



Neurosurgical
ASSOCIATES

Masaki Oishi, MD, PA

7030 New Sanger Rd., Suite 200
Waco, TX 76712
o 254-772-6760 • f 254-772-0050

ACCT # _____

PATIENT INFORMATION

PATIENT NAME _____ ADDRESS _____

CITY, STATE, ZIP _____ MOBILE # _____

PHONE # _____ SEX _____ DOB _____ SS # _____

MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____ OCCUPATION _____

CURRENT EMPLOYER _____ PHONE # _____

MINOR PATIENT (PARENT/GUARDIAN) _____ PHONE # _____

EMERGENCY CONTACT _____ PHONE # HOME _____ WORK _____

NAME OF SPOUSE _____ EMPLOYER _____ PHONE # _____

PATIENT WAS REFERRED BY _____ PHONE # _____

REASON FOR SEEKING TREATMENT _____

IS YOUR CONDITION WORK RELATED? _____ YES _____ NO

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

ADDRESS _____ ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

CLAIM PHONE # _____ CLAIM PHONE # _____

PRECERT PHONE # _____ PRECERT PHONE # _____

MEMBER NAME _____ MEMBER NAME _____

MEMBER # _____ MEMBER # _____

GROUP POLICY # _____ GROUP POLICY # _____

GROUP NAME _____ GROUP NAME _____

MEMBER RELATION TO PATIENT _____ MEMBER RELATION TO PATIENT _____

MEMBERS DOB _____ MEMBERS DOB _____

PLEASE BRING IN YOUR INSURANCE CARD(S) AT THE TIME OF YOUR VISIT. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU. PATIENT IS LIABLE FOR ALL CHARGES INCURRED FOR PURPOSES OF COLLECTION IN THE EVENT OF DEFAULT.

I give **Masaki Oishi, M.D.** permission to examine/treat my condition. If any insurance claim or Workers Compensation claim is filed, I agree that clinical and all other necessary information concerning my condition/treatment may be released to my insurance company, employer, Workers Compensation Carrier, or other treating doctor. I authorize payment to the above named physician and others that may assist him. I understand that if at any time my injury is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be rendered. I also understand that if my Workers Compensation coverage is denied for any reason, or my employer fails to honor their agreement to pay my medical bills, I will be held responsible for my total bills.

Signature of Patient/Guardian

Date

Attorney Representing You (If Applicable)



CLINICAL INFORMATIONAL FORM

PATIENT NAME: _____ DOB: _____

REFERRED BY: _____ FAMILY DR: _____

CURRENT MEDICATIONS (include routine and as needed medications): _____

MEDICATION ALLERGIES: _____

PAST SURIGICAL HISTORY: _____

FAMILY MEDICAL HISTORY (cancer, diabetes, etc.): _____

HAVE YOU HAD ANY X-RAYS (or other diagnostic studies)? IF YES, WHAT AND WHERE? _____

(FEMALES) ARE YOU PREGNANT? _____ YES _____ NO

WT _____
HT _____

**PAST MEDICAL HISTORY
REVIEW OF SYMPTOMS**

PLEASE INDICATE YES OR NO TO THE FOLLOWING:

- High blood pressure _____
- Heart disease, murmur _____
- Chest pain _____
- Stroke _____
- Circulatory problems _____
- Liver disease _____
- Gallbladder disease _____
- Hepatitis _____
- Ulcers _____
- Hernias _____
- Digestive problems _____
- Kidney problems _____
- Prostate problems _____
- Cancer _____
- Diabetes _____
- Psychiatric disorders _____

- Skin disorders _____
- Thyroid disorders _____
- Infectious disease _____
- Seizures/epilepsy _____
- Migraines _____
- Anemia _____
- Arthritis _____
- Immune system disorder _____
- Tuberculosis _____
- Asthma/Emphysema _____
- Bronchitis _____
- Pneumonia _____
- Paralysis _____
- Tobacco use _____
- Alcohol use _____

Reviewing Physician _____ Date _____

We will use your health information for regular health operations.

For example: Members of the medical staff, the Medical Director, director of Risk Management and/or Quality Improvement, or members of the Quality Improvement Team, may use information in your health record to access the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Example include a pharmacist consultant, transcriptionists who transcribe physician dictation that is included in your health record, a computer company whose software we use to file electronic claims, and a collection agency. When we contract for these services, we may disclose your health information to our business associate so that they can perform the job they have contracted with us to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to a family member, personal representative, or another person responsible for your care, about your location and general condition. We may leave a telephone message for you or mail information to your address regarding appointments, test results, or other aspects of your care.

Communication with family: Using their best judgment, health professionals may disclose health information to a family member, other relative, close personal friend or any other person you identify, relevant to that person's involvement in your care or payment related to your care.

Research: This office does not currently participate in any research programs. If we do, however, we may disclose information to researchers when their research has been approved by an institution review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or dispensation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law also makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES



Masaki Oishi, MD, PA

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This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction:

This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding your health record/information

Each time you visit this office, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of this office, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

We are required to:

- Maintain the privacy of your health information
- Provide you with this notice as to 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 alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a new notice in the office where it can be seen. We will not use or disclose your health information without your authorization except as described in this notice. We will also discontinue to use or disclose your health information after we have received written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem:

If you have questions and would like additional information you may contact the practice's Privacy Officer at (254) 772-6760. If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer, Nancy Potts, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer of the Office for Civil Rights.

U.S. Dept. of Health and Human Services
HIPAA Complaint
7500 Security Blvd.
C5-24-04
Baltimore, MD 21244

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team, record the actions they took and their observations. In that way, the physicians will know how you are responding to treatment.

We will also provide your physician or subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from the hospital or our office.

We will use your health information for payment.

For example: A bill may be sent to you or a third party payer. This information accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.



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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



FINANCIAL POLICY

Patient Name _____

Account#: _____

It is our office policy to inform you of our patient payment procedure policy. Please review the section below that is applicable to you.

____ **1. Patient with Insurance**

You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payment and coinsurance amounts as services are rendered.

Prior to surgery, our billing office will compute an estimate of our total charge for surgery and an estimate of the amount your insurance company will require you to pay. Your portion of the surgery charges are required to be paid prior to the surgery. We will bill your insurance company for the balance that they owe.

If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. Any remaining balance you owe after the insurance company has made payment should be remitted to us within one month of the notice from the insurance company.

____ **2. Worker's Compensation Patient**

As a Worker's Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform our office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

____ **3. Personal Injury (Accident)**

Our office will only bill health insurance companies. We do not bill for other types of insurance. Patient is ultimately responsible for charges for services rendered including situations where patient is working with an attorney.

____ **4. Medicare**

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

____ **5. Medicaid**

Please have your current Medicaid card with you for every office visit.

____ **6. Patient Without Insurance (Private Pay)**

Please make payment for your care at each office visit. Prior to surgery, our billing office will compute an estimate of our total charge for surgery. You are requested to pay at least one-half (1/2) of the estimated charge two weeks prior to surgery. You will be asked to make financial arrangements prior to surgery for the estimated balance due by completing and signing a Financial Arrangement Statement.

I have read and agree to the Financial Policy paragraphs stated above that apply to me.

Patient or responsible party signature

Date

Person signing on behalf of patient

(Print Name)

Reason person cannot sign

Relationship to Patient

Address

Phone



PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician may prescribe controlled substance medications to help manage my pain, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced or stolen or if I “run out early,” I understand that it will not be replaced.
2. Refills of controlled substance medications:
 - a. Will be made only during regular office hours Monday through Friday. Refills will not be made at night, on weekends, or during holidays.
 - b. Will not be made if I “run out early” or “lose a prescription,” or “spill or misplace my medication.” I am responsible for taking the medication in the dosage prescribed and for keeping track of the amount remaining.
 - c. Will not be made as an “emergency,” such as on Friday afternoon because I suddenly realize I will “run out tomorrow”. I will call at least twenty-four (24) hours ahead if I need assistance with a refill.
3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.
4. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.
5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.
6. I understand that the main treatment goal is to reduce pain and improve any ability to function and/or work. In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
7. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances.
8. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

Name: _____ Phone: _____

9. If you are currently receiving prescription pain medications from another physician or surgeon of any specialty, please list the names and dosages of all such medications and the names of the prescribing physicians. If you are not currently receiving prescription pain medications, please write "NOT RECEIVING".

10. I agree to adhere to the treatment regimen as deemed appropriate by Dr. Oishi in regards to prescription medications as long as I am under his care. I will not seek prescription pain medications from other physicians except when mutually agreed between Dr. Oishi and myself. I agree that when Dr. Oishi has deemed that my treatment is complete and/or he has released me from his care, I will no longer seek prescription pain medications from his office, as I recognize that he is a surgeon and not a pain management specialist.

I have read this contract and I fully understand the consequences of violating this agreement.

Date: _____ Patient Signature: _____

Patient Name Printed _____



IF YOU INDICATED ON THE PATIENT INFORMATION SHEET THAT YOUR CONDITION IS NOT RELATED TO WORK, PLEASE SIGN THIS STATEMENT.

The condition for which I am being treated is not related to my employment and it is not an injury compensable under the Texas Department of Insurance, Division of Workers' Compensation

(TDI-DWC). I have not notified nor do I intend to notify my employer or any previous employer that this condition is a work related injury and I have not filed nor do I intend to file a claim for this condition with TDI-DWC.

I am personally liable for all costs related to the treatment of my condition for which my personal health insurance does not cover.

I authorize you to contact my employer _____ Yes _____ No

Employer contact person: _____ Telephone #: _____

Signature _____

Printed Name _____

Date signed _____



BRIEF PAIN INVENTORY

Date: _____

Name: _____

Last

First

Middle Initial

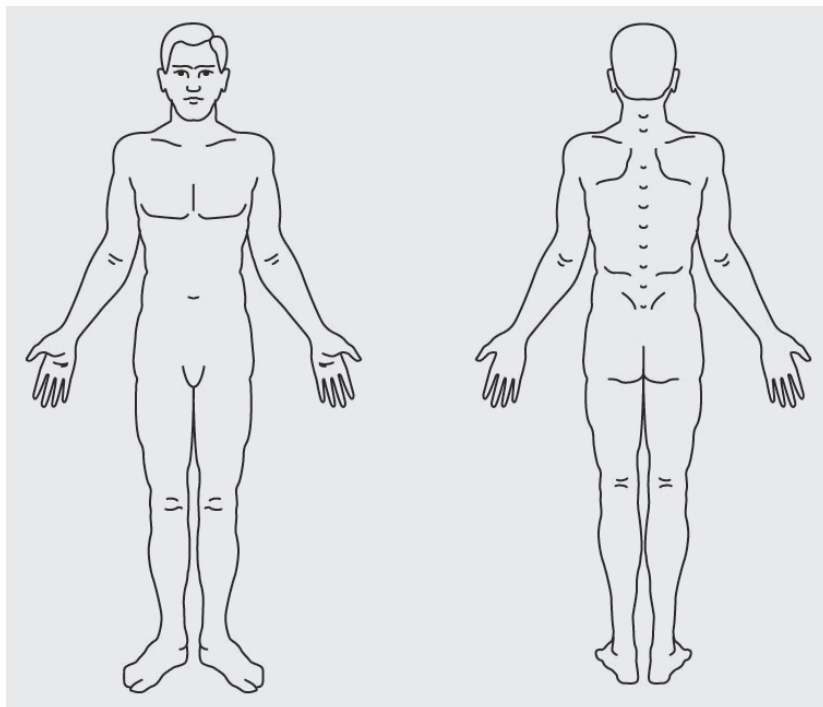
1. On the diagram, shade in the areas where you feel pain. Put an "X" on the area(s) that hurt the most. Also please identify area(s) of numbness and weakness by placing a "Z" on specific area(s).

2. Please rate your pain by circling the one number that best describes your typical pain.

No Pain

Very High Pain

0 1 2 3 4 5 6 7 8 9 10





Neurosurgical ASSOCIATES

MASAKI OISHI, MD, PA

Name: _____

Date: _____ / _____ / _____
mm dd yy

This questionnaire has been designed to give your surgeon information as to how your back/neck pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition.**

Pain Intensity

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad but I can manage without having to take pain medication.
- Pain medication provides me complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication provides me with little relief from pain.
- Pain medications has no affect on my pain.

Personal Care (Washing, Dressing etc.)

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally but it increases my pain.
- It is painful to take care of myself and I am slow and careful.
- I need help but I am able to manage most of my personal care.
- I need help every day in most aspects of my care
- I do not get dressed, wash with difficulty and stay in bed.

Lifting

- I can lift heavy weights without increased pain.
- I can lift heavy weights but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I can not lift or carry anything at all.

Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want but increases my pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take pain medication, I sleep less than 6 hours.
- Even when I take pain medication, I sleep less than 4 hours.
- Even when I take pain medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Social Life

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (ex. Sports, dancing, etc).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain

Traveling

- I can travel anywhere without increased pain.
- I can travel anywhere but it increases my pain.
- My pain restricts travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under 1/2 hour.
- My pain prevents all travel except for visits to the doctor/ therapist or hospital.

Employment/Homemaking

- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain but I can still perform all that is required of me.
- I can perform most of my homemaking/job duties but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

Patient's signature: _____.

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