NORTH TEXAS BRAIN & SPINE INSTITUTE

North Texas Brain and Spine Institute - works as a team to help you improve your condition whether it requires surgery or not.

Dr. Dickerman will be in charge of your healthcare and performing your surgery but also depends on his Nurse practitioner, Ashley Reynolds and staff to assist with your postoperative care.

On rare occasion, Dr. Dickerman has emergency surgeries that may affect his clinic or surgeries and our office will do everything possible to accommodate any changes in schedules.

Our goal is to provide you with the best possible neurosurgical care in the nation and we take pride in our results from the initial visit through the postoperative period.

If there are ever any questions we are always available through our office number, email or 24 hour emergency line.

There's a reason we see patients from around the world,
it'sour team approach.

Thank you for your understanding,

-Dr. Dickerman & Staff

New Patient Office Information

Patient's Name_____ D.O.B___/___/___
Address_____ SSN____/____/_____
City_____ State_____ Zip_____ Home # (___) _____-_____
Alternate Phone (Cell, Work) (____) _____-_____
Employer_____ Phone # (___) _____-_____Ext____
Email Address_____
Address_____
Emergency Contact_____ Phone # (___) ____-_____

Primary Insurance (Please Print)
Insurance Company Name_____ Phone # (___) ____-_____
Address for Claims_____
Insurance Policy Holder_____
Policy Holder's SSN____-___-_____ D.O.B. _____/_____/_____

Secondary Insurance (Please Print)
Insurance Company Name_____ Phone # (___) ____-_____
Address for Claims_____
Insurance Policy Holder_____
Policy Holder's SSN____-___-_____ D.O.B. _____/_____/_____

If This Is Workers Comp Claim, Please Complete Below
Date of Injury _____/_____/_____ Workers Comp Claim #_____
Adjustor's Name _____
Adjusting Insurance Co_____
Address_____
Phone #: _____ Fax #:_____
Employer at Time of Injury_____
Supervisors Name_____

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage.
The afore mentioned patient requests that payment of authorized Medicare/other insurance company benefits be made on my behalf to one of the following physicians that treated my condition: Brent C. Morgan, M.D., Jeffery F. Cattorini, M.D., John R. Tompkins M.D. or Rob D. Dickerman D.O.,Ph.D. For any services furnished me by that party who accepts assignment regulations pertaining to Medicare/other insurance company benefits apply.
I authorize any holder of medical or other information about me, be released to the social security administration, healthcare financing administration, Intermediaries, any other insurance company or carrier of any information needed for this or a related Medicare/other insurance company claim.
I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim if item 9 of hcfa-1500 is completed, my signature authorizes releasing of the information to the insurer or agency shown in Medicare/other insurance company assigned cases, physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge and the patient is responsible only for deductible coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/other insurance company.

_____ _____ _____
Printed Name **Patient's Signature** **Date**

Office 972.238.0512 **Fax** 972.378.6925

Financial Policy for the Office of Dr. Rob D. Dickerman, D.O., Ph.D., FACOS

Thank you for choosing us as one of your healthcare providers; we are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we request you read and sign.

All Patients Are Required To Complete This Information Prior to Seeing the Physician.

Co-Payment Is Due At Time of Service
We Accept Cash, Checks, Visa, MasterCard.

Regarding Insurance:
We may accept assignment of insurance benefits after your visit. However, we do require your copayment to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We shall file your private insurance as a courtesy for all patient procedures. We cannot bill your insurance company unless you bring all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

In the event your insurance company has not paid the balance in 45 days, it will be automatically transferred and billed directly to you.

We are Medicare providers and members of several HMO's and PPO's. We do file insurance for those carriers; however, you will be responsible for your deductible and co-insurance. Please give your insurance card(s) to the receptionist so we may copy the card a picture ID so as to help us file the claim.

All debts that exhausted insurance collection and that are greater than 120 days will be turned over to a collection agency unless arrangements with this office have been made.
Thank you for understanding our financial policy. Please let our staff know if you have any questions or if we can help you understand your insurance carrier's paperwork.

I have read and understand the financial policy for this office and agree to adhere to this policy.

_____	_____	_____
Printed Name	**Patient's Signature**	**Date**

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Dr. Rob Dickerman D.O., Ph.D, FACOS, 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 practice 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 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 of 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 or fax of 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 of treatment, payment or health care operations, be restricted. I also understand that the practice and I must: agree to any restrictions in writing that I request on the use 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 Printed Name **Date**

_____ _____-____-_____
Patient's Signature **Social Security Number**

Any other person whom you would like to have your personal health information released to? _____
_____

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Patient Agreement for Controlled Substance Medication

Controlled substance medications (narcotics) can be very useful, but have high potential for misuse and abuse and are closely controlled by the local, state, and federal governments. Used properly, they are very effective pain medications. If used excessively however, they can cause adverse effects such as vomiting, constipation, lethargy, liver and kidney failure, or even death.

To insure these medications are used properly, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, stolen, or I use it up sooner than prescribed, I understand that it will not be replaced.

2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medication Dr. Rob D. Dickerman, D.O, Ph.D., FACOS, (except if I am a patient in a hospital). Besides being illegal to do so, it may endanger my health.

3. I agree to use one and only one pharmacy.

4. For your safety, your physician may, from time to time, request a urinalysis test to better regulate the medications.

5. I understand that if I violate any of the above conditions or refuse to take a urine test at my physician's request, my controlled substance prescription and treatment by Dr. Rob D. Dickerman, D.O., Ph.D., FACOS May be ended immediately.

If the violation involves obtaining controlled substances from another individual as described above, I may also be reported to my primary physician, local medical facilities, and other authorities.

I have been informed by my physician about narcotic effects, including normal physiologic effects of tolerance (need for more medicine to achieve pain relief), dependence (withdrawal will occur if I stop the medicine abruptly), and addiction (abnormal physiological dependence), which is rare in patients with pain. Withdrawal can be a consequence of overuse, and oftentimes can be unpleasant (e.g. nausea, vomiting, diarrhea, sweating, rapid pulse, etc.)

Printed name: _____

Patient's signature: _____

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DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

This document is to disclose that Dr. Rob Dickerman and/or his partners have a financial interest in the following:

- Gateway Imaging
- Stonebriar Imaging
- THR Surgery Center of Addison

Dr. Dickerman also consults with several brain and spine companies to improve technology and specializes in minimally invasive brain and spine surgery.

- Amendia
- Vertiflex Spine
- Spinal USA
- Wound Care Innovations

Dr. Dickerman's collaboration has led to over 100 peer-reviewed publications and numerous textbook chapters. All research is available on our website, www.neurotexas.com.

Dr Dickerman wants you to know that you do have the option to use an alternative health care facility.
Should you receive a bill from **Head & Spine Institute of Texas, P.A**., Please notify us immediately.

Please sign below acknowledging receipt of this disclosure:

_____ _____

Patient's Signature **Date**

Referring physician/other: _____
Primary care physician: _____
Pharmacy name/ phone: _____

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Dr. Rob D. Dickerman, D.O., Ph.D., FACOS

PLEASE PRINT:

Patient Name: _____ Today's Date_____/_____/_____

Date of Birth: ____/____/_____ Age: _____ Circle One: Female Male

Height: _____ Weight: _____

We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem.
From this information, we can provide you the best medical care possible.
Please help yourself, and us by taking the time required to answer the questions accurately.
Be careful to follow the directions in each section.
Clearly mark the check boxes, circle appropriate items or write legible where indicated.

Thank you for your cooperation.

Are you allergic to any medications? _____

List all medications that you are taking, including prescriptions, over-the-counter, and herbals.
For prescription medications, indicate the doctor who prescribed them.
If you are not taking any medication, check this line _____

Medication Name	Reason Taken	How Often Taken	Prescribing Doctor

What do you want to happen as a result of this visit?

_____
_____
_____
_____

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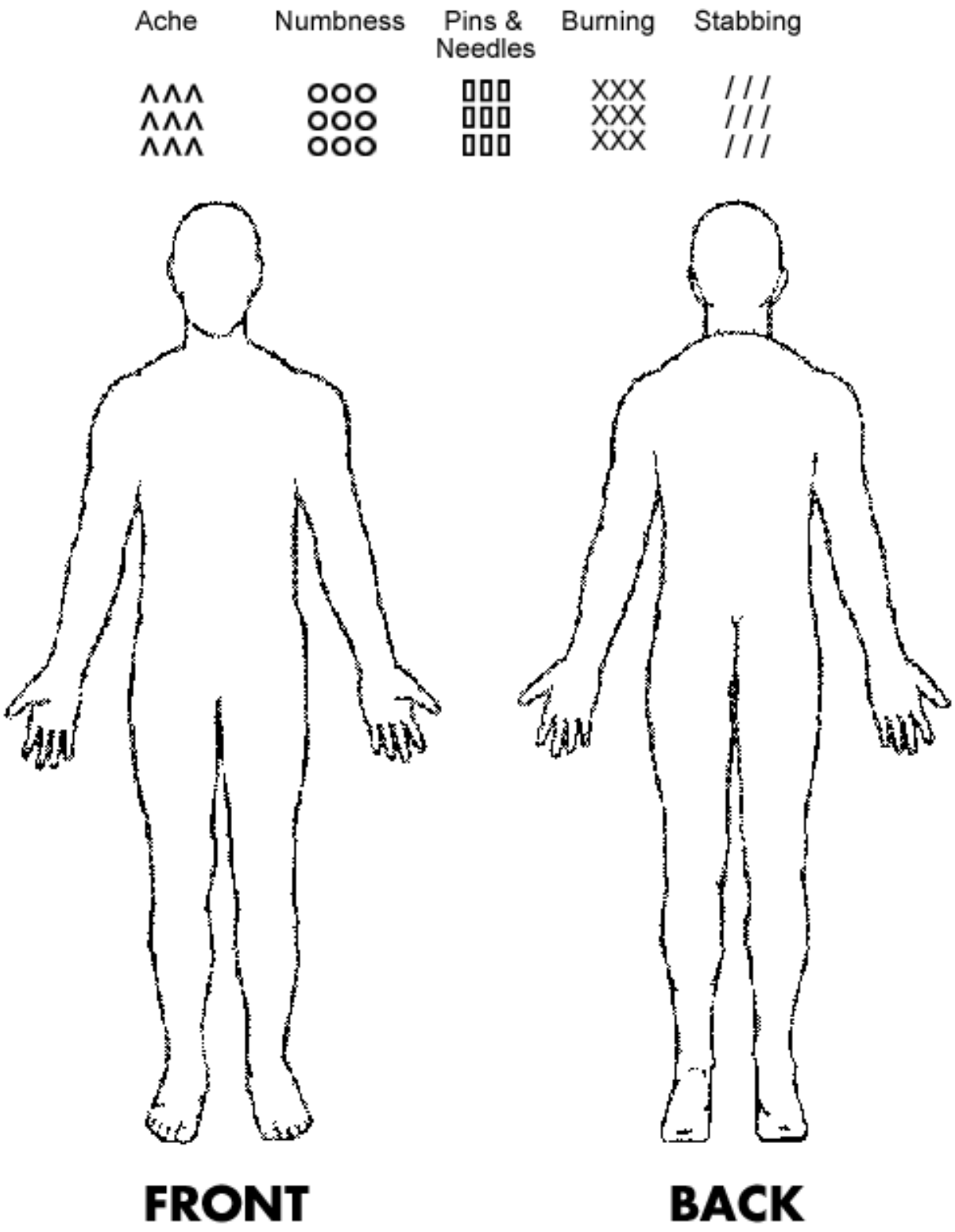
Dr. Rob D. Dickerman, D.O., Ph.D., FACOS

Pain Diagram

Please mark the areas where you experience the following sensations:



Previous Tests

Please Check this Line if You Have Had None of the Following Tests Performed _____
Have You Had the Following Tests Performed:
Circle Yes or No. If yes, please provide date of procedure:

X-Rays:	No	Yes	Date: _____
MRI Scan:	No	Yes	Date: _____
CT Scan:	No	Yes	Date: _____
Myelogram:	No	Yes	Date: _____
Discogram	No	Yes	Date: _____
Nerve Test (EMG/NCV):	No	Yes	Date: _____

General Medical History

Circle All The Conditions Below That You Currently Have Or Have Had Previously:

Heart Attack	Degenerative Arthritis	Heart Murmur
Rheumatoid Arthritis	Angina Gout	High Blood Pressure
Anxiety	Stroke	Depression
Varicose Veins	Emphysema	Stomach Ulcer
Tuberculosis	Duodenal Problems	Chronic Bronchitis
Colon Problems	Frequent Pneumonia	Diabetes
Asthma	Hepatitis	Anemia
Cirrhosis	Bleeding Tendency	Kidney Stones
Sexual Difficulty	Kidney Infection	Enlarged Prostate
Menstrual Problems	Osteoporosis	Ulcers
Hyperlipidemia	Hyperthyroidism	Hypothyroidism
Vitamin D Deficiency	Hypogonadism	Cancer/Type: _____

Other _____

List Any Major Surgery You Have Had, **Other Than** On Your Back Or Neck:

	Type of Surgery	Year
1.	_____	_____
2.	_____	_____
3.	_____	_____

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4._____ _____
5._____ _____

Family Medical History

Please Check this Line If You Do Not Know Past Family Medical History _____

Mother: _____My Mother Is Alive & Is _____ Years Old.
_____She is In Good Health
_____She Suffers With _____
_____My Mother Is Deceased: Age: _____ Cause: _____

Father: _____My Father Is Alive & Is _____Years Old
_____He is In Good Health
_____He Suffers With_____
_____My Father Is Deceased: Age: _____ Cause: _____
I Have _____ Living Brothers/Sisters
I Have _____ Deceased Brothers/Sisters, Cause(s)_____

Members of My Family (Parents, Brothers/Sisters, Grandparents, Aunts/Uncles) Suffer With The Following (Circle All That Apply):

Stroke	Back Problems	Arthritis
Diabetes	Cancer	Lung Disease
Osteoporosis	High Blood Pressure	Scoliosis
Heart Trouble	Kyphosis	I Do Not Know
None of These	Other_____	

Work Status

What Is Your Usual Occupation (The Job You Had Before Your Current Problem Began)?
_____

Before Having Back Or Neck Pain, Did You Normally Work:
Full Time Part Time

Please Indicate Your Current Work Status: (Circle One Answer)
Working Full Time Working Part Time Seeking Employment
Not Working By Choice (Retired, Homemaker, Student, Etc.)
Physically Unable To Work **Due** To Back/Neck Pain
Physically Unable To Work **Not Due** To Back/Neck Pain

Has your pain affected your ability to:

Do your Job or to get a Job?	Yes	No	N/A
Do You Like Your Work Situation?	Yes	No	N/A
Have You Been Laid Off From Your Job?	Yes	No	N/A

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Social History
Marital Status: (Circle One Answer)

Married Single Separated Widow / Widowed Divorced

Smoking
Do You, Or Have You Ever, Smoked? No Yes

If Yes, Complete The Following:
I Smoke _____ Packs a Day & I Have Smoked For _____Years.
I Did Smoke _____ Packs Per Day, But I Quit Smoking _____ Years Ago.

Do You Use Any Smokeless Tobacco Products? Yes No

Alcohol
Do You Drink: (Circle Your Answers)
Beer: Yes No
Wine: Yes No
"Hard" Drinks: Yes No
Frequency of Drinking: Never Rarely Socially Daily

Education
(Circle the Highest Level of Education You Completed)
Grammar School College High School Post-Graduate

Effect of Your Back/Neck Pain on Your Lifestyle: (Circle Your Answer)

I describe my home setting as supportive of me during this time. Yes No

I describe my work setting as supportive of me during this time. Yes No

My pain has affected my interaction with my family and friends. Yes No

The changes in my lifestyle due to my problem have been difficult for me. Yes No

What is your ability to enjoy life? Excellent Very Good Good Fair Poor

Are you currently involved in litigation with regards to your back pain? Yes No

Is there anything we have failed to ask that you believe is important for us to know? Yes No

If Yes, Explain _____
_____
_____
_____

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How Does Each Of The Following Affect Your Pain? Please Circle Your Answer.

Sitting:	Better	Worse	No change
Standing:	Better	Worse	No change
Walking:	Better	Worse	No change
Lying Down:	Better	Worse	No change
Rising From A Chair:	Better	Worse	No change
Heat:	Better	Worse	No change
Cold:	Better	Worse	No change
Massage:	Better	Worse	No change
Physical Activity:	Better	Worse	No change

Previous Treatments

We Need To Know About the Treatment You Have Already Received For Your Current Back/Neck Pain.

Have You Had:	Circle Answer		Date of Last Treatment
Physical Therapy	Yes	No	_____
Chiropractic Care	Yes	No	_____
Injections	Yes	No	_____
Psychological Consultation	Yes	No	_____
Other	Yes	No	_____

Have You Had Surgery On Your Spine? Yes No

If Yes, Complete The Following:
Type of Surgery: (Most Recent) _____

When: _____ Surgeon: _____

Did It Help Your Pain? Yes No

Type of Surgery: (Earlier) _____

When: _____ Surgeon: _____

Did It Help Your Pain? Yes No

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Factors of Complaint

How & When Did Your Problem Begin? (Please Mark Each Answer That Applies To Your Back/Neck Pain):

___I Do Not Know How It Began
___It comes and Goes
___I have Had It a Long Time (About _____Years)
___Injury (Date Of Injury: _____)
___On The Job Injury (Date: _____)
Explain How the Injury Happened: _____

How Bad is your Pain?
Place an "x" (-----x-----) on each of the lines below to indicate your current pain.

Low Back? No Pain----------Worst Possible

Leg? No Pain----------Worst Possible

Middle Back? No Pain----------Worst Possible

Neck? No Pain----------Worst Possible

Arm? No Pain----------Worst Possible

Do You Have The Following Problems? Please Circle An Answer For Each Question.

Weakness: Arms Hands Legs Feet None
Numbness: (Loss of Feeling) Arms Hands Legs Feet None
Tingling: (Falling Asleep) Arms Hands Legs Feet None

Is You Pain Worst At Night? Yes No

Does Your Pain Awaken You From Sleep? Yes No

Does Coughing Affect Your Pain? Yes No

Do Your Legs Tire/Hurt If You Walk Too Far? Yes No
If Yes, Answer The Following:

How Far Can You Walk? Less Than 1 Block 1-3 Blocks More Than 3 Blocks

Does Resting Your Legs Relieve The Pain? Yes No

Does Bending Forward Relieve The Pain? Yes No

Bladder Control: (Urine) No Problem Cannot Empty Bladder Loss of Control

Bowel Control: No Problem Constipation Loss of Control

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