Neurosurgical Associates, L.L.C.

Patient Full Legal Name:		**Maiden Name:**	**Social Security #:**
Date of Birth:	**Age:**	**Sex:** ☐ **M** ☐ **F**	**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Other**
Ethnicity, please indicate: ☐ **Caucasian** ☐ **African American** ☐ **Asian** ☐ **Hispanic** ☐ **Other** ☐ **Native American** ☐ **Asian Pacific American** ☐ **Pacific Islander**			
Home Phone:		**Work Phone:**	
Cell Phone:		**Email:**	
Home Address, City, State, Zip:			
Mailing Address, City, State, Zip (If not the same as home):			
Employer:	**Employer Address, City, State, Zip:**		
Is Patient at a Care Facility/Rehabilitation Center? ☐ **Yes** ☐ **No If yes, Facility Name:**			
Facility Phone:		**Facility Address, City, State, Zip:**	
Emergency Contact Name:		**Relationship to Patient:**	
Home Phone:	**Work Phone:**		**Cell Phone:**
Name of Other Contact Not Living with You:			**Relationship to Patient:**
Home Phone:	**Work Phone:**		**Cell Phone:**
Referring Source, please indicate: ☐ **Physician/Clinic** ☐ **Family/friend** ☐ **Employer/Coworker** ☐ **Insurance** ☐ **Self** ☐ **NSAMD Website** ☐ **Other:**			
Referring Provider's Full Name:			**Provider Type?** ☐ **MD** ☐ **NP** ☐ **PA** ☐ **Other**
Office Phone:		**Office Fax:**	
Office Address, City, State, Zip:			
Primary Care Provider's Full Name:			**Provider Type?** ☐ **MD** ☐ **NP** ☐ **PA** ☐ **Other**
Office Phone:		**Office Fax:**	
Office Address, City, State, Zip:			
Physical Therapist Full Name:			
Office Phone:		**Office Fax:**	
Office Address, City, State, Zip:			
Physiatrist / Physical Medicine & Rehabilitation / Pain Management Provider's Full Name:			**Provider Type?** ☐ **MD** ☐ **NP** ☐ **PA** ☐ **Other**
Office Phone:		**Office Fax:**	
Office Address, City, State, Zip:			
Chiropractor Full Name or Clinic Name:			

This section is for office use only		Staff Initials:	
Advance Directive	☐ Yes ☐ No		
		Account #:	

Please Complete The Applicable Sections Regarding Your Brain Condition	
What type of brain injury have you sustained?	
Date of Injury?	**Have you had a seizure(s)? ☐ Yes ☐ No If yes, date of last seizure?**
Current symptoms?	

Epilepsy	
Date of onset of seizures?	**Date of last seizure?**
How often do you have seizures?	**What type of seizures do you have?**
What seizure medications are you currently taking?	
What seizure medications have you tried in the past?	
What type of surgery are you interested in?	

Parkinson's Disease	
Date of onset of Parkinson's?	
Current symptoms?	
Have you had Depression? ☐ Yes ☐ No	**Do you have Cognitive problems? ☐ Yes ☐ No**

Brain Tumor / Pituitary Tumor
Date of onset of symptoms?
Current symptoms?
Who is your Endocrinologist (for Pituitary Tumors only)?
If you are coming in for a routine checkup, are you having any symptoms? If yes, please list them.

Trigeminal Neuralgia
Date of onset of symptoms?
Current symptoms?
What Trigeminal Neuralgia medications are you currently taking?
What Trigeminal Neuralgia medications have you tried in the past?

Your Medical History, if applicable to you please check the "Yes" box.

	Yes		Yes		Yes		Yes
Glaucoma		Diabetes Type I or Type II		Cancer		Thyroid Trouble	
Cataracts		If yes, type of Diabetes:		If yes, type of Cancer:		MRSA Infection	
Coronary Artery Disease		Onset of Diabetes:				Hepatitis	
Atrial Fibrillation		COPD		Convulsions (Epilepsy)		AIDS	
Palpitations		Asthma		Depression		HIV Exposure	
Heart Attack		TB		Anxiety		Adverse Reaction to Anesthesia	
Angina		Other Lung Problems		Bipolar			
Heart Murmur		Sleep Apnea		Headaches		Other:	
Pace Maker or Defibrilla-tor		C-PAP		Anemia			
High Blood Pressure		Bi-PAP		Hemophilia		None of The Above Apply to You	
High Cholesterol		Kidney Disease		Other Bleeding Disorder			

Are you allergic to any medications? If applicable to you, please check the "Yes" box.

	Yes		Yes		Yes		Yes	
No Known Allergies		Morphine		Demerol		Anesthetic - If yes, note type.		
Aspirin		Codeine		Latex		Diagnostic Dyes /Contrast		
Penicillin		Lortab		Sulfa Drugs		Others:		
Please describe allergic reactions and severity:								

Preferred Pharmacy Name:	Pharmacy Phone:

Medications, please list all medications that you are currently taking. Please include all over the counter, prescriptions, vitamins, and herbal products. Indicate "None" on the first line below if you are not currently taking any medications.

Name	Dose	How Often?	Why Do You Take This	Date Started	Date Stopped

List any Neurologic Surgeries or Hospitalization, as well as your Surgical or Hospitalization History within 10 years. If no surgical/hospitalization history, please indicate "None" on first line below.

Surgeries or Hospitalizations	Date	Reason

Family Medical History, please check the applicable box.

	Dad	Mom	Sibling	Grand-parent		Dad	Mom	Sibling	Grand-parent
Heart Disease					Psychiatric History				
Heart Attack					Alcohol Abuse				
High Blood Pressure					Drug Abuse				
Diabetes					Adverse Reaction to Anesthesia				
Lung Disease					Any Familial or Inherited Disease				
Kidney Disease					Other				
Cancer					Other Condition:				
Cancer Type:					None of the above				

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
If you are on a special diet, what is it?
Do you regularly exercise? ☐ Yes ☐ No If yes, please describe:
What is your occupation?
Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker
Time off work prior to your appointment: ☐ 1-3 Months ☐ 4-6 Months ☐ 7-9 Months ☐ 10-12 Months
Does your occupation require moderate or heavy labor? ☐ Yes ☐ No If yes: ☐ Moderate ☐ Heavy Describe type of activity:
Do you smoke? ☐ Yes ☐ No If Yes, how any years? How much per day or week?
If yes, have you had smoking or nicotine counseling? ☐ Yes ☐ No
If yes, who did you receive counseling by and when?
Have you been able to stop or reduce your smoking? ☐ Yes ☐ No
Do you use electronic cigarettes? ☐ Yes ☐ No If yes, what kind (Nicotine or Other Substance)?
Do you drink alcohol? ☐ Yes ☐ No If yes, what kind and how much in a day, week or month?
Do you use recreational drugs? ☐ Yes ☐ No If yes, what kind and how much in one week?

Review of Systems, please check the "Yes" box if you currently have, or have had any of these symptoms in the last 6 months:

	Yes		Yes		Yes		Yes
Weight Loss or Gain		Hearing Loss		Balance Disturbance		Lupus	
Obesity		Ringing in Ears		Headaches		Scleroderma	
Vision Changes		Claustrophobia		Psoriasis		Drug Abuse	
Change in Bowel Habits		Weakness		Osteoporosis		Alcohol Abuse	
Difficulty Starting or Stopping Urinary Stream		Other Neurologic Deficits		Adverse Reaction to Anesthesia		Current Skin or Wound Infection	
Nausea		Shortness of Breath		Depression		Peripheral Vascular Disease	
Vomiting		Sexual Dysfunction		Rheumatoid Arthritis			
Other:						NONE OF THE ABOVE	

If the patient is under 18 years old or if you are the legally authorized individual with a Medical Power of Attorney, please complete.

Guarantor Relationship to Patient? ☐ Parent ☐ Legal Guardian	Other: (please explain)	
Full Legal Name:	Date of Birth:	Social Security #:
Sex: M / F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	
Home Address, City, State, Zip:		
Home Phone:	Work Phone:	
Cell Phone:	Employer:	
Employer Address, City, State, Zip:		

NEUROSURGICAL ASSOCIATES, LLC NOTICE OF PRIVACY PRACTICES

Neurosurgical Associate's **Notice of Privacy Practices** provides detailed information on how your Protected Health Information (PHI) may be used and disclosed. Neurosurgical Associates reserves the right to amend the Notice of Privacy Practices periodically. You may obtain a current copy of the Notice of Privacy Practices by contacting the office staff at any time or accessing this notice at www.nsamd.com. Neurosurgical Associates, LLC will disclose your PHI to other health care practitioners and facilities involved in my medical care. Neurosurgical Associates, LLC will also disclose your PHI to your health insurance carrier to support payment for your medical services. You must file a written request in order to obtain a copy of your PHI, and a HIPAA compliant release must be completed before your PHI will be shared with any third party not referenced above.

E-PRESCRIBING PHARMACY BENEFIT MANAGEMENT (PBM) CONSENT - E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an e-Prescribe program. These include: **Formulary and benefit transactions-** Gives the prescriber information about which drugs are covered by the drug benefit plan. **Medication history transactions--** Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent form, you are agreeing that Neurosurgical Associates, LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

CONSENT TO SHARE HEALTH STATUS, TREATMENT, OR PAYMENT INFORMATION - If you would like to have information regarding your condition, treatment, or account discussed with another person (such as your spouse, parent, friend, etc.) please complete the following information. This consent may be revoked at any time by notifying the office verbally or in writing. **We can share your personal health and billing information with your treating physicians and your insurance, please do not indicate them below. For patient / attorney communications a separate release form is required.**

Share your information with:	Spouse	Child	Parent	Other	Date of Birth	Phone
Name:						
Name:						
Name:						
Name:						

CONSENT AND CONDITIONS OF SERVICE - As either the patient, or the legally authorized and financially responsible representative of the patient, the following consents, understandings, and agreements are made on my own behalf or on behalf of the patient in partial consideration of the health care services to be provided to the patient by Neurosurgical Associates: On behalf of the patient, consent is hereby given to Neurosurgical Associates to provide health care services to patient and to administer physician orders for the benefit of the patient for this visit and any subsequent visits. It is understood that this consent may be revoked, in writing, at any time. It is understood that there is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. It is understood and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that physicians are separately responsible to explain what they do. The law requires health care providers to make and keep records of your medical treatment. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at Neurosurgical Associates, you agree to the release of medical record information for the uses specified above. You also agree to release claims related information to insurance companies or other third parties to assist in paying your health care costs. I hereby assign all medical and/or surgical benefits, to include medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Neurosurgical Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services rendered to patient from Neurosurgical Associates including but not limited to any amounts not paid by any insurance company or other third-party payor. Patient and the undersigned, if other than the patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third-party payor. It is understood and agreed that charges not paid in full within 60 days of billing will be subject to interest at the rate of 18% annually. Accounts not paid in full in a timely fashion may be placed with a collection agency or attorney for purposes of collection. It is further understood and agreed by the patient and the undersigned, if other than the patient, each jointly and severally agree to pay costs and reasonable attorney's fees in connection with the collection process. Accounts not paid in full in a timely fashion may be placed with a collection agency or attorney for purposes of collection. Accounts transferred for collection are subject to a 35% collect fee. A service charge may be collected in connection with any check or other instrument tendered by the patient or the undersigned but returned unpaid to Neurosurgical Associates. I have read and understand the document and I intend it to be legally binding subject to applicable law. Jurisdiction and Venue: The terms and conditions contained within this agreement shall be governed by the laws of the State of Utah and shall be construed and interpreted in accordance with those laws. Any action or proceedings brought by either party which is based upon or derived, from or in any way related to this agreement shall be brought in a court of competent jurisdiction with the State of Utah. The parties hereto consent to their personal jurisdiction of said court. I represent and warrant that all of the information provided to Neurosurgical Associates in this information form is true, complete and accurate. I understand and expect that Neurosurgical Associates will rely upon this information in providing services to me.

Patient Name:		**Account #:**
SIGNATURE OF PATIENT / RESPONSIBLE PARTY	**RELATIONSHIP**	**DATE**
X		

Third Party Liability Questionnaire / Injury Related Coverage - Your health insurance company will not pay for an accident or injury related claim without proof of third-party liability. In order to process your insurance claim, please complete the following third-party liability questionnaire:

Is your medical problem the result of an injury or accident? ☐ NO - please skip and move to the next section. ☐ YES - please answer the following questions.		
What date did the accident or injury occur?		
Where did the accident or injury occur? (i.e. work, home, grocery store, etc.)	**Address of injury?**	
How did the accident or injury occur?		
At what medical facilities were you treated for the accident or injury?		
Have you reported the accident or injury? ☐ Yes ☐ No	**Have you contacted an attorney? ☐ Yes ☐ No**	
If you have retained an attorney, please note their name:		
Phone Number:	**Address, City & State:**	
Is your accident or injury automobile related? ☐ Yes ☐ No	**If yes, is there personal injury protection (PIP) benefits remaining? ☐ Yes ☐ No**	
Personal Automobile Insurance Coverage:		**Claim #:**
Personal Automobile Insurance Address, City, State, Zip:		
Adjustors Name:		**Phone Number:**
Is your accident or injury work related? ☐ Yes ☐ No If yes, please complete the Workers Compensation section below.		
Workers Compensation Insurance Coverage:		**Claim #:**
Insurance Address, City, State, Zip:		
Adjustors Name:		**Phone Number:**
Did the accident or injury occur at home? ☐ Yes ☐ No		**Claim#:**
Homeowners Insurance Company:		
Insurance Address, City, State, Zip:		
Adjustors Name:		**Phone Number:**
Did the accident or injury occur at any location not referenced above? ☐ Yes ☐ No	**Date:**	**If yes, please provide the name, address, and phone number for the responsible party:**

Please bring your insurance card(s) with you to your appointment. If you don't have insurance card(s) please contact your insurance carrier and complete the following information. <u>If your condition is accident or injury related, please complete Third Party Liability Questionnaire above.</u>

Primary Health Insurance Plan:		
Primary Policy / ID #:		**Group Name or #:**
Primary Policy Holder's Full Legal Name:	**Policy Holder's Social Security #:**	**Policy Holder's Date of Birth:**
Primary Policy Holder's Employer:		
Secondary Health Insurance Plan:		
Secondary Policy / ID #:		**Group Name or #:**
Secondary Policy Holder's Full Legal Name:	**Policy Holder's Social Security #:**	**Policy Holder's Date of Birth:**
Secondary Policy Holder's Employer:		
Third Health Insurance Plan:		
Third Policy / ID#:		**Group Name or #:**
Third Policy Holder's Full Legal Name:	**Policy Holder's Social Security #:**	**Policy Holder's Date of Birth:**
Third Policy Holder's Employer:		