WELCOME TO OUR PRACTICE

PLEASE PRINT, COMPLETE AND BRING WITH YOU TO YOUR OFFICE VISIT

PATIENT REGISTRATION FORM

REFERRING PHYSICIAN: **PRIMARY CARE PHYSICIAN**

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ PHYSICIAN REFERRAL ☐ FRIEND REFERRAL ☐ ADVERTISING ☐ YELLOW PAGES ☐ WEBSITE ☐ OTHER

PATIENT INFORMATION

LAST | FIRST | MIDDLE | PREVIOUS LAST | NICKNAME

SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | GENDER ☐ Male ☐ Female | RACE | LANGUAGE

ETHNICITY: PLEASE CHECK

☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR NON-LATINO ☐ UNKNOWN ☐ DECLINED TO SPECIFY

MARITAL STATUS | SMOKER ☐ Yes ☐ No

STREET ADDRESS | BILLING ADDRESS | CITY | STATE | ZIP

PLEASE CHECK PREFERRED METHOD OF CONTACT:

☐ HOME PHONE ☐ DAY PHONE ☐ CELL PHONE ☐ EMAIL ADDRESS

OCCUPATION | PATIENT EMPLOYER

EMERGENCY CONTACT:NAME | RELATIONSHIP | DAYTIME PHONE

Did your injury happen on the job? ☐ YES ☐ NO If yes, on what date did the injury occur?_____

Did you report the accident to your employer? ☐ YES ☐ NO

RESPONSIBLE PARTY (COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE OR THE PATIENT IS UNDER THE AGE OF 18.)

LAST | FIRST | MIDDLE | SOCIAL SECURITY NUMBER | DATE OF BIRTH

STREET ADDRESS | BILLING ADDRESS | CITY | STATE | ZIP

RELATIONSHIP | DAYTIME PHONE | EMAIL ADDRESS

For verification of insurance benefits, we require a copy of your insurance card(s) at time of registration.

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE CO. NAME	INSURANCE CO. NAME
POLICY HOLDER'S NAME DATE OF BIRTH	POLICY HOLDER'S NAME DATE OF BIRTH

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. Fees are payable at the time of service.

Preferred Method of Payment ☐ **Cash** ☐ **Check** ☐ **MasterCard/Visa**

Authorization to Release Medical Information:

I authorize Georgia Neurological Surgery & Comprehensive Spine to release information to any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I also authorize any physician, hospital or clinic to provide medical information required in the course of my examination or treatment.

Assignment of Benefits and Payment:

I authorize my health insurance benefit plan to pay directly to Georgia Neurological Surgery & Comprehensive Spine. I understand that I am financially responsible to Georgia Neurological Surgery & Comprehensive Spine for any non-covered charges.

Signature_____ **Date**_____

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

PATIENT NAME_____PT ACCOUNT #_____

ADDRESS_____

ADDRESS _____

CITY_____ STATE_____ZIP_____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Georgia Neurological Surgery & Comprehensive Spine Physicians and staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Conditions for Disclosure (Check the item(s) that apply):

☐ The practice may disclose my personal health information to the individual(s) above **only** in my presence.

☐ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.

☐ Other Conditions of Disclosure: _____
_____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____

Witnessed by: _____ Title/Position:_____

Print Name of Witness:_____

Date: _____

PATIENT ACKNOWLEDGMENT/CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that as part of my healthcare, ***Georgia Neurological Surgery & Comprehensive Spine*** creates health records describing my past and present health history, and any future plans for treatment. I understand that records may contain information originated by another healthcare provider other than ***Georgia Neurological Surgery & Comprehensive Spine*** and that ***Georgia Neurological Surgery & Comprehensive Spine*** is not responsible for information contained within these incorporated records (including accuracy, completeness, legibility or lack thereof).

I acknowledge, by my signature below, that I have received a copy of ***Georgia Neurological Surgery & Comprehensive Spine's*** Notice of Privacy Practices. I understand that I have the right to review the Notice in full prior to signing this acknowledgement. I understand that ***Georgia Neurological Surgery & Comprehensive Spine*** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice may be obtained by requesting one to be mailed to me or by asking for a copy at my next visit to the office.

I understand that I have the right to request ***Georgia Neurological Surgery & Comprehensive Spine*** restrict how it uses or discloses my protected health information (PHI) for the use of treatment, payment or healthcare operations (TPO). However, ***Georgia Neurological Surgery*** is not required to agree to my requested restrictions.

Georgia Neurological Surgery & Comprehensive Spine will not use or disclose health information without my authorization, except as described in the Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has made disclosures in trust prior to this consent. If I do not sign this consent, or later revoke it, I understand that ***Georgia Neurological Surgery & Comprehensive Spine*** may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian Patient's Name

OFFICE USE ONLY:

Georgia Neurological Surgery & Comprehensive Spine was unable to obtain this acknowledgment due to:

- ☐ Emergency
- ☐ Patient Refused – Reason: _____
- ☐ Patient Confused/Disoriented
- ☐ Other: _____

Effective Date: April 14, 2003

GEORGIA NEUROLOGICAL SURGERY & COMPREHENSIVE SPINE
2142 West Broad Street, Bldg. 100, Suite 200, Athens, GA 30606
(706) 548-6881

Financial Policy

Thank you for choosing our practice for your neurosurgical healthcare. We are committed to the success of your medical treatment and care. Payment of your bill is considered a part of your treatment. The following statement explains our financial policy.

- Accurate and complete personal and insurance information is required prior to being seen by the provider.
- All co-pays and personal balances, both current and prior, are *due at time of service.*
- We accept cash, personal checks, MasterCard, Visa, American Express and Discover.

Health insurance is an agreement between you and your insurance company. You are responsible for payment of your bill regardless of the status of your insurance claim. Our fees are customary for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

- ***Contracted Insurance:*** Members of an insurance plan with which our office is contracted will be asked to pay all co-pays, deductibles and any non-covered services **at the time of service.** If you receive two different types of service on the same day, you will be asked to pay two different co-pay amounts as required by your plan. Please verify with our receptionist if we are a participating provider with your insurance plan. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.

- ***Non-Contracted Insurance:*** If your healthcare plan is a non-participating plan, payment is **due at the time of service** and you will be given a receipt to file with your insurer. If surgery is indicated, you will be given an estimate of our charges. Prior to surgery, we ask for a 50% down payment and any unpaid deductible.

- ***Medicare:*** We accept assignment from Medicare. Therefore, Medicare payments will be made directly to the provider. We are required by Federal Law to collect 20% of the allowed amount either out of pocket or by your supplemental insurer. You are responsible for the annual Medicare deductible.

- ***Medicaid:*** We are participating providers with Georgia Medicaid. You are responsible for co-payments **at the time of service.** If you have exceeded your 12 visits for the year, you will be held financially responsible.

- ***Workers' Comp:*** Authorization is necessary prior to your treatment.

- ***Auto:*** We do not file auto insurance. Payment is **due at the time of service** unless health insurance is available.

- ***Self-Pay:*** Payment is **due at the time of service.** If surgery is indicated, you will be given an estimate of charges and asked to make a 50% down payment prior to scheduling.

- ***Minor Children:*** The parent listed as the guardian for the child will be the parent held responsible for the charges in case of parental separation or divorce.

- ***Surgery/Injections:*** Please be aware that you will receive separate bills from the surgeon, the facility and the anesthesiologist.

Past Due Accounts: Unfortunately, we are not in a position to finance healthcare and we make no arrangements for long-term payments. If unusual circumstances make it impossible for you to meet our credit terms, we ask that you discuss the matter with our financial coordinator. This will avoid any misunderstandings and enable you to keep your account in good standing. Accounts that are greater than 90 days past due will be referred to our collection agency.

Returned Checks: There will be a $25.00 charge added to your account for any check returned for non-payment.

Please contact our financial coordinator if you have any questions or concerns at (706) 548-6881.

I have read the Financial Policy and understand the terms.

_____	_____	_____
Print Name	Signature	Date

GEORGIA NEUROLOGICAL SURGERY & COMPREHENSIVE SPINE
2142 West Broad Street, Bldg. 100, Suite 200, Athens, GA 30606
(706) 548-6881

Patient Name | **Chart Number**

MEDICATION AGREEMENT

The purpose of this agreement is to inform you of the requirements to receive prescribed medication from Georgia Neurological Surgery & Comprehensive Spine. Should you not understand these requirements in full, please discuss with your physician or practitioner. Your signature indicates that you have read and understand these guidelines. Non-compliance could result in no further prescribed medications or a discharge from the practice.

- All medications are to be taken according to the directions on the bottle. Prescribed medications can be dangerous if taken incorrectly or not as prescribed. Please contact our office if you have any questions about those directions.
- You will need to choose and use only one pharmacy for your narcotic medications. Advance notice of pharmacy change is necessary. Please provide us with your pharmacy name and phone number.
- If we prescribe narcotic medication to you, it is understood that you will not receive any narcotic medications from any other physician. Should we receive knowledge of narcotic medications being prescribed to you by other physicians, Georgia Neurological Surgery & Comprehensive Spine will no longer prescribe narcotic medications to you.
- Should your prescribed medications become lost or stolen, they will not be replaced.

- **REFILLS**
  - You must be a current patient that has been seen within the last 6 months.
  - Requests for non-narcotic medication refills are taken during 8 am – 4 pm, Monday-Friday.
  - **Narcotic medications** require physician approval. These requests may take 1-2 business days to process. Request should be made **Monday-Thursday, 8am – 4pm** to allow for physician review.
  - Any request after 4:00 pm will not be reviewed until the next business day. We do not refill requests after business hours or on weekends.
  - To place a refill request, please call our office. Be sure to have the name of the medication, the pharmacy phone number, the patient's full name and date of birth in order to process your request.
  - In order to check on your request, please check with your pharmacy after 4:00 pm. If your request is denied or changes have been made, the triage nurse will contact you with further information or recommendations. Please note that multiple calls are not necessary and actually hinder the process.

Please understand that this agreement is to ensure your well-being and safety as well as to allow the prescribing physician/practitioner to abide by the narcotic responsibilities placed upon them.

Patient or Legal Guardian's Signature | Witnessed By | Today's Date

Pharmacy Name | Pharmacy Phone Number

GNSCS ~PATIENT HEALTH HISTORY

Full Name of Patient	Date of Birth	Exam Date	Medical Record #

Full Name of Referring Physician	Full Name of Primary Care Physician

CHIEF COMPLAINT

What are your current symptoms?

How long have you had these symptoms?

What is your pain level today?
Please circle a number 1 to 10 **that most closely measures** the level of pain you feel **today**.

	0	1	2	3	4	5	6	7	8	9	10
No Pain	*Hardly Noticeable*				*Noticeable & Wearing*					*Worst Pain Imaginable*	

In the last 6 months, have you tried any of the following treatments to relieve your symptoms?

- ☐ pain medication
- ☐ oral steroids
- ☐ muscle relaxants
- ☐ *pain control clinic*
  - *Where?*_____
  - *When?* _____
- ☐ TENS unit
- ☐ home exercise program
- ☐ chiropractic treatment
- ☐ *physical therapy*
  - *Where?*_____
  - *When?*_____
  - *How Long?*_____
- ☐ massage therapy
- ☐ steroid/cortisone injections
- ☐ *anti-inflammatory medications*
  - *What was taken?*_____
  - *For how long?*_____
- ☐ others: _____

What makes your symptoms worse?

What makes your symptoms better?

Please name any physicians that you have seen about your current medical problem.

Have you ever had the same or a similar condition? Yes ☐ No ☐ If Yes, When? _____

If your symptoms are related to any injury, please mark the box indicating the type of injury.
☐ auto injury ☐ personal injury ☐ work-related injury ☐ other _____

Date of injury: _____ If no specific date, when did you first notice your problem? _____

If work-related, did you report this to your employer? Yes ☐ No ☐

Full Name of Patient	Date of Birth	Exam Date	Medical Record #

PAST MEDICAL HISTORY

LIST ANY MEDICATION ALLERGIES & THE REACTION:

Other allergies: please check all that may apply.
☐ iodine/dyes ☐ latex ☐ tape ☐ shellfish

Current Medications: Please bring medications with you to your appointment. A staff member will review these with you.

Pharmacy Name & Number: _____

Please list any prior ***surgeries*** and/or ***hospitalizations:***

SURGERIES	DATE	COMPLICATIONS

Have you ever had an MRSA or STAPH infection? If so, please give dates and treatment received.

For Diagnostic Purposes: Do have a pacemaker or an aneurysm clip? Y N
Are you claustrophobic? Y N

Please check any previous illnesses that apply.

☐ Anemia	☐ High Blood Pressure	☐ Diabetes	☐ Reflux
☐ Asthma	☐ Heart Disease	☐ Ulcers	☐ Seizures
☐ Cancer	☐ Heart Murmur	☐ CVA/Stroke	☐ Enlarged Prostate
☐ Hepatitis B	☐ High Cholesterol	☐ Thyroid Disease	☐ Osteoporosis
☐ Hepatitis C	☐ Kidney Disease	☐ Sleep Apnea	☐ Osteoarthritis
☐ HIV/AIDS	☐ COPD	☐ Depression	☐ Rheumatoid Arthritis

Other: _____

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED	HEALTH STATUS OR CAUSE OF DEATH
Father			
Mother			
Sister			
Sister			
Sister			
Sister			
Brother			
Brother			
Brother			

Full Name of Patient	Date of Birth	Exam Date	Medical Record #

SOCIAL HISTORY

Current Work Status:

Working: Yes ☐ No ☐ Occupation: _____

Medical Leave Yes ☐ No ☐ Who took you out of work? _____

Last Day Worked? _____

Disabled: Yes ☐ No ☐ Reason for disability: _____

Retired: Yes ☐ No ☐ Prior Occupation: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ No ☐ Yes How many sons _____ daughters _____

Do you use tobacco products? ☐ No, never ☐ No, but I used to Quit date: _____

☐ Yes Form of tobacco? _____ Packs/day? _____ For how long? _____

Do you drink alcohol? ☐ No, never ☐ No, but I used to ☐ Yes

If yes, ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially

Do you currently use illegal drugs? ☐ No ☐ If Yes, list _____

REVIEW OF SYSTEMS - Please check all that apply

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Generalized weakness
- ☐ Weight gain
- ☐ Weight loss

HEAD, EYES, EARS
NOSE, THROAT
- ☐ Hearing loss R / L
- ☐ Sinusitis
- ☐ Swallowing difficulty

RESPIRATORY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Known TB exposure

HEART
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Leg swelling

GASTROINTESTINAL
- ☐ Bowel incontinence
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Bladder incontinence
- ☐ Frequent urination
- ☐ Urinary retention

METABOLIC/ENDOCRINE
- ☐ Hormone problems
- ☐ Irregular menses

NEUROLOGICAL/PSYCH
- ☐ Depression
- ☐ Dizziness
- ☐ Headache
- ☐ Memory impairment
- ☐ Speech changes

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Muscle pain/ spasms
- ☐ Numbness/ tingling
- ☐ Weakness

HEMATOLOGIC
- ☐ Easy bleeding
- ☐ Easy bruising

HEIGHT: _____ WEIGHT: _____

Revised: 9/18/14, 6/23/16