MINT
Minimally Invasive Neurosurgery of Texas

Scott C. Kutz, MD
Neurosurgeon

Dear Patient:

We appreciate having you as a patient of Scott C. Kutz, 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 through 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 a 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 (972) 535-2180. 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 do 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) 244-3491 regarding any questions you may have. We look forward to meeting you and caring for your medical needs.

Sincerely,

Scott C. Kutz

Scott C. Kutz, MD

Scott C. Kutz, 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 MINT, Inc. 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 (check 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

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION ALLERGIES: _____

Social History

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

Stresses (check 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 Scott C Kutz, MD

Check **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: _____

_____

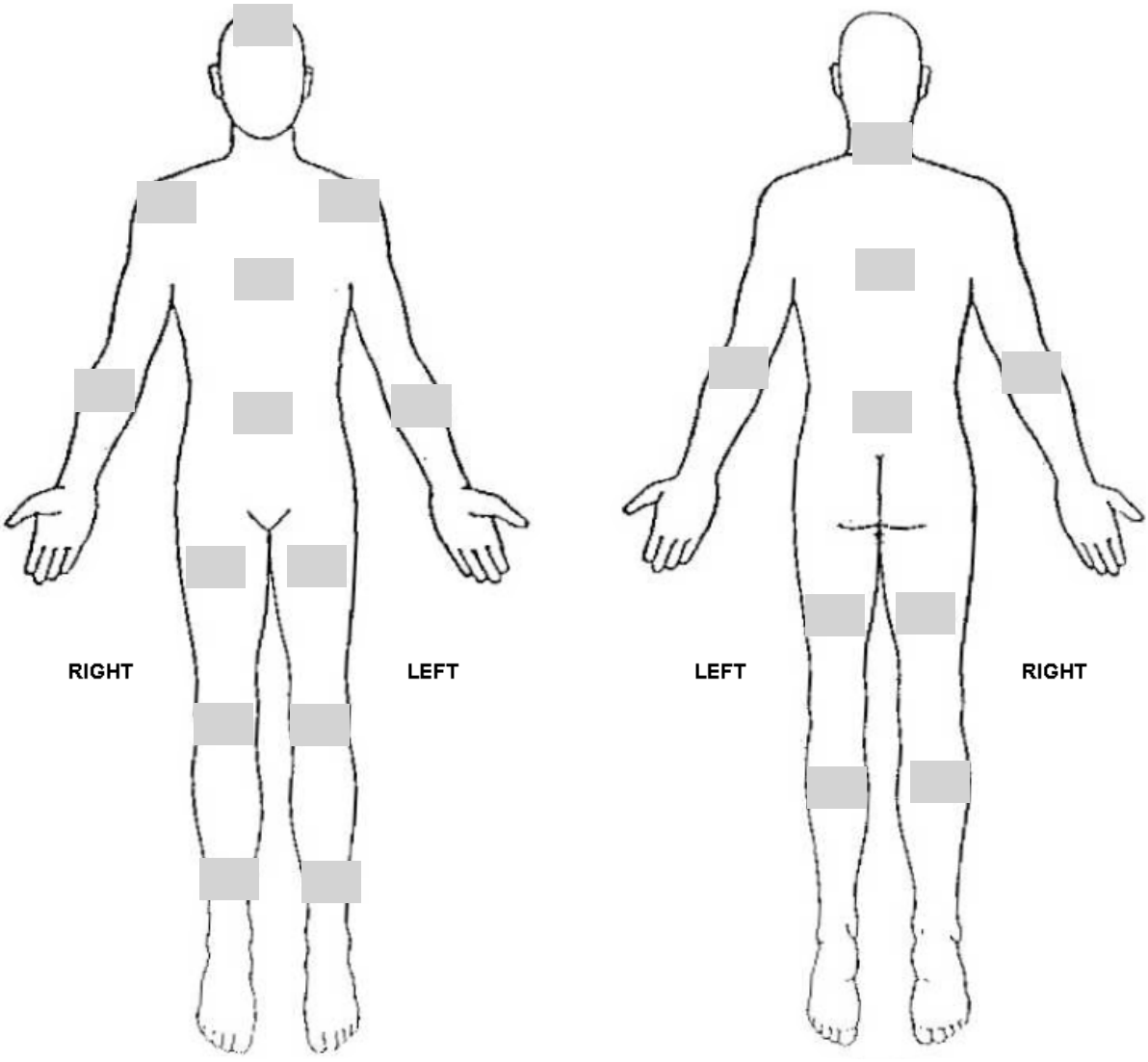
PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU WERE INJURED ON THE JOB OR IN AN ACCIDENT

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 ☐

WHERE IS YOUR PAIN NOW?

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

ACHES	^^^^^ ^^^^^ ^^^^^	**NUMBNESS**	0 0 0 0 0 0 0 0 0 0 0 0	**PINS & NEEDLES**	- - - - - -- - - - - --	**BURNING**	XXXX XXXX XXXX	**STABBING**	/ / / / // / / / // /



FRONT **BACK**

Scott C Kutz, 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 MINT, Inc. (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.

Scott C Kutz, MD
5425 Spring Creek Pkwy. Ste. 133
Plano, TX 75024
972-244-3491

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

MINT
Minimally Invasive Neurosurgery of Texas

Scott C. Kutz, MD
Neurosurgeon

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, MINT, 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

Scott C. Kutz, 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 understood the financial policy for the office of MINT, Inc 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*

MINT

Minimally Invasive Neurosurgery of Texas

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.

_____ _____ _____

Signature *Printed Name* *Date*

Scott C. Kutz, 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 MINT, Inc. 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

MINT

Minimally Invasive Neurosurgery of Texas

Scott C. Kutz, MD
Neurosurgeon

Assignment of Benefit Form

I, _____ hereby assign my healthcare benefit payments,
Name of patient/insured
to which I am entitled through_____
Name of insurance company
to :

MINT, Inc. 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.

MINT, Inc 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).

MINT, Inc 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.

MINT, Inc. 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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Minimally Invasive Neurosurgery of Texas

Scott C. Kutz, MD
Neurosurgeon

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORAMTION

Patient Information:

Name: _____ SS# _____ DOB _____

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

_____ All Medical Records _____ All Billing Records

I, the above mentioned person, release Dr. Scott C. Kutz, MINT, Inc 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

MINT
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Scott C. Kutz, 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 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 the 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

MINT
Minimally Invasive Neurosurgery of Texas

Scott Kutz, MD
Neurosurgeon

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

This document is to disclose that either the Minimally Invasive Neurosurgery of Texas or one or more of its affiliates, physicians, or owners have a financial interest in one or more of the following organizations:

- Dallas Procedure Center, Lewisville, TX
- Legent Orthopedic Hospital, Carrollton, TX

Minimally Invasive Neurosurgery of Texas: Invested in Your Future

Industry Relationships

Minimally Invasive Neurosurgery of Texas 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 Minimally Invasive Neurosurgery of Texas 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 Minimally Invasive Neurosurgery of Texas 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
Excelsius Angel Partners, LLC	
Globus/Excelcius	
Globus Spine	
Tenon, INC	
Indius Medical, INC	

We hope this helps clarify the nature of our involvement in research and development leading to advances in neck and back care. We are very proud to be leaders in technological innovation that results in better patient care.

Minimally Invasive Neurosurgery of Texas: Invested in Your Care

Facility Relationships

The physicians Minimally Invasive Neurosurgery of Texas may have financial interests in facilities and providers in North Texas. These facilities and our physicians are committed to providing clinical excellence to our patients in a safe, high-quality environment. Their financial interest in these facilities often provides them a voice in administration and in clinical and operational policies. This involvement helps to ensure the highest level of patient care and customer service. Patients of the Minimally Invasive Neurosurgery of Texas always have the option of utilizing an alternate health care facility or provider. Please ask one of our representatives for a list of alternate facilities. Minimally Invasive Neurosurgery of Texas physicians welcome any questions regarding this aspect of their patient's care. The following is a list of providers with whom Minimally Invasive Neurosurgery of Texas, a Minimally Invasive Neurosurgery of Texas affiliate, or one or more Minimally Invasive Neurosurgery of Texas physicians have a financial interest:

• Texas Health Presbyterian Plano Center for Diagnostics & Surgery (same as Plano Medical Center)

Minimally Invasive Neurosurgery of Texas: Invested in Your Future

Patients of the Minimally Invasive Neurosurgery of Texas always have the option of utilizing an alternate health care facility or provider. Minimally Invasive Neurosurgery of Texas physicians welcome any questions regarding this aspect of their patient's care.

Minimally Invasive Neurosurgery of Texas wants you to know that you do have the option to use an alternative health care provider.

Please sign below acknowledging receipt of this disclosure:

_____	_____	_____
Printed Name	Signature	Date