MINIMALLY INVASIVE
neurosurgery

Abdul A. Baker MD, FAANS

Dear_____,
Thank you for choosing Minimally Invasive Neurosurgey PLLC to provide your health care needs. Your appointment is scheduled for ___/___/___ at __:____ AM/PM with _____. Our goal is for you to have a pleasant patient experience while visiting our office. Please read and complete the attached documents.
The following information is needed to ensure that your appointment process goes smooth and is efficient:

A valid photo ID to verify identity (DL, Passport, School ID etc.)
Medical Insurance Cards (If no insurance card is provided at the time of your appointment or you are unable to provide details of your insurance plan such as ID number and group number, you may be asked to pay privately or reschedule your appointment) PLEASE NOTE THAT WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE
Copay/Deductible/Coinsurance Payments are due at the time of service
Completed Registration Paperwork
A written referral by your primary care physician if it is required by your insurance. Please do not assume that your referral is approved unless you have received CONFIRMATION from your insurance company. Please contact your primary care physician to ensure that your referral has been completed prior to your appointment.

Please arrive 30 minutes early to your appointment to allow time for staff to complete the administrative portion of your chart into our database. You may be asked to reschedule if you arrive more than 15 minutes after your appointment time or do not have the above listed items. Should you anticipate running late to your appointment, PLEASE call our office to let us know and we can verify if you can still be seen. Please feel free to contact our office at (469)-947-7463 if you have any questions. We are available Mon-Fri from 8AM-5PM.
Thank you and we look forward to seeing you!

Minimally Invasive Neurosurgery

600 E Taylor St, Suite 4001
Sherman, TX 75092

940 W Stacy Rd, Suite 110
Allen, TX 75013

P: 469-94-SPINE (77463) www.DrBakerNeurosurgery.com F: 1-866-559-0952

MINIMALLY INVASIVE
neurosurgery

Abdul A. Baker MD, FAANS

Patient Registration Form

Last Name:_____ First Name:_____ DOB:_____ Age:_____

Address:_____ Apartment #:_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Alt #:_____

Email:_____ SSN:_____

Employer:_____ Occupation:_____

Referring Doctor:_____ PCP:_____

Reason for Visit:_____

Pharmacy/Location (cross roads):_____ Phone:_____

Insurance Information ☐ **Check here if you have no insurance (Self Pay)**

Primary:

Insurance Company:_____

Name of Policy Holder:_____ Relationship:_____

Policy Holder DOB:_____ Policy Holder SSN:_____

Policy ID Number:_____ Group Number:_____

_____ Check here if your insurance requires a referral or pre-authorization

Secondary:

Insurance Company:_____

Name of Policy Holder:_____ Relationship:_____

Policy Holder DOB:_____ Policy Holder SSN:_____

Policy ID Number:_____ Group Number:_____

_____ Check here if your insurance requires a referral or pre-authorization

_____ _____

Patient's Signature Date

MINIMALLY INVASIVE neurosurgery

MEDICAL QUESTIONAIRE 1

Patient Name:_____ DOB:_____

Cardiology:
___ Hypertension
___ Angina
___ Heart Attack
___ Heart Failure
___ Atrial Fibrillation
___ Irregular Heart Beat
___ Heart Murmur
___ Peripheral Vascular Disease
___ Aortic Aneurysm

Pulmonary:
___ Asthma
___ Chronic Bronchitis
___ Emphysema
___ COPD
___ Pneumonia
___ Pulmonary Hypertension
___ Clot in the lungs
___ Sleep Apnea
___ Lung Cancer

Endocrine:
___ Diabetes Type I
___ Diabetes Type 2
___ Thyroid Issues (high/low)
___ Addison's Disease
___ Cushing's Syndrome
___ Pituitary Adenoma
___ High Cholesterol
___ Obesity

Gastrointestinal:
___ Acid Reflux
___ Ulcer Disease
___ Gall Bladder Disease
___ Vomiting Blood
___ Blood in Stool
___ GI Cancer
___ Diverticulosis
___ Polyps

Liver Disease/Pancreas:
___ Hepatitis (type____)
___ Cirrhosis
___ Liver Cancer
___ Gallbladder Stones
___ Pancreatitis
___ Pancreatic Cancer

Genitourinary:
___ Recurrent UTI
___ Kidney Stones
___ Chronic Kidney Disease
___ Nephritis
___ Prostate Problem
___ Kidney Cancer
___ Bladder Cancer

Hematology:
___ Anemia
___ Leukemia
___ Bleeding Disorders
___ Blood clots (legs)
___ Multiple Myeloma
___ Varicose Veins
___ HIV

Neurology:
___ Neuropathy
___ TIA
___ Stroke
___ Migraine
___ Seizures
___ Scleroderrnu
___ Parkinson's
___ Alzheimer's

Arthritis & Musculoskeletal:
___ Rheumatoid Arthritis
___ Osteoarthritis
___ Gout
___ Osteoporosis/Osteopenia
___ Lupus (SLE)
___ Scleroderrna
___ Sjogren's Syndrome
___ Fibromyalgia

OTHER MEDICAL PROBLEMS (USE BACK IF NEEDED)

_____

_____

_____

_____ _____

Patient's Signature Date

MINIMALLY INVASIVE
neurosurgery

MEDICAL QUESTIONAIRE 2

Patient Name:_____ DOB:_____

SURGICAL HISTORY: ☐ NO PREVIOUS SURGERY

TYPE OF SURGERY	SURGEON	YEAR

MEDICATIONS: List prescription medications being taken regularly including dosage

NAME	DOSAGE	FREQUENCY

ALLERGIES: List all allergies to medications, immunizations, foods, etc.

MEDICATION	REACTION

SOCIAL HISTORY

Alcohol: ☐ No Alcohol consumption ☐ 1-3 drinks a week ☐ 4-7 drinks a week ☐ 8 or more drinks a week

Smoking: ☐ Never a smoker ☐ Previous smoker and quit in_____ ☐ Current smoker ____ packs per day

Illicit Drugs: ☐ No drug use ☐ Current Use:_____ ☐ Previous Use:_____

_____ _____

Patient's Signature Date

MINIMALLY INVASIVE neurosurgery

HIPAA COMPLIANCE

Abdul A. Baker MD, FAANS

Patient Name:_____ DOB:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

According to the Health Insurance Portability and Accountability Act of 1996 (HPAA) patients have certain rights to privacy regarding their protected health infonnation. Your protected health infonnation will be used to:

- Conduct, plan, and direct treatment by the physicians employed by Minimally Invasive Neurosurgery and will be shared in cooperation with healthcare prnviders who are involved in your care directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waved your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Minimally Invasive Neurosurgery, PLLC has previously released relying on this consent.

Print Patient Name:_____

Do we have permission to:

1. Leave a message at your home regarding appointments and/or treatments? ☐Yes ☐No
2. Leave a message at your place of employment regarding appointments/treatments? ☐Yes ☐No
3. Leave a name and call back number at your home and place of employment? ☐Yes ☐No
4. Mail test results and appointment infonnation to your home address currently on file? ☐Yes ☐No
5. Email at filed email address regarding appointments and treatments? ☐Yes ☐No
6. Discuss your personal information, including appointments and treatments with someone other than yourself? ☐Yes ☐No

NAME	RELATIONSHIP	PHONE NUMBER

☐ I understand I have the right to revoke this authorization in writing at anytime.
☐ I understand the revocation will NOT apply to information that has already been released.
☐ The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

_____ _____

Patient's Signature Date

MINIMALLY INVASIVE
neurosurgery

NOTICE OF PRIVACY PRACTICES

Abdul A. Baker MD, FAANS

Patient Name: _____ DOB: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
EFFECTIVE January 01, 2016
This Notice of Privacy Practices (the "Notice") tells you about the ways we may use and disclose your protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Minimally Invasive Neurosurgery, including its providers and employees (the "Practice").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you
- Notify affected individuals following a breach of unsecured medical information under federal law
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe the different reasons that we typically use and disclose medical information. These categories arc intended to be general descriptions only, and not u list or every instance in which we may use or disclose your medical information. Please understand that for these categories. the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you {both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical inrormation in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical infonnation about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company. and that claim may have a code on it that describes the servkcs thut have been rendered to you. If however, you pay for an item or service in full, out of pocket, and request that we not disclose to your health plan the medical infomation solely relating to that item or service, as described.

_____ _____

Patient's Signature Date

MINIMALLY INVASIVE
neurosurgery

PATIENTS RESPONSIBILITY & COMPLIANCE

Patient Name: _____ DOB: _____

PRACTICE COPY

PRESCRIPTION REFILLS

Please have your pharmacy fax us a refill request at (469) 947-7463. Prescriptions will not be refilled on the weekends. Note: By signing this form, you are granting Minimally Invasive Neurosurgery, PLLC permission to access your past medication history.

LATE/NO SHOW POLICY

If you are over 15 minutes late to your appointment, you may be asked to reschedule. Patients who schedule appointments but fail to show up are documented as "no-shows" and will be fined a $25 fee. In addition, patients with multiple "no-shows" may be terminated from the practice.

WALK-IN APPOINTMENTS

Minimally Invasive Neurosurgery, PLLC is an appointment only office. Examination by a physician cannot be guaranteed if you present to the office without an appointment.

PAYMENTS

Payment is expected at the time of service. Accepted methods of payment include credit card (American Express, Visa, Master Card, and Discover are accepted).

THIRD PARTY BILLING

We do not accept LOP's (Letter of Protection) from attorneys or accept car insurance. We can file a claim with your health insurance, but you are ultimately responsible for payment, and it is our responsibility to inform the insurance company of the accident.

FORM COMPLETION

Please be aware that we legally have 7-10 business days to complete forms. Patients are required to pay a $50 completion fee for disability/FMLA forms. If you have made the decision to move forward with surgery, it is your responsibility to get these types of form requests prior to your surgery.

COPYING OF MEDICAL RECORDS

Patients requesting copies of their medical records will receive a one-time complimentary copy. Any additional copies requested will access a fee of $25. If an abstract is sent to a continuing care provider, there is no charge. An authorization for release of information must be signed and submitted before any request for records will be processed.

HMO REFERRAL POLICY

If you have an HMO or any other insurance policy that requires a referral and we have referred you to another specialist (such as pain management), it is your responsibility to contact your primary care doctor and obtain a referral for the new specialist.

PATIENT TERMINATION POLICY

Although it is an infrequent occurrence, a patient may be terminated from the office. Patient termination is at the discretion of the patient's provider. Common reasons for terminations include, but are not limited to, non-compliance with medications (including the abuse of opioids/narcotics, by seeking these prescriptions from other providers while under our care), use of foul language, failure to comply with signed agreements, chronic non-compliance, and inappropriate behavior to staff, physicians, visitors or other patients.

DRUG SCREENS

Drug screens are performed on a scheduled basis or may even be randomly requested at provider's discretion.

_____ _____

Patient's Signature Date

MINIMALLY INVASIVE
neurosurgery

PATIENTS FINANCIAL RESPONSIBILITY AND ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

ACKNOWLEDGEMENT AND AUTHORIZATION (please read and INITIAL each statement)

_____ I authorize payments from my insurance benefits to be made to Minimally Invasive Neurosurgery, PLLC on my behalf for any services furnished to me by any healthcare providers associated with this group. I authorize release of my medical infonnation to the Health Care Financing Administration or insurance company, if needed to determine these benefits.

_____ I appoint Minimally Invasive Neurosurgery, PLLC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ I will receive appointment reminders on my telephone answering system.

_____ Minimally Invasive Neurosurgery, PLLC physicians may refer me to businesses and facilities where they may have vested interests. 1 have a right to choose my own provider and request a list of alternative providers within the area.

_____ _____

Signature of Patient or Authorized Representative Date

FINANCIAL RESPONSIBILITY

It is important that we have a good understanding with our patients regarding financial responsibility. We encourage you to discuss it with us and to ask questions.
We understand that your health coverage is provided through _____ (insurance company) _____

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1. This is a pre-existing illness that is not covered by your plan
    2. You may have not met your full calendar year deductible
    3. The type of medical service required is not covered by your plan
    4. The health plan was not in effect at the time of service
    5. You have other insurance which must

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by tiling your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. lfyour health plan denies this claim for any of these or other reasons, it is your responsibility to pay the denied amounts in full. be filed first.

I have read and understand my obligations and responsibilities. I have completed this form with accurate information. l acknowledge that I am fully responsible for supplying correct insurance information, billing infonnation, and payment of any services not covered or approved by my insurance carrier.

_____ _____

Signature of Patient or Authorized Representative Date

MINIMALLY INVASIVE
neurosurgery

Minimally Invasive Neurosurgery, PLLC

IMAGING CONSENT FORM

The doctor has explained that the purpose of the x-rays about to be taken are to analyze the spine for various disease processes.

MINOR PATIENTS ONLY → CONSENT TO EVALUATE A MINOR CHILD

☐ By my signature below, I, the Parent/Legal Guardian of the minor patina, hereby grant permission for my child to receive chiropractic examinations and x-rays.

FEMALE PATIENTS ONLY → PREGNANCY RELEASE

Please read carefully and check boxes, include the date and sign below. Please see our office manager for further explanation or to discuss any questions.

☐ The date of my last menstrual cycle was on _____/_____/_____ date.
☐ I have been provided a full explanation of when I am most likely to become pregnant.
☐ To the best of my knowledge I am not pregnant.
☐ By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child. I have conveyed my understanding of the risks associated with exposure to x-rays.

ALL PATIENTS

After careful consideration I hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MRI/CT IMAGING

The Physician or Physician Assistant will not give imaging results over the phone. Please call and schedule your follow-up appointment once you have been contacted by the imaging facility. The imaging facility will call you once insurance has approved your study. **PLEASE BRING YOUR IMAGING DISC AT THE TIME OF YOUR APPOINTMENT.** Failing to do so can result in being rescheduled without you seeing the physician or the physician assistant.

PRINT PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

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Minimally Invasive Neurosurgery, PLLC

POLICIES & CONSENT TO TREAT

(PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM)

_____ FINANCIAL RESPONSIBILITY AGREEMENT:

I agree to assign insurance benefits to Minimally Invasive Neurosurgery, PLLC. We bill all primary insurance companies that we are contracted with as "in-network" providers as a courtesy to our patients.

I acknowledge full financial responsibility for services rendered by Minimally Invasive Neurosurgery, PLLC, and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, co-pays, deductibles, co-insurance, pre-existing clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of a default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Minimally Invasive Neurosurgery. Payment is always due at the time of service. We require that patients owing money pay their account balances to zero prior to receiving further services by our practice. There will be a twenty-five-dollar ($25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.

_____ CANCELLATIONS/NO SHOW POLICY:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from getting much needed treatment. Equally, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit in their place.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee for office visits and $50.00 for procedure/surgical visits; this <u>will not</u> be covered by your insurance company.

_____ CONSENT OF TREATMENT:

I authorize Minimally Invasive Neurosurgery, PLLC Physician and the Physician Assistant to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies.

_____ PHYSICIAN ASSISTANT CONSENT:

This facility has an on staff certified Physician Assistant (PA-C) to assist in the delivery of medical care. I acknowledge a Physician Assistant is not a physician. A PA-C is licensed by the state medical board and under the supervision of a physician can diagnose, treat, and monitor common acute and chronic disease as well as provide health maintenance care. "Supervision" does NOT require constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. A list of services may be provided that are within the scope of practice for a PA-C upon request. I hereby acknowledge the above information and consent to the services of a Certified Physician Assistant for my health care needs. I understand that at any given time I can request to see the Physician instead of the PA-C.

_____ DISCLOSURE OF FINANCIAL INTEREST:

The physician at Minimally Invasive Neurosurgery, PLLC that you are seeing may have a financial interest in the facilities listed on page 2. The facilities and our physician are committed to providing clinical excellence In a safe and attractive environment for you and your family member. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you. Should you have any concerns regarding this notice, please ask your physician or a member of the staff. My initials above verify that I have read and understand the above statement and information.

MINIMALLY INVASIVE
neurosurgery

Minimally Invasive Neurosurgery, PLLC

POLICIES & CONSENT TO TREAT

(PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM)

_____ MEDICATION POLICY CONSENT:

I authorize Minimally Invasive Neurosurgery, PLLC Physician and the Physician Assistant to obtain a medication history and/or list of current medications via my pharmacy for medical records.

If you need a refill on your medications, please call between:

8:30 A.M.- 4:00 P.M. Monday-Thursday; 8:30 A.M.- 11:30 A.M Friday

NO REFILL REQUESTS WILL BE ANSWERED AFTER 11:30 A.M. ON FRIDAYS.

**Allow 48 hours to process a request for pain medication. Refills are approved on a patient-by-patient basis, NEVER refilled same day and NEVER refilled over the weekend or after business hours. Do NOT call the office to try to get medicine over the weekend. If pain is too severe to tolerate over the weekend seek ER treatment.

Please call two days before your supply of medication runs out.

"A MISTAKE ON YOUR PART DOES NOT NECESSITATE AN EMERGENCY ON OUR PART"

We request that you use the same pharmacy for all your prescriptions. Use only one physician to obtain pain medications. Regardless of whether you are a surgical candidate, Dr. Baker, will NOT prescribe pain medication long term.

Place issued pain medication prescriptions in a secure location (ex. Wallet, purse, etc.). A "lost or stolen" narcotic prescription will be noted in your chart and can not be refilled 7 days before the issued date.
The theft or loss of an official prescription form must be reported to:

Texas State Board of Pharmacy Prescription Monitoring Program
333 Guadalupe Street
Suite 3-500
Austin, TX 78701
texaspmp@pharmacy.texas.gov

I understand if a family member or a friend picks up my narcotic prescription they are held to the same standards as above.

Printed Name	Patient Signature	Date

Minimally Invasive Neurosurgery, PLLC
Phone: 469-947-7463 Fax: 866.559.0952

Marketing Consent and Release Form

I, (patient/individual)_____, hereby grant Minimally Invasive Neurosurgery, PLLC (herein after MIN, PLLC) the irrevocable right and permission to use my name, voice, photograph(s), image(s), video, or likeness, and any statements, including personal health information concerning any illness or injury and medical treatment performed at MIN, PLLC (collectively known as the "Recording" herein) made on the Recording date(s) below to be used by MIN, PLLC for marketing, advertising, or public relations purposes, which could include, but not be limited to, distribution to news media outlets, television commercials, digital, electronic, or online advertisements, radio advertisements, social media posts and marketing, print advertisements, direct mail marketing, email marketing, print or video press releases, or any other form of marketing, advertising, or publicity.

This consent and release agreement fully represents all terms and considerations. No other inducements, statements, or promises have been made to me. I understand that MIN, PLLC shall own any Recording or other marketing or public relations material. I am not entitled to any compensation or royalties or other remuneration resulting from such Recording, media, marketing, or public relations material. This authorization does not have an expiration date. I understand that I may revoke this authorization by notifying MIN, PLLC, but that MIN, PLLC may have a continued right to use or disclose my health information if MIN, PLLC has already used or disclosed that information on the basis of this authorization.

I further understand and agree that I will not have the option to review or approve the final marketing, advertising, media, or public relations material before MIN, PLLC publishes, makes public, posts, or broadcasts and I acknowledge that other news media may reprint or rebroadcast all or part of the Recording I am releasing to MIN, PLLC following its initial publication, release, or broadcast.

_____ _____
Signature of Consenting Patient/Person Signature of Patient Representative

_____ _____
Date of signing Recording Date(s)

For MIN, PLLC Communications & Marketing Use Only:
Marketing/Event/PR description:_____
Person or organization taking Photo/Audio/Video_____
Rev. 10/2020

MINIMALLY INVASIVE
neurosurgery

Minimally Invasive Neurosurgery, PLLC
Abdul Baker, MD FAANS
Board Certified Neurosurgeon Spine Fellowship Trained, Minimally Invasive Robotic Spine Surgeon

FORM OF PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST AND OWNERSHIP

As required by Section 102.006 of the Texas Occupations Code Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician, Abdul Baker, MD FAANS, may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

Baylor Scott & White Surgical Hospital at Sherman
Surgery Center of North Texas
Methodist McKinney Hospital
Eminent Medical Center
Minimally Invasive Durable Medical Equipment, LLC
Minimally Invasive Neurosurgery Associates, PLLC
Minimally Invasive Neuromonitoring, PLLC

Accordingly, I hereby acknowledge that Abdul Baker, MD FAANS has disclosed to me, at the time of initial contact and at the time of referral (I) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred, and (II) that he/she will receive, directly or indirectly, remuneration for the referral to such healthcare provider. Dr. Baker wants to be fully transparent regarding his financial and ownership interest. I understand that, I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

Patient Name: _____

Patient Signature: _____

Date: _____