Dear New Patient,

Welcome to **New York Brain, Spine, & Joint**. We are happy to welcome you to our practice and appreciate the opportunity to care for you.

To help us provide you with the best possible care, please take some time to complete **all pages** of the enclosed new patient packet in their entirety. The information you provide allows your provider to better understand your medical history and tailor care to your individual needs. Kindly return all completed forms to the **front desk** on the day of your visit.

On the day of your appointment, please bring the following items with you:

- The CD or films from any relevant X-ray, MRI, or CT scans
- Reports from any previous nerve testing (EMG/NCS), if applicable
- Reports from any prior procedures related to your current condition (if performed at another practice)
- Your completed new patient history forms
- Your insurance information

If you are unable to complete the paperwork before your appointment, please plan to arrive **30 minutes early** to allow sufficient time for completion.

Having this information available helps your provider perform a thorough evaluation and develop a safe, effective treatment plan designed specifically for you.

Thank you for choosing **New York Brain, Spine, & Joint**. We look forward to partnering with you in your care.

Name: _____ DOB: _____

Today's Date: _____ MRN(Office Use):_____

New York Brain, Spine, & Joint

Please complete this packet **before** arriving at the office. Thank you!

Your Email Address:

Pharmacy Name: Pharmacy Phone:

Pharmacy Address:

Alternate Pharmacy Name: Alt. Pharmacy Phone:

Alt. Pharmacy Address:

PLEASE LIST ALL OF THE FOLLOWING THAT APPLY TO YOU

Primary Care: Phone:

Cardiologist: Phone:

Orthopedist: Phone:

Pain Management: Phone:

Other: Phone:

Name: _____ DOB: _____

Today's Date: _____ MRN(Office Use):_____

List any allergies to medications, foods, shellfish, iodine, contrast dye, etc. Please explain the reaction (mild, moderate, severe):

IF NONE EXIST, WRITE NKA IN THE FIRST BOX

Allergy	Mild, Moderate, or Severe?	Allergy	Mild, Moderate, or Severe?	Allergy	Mild, Moderate, or Severe?

Past Medical History: Please mark Y or N if you have had any of the following conditions:

Angina		Anxiety Disorder		Asthma/COPD/ Emphysema		Bleeding Disorder	
Cancer (If "Y" Describe Below)		Congestive Heart Failure		Diabetes		Depression	
Epilepsy/Seizures		GERD/Reflex/Ulcers		Heart Attack		High Cholesterol	
High Blood Pressure		Kidney Disease		Liver Disease		Multiple Sclerosis	
Neuropathy		Osteoarthritis		Osteoporosis		Pacemaker/ Defibrillator	
Rheumatoid Arthritis		Stroke		Thyroid Disorder		Other (List Below)	

Please clarify, if necessary, any of the above selections

Name: _____ DOB: _____

Today's Date: _____ MRN(Office Use):_____

Past Surgical History: Have you had previous surgery? ◯◯ If "Y" please elaborate below.

Type of Surgery	Approximate Date	Surgeon	Problem with Anesthesia? Describe.

Family Medical History: Please list any medical condition and/or cause of death for members of your family:

Parents:

Siblings:

Social History:Do you use tobacco? ◯◯ Have you ever used tobacco? ◯◯

Do you drink alcohol? ◯◯ Do you have a history of substance abuse? ◯◯

Medications: Please list all Prescription, Over-the-counter, Vitamins, Supplements, and Herbal remedies you take. If you have a list, please write SEE ATTACHED in the first box and bring the list to your visit.

Drug / Dose	Frequency	Drug / Dose	Frequency

Name: _____ DOB: _____

Today's Date: _____ MRN(Office Use):_____

New Patient History Form

New York Brain, Spine, & Joint

Please answer the questions as thoroughly as possible. If a question does not apply to you, please write N/A.

Patient name: Gender: SSN:

Home Phone:( ) Work:( ) Cell:( )

Street Address: City:

State: Zip: Date of Birth: Age:

Marital Status: Occupation: Currently Employed?

Primary Complaint: What are you here to see the doctor for today?

When did it begin?

Is this a No-Fault or Workers Compensation claim? ☐ Yes ☐ No

Was there a cause for this injury (accident, fall, moved heavy object, etc)?

When is this problem worse (specific activities, positions, time of day, etc.)?

When is the problem better (specific activities, positions, time of day, etc)?

What hobbies/chores/activities are you unable to do as a result of this problem?

Is this problem interfering with your ability to fall or stay asleep?

Are you presently not working as a result of this problem?

Are you presently involved in any litigation related to this problem?

Name: _____ DOB: _____

Today's Date: _____ MRN(Office Use):_____

Have you had any prior studies within the last year for this problem? Please write the most recent dates for each.

TREATMENT:	DATE(s):	PROVIDERS:	EFFECTIVENESS:
Physical therapy			
Chiropractor			
Acupuncture			
Epidural Injections			
Trigger Point Injections			
Facet Injections			
Massage			
Medications			
Other			

Miscellaneous History: Are you **RIGHT** or **LEFT** handed?

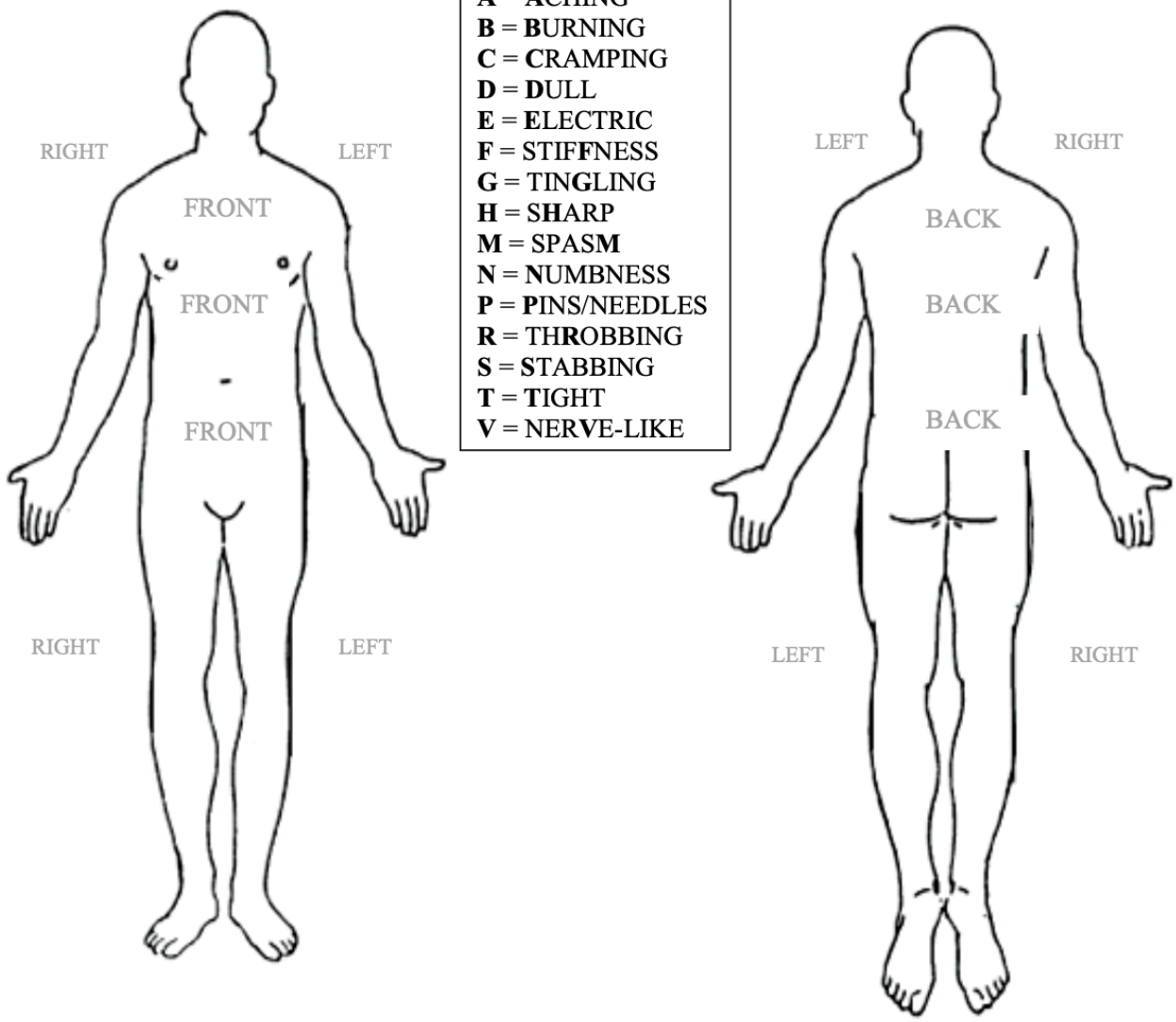
Review of Systems: Please check if you experience any of the following.

Difficulty Sleeping		Fatigue		> 20 lbs weight gain or loss	
Abdominal Pain		Nausea / Vomiting		Heartburn	
Constipation		Diarrhea		Bowel Incontinence	
Painful Urination		Urgent / Frequent Urination		Urinary Incontinence	
Wear Glasses / Contacts		Blurry / Double Vision		Heat or Cold Intolerance	
Unusual Hair Growth		Unusual Hair Loss		Hearing Loss	
Ringing in Ears		Dentures		Sore Thorat	
Seasonal Allergies / Hay Fever		Chest Pain		Shortness of Breath	
Heart Palpitations		Coughing		Wheezing	
Joint Pains		Muscle Aches		Headaches	
Rash		Hives		Anxiety	

Depression		Fainting		Numbness	
Tingling		Weakness		Anemia	
Easy Bruising		Prolonged Bleeding		Nosebleeds	
Bleeding Gums		Tremor		Seizures	

Please indicate the location and type of pain you experience on the diagram below, using the appropriate letter(s) from the chart below

A = **A**CHING
B = **B**URNING
C = **C**RAMPING
D = **D**ULL
E = **E**LECTRIC
F = STIF**F**NESS
G = TIN**G**LING
H = S**H**ARP
M = SPAS**M**
N = **N**UMBNESS
P = **P**INS/NEEDLES
R = TH**R**OBBING
S = **S**TABBING
T = **T**IGHT
V = NER**V**E-LIKE



NO PAIN |----------|----------|----------|----------|----------|----------|----------|----------|----------|----------| WORST PAIN

I have reviewed the above 6-page packet and believe it is complete to the best of my knowledge.

PATIENT signature:_____ Date: _____

Insurance Information (MANDATORY)

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

Attorney phone:_____ Attorney name:_____

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_____

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 Mariwalla Neurosurgery.

Thank you for your understanding.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

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_____

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 Mariwalla Neurosurgery, 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 by Mariwalla Neurosurgery. 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 Mariwalla Neurosurgery consent to charge my credit card listed above.

Signature: _____
Print Name: _____ Date: _____

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: _____