Texas Ave Ste. 3200
Webster, TX 77598

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the *Nasa Spine Institute's* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *Nasa Spine Institute* and how I may obtain access to and control this information.

Signature of Patients or Personal Representative

Date

Signature of Patients or Personal Representative

Date

COMPLETE SECTION BELOW IF WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

_____ The individual refuses to sign or otherwise fails to provide an acknowledgement

_____ The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

Nasa Spine Institute Representative Signature

Date

NASA SPINE INSTITUTE: R. Eric Santos / Kim J Garges
333 N. Texas Ave Ste 3200 Webster TX 77598
Disclosure and Authorization Form for
Patient Referral to Other Non-Participating Physician(s) or Facility

Patient Name: _____
Diagnosis: _____
For Treatment: _____
Patient Plan In-Network: _____

Physician Name: _____
Other Physician: _____
Other Entity: _____
Location: _____

Dear Patient:

In order to better serve you with the highest care quality and safety at most affordable cost, sometimes it is necessary and important to have other or more provider(s) or entities to join our team to complete or continue your medical procedures or treatment in order to ensure the speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other providers(s) or entities and obtain your informed authorization before referral and scheduling for your next treat procedure(s).

While no provider or entity could be participating every managed care network, such as the one your health plan has contracted with, these other provider(s) or entities may or may not be in your health plan's network. This form is used to inform you of our verification that the above named provider(s) or entities are non-participating provider(s) or entities with your health plan.

We have verified your insurance coverage for non-participating provider(s) or entities and the recommended treatment procedure(s) and obtain pre-certification if applicable for all services as a courtesy to you.

Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan.

If you have any question concerning whether you have out of network benefits or your financial obligation under your benefit plan if you use an out of network provider, please call the member services number on your Insurance Identification Card.

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 of patient satisfaction, and my knowledge in my decision-making in exercising my right with respect to the in-network or out-network coverage and cost sharing, my attending doctors(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to choice of a doctor or facility solely in 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-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.

Doctors or Facility with affiliation and remuneration: **Houston Physician Hospital**

I certify that I was informed of the effective alternative resources available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorized this referral to non-participating out-of-network provider(s) or entities as named above.

Patient Name (print)

Patient Signature

Date



Authorization to Release Medical Information

Date: _____

Patient Name: _____

DOB: _____

SS#: _____

I _____ hereby authorize the release of my medical records or in addition, request they be sent to:

Information being requested:

- Entire record file
- All Clinic notes
- Clinic notes from _____ to _____
- Laboratory reports
- Radiology studies (MRI, X-Ray, CT Scans, Etc.)
- OP Reports, Injection reports, Etc.

- I am authorizing this information to be faxed.
- I am authorizing this to be mailed to the above Facility.
- I will be picking up imaging disk/imaging report.
- I am authorizing these imaging disk/imaging report to be picked up by _____

Relationship to patient: _____

CONTINUED MEDICAL CARE

Signature of Patient or Patient Guardian

Date

Nasa Spine Institute Representative Signature

Date

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA MAIL

PLEASE INITIAL

OK TO MAIL TO HOME ADDRESS _____

OK TO MAIL TO WORK ADDRESS _____

VIA HOME TELEPHONE

OK TO LEAVE DETAILED MESSAGE _____

LEAVE CALL BACK NUMBER ONLY _____

VIA WORK TELEPHONE

OK TO LEAVE DETAILED MESSAGE _____

LEAVE CALL BACK NUMBER ONLY _____

VIA FAX

OK TO FAX TO: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____