



Dear Patient:

We appreciate having you as a patient of Kalra Brain and Spine. As physician, nurses, and office personnel, it is our desire to provide you with the best possible medical care. You may have questions regarding our clinic policies, and this letter is designed to answer some of your questions.

APPOINTMENTS: To facilitate your appointment process, please make sure you bring the following items:

1. All pages of paperwork completely filled out.
2. Driver's license and insurance card.
3. All radiological CD/films and reports (i.e. MRI, CT, X-Ray). **Failure to have these will result in rescheduling your appointment.**
4. Referrals if required by your insurance company. (Contact your primary care physician if unsure)

PLEASE ARRIVE 20 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

OFFICE HOURS: Our regular office hours are 8 a.m. to 5:00 p.m., Monday through Thursday, and 8 a.m to 3 p.m. on Friday. Patient appointments are available Monday- Friday from 8:00 a.m. to 3:00 p.m. We know your time is valuable, as is ours, and we do our best to see you at your scheduled time. If you find it necessary to cancel an appointment with us, please give us at least 24-hour notice so that we can open that time slot for another patient. **Failure to do so may result in a \$50.00 charge.**

TELEPHONE CALLS: We answer our telephones from 7:30 a.m. to 4:30 p.m. When you call with a question regarding your medical care, the office staff may find it necessary to take a telephone message as the doctor and physician assistants may be with other patients. The message will be given to the medical staff, and one of them will return your call within 24 hours. Please notify the office staff if your call is an emergency.

If your call is regarding insurance or billing information, your call will be directed to billing personnel who can help you with this need. If you want to make an appointment, the office staff will help you.

Should you find it necessary to contact the doctor other than during our regular office hours, the answering service will forward the message to the physician on call.

PRESCRIPTION REFILLS: Prescription refills will be done during regular office hours only. You will need to have your pharmacy send a refill request. If the physician approves the refill, it will be returned by fax to the pharmacy as soon as possible. **Please allow 1-3 business days for all medication refills. We do not refill requests after 2:00 p.m.**

RELEASE OF MEDICAL RECORDS: To protect your privacy, we require an authorized signature from you to release your medical records. In some instances where an attorney is involved, the attorney will need to obtain your authorized signature, which must be notarized, and the attorney's office will need to request the release of your medical records.

DISABILITY/FMLA PAPERWORK: Disability paperwork will be filled out after your surgery is complete. **There is a \$25.00 fee for each set of paperwork. Please allow 7-10 business days after your surgery to complete your paperwork.**

Please feel free to call the office at (972) 905-9226 regarding any questions you may have. We look forward to meeting you and caring for your medical needs.

Sincerely,

A handwritten signature in cursive script that reads "Ricky Kalra MD".

Ricky Kalra, MD

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____ SOCIAL SECURITY #: ____-____-____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (____) ____-____ CELL #: (____) ____-____ WORK #: (____) ____-____ xt. ____

EMAIL ADDRESS: _____ OTHER #: (____) ____-____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT/RELATIONSHIP: _____

PHONE #: (____) ____-____

HOW DID YOU HEAR ABOUT US: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: (____) ____-____

PHARMACY: _____ ADDRESS _____

PHONE #: (____) ____-____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME: _____ PHONE #: (____) ____-____

CLAIMS ADDRESS: _____

INSURANCE POLICY HOLDER: _____ RELATION: _____

POLICY HOLDER'S SOCIAL SECURITY #: ____-____-____ DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE CO. NAME: _____ PHONE #: (____) ____-____

CLAIMS ADDRESS: _____

INSURANCE POLICY HOLDER: _____ RELATION: _____

POLICY HOLDER'S SOCIAL SECURITY #: ____-____-____ DATE OF BIRTH: ____/____/____

The above information is true to the best of my knowledge. I have read the office policies provided and understand them fully. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kalra Brain and Spine or my insurance company to release any information required to process my claims.

SIGNATURE

PRINTED NAME

DATE

Medical History Questionnaire

Thank you in advance for taking the time to complete the detailed confidential questionnaire.

Name: _____ Referring Physician: _____

Date: _____ Height: _____ Weight: _____ Age: _____ Handedness: Right Left

Chief Complaint (reason for visit):

Past Medical History (circle all previous or current medical problems)

Cancer Type: <input type="checkbox"/>	Diabetes Type: <input type="checkbox"/>	High Cholesterol <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Sleep Apnea <input type="checkbox"/>
COPD <input type="checkbox"/>	Seizure <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>	Blood clots <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Arrhythmia <input type="checkbox"/>	History of Stroke <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Reflux <input type="checkbox"/>

Other:

Previous Surgeries (list dates):

Family History (List any medical problems that run in your family and how he/she is related to you)

Current Medications:

Medication	Dose	Frequency	Reason

MEDICATION ALLERGIES: _____

Social History

Marital Status (circle one): Single Partnered Married Divorced Widowed

Do you live in a: House Apartment **Other:** _____ **Are there stairs?** _____

Do you smoke? No Yes **If Yes, how many packs/day?** _____ **Date Quit:** _____

Do you chew tobacco? _____ **Recreational drug use:** No Yes **Type of Drug use:** _____

Do you drink alcohol? No Yes **If yes, how much per day?** _____

HISTORY OF PRESENT ILLNESS

What caused your illness/pain? Disease Accident Surgery
Other _____

Describe what happened

Pain onset: Sudden Gradual

The pain is: Constant Intermittent Occasional

Pain radiates/shoots: Yes No

Where?: _____

How many hours per day do you have pain?

Is the pain disturbing your sleep? Yes No

How many hours per night do you sleep? ____

What relieves your pain?

What aggravates your pain?

What activities are most affected by the pain?

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10
(severe pain)

Today _____ Average day _____

What diagnostic test have you had? Xray CT Scan MRI EMG

What treatments have you received? Physical Therapy TENS

Surgery Acupuncture Steroid Injections Manipulation

Other: _____

Have you had any previous work related injuries? No Yes

Explain _____

Is there a lawyer involved in your case? No Yes

Name: _____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU
WERE INJURED ON THE JOB OR IN AN ACCIDENT

Is this a work related injury? No Yes Is this an accident injury?

No Yes

Date of injury/accident _____

When did you first notice pain? _____

When did you first seek medical help? _____

Where? _____

Are you currently working? No Yes Full duty ____ Light duty

IF YES, how many hours/day _____

Describe your job duties :

Sitting _____ hours Standing _____ hours

Overhead work? _____

Climbing? No Yes Repetitive upper extremity use? No Yes

IF NO, how long have you been out of work? _____ Why did you stop?

Have you tried to return to work? No Yes

How long did you work at this job before this injury?

If you were injured in a car accident, were you? Driver Passenger

Rear-ended Side-swiped Broad-sided

Was seat belt on? No Yes

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At Kalra Brain and Spine. (hereinafter referred to as “the Practice”), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address and claims information. We use this information to provide service to you, to process your claims and to provide you with health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We will take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why – information is shared

We limit who receives information and what type of information is shared.

* *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

* *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

* *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE FORM INSTRUCTIONS

A physician with a direct patient relationship with an individual is not required to obtain the consent of the patient prior to using protected health information (or disclosing it to third parties) for purposes of carrying out treatment, payment or health care operations. While the modifications to the final Privacy Rule reduced the necessity for a mandatory consent form, it provided for an acknowledgement of receipt of a Notice of Privacy Practices. This consent form accomplishes that purpose. A consent form should be signed prior to or during initial paperwork for each new patient and as soon as possible for existing patients. This form does not require a witness; however, we recommend that the form be witnessed whenever possible as it may help prevent misunderstandings at a future date.

REFERENCE

Policies & Procedures: Permitted Uses and Disclosures without Authorization
Minimum Necessary Use and Disclosure of Protected Health Information
Uses and Disclosures of PHI by and for Personal Representatives, Minors and
Deceased
Incidental Uses and Disclosures

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Kalra Brain and Spine, 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 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 been 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 restriction 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 NAME PRINTED

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY # (FOR ID PURPOSES ONLY)

WITNESS (Optional)

DATE



Physician Assistant and Nurse Practitioner

Consent for Treatment

This facility has on-staff physician assistants and a nurse practitioner to assist with the delivery of medical care related to your neurosurgery needs.

A physician assistant (PA) and a nurse practitioner (NP) are not doctors. PAs and NPs are graduates of an accredited graduate program and are licensed by the Texas state board. Under the supervision of a medical doctor, a PA/NP can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does not require the constant physical presence of a supervising doctor, but rather overseeing the activities of and accepting responsibility for medical services provided.

A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining history and performing physical examinations
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of a physician assistant and a nurse practitioner for my health care needs.

Signature	Date
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FINANCIAL POLICY ACKNOWLEDGEMENT

I understand and agree that I will be charged \$50.00 for any missed office appointments, not rescheduled, or cancelled with a 24-hour notice.

Furthermore, I understand that I am responsible for any/all surgical deductibles, co-insurances, and non-covered services. All surgical fee estimates are due and payable prior to the patients' surgical pre-operative appointment. An estimate of surgical fees will be presented to the patient at the time of scheduling.

I have read and understand the financial policy for the office of Kalra Brain and Spine and agree to adhere to the terms of this policy. I also understand that such terms may be amended by the practice from time to time. I understand that a written copy of the financial policy will be provided to me upon request.

Signature

Printed Name

Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

Name: _____ SS# _____
DOB _____

I, the above-mentioned person, release that the following medical information be sent from Dr. Kalra's office.

_____ All Medical Records

_____ All Billing Records

I, the above-mentioned person, release Dr. Ricky Kalra, and staff from any liability concerning the above mentioned records. Information can be released and sent to:

Who is authorized to receive information:

Name: _____

Name:

Name: _____

Name:

Name: _____

Name:

Name: _____

Name:

By signing this form, I the above named person release the physician and his staff from any liability concerning my medical records.

Printed Name

Signature

Date

Pain Medication Notice

This office does not prescribe hydrocodone, oxycodone, or the like, on an initial visit for pain control or prior to any planned or scheduled surgical procedures.

Patients who are undergoing surgery, will be limited to three 10 day prescriptions after their surgical procedure. After, the patient will be weaned to another pain medication if needed for pain control. Per Texas Medical Board, no more than a 10-day supply of narcotic can be prescribed at once and the patient must be reevaluated, in-office, for any subsequent refills.

- Lost or misplaced medication or their prescriptions will not be refilled at any early date.
- Do not drink alcohol while on narcotics.
- Pain medication prescriptions should be obtained only from one physician. If you currently have a pain management doctor you may be referred back to them for current medication management.
- Fill your prescription medication at only one pharmacy.
- Early medication: We will not refill medications prior to their scheduled due date. If you run out of medication for any reason prior to scheduled due date, they will not be refilled.

Patient signature

Date

