



**RESTORATIVE  
SPINE & BRAIN**  
CENTER OF DALLAS

*Todd Shanks, MD*  
*Neurosurgeon*

Dear Patient:

We appreciate having you as a patient of Todd Shanks, MD. As physician, nurses, and office personnel, it is our desire to provide you 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 Friday. Patient appointments are available Monday and Friday from 8:00 a.m. to 4:30 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 8 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 nurse practitioner may be with other patients. The message will be given to either the doctor or nurse practitioner, and one of them will return your call as soon as possible. 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 by fax to (877) 300-2406. 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 (214) 807-0445 regarding any questions you may have. We look forward to meeting you and caring for your medical needs.

Sincerely,

*Todd Shanks*

Todd Shanks, MD



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SPINE & BRAIN  
CENTER OF DALLAS**

*Todd Shanks, MD  
Neurosurgeon*

**PATIENT OFFICE INFORMATION**

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ CELL #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ WORK #: (\_\_\_\_)\_\_\_\_-\_\_\_\_xt.\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ OTHER #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT/RELATION: \_\_\_\_\_ PHONE #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

WHO OR HOW REFERRED: \_\_\_\_\_ PHONE #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

**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 RSBCD, PLLC. 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)

Diabetes      Heart      Cancer      Arthritis      Liver      Lung      High Blood Pressure  
Stroke      Seizure      Blood Clot      Stomach Ulcer      Thyroid Problem

Previous Surgeries (list dates):  
\_\_\_\_\_  
\_\_\_\_\_

### **Family History**

Has anyone in your immediate family (parents, grandparents, and siblings) had or have any of the following diseases? If deceased, at what age and of what disease. **(Place "X" in the blank)**

Family Member	Diabetes	High BP	Heart Disease	Stroke	Cancer	Deceased
Mother						
Father						
Sibling						
Sibling						
M. Grandmother						
M. Grandfather						
P. Grandmother						
P. Grandfather						

**Current Medications:**

Name	Amount/Dose	Frequency	Reason
_____			
_____			
_____			
_____			

**PREFERRED PHARMACY:** \_\_\_\_\_

Preferred Pharmacy phone # and address: \_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_

### **Social History**

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

**Stresses** (circle one):      Home      Relationship      Work      School

**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      If yes, last date of use: \_\_\_\_\_

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

## Health Questionnaire for Todd Shanks, MD

Circle **yes** for items you have had / **no** for items you have not had. Unknown items leave blank

### Childhood Diseases

Measles	yes	no	Mumps	yes	no	Rubella	yes	no
Diphtheria	yes	no	Tetanus	yes	no	Polio	yes	no
Smallpox	yes	no	Rheumatic Fever	yes	no	Whooping Cough	yes	no
Tuberculosis	yes	no	Scarlet Fever	yes	no	Chickenpox	yes	no

### Neurological

Blackouts	yes	no	Seizures	yes	no	Migraine Headaches	yes	no
Concussions	yes	no	Hit in Head	yes	no	Lyme Disease	yes	no
Brain Surgery	yes	no	Unconscious	yes	no	Epilepsy	yes	no
Dizziness	yes	no	Stroke	yes	no	Difficulty Walking	yes	no
Blurred vision	yes	no	Double Vision	yes	no	Difficulty Hearing	yes	no

### Cardiovascular

Angina	yes	no	Palpitations	yes	no	Arrhythmia	yes	no
Lightheaded	yes	no	Fainting	yes	no	Bypass Surgery	yes	no
Hypertension	yes	no	Low BP	yes	no	Anemia	yes	no
Heart Disease	yes	no	Pacemaker	yes	no	AICD	yes	no
Mononucleosis	yes	no	Bleeding Tendency	yes	no	Mitral Valve Prolapse	yes	no

### Respiratory

Hay Fever	yes	no	Bronchitis	yes	no	Lung Surgery	yes	no
Allergies	yes	no	Emphysema	yes	no	Pulmonary Edema	yes	no
Asthma	yes	no	Wheezing	yes	no	Pneumonia	yes	no
Short of Breath	yes	no						
Tuberculosis	yes	no	If yes, date of + ppd _____ or date of last chest x-ray					

### Gastrointestinal

Reflux	yes	no	Nausea	yes	no	Persistent vomiting	yes	no
Diarrhea	yes	no	Hiatal Hernia	yes	no	Lactose Intolerance	yes	no
Constipation	yes	no	Peptic Ulcer	yes	no	Vomiting blood	yes	no

### Genitourinary

Incontinence	yes	no	Discharge	yes	no	Painful Urination	yes	no
Frequency	yes	no	Bladder Infection	yes	no	Venereal Disease	yes	no
Kidney Disease	yes	no	Blood in urine	yes	no			

### Other

Cataracts	yes	no	Thyroid Disease	yes	no	Glaucoma	yes	no
Arthritis	yes	no	Atherosclerosis	yes	no	Poor blood circulation	yes	no
Sinus trouble	yes	no	Cancer	yes	no	Organ Transplant	yes	no
HIV/AIDS	yes	no	Hernia R or L	yes	no	Hemorrhoids	yes	no
Hives or Eczema	yes	no	Weight loss unexplained	yes	no	Weight gain unexplained	yes	no
Blood Transfusion	yes	no	If yes, when _____			Back Trouble	yes	no
Diabetes	yes	no	Unexplained rash	yes	no	Hepatitis A B C D E	yes	no

**Type of birth control:** \_\_\_\_\_ **Are you claustrophobic? Yes No**

**Explain any Yes answers:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## 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 \_\_\_\_\_ Good day \_\_\_\_\_ Bad day \_\_\_\_\_

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

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: \_\_\_\_\_

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## 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 Lifting \_\_\_\_\_ 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? \_\_\_\_\_

Job satisfaction? No Yes Why? \_\_\_\_\_

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

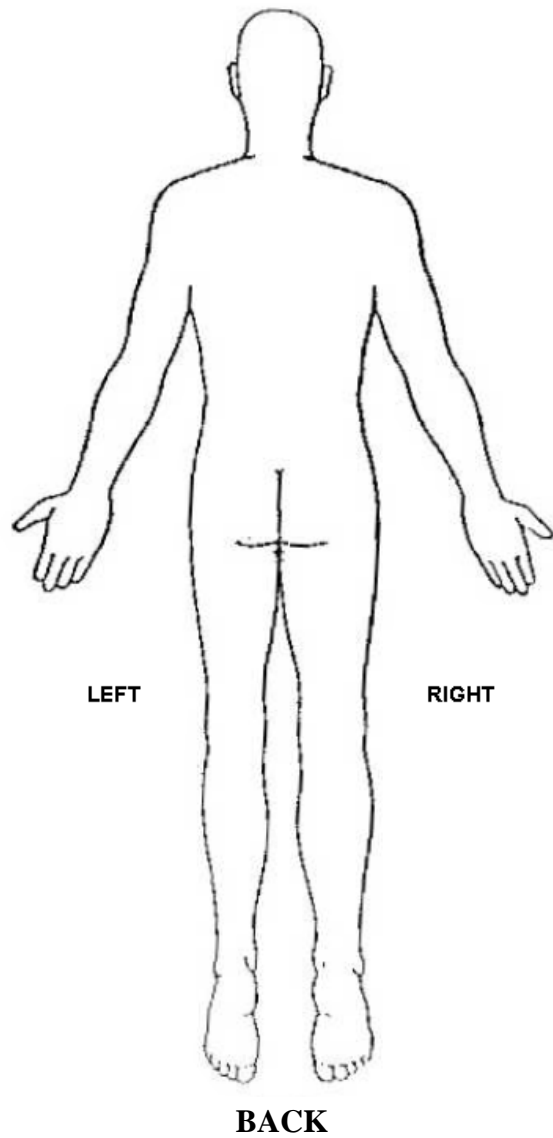
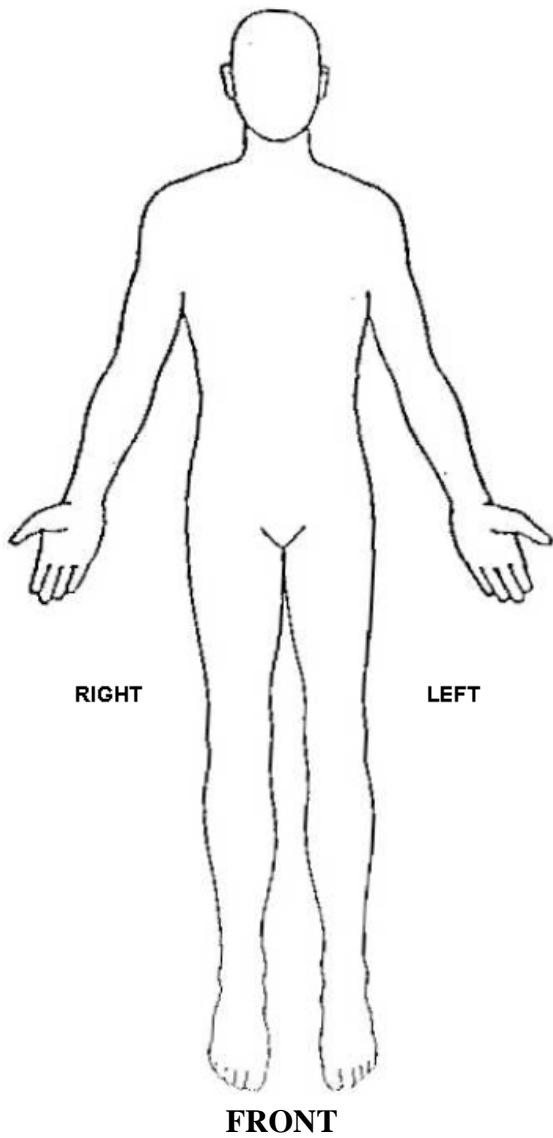
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# WHERE IS YOUR PAIN NOW?

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Mark the areas on your body where you feel the described sensations. Please use the appropriate symbols. Include all affected areas.

<b>ACHES</b>	~~~~~ ~~~~~ ~~~~~	<b>NUMBNESS</b>	00000000 0000	<b>PINS &amp; NEEDLES</b>	----- ----	<b>BURNING</b>	XXXX XXXX XXXX	<b>STABBING</b>	/////// ///
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*Todd Shanks, MD  
Neurosurgeon*

## **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 RSBCD, PLLC. (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 bring you 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.

**Todd Shanks, MD**  
**5425 Spring Creek Pkwy. Ste. 133**  
**Plano, TX 75024**  
**214-807-0445**

## **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 acknowledgment 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



*Todd Shanks, MD  
Neurosurgeon*

### **Patient Consent and Acknowledgement of Receipt of Privacy Notice**

I understand that as part of the provision of healthcare services, RSBCD, PLLC, 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.

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PATIENT'S NAME PRINTED

---

DATE

---

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

---

SOCIAL SECURITY # (FOR ID PURPOSES ONLY)

---

WITNESS (Optional)

---

DATE



*Todd Shanks, MD  
Neurosurgeon*

**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 and co-insurances. 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 RSBCD, PLLC 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*



**RESTORATIVE  
SPINE & BRAIN**  
CENTER OF DALLAS

## ACKNOWLEDGEMENT FOR COMPONENTS TO SURGERY

When treating our patients and surgery is suggested, we want to make sure that they are treated with the most recent technology for the best results and prognosis. Most all of the components to your surgery should be covered by insurance, but some insurance companies do not give benefits for some of the requirements for your procedure. Some of the components to your procedure may include but not limited to; **Inter-operative monitoring, anesthesia, B.M.A (bone marrow aspirate), P.R.P (plasma rich protein) and D.M.E's (durable medical equipment) such as cervical and lumbar braces as well as both growth stimulators.** We will authorize and file all of these components with your insurance. If there is not any coverage or if there is a remainder after your insurance benefits, you will be responsible for the balance.

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*Signature*

---

*Printed Name*

---

*Date*



**RESTORATIVE  
SPINE & BRAIN**  
CENTER OF DALLAS

*Todd Shanks, MD  
Neurosurgeon*

### Authorized Representative

I, \_\_\_\_\_ am the \_\_\_\_\_ ,  
**Patient name** **insured name (in the case of minor )**

have  
health insurance benefits, through \_\_\_\_\_,  
**Name of Insurance Company**

that are provided to me by the following named employer

\_\_\_\_\_  
**Employer name and Plans Administrator name (Human Resources)**  
that is engaged in commerce, as defined in 29 USC 18,§ 1003(a).

I do hereby designate RSBCD, PLLC. and provider's directly employed business associates, to be my authorized representative as defined in Federal Regulation 29 CFR 2560-503-1, to fully act on my behalf to submit my claim(s) for healthcare benefits payments, to obtain any and all information from my health insurance company, \_\_\_\_\_

**Name of insurance company**

that may be used in an appeal of an adverse benefit determination, as defined in 29 CFR 2560-503-1, and to represent me in a Federal Court of law, to appeal any and all adverse benefit determinations and any and all actions to ensure that my employer provided health benefit payments are correctly paid.

My health insurance company is to provide myself and my provider with any and all requests for the discovery of any and all documents used by:

\_\_\_\_\_ to deny my health benefit payment when  
**Name of insurance company**

not paid in full. If any outside policies or consultants were used to perform the adverse benefit determination \_\_\_\_\_

**Name of insurance company**

is directed to provide my authorized representative with a legible copy of said policy, the name and specialty of the person who performed the adverse benefit determination, the name and credentials of any consultants, and any and all documents provided by said consultant.

My authorized representative is authorized to file grievances with any and all applicable State or Federal regulatory agencies and to represent me in any legal action in a Federal Court of law. Copies of this authorization are to be treated as if it were the original document.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date



**RESTORATIVE  
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*Todd Shanks, MD  
Neurosurgeon*

## Assignment of Benefit Form

I, \_\_\_\_\_ hereby assign my healthcare benefit payments,

to which I am entitled through \_\_\_\_\_  
**Name of patient/insured** **Name of insurance company**

to :

**RSBCD, PLLC. 5425 W.Spring Creek Pkwy suite 133 Plano TX 75024**

This assignment is pursuant to the Employee Retirement Income Security Act (ERISA) as defined in 29 CFR 2560-503-1, and applicable State law, and it will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize said assignee to release all information Necessary to secure the payment of said benefits.

RSBCD, PLLC is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefit payments or adverse benefit determinations as defined in 29 CFR 2560-503-1, with the State Insurance Commissioner for a possible violation of State Insurance Laws or the Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003(a) and 1144(a).

RSBCD, PLLC is allowed full discovery of any and all information, documentation, policies, procedures and resources used by \_\_\_\_\_ to perform an adverse benefit determination, \_\_\_\_\_ **Name of Insurance Company** as defined in 29 CFR 2560-503-1 of my covered health benefits.

RSBCD, PLLC is authorized to represent me in any and all Federal Lawsuits against my insurance company, \_\_\_\_\_, pursuant to the ERISA.

A copy of this document is as valid as the original.

\_\_\_\_\_  
Signature of Patient/Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Insured

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness



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## **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. Shanks office.

\_\_\_\_\_ All Medical Records

\_\_\_\_\_ All Billing Records

I, the above mentioned person, release Dr. Todd Shanks, RSBCD, PLLC and their 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



*Todd Shanks, MD  
Neurosurgeon*

## **Pain Medication Notice**

Since the pain drug Hydrocodone became a Schedule II drug on October 6, 2014, prescriptions for this medication have been limited.

This office will does not prescribe hydrocodone on initial visit for pain control or prior to any planned or scheduled surgical procedures.

Patients, who are undergoing surgery, will be limited to 2(two) 30 day prescriptions after their surgical procedure, then the patient will be switched to another medication if needed for pain control. Patients will not receive this medication in office prior to a surgical procedure or for pain management.

If you are already on hydrocodone from another physician, you will be changed to another pain medication. If you cannot tolerate this new medication, or it does not control your pain, you may be referred to pain management for medication management.

### **Update, Effective 04/01/2016**

- 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' office, 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



*Todd Shanks, MD  
Neurosurgeon*

**DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST**

This document is to disclose that either the Restorative Spine and Brain Center of Dallas, PLLC. or one or more of its affiliates, physicians, or owners have a financial interest in one or more of the following organizations:

**Restorative Spine and Brain Center of Dallas: Invested in Your Future**  
*Industry Relationships*

Restorative Spine and Brain Center of Dallas is frequently sought out by medical device manufacturers to participate in product development, research and education. Manufacturers and research organizations realize that surgeons are necessary contributors to the development and improvement of devices and instruments used in the treatment of many orthopedic and spinal conditions. Without contributions by surgeons, engineers working in the medical device industry would lack the real-life experience necessary to fully develop and improve their inventions and advancements in spine care.

Surgeons at the Restorative Spine and Brain Center of Dallas work with many companies, both large and small, to help create and improve products for patient care. As such, they are compensated for their intellectual efforts and for their time. This is a standard industry practice. They participate as Consultants, on Scientific Advisory Boards, and even on Boards of Directors. Compensation for such services may come in various forms including, but not limited to: (1) consulting fees for services provided by the orthopedic surgeons, (2) royalty fees for patents based on the sale of products for which the surgeons made important contributions, and (3) equity interests in the manufacturers or distributors of medical products. Some of the products or devices made or distributed by these companies may be used in your medical treatment. However, a doctor’s decision as to which, if any, products or devices to be used in your care and treatment is made based upon what is in your best medical interest.

The following is a current list of companies with whom Restorative Spine and Brain Center of Dallas may have financial relationships. Please feel free to learn more about these companies from their websites, and to ask your surgeon any specific questions or concerns you may have about a company, product, or your doctor’s relationships with the company.

Company Name	Website/Product
ZAVATION SPINE	ZAVATION.COM
REPUBLIC SPINE	RSPINE.COM

