Frank Castillon, III, M.D.

Frank Castillon, III, P.A.
2424 50th St., Suite 100
Lubbock, TX 79412
Phone: 806-761-0722
Fax: 806-797-1265

IMPORTANT PLEASE READ

Thank you for choosing our practice for your medical care. In order to serve you better, please bring the following with you to your appointment.

- Completed new patient packet
- Referring physician's address and phone number
- Primary care physician information
- Referrals from your primary care physician
- Insurance cards
- Drivers License
- **Films or CD of your most recent MRI, CT, or X-rays (including the report)**
- Any previous medical records relevant to the reason you are here
- If you have an *Advanced Directive* or *Living Will*, please bring a copy for your chart

OFFICE POLICIES:

- **If unable to keep appointment please give us a 24 hour notice, failure to notify will result in a $35.00 charge.**
- Please arrive 30 minutes prior to your appointment time in order to complete all of the necessary paperwork (new patients). Established patients are recommended to arrive 10-15 minutes prior to appointment. For the courtesy of our other patients and staff, please call if you are running late.
- Co-pay is due at time of service.
- We **DO NOT CALL PRESCRIPTIONS ANY TIME AFTER HOURS**. This includes evening and weekends. Prescriptions are refilled Monday – Thursday from 9am to 4pm, Friday 9am to noon.
- We do not evaluate or treat patients for work-related injuries unless prior authorization has been obtained (ie, "Work Comp"). We do not evaluate or treat patients with injuries or symptoms related to accidents involving litigation/legal issues.

We appreciate your time and assistance in this process. Should you have any questions please feel free to call.

I understand and accept the above office policies.

_______________________________ _______________________________ ______________

Printed Name Signature Date

NEW PATIENT INFORMATION

Frank Castillon, III, M.D., P.A.

Last Name First Name Middle Name/Initial

Address/City/State/Zip Code

Date of Birth Age Gender Marital Status

Driver's License#/State Social Security Number

Home Phone Work Phone Cell Phone

Employer and Address

Job Title

Spouse's Name/Parent's Name if minor Spouse's (or Parent's) Date of Birth

Spouse's (or Parent's) Employer Work Phone Cell Phone

PRIMARY CARE DOCTOR (PCP) Name/City/Phone Number/Fax Number

REFERRING DOCTOR Name/City/Phone Number/Fax Number

Emergency Contact other than Spouse Name/Phone Numbers/Relationship

Pharmacy Name, Address, Phone and/or Fax Number

Email Address

May we contact you at your email address? YES NO

Please Have Your Insurance Card(s) For Your Appointment

Primary Insurance Coverage Member ID Number

Insurance Phone Number Group Number Co-Pay Amount

Insured Name/Relationship if not Self Coverage Type (PPO, HMO, Indemnity, None)

Secondary Insurance (if applicable) Member ID Number

Insurance Phone Number Group Number Co-Pay Amount

Insured Name/Relationship if not Self Coverage Type (PPO, HMO, Indemnity, None)

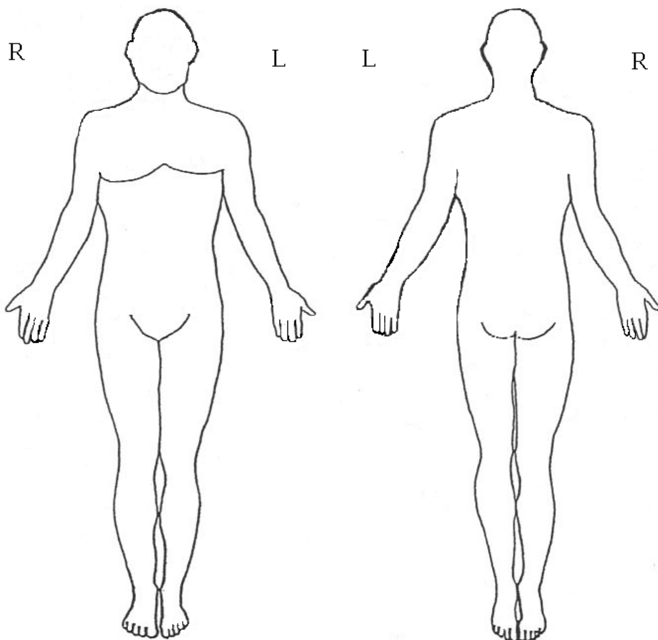
Name:____**DOB**:________________**Date**:_________________

Chief Complaint (reason for visit): ____

____

History of Present Illness:

- How long have you had these symptoms? ____
- Explain how this illness or injury occurred, if applicable: ____
  ____
- How severe is the pain, on a scale of 1-10? ____Describe:_____________________Constant/intermittent
- Any weakness? ____________________ Numbness or tingling? _________________________________
- What relieves the pain/symptoms? ____
- What makes the pain/symptoms worse? ____
- Any similar symptoms in the past? ____



- **Use the drawing to illustrate your symptoms. Indicate pain, numbness, or both.**
- List any doctors you have seen for this condition and any treatment, medications, or recommendations given:
  ____
  ____
  ____
- Please list any physical therapy, chiropractic treatments, or injections. Include dates and results.
- ____
  ____
  ____

Past Medical History: (Please check/circle all appropriate medical conditions; explain if necessary)

____ Heart problems: CAD, MI, CHF, Afib, other/specify:__________________
____ Lung problem: COPD, asthma, sleep apnea, other:___________________________
_____High blood pressure
____ Blood clotting disorder
____ Diabetes
____ Kidney disease
____ Stroke or TIA
____ Thyroid disease
____ Vascular disease
____ High Cholesterol
____ Arthritis
____ Gout
____ Neuropathy
____ Seizures/Epilepsy
____ Cancer:___________________________________

_____Psychological: depression, anxiety, bipolar, PTSD, ADD, ADHD, other:_______
____ Migraines or other chronic headaches
____ Osteoporosis or osteopenia
____ Acid reflux, ulcers, or stomach problems
____ Hepatitis, cirrhosis, or other liver disease
____ Deficient immune system
____ HIV/AIDS
____Autoimmune disease: Rheumatoid arthritis, lupus, other:__________________________
____ Other: ________________________________
____

Name:____ **DOB**:________________**Date**:________________

Surgical and Other Medical History: (Please list all previous surgeries and hospitalizations)

____

____

____

Medications (Please list all current medications and their dosage; include herbals and supplements):

If you have a list, please provide to us and we will copy.

1. ___________________________________ 8. ___________________________________
2. ___________________________________ 9. ___________________________________
3. ___________________________________ 10. ___________________________________
4. ___________________________________ 11. ___________________________________
5. ___________________________________ 12. ___________________________________
6. ___________________________________ 13. ___________________________________
7. ___________________________________ 14. ___________________________________

Are you in a medication contract with a pain management or other physician? Y N

Medication Allergies:

Medication	Reaction
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

Social History:

- Occupation: _____________________________________ Marital Status: __________________
- Tobacco use: None_____ Current or previous tobacco use (specify):________________________
- Alcohol use: Never_____ Rarely_____ Moderate_____ Daily_____
- Illegal/"Street" Drug use None_____ Type/Frequency________________________
- History of alcohol or drug abuse problems? Y N

Family Medical History:

	Age	Diseases	Cause of death, if applicable
Father	_____	________________________________	________________________
Mother	_____	________________________________	________________________
Siblings	_____	________________________________	________________________
	_____	________________________________	________________________
	_____	________________________________	________________________
Children	_____	________________________________	________________________
	_____	________________________________	________________________
	_____	________________________________	________________________

Name:____ **DOB**:________________**Date**:________________

Review of Symptoms (please specify if applicable):

Constitutional		
Weight gain	N	Y
Weight loss	N	Y
Fatigue	N	Y
Poor appetite	N	Y
Fevers	N	Y
Chills	N	Y
Night sweats	N	Y
Eyes		
Blurry vision	N	Y
Double vision	N	Y
Blind spot(s)	N	Y
Cataracts	N	Y
Glaucoma	N	Y
Other eye disease (specify)	N	Y
ENT		
Hearing loss	N	Y
Ringing in ears	N	Y
Earaches	N	Y
Ear drainage	N	Y
Sinus problems	N	Y
Hayfever/seasonal allergies	N	Y
Nose bleeds	N	Y
Hoarseness/voice change	N	Y
Cardiovascular		
Chest pain	N	Y
Palpitations	N	Y
Swelling of feet, ankles	N	Y
Poor circulation	N	Y
Respiratory		
Shortness of breath	N	Y
when lying flat	N	Y
Frequent cough	N	Y
dry	N	Y
productive	N	Y
GI		
Ulcers	N	Y
Heartburn/acid reflux	N	Y
Constipation	N	Y
Frequent diarrhea	N	Y
Nausea/vomiting	N	Y
Blood in stool	N	Y
Abdominal pain	N	Y
Hemorrhoids	N	Y
Difficulty swallowing	N	Y
Painful swallowing	N	Y
GU		
Frequent urination	N	Y
Burning with urination	N	Y
Blood in urine	N	Y
Incontinence	N	Y
Kidney stones	N	Y
Sexual difficulties	N	Y
(Male) Prostate problems	N	Y

	N	Y
(Female) Painful periods	N	Y
Irregular periods	N	Y
Pregnancies:_______		
Miscarriages:______		
Last period:______		
Musculoskeletal		
Neck pain	N	Y
Back pain	N	Y
Joint pain	N	Y
Joint stiffness	N	Y
Muscle weakness	N	Y
Muscle spasms	N	Y
Integument		
Skin problems	N	Y
Change in hair or nails	N	Y
Varicose veins	N	Y
Excessive sweating	N	Y
Breast pain	N	Y
Breast discharge	N	Y
Neurological		
Dizziness	N	Y
Lightheadedness	N	Y
Seizures	N	Y
Spasticity (limb stiffness)	N	Y
Tremors	N	Y
Numbness/tingling	N	Y
Paralysis	N	Y
Head injury	N	Y
Psychiatric		
Memory loss/confusion	N	Y
Depression	N	Y
Anxiety	N	Y
Insomnia	N	Y
Delusions or hallucinations	N	Y
Mood swings		
Endocrine		
Hormone problems	N	Y
Excessive thirst	N	Y
Excessive appetite	N	Y
Change in hat or glove size	N	Y
Heme/Lymph/Immune System		
Easy bruising	N	Y
Excessive bleeding	N	Y
Slow or poor wound healing	N	Y
Anemia	N	Y
Enlarged glands/lymph nodes	N	Y
Previous blood transfusion	N	Y
Frequent or serious infections	N	Y
HIV or AIDS	N	Y
Current daily steroid or other immunosuppressant	N	Y
Current chemotherapy	N	Y

_____________________________ Patient Signature

_____________________________ Provider Signature

Frank Castillon, III, M.D.
Medication Regulations

This office diagnoses and treats neurosurgical conditions. We may prescribe medications for the management of your symptoms. These medications, when properly taken, are expected to help patients feel better and be more functional. Some of the medications we prescribe have abuse potential which may cause harm to patients and others. The *State of Texas Department of Public Safety* (TX DPS) and the *Federal Drug Enforcement Agency* (DEA) regulate the prescription and use of medications. Our office follows those laws and regulations. Our policies are as follows:

1) Written prescriptions for controlled substances and pain medications will not be replaced if lost, misplaced, or stolen.
2) Prescriptions are to be taken as directed. **Patients do not have the right to increase the amount or frequency of medication** doses unless directed to do so by Dr. Castillon, one of his staff members, or a physician covering (on-call) for Dr. Castillon. Changes to medication use will be documented in your office chart for accuracy.
3) Certain controlled substances such as hydrocodone (Norco), Oxycontin, Oxycodone, Percocet, MS Contin, Fentanyl, or Dilaudid, are classified as Class II narcotics and their prescription is highly regulated. These medications can only be written for a 30 day supply. Refills are not legal, nor can these medications be called in or faxed to a pharmacy. A pharmacist will require a new written prescription each month. Therefore, if you are running low on these medications, you need to contact our office for an appointment if we are the prescriber. If we are not the prescriber, contact the prescribing physician's office directly.
4) Some medications may be refilled for up to several months at a time or longer, depending on the type of medication. These are medications with little or no abuse potential. Prescriptions and refills for pain medications and other controlled substances will only be given for a limited time, and only for certain patients. In some cases, if you have not been seen in our office relatively recently, you will be required to make an appointment to discuss receiving a new prescription. In such cases, requests received over the phone or by fax from your pharmacy will be denied.
5) If you are running low on your medications, unless they are the highly regulated Class II medications (see #3 above), please contact your pharmacy to send us a refill request. Depending on your standing with our office (see #4 above) we may refill your medication or deny the request with a comment sent to the pharmacy if there is a denial.
6) **Refills will not be authorized outside of office hours.** In other words, refills will not be authorized at night, on weekend, or on holidays. It is every patient's responsibility to manage your medications and plan ahead for refills.
7) **Refills for medications written by any provider outside of our office will not be authorized**.
8) If you believe you may be pregnant, discover that you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately for directions concerning your medication use.
9) Patients who have Pain Management Providers prior to, or since treating with our office, may be directed – at any time while treating with our office – for referral back to that provider to take over medication management.
10) Patients who need continuing prescriptions may – at any time while treating with our office – be referred to a Pain Management Provider or to their PCP for medication prescriptions and management.
11) It is unlawful for a patient to obtain or refill a controlled substance (narcotic pain medication) for another person, use someone else's medication, or obtain multiple prescriptions/refills from more than one provider (physician, clinic) without notifying the providers. **Violation of this policy is grounds for immediate discharge from our care**.

I have read the above policies regarding prescription medications, and I agree to the terms.

____

Signature   Date

FINANCIAL POLICY

PLEASE READ: We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff or the office manager**.**

Full payment is due at time of service, unless either or you or your health coverage carrier makes other arrangements in advance. If we are a participating provider on your insurance plan, we will file the claim as a courtesy to you. However, all patient co-payments, deductibles and co-insurance amounts are due at the time of service.

Please initial your acceptance and understanding of the following policies:

_______ (initial here) We do not accept LOP (letter of protection) from attorneys.

_______ (initial here) We do not accept PIP (personal injury protection) insurance policies.

_______ (initial here) We only accept limited workers compensation policies, which must be pre-approved.

REGARDING YOUR INSURANCE

Please call the customer service number on the back of your insurance card and confirm that we are in your plan as an in network provider. Due to constant changes in these plans we are unable to keep a current list updated at all times and would appreciate your participation in this process.

We have existing relationships and/or contracts with many insurance carriers and health plans. We will file for all in-network carriers and will collect any patient responsibility including co-payments, deductibles and/or co-insurance amounts at the time of service. In the event that we will bill you, payment is due upon receipt.

If you have insurance coverage with a plan with which we are not contracted, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore, charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Outstanding balances not paid within 90 days will be forwarded to a collection agency and reported to all major credit bureaus.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients' appointments should be cancelled or rescheduled at least one-day prior. This will allow us to give this time to someone else waiting for an appointment. Failure to provide at least 24-hour advance notice will result in a no-show/cancellation fee of $35.00.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms are amended from time to time by the practice.

____ _______________________

Signature of Patient **Date**

____

Signature of Co-responsible Party (if applicable)

3/15/16

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Frank Castillon, III, M.D., (through ***Frank Castillon, III, P.A.***), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Frank Castillon, III, M.D., regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Frank Castillon, III, M.D., of ***Frank Castillon, III, P.A.***, to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Frank Castillon, III, P.A., any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Frank Castillon, III, P.A., or its attorneys, in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Frank Castillon, III, P.A, any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees, or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from Frank Castillon, III, P.A., (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Frank Castillon, III, P.A. all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by Frank Castillon, III, P.A., including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Frank Castillon, III, P.A.) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Frank Castillon, III, P.A. as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

All professional services rendered are charged to the patient and the necessary insurance forms will be completed on their behalf to expedite insurance carrier payments. The patient is responsible for all co-pays and deductibles according to his/her contract with his/her insurance carrier. Payment is due at the time that services are rendered. In the event that surgery is performed, any fees due from the patient will be expected prior to the date of surgery.

I authorize my records to be transmitted electronically and absolve Frank Castillon, III, P.A. of any and all liability if payments/claim information are received by another party in error.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

____

Patient Signature Date

____

Patient Name

Authorization Form
For Disclosure of Protected Health Information

By signing this form, I authorize **Frank Castillon, III, M.D.**, of **Frank Castillon, III, P.A.**, to use and disclose the protected health information described below.

Patient Name: ____ DOB: _________________

Please list below any person that you authorize us to share information with, including but not limited to, your medical care, appointments, test results, prescriptions and/or financial matters. Most commonly, this is a family member (spouse or significant other, adult children or siblings, caregiver, etc).

Doctors SHOULD NOT be on this list. Privacy Laws allow us to share information with your referring physician, other physicians participating in your medical care and/or facilities where we order/schedule medical tests, studies, treatments or evaluations.

1. ______________________________Relationship:_________________Phone#___________

2. ______________________________Relationship:_________________Phone#___________

3. ______________________________Relationship:_________________Phone#___________

4. ______________________________Relationship:_________________Phone#___________

5. ______________________________Relationship:_________________Phone#___________

I AM FULLY AWARE THAT A CELL/MOBILE PHONE IS NOT A SECURE AND/OR PRIVATE LINE.

May confidential messages (i.e., appointment reminders, MRI results) be left on your telephone answering machine or voice mail? **Yes No**

This authorization shall be in force and effective until you inform us otherwise. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

I understand that I have a right to revoke this authorization, in writing, at any time by providing written notification.

Frank Castillon, III, M.D., P.A.
2424 50th Street, Suite 100
Lubbock, Texas 79412
P: (806) 761-0722 F: (806) 797-1265

Medical Records Release

By signing this form, I authorize **Frank Castillon, III, M.D**., to request medical records and radiology reports.

Patient Name: ____

DOB: ____

The health information requested:

____

____

____

____

Release my protected health information to the following:

Frank Castillon, III, M.D.
2424 50th Street, Suite 100
Lubbock, TX 79412
Office: (806) 761-0722
Fax: (806) 797-1265

____
Signature Date

3/15/16

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a part of this practice) may be used and disclosed, and how you can get access to your health information. Please review this carefully. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate officials.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official or correctional institution.
8. For Workers' Compensation or similar programs.

Your rights regarding your health information

1. Communications: You may request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by that agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by our practice. To request an amendment, your request must be made in to our office.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice. You may ask us to give you a copy of this notice at any time.
6. Right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

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 again at any time.

____

Signature of Patient/Patient Representative   Printed Name of Patient/Patient Representative

____

Date   Relationship (If Signed By Representative)

If you have any questions or want to make a request pursuant to the rights described in our notice of privacy practices, please contact:

Christie Garcia
Office Manager
2424 50th Street, Suite 100
Lubbock, TX 79412
Office: (806) 761-0722
Fax: (806) 797-1265

Jurisdiction Waiver for Patients Living Out of State

Please initial the following statements if you agree:

____ I recognize that I have a choice when it comes to healthcare. I have made the decision to come to Lubbock, Texas to see Dr. Castillon, rather than seeing a different physician in my home state.

____At no point has Dr. Castillon provided medical services outside of his office or the hospital in Lubbock, Texas (surgery, consultation, follow-up visit).

Governing Law. **It is agreed that the healthcare provided by this practice is governed by, construed and interpreted according to the laws on the State of Texas. In the event of a dispute, venue shall be in Lubbock County, Texas, where the services were provided. This includes, but is not limited to, a "healthcare liability claim" as defined in Tex. Civ. Prac. & Rem. Code Ann, Sec. 73.001(a)(13).**

This agreement is hereby signed voluntarily and without coercion or outside influence. I understand that I am waiving my rights to file any claims in my home state regarding the care received by Dr. Castillon, his staff, or the hospital, all of which are in Lubbock, Texas.

____ ______________________

Patient signature Date

____ ______________________

Witness Date