NEUROSURGICAL CONSULTANTS, LLP

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The Springs
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Owensboro, KY 42303
(270) 688-1770
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Deaconess Physicians' Center
520 Mary St., Suite 470
Evansville, IN 47710
(812) 426-8410
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St. Vincent Med. Office Bldg.
801 St. Mary's Dr., Suite 410**W**
Evansville, IN 47714
(812) 471-3676
FAX: (812) 471-3684

PATIENT INSTRUCTIONS

PATIENT NAME:_____ APPT. & TIME: _____

PHYSICIAN: _____
** In order for you to be evaluated/treated appropriately, complete all enclosed forms and bring with you at the time of your appointment. Also, bring the following items:

- ☐ **Health Insurance Cards (Primary & Secondary)** – As a courtesy to you, we will file your insurance. Please bring all insurance cards with you to your appointment. If we do not have a copy of your cards, we are not able to file with the insurance, and you will then be responsible for any charges at the time of service. **ALL CO-PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT. ***<u>PATIENT IS RESPONSIBLE FOR VERIFYING THAT OUR DOCTORS ARE IN THEIR NETWORK</u>***

- ☐ **Medicare** – We are a Medicare participating office, and we do accept assignment. Accepting Medicare assignment means that after the deductible is met Medicare will pay 80% of our charges. If you have a supplemental insurance, we will bill the remaining 20%. Any porton not paid will become your responsibility. If you have Medicare only, you will be responsible for the 20% balance Medicare does not pay.

- ☐ **Photo I.D.** – Identification is required to prevent fraudulent claims.

- ☐ **CT Scan, MRI, X-Rays & Reports** – The physician must have the actual CD. If you **DO NOT** bring your CD, your appointment will be rescheduled. Any testing done at Deaconess Hospital, St. Vincent-Evansville, or RDI (Owensboro) can be accessed from the internet. No CD would be necessary to bring.

- ☐ **Workers Compensation OR Personal Injury Claims** – Your employer or insurance carrier **MUST** provide written or verbal verification to this office **PRIOR** to your appointment. If this is not done, your appointment will be rescheduled.

- ☐ **Self-Pay Patients** – Payment is **DUE IN FULL** at the time of service, unless arrangements have been made prior to the appointment.

- ☐ **Medication List** – Needs to be provided at time of visit.

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Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Ph # _____ Cell # _____ Work #_____

Social Security # _____ DOB _____ Age _____

Marital Status _____ Male _____ Female _____

Employer_____ Email _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician _____

Referring Physician _____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient: Self _____ Spouse _____ Parent_____ Other _____

Name_____ DOB _____ Social Security# _____

Employer _____ Occupation _____

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Name _____ Relationship _____ Phone # _____

REASON FOR APPOINTMENT

Brief Description of Accident/Illness _____

Date of Onset _____ Accident related to: Work _____ Auto _____

Are you off work due to problem: YES / NO If so, last date worked: _____

Authorization to Release information:

I hereby authorize the release of information regarding my condition and treatment to any referring or consulting healthcare personnel; any health, accident, auto, or workers' compensation insurance carrier; any agent, attorney, or other representative governmental agencies (FMLA/Disability) purporting to act on my behalf; and any facility at which I may be treated, examined or evaluated. If I am here for independent medical examination or second opinion, I further authorize the release of information regarding my condition and treatment to the person or entity requesting such examination or opinion, and to any agent, attorney, or other representative of such person or entity.

Assignment of Insurance Benefits:

I do hereby authorize (Insurance Company) _____ to pay Neurosurgical Consultants including Dr. David Eggers, Dr. Harold Cannon, Dr. Neil Troffkin, Dr. Eric Goebel, Dr. David Weaver, and Dr. Kutluay Uluc to pay benefits due on this claim. I understand I am financially responsible for any charges not covered under this assignment. (A copy is as valid as the original)

Payment Policy:

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains responsible for payment. As a courtesy, however, we will process insurance claims to assist in making collections from insurance companies. Any money received from insurance companies will be credited toward the patient's account.

CO-PAYMENTS and PAYMENTS which are patient's responsibility are due at time of service.

Surgical Services:

For elective surgical cases, any deductible or co-insurance amounts must be paid prior to surgery date. If you do not have benefit coverage to pay for surgical procedures, then you must pay at least 50% of the total surgery cost.

Neurosurgical Consultants do not get involved with the financial aspects of disputed cases with insurance companies, workers' compensation, motor vehicle accidents, liability cases or any other types of claims. Each patient (parents is minor) is ultimately responsible for the payment of their account. If you are unable to pay the full amount at the time of each date of service, a monthly payment agreement must be signed and approved. In these cases, a partial payment must be made each and every month in order to keep the account current. All accounts paid in full with 90 days following each date of service. A delinquent account will automatically be sent to our collection agency for legal action.

Signature of patient/responsible party_____ Date _____

PLEASE PROVIDE CURRENT INSURANCE CARDS AND PHOTO ID AT TIME OF APPOINTMENT!

NEUROSURGICAL CONSULTANTS, LLP

Patient Protected Health Information
Consent Form

I hereby consent to Neurosurgical Consultants, using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the Practice's healthcare operations. I, also, consent NSC to using or disclosing my protected health information for treatment activities provided by another healthcare provider or entity. I further consent to the disclosure of my protected health information for another provider or entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Specific records Expressly included. I authorize release of the following information for the purposes of treatment, payment and healthcare operations, if it is a part of my protected health information: Chemical Dependency/Substance Abuse, Drugs; including Alcohol, Sexually Transmitted Diseases unless you specify otherwise. I further acknowledge the Practice has provided me a copy of its "Notice of Privacy Practices", which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. I authorize other providers to release my protected health information for treatment purposes. I have been given a copy of, and agree to abide by, the Practice's financial policies.

Additional Consent to Release Information

I authorize Neurosurgical Consultants to discuss and release medical information regarding my care, schedule procedures, and to release financial information to the following family members, legal representative, and/or other designee specific:

Name: _____

Relationship _____ Phone: _____

Name: _____

Relationship _____ Phone: _____

Name: _____

Relationship _____ Phone: _____

Signature of Patient/Personal Rep: _____ Date _____

Name of Patient/Personal Rep: _____ Date _____

Neurosurgical Consultants, LLP
CONSENT FOR TREATMENT WITH CONTROLLED SUBSTANCES
(This is not a pain management contract, only consent to treat for pain after surgery!!)

NAME _____ **DOB** _____

1. **Controlled Substances**. Certain controlled substances are prescribed to treat a variety of conditions, including the relief of moderate to severe pain. Pain relief is an important medical reason to take control substances. Controlled substances are drugs or chemical substances whose possession and use are regulated under the Controlled Substances Act. The law requires that patients be informed of the risks, benefits and alternatives of taking certain of these controlled substances, such as Morphine, Demerol, Fentanyl, Codeine, Dilaudid, Oxycodone, and Hydrocodone.

2. **Adverse Effects**. As with any medication, there are risks and adverse effects associated with the use of these controlled substances. Common adverse effects include, but are not limited to, sedation or sleepiness, nausea, vomiting, constipation, pruritus ("itching"), confusion, respiratory depression, and urinary retention. Some of these effects may make it unsafe for you to drive a vehicle, operate heavy machinery or perform other tasks that require concentration. Excessive use of these controlled substances can lead to profound sedation, respiratory depression, coma, and/or death.

3. **Physical Dependence, Tolerance and Addiction**. Although uncommon when used for the treatment of acute pain, these controlled substances can cause physical dependence, tolerance and/or addiction when used for a prolonged period to treat chronic pain. Maintenance therapy with these controlled substances can cause physical dependence. This means that if these medications are abruptly stopped or decreased significantly over a short period of time, a patient may experience withdrawal symptoms such as nervousness, irritability, insomnia, sweating & abdominal cramping nausea, vomiting, and diarrhea. Tolerance occurs when the effects of these controlled substances are decreased over a period of prolonged use making it necessary to increase the dosage. Physical dependence and tolerance are different than addiction. Addiction is a complex disease characterized by compulsive craving or seeking and use of a substance despite its extreme negative effects on a person. The risk of addiction may be increased in a patient with a history of alcoholism or other addiction.

4. **Alternatives**. These controlled substances are routinely prescribed to treat moderate to severe pain in hospitalized patients. Other medicines are available to treat pain that are not associated with tolerance or addiction, however, are associated with a lower level of pain relief. It is also an alternative to not take any medicine to treat pain, or to use alternative modalities, other than medicine to treat pain.

I voluntarily consent to the receipt of controlled substances for the treatment of pain and/ or other symptoms as prescribed by my **Physician/PA/APRN of Neurosurgical Consultants**. I have been informed of the benefits, risks, and alternatives to taking these medications. I acknowledge that I have read and understood all the information above and have had the opportunity to ask questions and have them answered to my satisfaction.

_____ _____
Signature of Patient/Parent/Guardian/Power of Attorney Date

NEUROSURGICAL CONSULTANTS
PATIENT QUESTIONNAIRE/ SYSTEM REVIEW

Patient's Legal Name: _____ Age: _____ Date of Birth: ____ / ____ / ____
Referring Physician/Provider (first and last name): _____Height: _____ Weight: _____
Family Physician/Provider (first and last name): _____

Major Complaint for today's visit. Please give history of problem. If work related, provide date of injury:

_____
_____
_____

Please check any of the following treatments received for this problem within the last six (6) months:

_____ MRI _____ X-Rays _____ CT _____ CT Myelogram _____ EMG
_____ Chiropractic Treatment. If yes, how many treatments and where? _____
_____ Physical Therapy. If yes, how many sessions completed and at what location? _____
_____ Injections with pain management. If yes, date and type of last injection? _____

Please list all prescriptions or over-the-counter medications taken for pain or inflammation:_____

_____

Are you in a pain medication management contract? If yes, please list provider/group and medication(s) managed: _____

Please list previous surgeries:

Date	Surgery	Surgeon

Please select any specialists that you are under the care of:

_____ Cardiology _____ Electrophysiology _____ Pulmonology _____ Endocrinology
_____ Nephrology _____ Hematology/Oncology _____ Other
Please list the names of specialists selected above: _____

_____

Please list all drug allergies: _____
Are you right or left-handed? _____

Patient Social History:

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____
Use of Alcohol: Never_____ Rarely_____ Moderate_____ Daily_____ Previously, but quit_____
Please Explain: _____
Use of Tobacco: Never_____ Previously, but quit_____ Current packs/day_____ Smokeless_____ E-Cig_____
Use of Drugs: Never_____ Type/ Frequency_____

Patient Work History:

Occupation:_____ Previous Occupation:_____
Describe type of work:_____
Current Work Status: Full-Time_____ Part-Time_____ Laid-Off_____ Permanent Disability_____ Retired_____
Employer Short-Term Disability_____ Employer Long-Term Disability_____ Not Employed_____

Patient Medical History: Have you received ***medical treatment*** for any of the following? ***Please check applicable.**

Constitutional Symptoms:	Yes	Genitourinary:	Yes	Allergic/ Immunologic/ Infectious	Yes
General good health lately		Enlarged prostate		Change in skin/rash/shingles	
Recent weight change		Blood in urine		Slow to heal/chronic wounds	
Eyes Ears/Nose/Mouth/Throat:	**Yes**	Kidney disease		Fever	
Eye disease or injury		Sexual difficulty		Hx of requiring IV antibiotics	
Blurred or double vision		Urinary retention		MRSA	
Hearing loss or ringing		Urinary incontinence		**HIV/AIDS**	
Nosebleeds		**Musculoskeletal:**	**Yes**	**Hepatitis**	
Mouth sores		Osteoporosis/osteopenia		**History of reaction to:**	**Yes**
Cardiovascular:	**Yes**	Arthritis (osteo/rheumatoid)		Latex	
Heart attack/ Heart disease		Neck/back pain		Penicillin/ antibiotics	
High blood pressure		Cold extremities		Morphine/ Demerol	
Atrial fibrillation/flutter		**Neurological:**	**Yes**	Novocaine/ anesthetics	
Heart murmur		Headache/migraine		Iodine or other antiseptic	
High cholesterol		Syncope/ dizziness		**Implants/devices:**	**Yes**
Chest pain		Stroke/TIA		Pacemaker/AICD	
Shortness of breath/ home oxygen		Nerve/muscle disease		Loop recorder	
Respiratory:	**Yes**	Head injury		Coronary stent or other stent(s)	
COPD/emphysema		Seizures		Ventriculoperitoneal shunt	
Asthma or wheezing		Problems with memory		Aneurysm clips/coils	
Black Lung/TB		**Psychiatric:**	**Yes**	Deep brain stimulator	
Sleep apnea		Depression		Pain pump	
Gastrointestinal:	**Yes**	Anxiety		Nerve/spine stimulator	
Constipation		Insomnia		Bladder/bowel stimulator	
Frequent diarrhea		Substance abuse		Cochlear implant	
Bowel incontinence		**Hematologic/ Oncologic:**	**Yes**	GI scope within last 2 months	
Ulcers		Bleeding/ bruising easily		**Any other disease:**	
Liver disease		DVT/PE			
Endocrine:	**Yes**	Clotting/bleeding disorder			
Glandular/ hormone issue		Anemia			
Thyroid disease		Previous blood transfusion			
Diabetes		Cancer			
Chronic steroid use					

Women: Are you pregnant? _____ Date of last period: _____ #pregnancies: _____ #miscarriages_____

Please explain all yes answers and provide any additional pertinent medical information: _____

_____

_____

Family Medical History:

Relation	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sisters			
Brothers			
Number of Children:			

Patient's signature: _____ **Date:** _____

Name:_____ DOB:_____ Date:_____

NEUROSURGICAL CONSULTANTS
PATIENT MEDICATION RECORD

MEDICATION	DOSE	FREQUENCY

NEUROSURGICAL CONSULTANTS

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU WILL BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose yow protected health information, as necessary, to a home health agency that provides care to you, for example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By law, public health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect Food and Drug Administration requirements: Legal Proceedings: Law Enforcement Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect of copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notices of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest 'to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal.

You have the right to receive and accounting of certain disclosures we have made, if any, of your protected health information.

We reserve, the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us-or to the secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**