Grapevine Neurosurgery, PA
David E. Kosmoski, M.D.

PATIENT INFORMATION SHEET

Name:_____

Address:_____City:_____State:_____Zip:_____

Home #: _____Cell #_____ Work #_____

Date of Birth:_____ Sex_____ Marital Status:_____ Social Security #:_____

Employer:_____Employer Address: _____

Emergency Notification:_____ Phone #:_____

Relationship to patient:_____

Please list 2 emergency contacts not living with you:

1st Emergency Contact:_____ Phone #:_____

2nd Emergency Contact:_____ Phone #:_____

Which Physician requested this consultation:_____Phone #:_____

Primary Care or Family Physician:_____ Phone #:_____

Please describe the symptoms you are experiencing:_____

_____

_____

INSURANCE INFORMATION

Primary Insurance Company:_____ Phone #:_____

Is the patient the primary insurance policy holder? YES NO

Primary Policy Holder name:_____Insured's Name:_____

Primary Policy Holder's DOB:_____ Insured's DOB:_____

Insurance Policy #:_____Insurance Group #:_____

_____(initial) I herby authorize my physician to furnish information to insurance carriers concerning my illness/ treatment. I herby assign to my physician all payments otherwise payable to me for services. I understand that I am responsible for all charges incurred for my care.

_____(initial) I consent to treatment necessary for the care of the patient indicated on this form.

Authorization is herby granted.

SIGNATURE:_____DATE:_____

PATIENT HISTORY SHEET

Reviewed by Physician / Date:

Name: _____ Age: _____

WT: _____ HT: _____ Dominate hand : R / L TEMP: _____

Circle any that apply:

Do you have Back Pain? Yes / No How Long? _____ Neck Pain? Yes / No How Long? _____

Do you have Leg Pain? Yes / No Side: Right / Left / Both For How Long? _____

Do you have Arm Pain? Yes / No Side: Right / Left / Both For How Long? _____

Do you have Hip Pain? Yes / No Side: Right / Left / Both For How Long? _____

Do you have Bowel or Urinary Incontinence Yes / No For How Long ? _____

Symptoms in your Arms: Numbness Tingling Burning Weakness Side: Right / Left / Both

Symptoms in your Legs: Numbness Tingling Burning Weakness Side: Right / Left / Both

What seems to aggravate your symptoms ? Sitting Standing Lying Down Walking Other

Pharmacy Name: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

List ALL MEDICATIONS being taken now, including over-the-counter medications:

Medication Name	Dose and Frequency	Ordering Doctor

Are you currently taking any of the following medication Aspirin: Yes / No Plavix: Yes / No Coumadin: Yes / No

Do you have an allergic reactions to the following: Seafood: Yes / No Iodine: Yes / No

List any ALLERGIES you have to any medications:

_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

SOCIAL HISTORY:

Smoker : Yes / No ☐ Cigarettes ☐ Cigar ☐ Pipe How Much? _____

Alcohol : Yes / No ☐ Socially ☐ Moderate

MAJOR SURGERIES:

☐ Gallbladder ☐ Hysterectomy ☐ Colon ☐ Hernia

☐ Appendix ☐ Open Heart ☐ Neurosurgery ☐ Kidney ☐ Orthopedic

Other : _____

MEDICAL HISTORY:

☐ Cancer ☐ High Blood Pressure ☐ Hepatitis B ☐ Heart Disease

☐ Diabetes ☐ Respiratory / Asthma ☐ Tuberculosis ☐ Depression

Other : _____

FAMILY HISTORY:

☐ Cancer ☐ Diabetes ☐ Heart Disease

Patient Signature: _____ Date: _____

DAVID
KOSMOSKI, M.D.
NEUROSURGERY

DAVID E. KOSMOSKI, M.D.
Diplomate American Board of Neurological Surgery

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule give individuals the right to request a restriction on uses and disclosures of private health information. The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACT IN THE FOLLOW MANNER: (CHECK ALL THAT APPLY)

☐ **Home Telephone**
- ☐ Okay to leave a message with detailed information.
- ☐ Leave message with call back number only.

☐ Work Telephone
- ☐ Okay to leave message with detailed information on voice mail.
- ☐ Leave message with call back number only.

☐ Written Communication
- ☐ Okay to mail to my home address
- ☐ Prefer mail to be sent to my work/office address:_____
- ☐ Prefer to have information emailed to address:_____

☐ Please release my information to the following person(s):_____

_____

_____

_____ _____

Patient Signature Date

_____

Print Name

431 East State Hwy 114, Suite 450 • Southlake, TX 76092
(817) 310-9320 • Fax: (817) 416-2800

Grapevine Neurosurgery
David E. Kosmoski, M.D.
431 E State Highway 114 Ste 450 Southlake, Texas 76051
Phone: 817-310-9320 Fax: 817-416-2800 Website: davidkosmoski.com

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Grapevine Neurosurgery, P.A. creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice Of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure to protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax or this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes o treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use of and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected health Information which have been previously agreed upon.

_____ _____

Patient's Name printed Date

GRAPEVINE NEUROSURGERY
(H.E.B. Neurosurgery, PA)

OFFICE POLICY

We want to make your experience at our office a positive one. In order to accomplish this, we work together as a team to provide quality care in a supportive environment. We want and need you to be part of the team. This allows you to receive the best and most immediate services. Below is a summary of our office policies.

APPOINTMENTS: ***Due to the sensitivity of our specialty, some patients require longer appointment times than anticipated. Please excuse any delays. We will give you the same careful attention.***

New Patients: We value information provided by the patient we serve. It helps us to accurately understand the problems at hand and arrive at a correct diagnosis. We ask that all questionnaires and forms be completed in their entirety.
Our office does utilize a Physician Assistant. Patients not requiring immediate surgical attention may be offered an appointment with the Physician Assistant allowing for a more accessible appointment to treat your medical needs.

Follow-up Appointments: Your follow-up appointment will be offered at the completion of your visit and will be scheduled with either Dr. Kosmoski or the Physician Assistant.

INSURANCE:
Our goal is to help you in every way possible to utilize the insurance benefit you have. To accomplish this, we must verify all insurance coverage prior to you being seen by Dr. Kosmoski or the Physician Assistant. We will ask that you present complete and accurate insurance information at the time of your initial visit and present the insurance card at each follow-up visit thereafter. WE will make a copy of your card for our records at each visit as well. Please ask to speak with the Practice Manager if you have questions or concerns about your coverage that the insurance company has not been able to explain or provide.

Benefits: A summary of benefits will be obtained prior to you initial visit. Please ask about anything you may not understand. **Some procedures/surgeries performed by Dr. Kosmoski may be applied to your deductible and/or out of pocket expense. Based on your benefits, you may be required to provide a surgery deposit prior to surgery.**

Copays: You will be asked to pay your copay prior to seeing the physician or physician assistant. Payment is due as services are rendered.

Billing: This office mails statements every month. Payment is expected at the time of service for all patients. Refunds will be made after your insurance company has processed your claim.

Changes in insurance benefits: You must contact our office at least 48 hours before you next scheduled appointment to update us with your new information. This allows us to verify coverage and provide you with a summary of benefits at the time of your appointment.

_____
Initials

NURSING SUPPORT:
The clinical staff supports the doctor with patient care. This includes patient phone calls, prescription requests, etc. They make every effort to handle patient calls within 24 hours. All prescription refill requests require 24-hour notice to our office staff. We ask that you contact your pharmacy and they will fax a refill request to our office. These will be reviewed by Dr. Kosmoski and faxed back with the necessary authorization. Following the 24 hour processing time, you should contact your pharmacy to see if the prescription is ready to be picked up.

OFFICE STAFF:
We have an excellent office staff to assist you with appointments, phone calls, medical records, Disability paperwork and insurance questions. Our office does provide an answering service for after hours emergencies. We ask that you **do not call after hours for any refill requests or appointment issues**. Our answering service will only page the physician for an emergency.

FMLA/DISABILITY PAPERWORK:
Our office will complete your FMLA/Disability paperwork requests. There will be a charge of $25 to compete all FMLA/Disability paperwork. This charge will cover 90 days of paperwork. After 90 days, a new $25 charge may be applied for completion of additional paperwork. Please do not complete any portion under **Physician Statement** area or your paperwork will be returned uncompleted. Please notify the front desk or medical assistant if you will need paperwork to be completed. We will require 48 to 72 hours to process the paperwork from the day we receive the request. This is to allow for all office notes, consultations, etc to be completed and in your medical chart prior to completion of paperwork.

MEDICAL RECORDS:
All medical record requests require a written release of information with a signature from the patient or legal guardian. We will require 10 to 14 days for processing from the day we receive the request. There will a charge for copies released to the patient, attorneys and insurance companies, a charge of $25 for the first 20 pages of records and $.15 for each page after. No charge will be applied if the records are transferred to another treating physician.

PLEASE SIGN AND RETURN TO THE FRONT DESK FOR YOUR RECORDS. THANK YOU FOR YOUR TIME.

I have received and read a copy of the Office Policy for H.E.B. Neurosurgery, PA.

Today's Date:_____

_____ _____
Patient's name Patient's date of birth

_____
Signature of Responsible Party