



PLEASE BRING YOUR INSURANCE CARD TO ALL APPOINTMENTS

Patient Name: _____

Sex: M F

Mailing Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work: _____

Cell: _____

Date of Birth: _____

Age: _____

Social Security #: _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Other _____

Primary Insurance Coverage With: _____ Deductible or Co-Payment: _____

Policy Holder/Name on Card: _____ Group #: _____ ID#: _____

Secondary Insurance Coverage With: _____ Deductible or Co-Payment: _____

Policy Holder/Name on Card: _____ Group #: _____ ID#: _____

Patient's Employer (if not applicable, insert "n/a") _____

Spouse or Parent's Name: _____

Date of Birth: _____

Spouse or Parent's Employer: _____

Social Security # _____

Nearest Relative/Friend NOT living with you: _____ Phone: _____

Preferred Pharmacy: _____

Patients Email Address: _____

Do you approve of healthcare providers sending appointment reminders, lab results, etc. to this e-mail address?

YES ___ NO ___

Were you referred to our practice by another physician? YES ___ NO ___

If so, who? _____

ASSIGNMENT OF BENEFITS

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to Healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverages, in compliance with HIPPA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.



THIRD PARTY ACCESS FROM

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Chart #: _____ Social Security #: _____

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING:

SPOUSE: _____ PHONE: _____

CHILDREN: _____ PHONE: _____

FAMILY MEMBER: _____ PHONE: _____

EMPLOYER: _____ PHONE: _____

If any of these individuals contact us, they will be asked to provide your social security number. Please make sure they know this information. Anyone who is not named above or who cannot provide your social security number will be denied access to your Protected Health Information.

- I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.
- I understand I may revoke this authorization at any time by signing the revocation section of this form and returning it to St. Bernards Neurosurgery. I further understand any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
- I understand I am under no obligation to sign this authorization. I further understand my ability to obtain treatment will not depend in any way on whether or not I sign this authorization.
- I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
- I understand the clinic named above will not receive compensation for the uses and disclosures I have authorized.

Note: After the initial completion of this form, any additions or deletions must be given to the healthcare provider in writing.

Name (Please Print): _____

Signature: _____ Date: _____

REVOCATION SECTION

I hereby revoke this authorization: Signature: _____ Date: _____



**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of the clinic's Notice of Privacy Practices
Please Print Name

Signature of Patient or Legal Guardian: _____ Date: _____

If not signed by patient, please indicate relationship:

- ___ Parent or guardian of minor patient]
- ___ Guardian or conservator of an incompetent patient
- ___ Beneficiary or personal representative of deceased patient

I would like to receive a copy of any amended Notice of Privacy Practices. YES NO (Please Circle)

For Office Use Only:

Signed for & received by:
_____ "

Acknowledgment refused:

Efforts to obtain:

Reason for refusal:

Patient Date of Birth: _____ Patient Chart Number: _____

NEW PATIENT HEALTH HISTORY

Patient Name:		Dob:	Age:	Check if Yes:	✓ Y
Reason for Visit:		Date of Visit:		Review of Systems	
Consult Req By/Referred By:				Constitutional	
PAST MEDICAL HISTORY		✓ Y	ALLERGIES		
Arthritis			Meds/Reaction:		Fever
Cancer					Fatigue
Stroke/CVA					Weight Change
Cardiovascular (Heart) Disease					
Diabetes Mellitus					Eyes
Liver Disorders			Foods/Reaction:		Vision Changes
High Cholesterol/Lipids					
Hypertension - High Blood Pressure					Ear, Nose & Throat
PVD - Peripheral Vascular Disease			CURRENT MEDICATIONS:		Tinnitus - Ringing in ears
Psychiatric Disorders					Hearing problems
Renal/Kidney/Bladder Disease					
Respiratory Disorders - Breathing					Neck
Seizure/Epilepsy					Neck Pain/Stiffness
Sleep Disorders					
Alzheimer's Disease					Cardiovascular
Anemia/Bleeding/Hematological					Chest Pain
ENT/Eye Problems					Edema - Swelling
GI (Stomach) Disorders					Irregular Heartbeat
Headaches					
Paralysis					Pulmonary
Spine Disorders					Wheezing
Thyroid Disease					Cough
OTHER:					Dyspnea - Shortness of breath
Previous History of Injury		FAMILY HISTORY:		Family Member	Gastro-Intestinal
If yes, give detail:		**Dad - Mom - Sis - Bro - Child*			Abdominal Pain
		Alcoholism			Nausea/Vomiting
		Back Pain			
		Bleeding problems			Muscoskeletal
		Cancer			Joint Pain
		Diabetes Mellitus			Back Pain
Previous Surgery/Hospitalization		Heart Disease			Extremity Pain
CABG - Heart Surgery		High Chol/Lipids			Weakness
CEA - Carotid Artery Surg		Hypertension			
Appendectomy		Neurological Disorders			Renal/Kidney/Bladder
Tonsil/Adenoid		Migraine Headache			Incontinence
Hysterectomy		PVD - Peripheral Vascular Disease			Pain/Pressure
Neurology Procedure		Psychiatric Disorders			
Other Surgeries		Renal/Kidney/Bladder Disease			Psych
Surgery Details:		Respiratory Disorders			Anxiety/Depression
		Stroke/TIA			Mental Status Changes
		Thyroid Disorders			Sleep Problems
					Neuro
		Your Social History (Adult)		✓	Headache
					Numbness
Implanted Devices		Tobacco Use/Packs per day			Tingling
Do you have a pacemaker?		If quit: How long ago and years			Seizures
Do you have a defibrillator?		Alcohol Use			
Do you have Spinal Stimulator?		If quit: how long ago years drank?			Review of Systems - Other:
Do you have Brain Stimulator?		Caffeine Use/Servings per day			
Any other Implanted Device?		Illicit Drug Use			
Type?		Occupation			
		Other Social History:			

NEW PATIENT HEALTH HISTORY

EPWORTH SLEEPINESS SCALE	Chance of dozing			
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(Fill in the blanks below with the most appropriate number)

0 = would never doze					
1 = slight chance of doze					
2 = moderate change of doze					
3 = high chance of doze					
Situation:	Score:				
Sitting and reading					
Watching TV					
Sitting inactive in a public place					
As car passenger for an hour					
Lying down to rest in afternoon					
Sitting and talking to someone					
Sitting quietly after lunch without alcohol					
In a car, stopped for a minute in traffic					

Please answer yes or no if you have had the following vaccinations or screenings:

			Date of F/U exam or immunization (an approximate month/year is acceptable)
Flu Shot	Y	N	
Pneumonia Shot	Y	N	
Mammogram	Y	N	
Pap smear	Y	N	
Colonoscopy	Y	N	
Tobacco usage	Y	N	
High Blood Pressure	Y	N	

Have you traveled outside the US in the past 30 days or been in contact with a person who appears ill or has traveled outside the US?

Travel/Exposure	YES		
	NO		

Have you traveled to Guinea, Liberia or Sierra Leone in the past 21 days?

Travel/Exposure	YES		
	NO		

Have you traveled to Saudia Arabia, United Arab Emirates, Qatar, Oman, Jordan in the past Kuwait, Yeman, or Iran in the past 14 days?

Travel/Exposure	YES		
	NO		

Name: _____

Date: _____

Location of Pain: _____

Other Symptoms (eg, numbness, weakness)?

How long have you had pain and/or other symptoms?

What is the character of pain (eg, burning, aching, electric)?

Is it worse any time of day or night?

What makes it worse? What makes it better?

What treatment have you had?

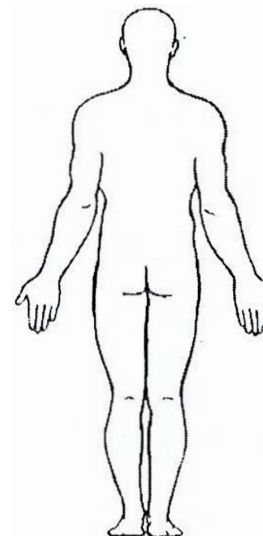
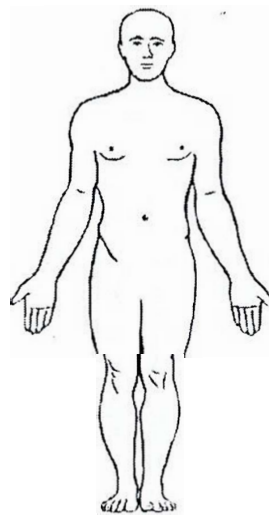
Medications?

Infection?

Physical Therapy?

Surgery? _____ Did it help? _____

Are symptoms getting better or worse?





PAYMENT POLICY

Thank you for choosing Jonesboro Neurosurgery Clinic, Inc. We are committed to providing you with quality and affordable healthcare. We have developed this policy to answer your questions regarding patient and insurance responsibilities for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do not business with, payment in full is expected at each visit. We accept personal checks, cash, MasterCard, Visa and Discover. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on your part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Also, please be aware that if Medicare does not cover a service, it may not be covered by your secondary insurance. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supple certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
6. **Coverage changes.** If your insurance changes, please notify us proper to seeing the doctor so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance may be billed to you.

7. Nonpayment. If your account is 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless arrangements have been made with our Business Office. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature _____ **Date:** _____