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Patient Demographics

Today's Date: _____

Patient Name (Last): _____ (First): _____(Middle)_____

Date of Birth: _____ Age: _____ SSN: _____-_____-_____ ☐ Male ☐Female

Race/Ethnicity: _____ Preferred language: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____State: _____ Zip: _____

Home Phone: (_____) _____ ☐ Ok to leave message Cell Phone: (_____) _____ ☐ Ok to leave message

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Employer/Company Name: _____ Employer/Company Address: _____

Occupation: _____

Emergency Contact Name: _____ Phone: (_____) _____

Relationship to patient: _____ Language: _____

How did you hear about us? _____

Responsible Party Information (if the patient is a minor)

Parent or Legal Guardian Name: _____ SSN: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____ Relationship to Patient _____

Address (if different from patient):
_____

City: _____ State: _____ Zip: _____

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*MANDATORY

Insurance Information

Is this a **Worker's Compensation** or **No-Fault** claim? _____ No ____ Yes (if yes go to the corresponding section).

Primary Insurance: _____ Phone: (_____) _____

Policy Holder's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance: _____ Phone: (_____) _____

Policy Holder's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Effective Date: _____

Worker's Compensation

If yes, what is your WCB claim number? _____ Date(s) of Injury: _____

Carrier: _____

Carrier case _____ Adjuster Name: _____

Phone: _____ Fax: _____

Claims submission address: _____

No-Fault

If yes, what is your claim number? _____ Date(s) of loss/Injury: _____

Policy number_____ Carrier: _____

Adjuster name: _____ Phone: _____

Claims submission address_____

Are you represented by an attorney for this visit? _____ Yes _____ No If yes, name of firm_____

Attorney phone: _____ Attorney name: _____

Referring Physician

Name: _____ Phone: (_____) _____ Fax: (_____) _____

Primary Care

Name: _____ Phone: (_____) _____ Fax: (_____) _____

I certify that the above information is true and correct to the best of my knowledge.
As the responsible party, I agree that unless otherwise stated, any amount not covered by my insurance will be my responsibility.

Patient Signature: _____ Date: _____

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ / _____ / _____

Height: ____ ft _____ in Weight: _____ lbs

Smoking Status: ☐ Never ☐ Former ☐ Current Everyday ☐ Current Some Days ☐ Unknown

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No If yes, what is the manufacturer? _____

Do you have any other implanted medical devices? ☐ Yes ☐ No If yes, please list: _____

Do you have any allergies? ☐ Yes ☐ No If yes, list allergies and reactions: _____

REVIEW OF SYSTEMS (ROS)

(Please check all that apply. If none, indicate "None" or "Negative")

CONSTITUTIONAL: ☐ Fever ☐ Chills ☐ Weight loss ☐ Fatigue ☐ Night sweats ☐ Malaise ☐ Weakness ☐ None

HEENT: ☐ Headache ☐ Vision changes ☐ Double vision ☐ Hearing loss ☐ Tinnitus ☐ Nasal congestion ☐ Sore throat ☐ None

RESPIRATORY: ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Chest tightness ☐ Sleep apnea ☐ None

CARDIOVASCULAR: ☐ Chest pain ☐ Palpitations ☐ Leg swelling ☐ Hypertension ☐ Orthopnea ☐ None

GASTROINTESTINAL: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Acid reflux ☐ Abdominal pain ☐ None

GENITOURINARY: ☐ Urinary frequency ☐ Urgency ☐ Incontinence ☐ Painful urination ☐ Erectile dysfunction ☐ None

MUSCULOSKELETAL: ☐ Joint pain ☐ Muscle aches ☐ Stiffness ☐ Back pain ☐ Neck pain ☐ Swelling ☐ None

NEUROLOGICAL: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Dizziness ☐ Seizures ☐ Memory loss ☐ Balance issues ☐ Headaches ☐ None

PSYCHIATRIC: ☐ Depression ☐ Anxiety ☐ Mood swings ☐ Sleep disturbances ☐ Suicidal ideation ☐ None

ENDOCRINE: ☐ Excessive thirst ☐ Frequent urination ☐ Heat intolerance ☐ Cold intolerance ☐ Weight changes ☐ None

HEMATOLOGIC/LYMPHATIC: ☐ Easy bruising ☐ Bleeding tendency ☐ Swollen lymph nodes ☐ Anemia ☐ None

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Authorization Disclosure of Protected Information

Patient Name: _____ DOB: _____/_____/_____

I hereby authorize the above-named medical practice to use, disclose, or obtain the following protected information:

- **All Medical Records**
- **Specific Medical Records – specify**_____
- **Medical Imaging (CD) – specify**_____
- **Other specify**_____

<u>These records may be obtained from:</u>

<u>Please Mail/Fax or Email to New York Brain Spine & Joint</u>

- **1175 Montauk Highway Suite 3, West Islip, NY 11795**
- **Fax: 631-500-9444**
- **Email: medicalrecords@mneurosurgery.com**

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature: _____ Print: _____ Date_____

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Assignment of Benefits Form

Name of Insured:_____

Name of Patient :_____

_____I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to the provider listed below for any services provided to me by that provider.

_____I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the provider, CMS, my insurance carrier, or other entity if requested. The original authorization will be kept on file by the provider.

_____I understand that I am financially responsible to the provider for any charges not covered by health care benefits. It is my responsibility to notify the provider of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the provider and/or my health care insurer if the submitted claim/claims or any part of them are denied for payment.

_____I understand that by signing this form I am accepting financial responsibility as explained above for all payments for services received.

_____I hereby authorize my provider to release all information acquired during the medical examination and treatment for insurance claim filing. Photocopies of this authorization shall be considered as effective and valid as the original.

- The patient issued and explained the NYSDOH Patients' Bill of Rights for Diagnostic and Treatment Centers (Clinics) in their preferred language.

Name of Person signing below (print)_____

Relationship to Insured_____

Signature of Insured or Patient/Guardian_____ Date_____

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LETTER OF AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD

Our practice has gone through many changes. We are happy to submit claims to your insurance company and accept payment from those insurance companies with whom we are out of network. As your provider, we want to continue providing you with excellent care, but in order to do so, it is necessary to ensure reimbursement for our services. Please read the following.

I, _____, authorize New York Brain, Spine & Joint, to charge the following described credit/debit card the amount equal to what my insurance states is my responsibility.

_____| understand the amount shall not exceed the amount my insurance deems as my responsibility.
_____| understand | will be sent an email/phone call informing me of the date of my visit, and the amount to be charged to my credit/debit card before charging my card. A receipt will be sent upon request.
_____| understand that this Credit/Debit Card Authorization will only be used in the event my insurance does not pay for any services provided. This may include but is not limited to **Deductibles, Co-Insurances, Co-Pays, No Show Appointments, Canceled Appointments, Policy Cancellations and Services not covered under my policy.**
_____| understand that if my credit card is declined and/or does not process the payment, an invoice will be mailed to me with a $15 surcharge added to my balance.

Card Holder's Name on Card: _____

Tel#_____

Card Holder's Address: _____

Card Type: _____MasterCard _____Visa _____AMEX _____Discovery

Card Number: _____ Exp. Date_____

Security Code: _____

Email Address: _____

| fully understand the above authorization and give New York Brain, Spine & Joint consent to charge my credit card listed above.

Signature: _____
Print Name: _____ Date: _____

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Guarantee of Payment Consent Form

Many insurance companies, including managed care organizations, require written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services.

If you have not received prior approval for the service or authorization has been denied, or if you do not have out-of-network benefits, you are fully responsible for all charges. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

Co-payments are collected at the time of service when they can be anticipated. All returned checks will incur a $50.00 service fee in addition to any fees assessed by our banking institution.

I understand that failure to pay a bill in a timely manner (after 3 bills have been sent) may result in a further review by a collection agency and I understand that I will be further responsible for any additional fees or legal fees associated with the collection of any balance of the visit and any related procedures will be collected at the time of the services rendered based upon the best information available to the practice.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

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No-Show And Surgery Cancellation Policy

Appointments

When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you **call our office and cancel your appointment no less than 24 hours after the scheduled visit**. This courtesy allows my office staff to schedule another patient who is also in need of medical care.

Surgery

We also understand the financial stress surrounding medical care and we aim to work with every patient no matter what the circumstances may be. Given the sensitive nature of surgical scheduling and the resources that are expended to reserve Operating Room time and staff, there is a **$1,500.00 fee** for all canceled surgeries once the date of surgery has been confirmed and a **$3,000 fee** for cancellation within 2 weeks of the stated date.

Your signature acknowledges that you understand that failure to cancel an appointment or a surgery once a date is selected may result in additional fees that are not covered by health insurance and reflect the cost of such cancellation to New York Brain, Spine & Joint.

Thank you for your understanding.

Patient Name (Print): _____

Patient Signature: _____ Date: _____