Revised 09/26/14

RALEIGH NEUROSURGICAL CLINIC, INC.

PATIENT INFORMATION **Age:_____ Sex: M___ F___ Date _____**

Last Name_____First Name_____Middle Initial_____

Mailing Address_____

City_____State_____Zip_____ Social Security # _____

Home Phone (_____)_____ Cell Phone (_____)_____ Date of Birth_____

Email _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Self-Employed ☐ Unemployed Other _____

Employer Name_____ Work Phone (_____)_____

In Case of Emergency, Notify_____ Relationship to Patient_____

Emergency contact Phone (_____)_____ ☐Cell ☐Home ☐Work

Spouse Name_____ Spouse Phone (_____)_____☐Cell ☐Home ☐Work

Pharmacy Name/Location_____ Phone (____)_____

INSURANCE INFORMATION Responsible Party (check one) ☐ Self ☐ Other _____

Primary Insurance_____ ID/Policy # _____

Subscriber Name _____ ☐Self ☐Spouse ☐Parent Subscriber Employer _____

Subscriber Social Security #_____ DOB _____Group #_____

Secondary Insurance_____ ID/Policy # _____

Subscriber Name _____ ☐Self ☐Spouse ☐Parent Subscriber Employer _____

Subscriber Social Security #_____ DOB _____Group #_____

ACCIDENT INFORMATION

Is Your Visit Related To An Accident? ☐ Yes ☐ No If So, Date of injury/Accident_____

Type of Accident ☐ Job* ☐ Automobile ☐ Other Brief Description of Accident_____

Are you represented by an attorney? ☐ Yes ☐ No Name_____ Phone_____

If your visit is due to a Worker's Compensation Claim, you must have a referral and your visit must be pre-approved
**Failure to provide this information will result in your appointment being rescheduled **

REFERRING INFORMATION **How did you hear about our practice?** ☐ Internet ☐ Yellowpages

☐ Prior Patient ☐ Friend/Family member ☐ Your Physician ☐ Insurance Carrier ☐ Other _____

Referring Doctor_____Address_____Phone(____)_____

Family Doctor_____Address_____ Phone(____)_____

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Name_____ Height:_____ Weight:_____ Date_____

MEDICAL HISTORY Chief Complaint (Describe your problem and what treatment you have had)

_____

_____ When Did your Symptoms Begin?_____

What doctors have you seen for this problem and what tests have you had? _____

_____

PAST MEDICAL HISTORY (ex: High Blood Pressure, Heart Disease, Diabetes) List all major illnesses and conditions you have ever been diagnosed with_____

_____

Past Surgeries_____

FAMILY HISTORY Please list any serious medical conditions that run in your family _____

_____

SOCIAL HISTORY Do you use tobacco products (including E Cigarettes)? ☐ Yes ☐ No Amount/How often?_ _____

Do you drink alcohol? ☐ Yes ☐ No Amount/How often?_____

Current Occupation_____ Last day worked_____ Right__ or Left__handed

REVIEW OF SYSTEMS (Have you had or are you having problems with any of the following related to your current condition?)

General
__fevers
__chills
__sweats
__fatigue
__weight change
__sleep disturbance

Cardiovascular
__palpitations
__chest pain
__fainting
__ankle swelling
__breathing difficulty

Musculoskeletal
__joint pain/swelling
__muscle pain/weakness
__trauma/fractures

Skin
__rash
__itching
__dryness
__suspicious lesions

Gastrointestinal
__constipation
__indigestion
__nausea/vomiting
__change in bowel habits
__abdominal pain
__bloody stool
__jaundice

Hematologic/Lymphatic
__abnormal bruising
__bleeding
__enlarged lymph nodes

Eyes
__blurry vision
__blindness
__eye pain/discharge
__sensitivity to light

Genitourinary
__urinary frequency
__painful urination
__blood in urine
__bladder control
__pelvic pain

Neurologic
__numbness
__paralysis
__seizures
__migraines/headaches
__memory loss

Respiratory
__cough
__wheezing
__coughing up blood
__shortness of breath
__asthma

Reproductive
__abnormal menstral period
__pain with intercourse
__sexual dysfunction
__sexual transmitted disease

Ear/Nose/Throat
__hearing loss
__earache
__ringing in ears
__nosebleeds

Other_____

MEDICATIONS **Also include non-prescription drugs with dosages** NONE_____

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

DRUG ALLERGIES **Allergic to shellfish or x-ray dye?** ☐ Yes ☐ No **Reaction**:_____

{*PLEASE LIST REACTIONS*} **Latex allergy?** ☐ Yes ☐ No **Reaction**:_____

1._____ 3._____
2._____ 4._____

Do religious beliefs prevent you from receiving blood or blood products? ☐ Yes ☐ No

(For office use only) Updated: _____ Updated: _____ Updated: _____ Updated: _____

MD Sign: _____ MD Sign: _____ MD Sign: _____

Date:_____ Date:_____ Date:_____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL MEDICAL EXPENSES, REGARDLESS OF INSURANCE COVERAGE AND WHETHER OR NOT THERE IS A JOB RELATED ACCIDENT OR AN ACCIDENT WITH ANOTHER PERSON AT FAULT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE RALEIGH NEUROSURGICAL CLINIC, INC.:

- TO FILE INSURANCE CLAIMS FOR ALL SERVICES PROVIDED TO ME, AND I AUTHORIZE PAYMENT FOR THOSE SERVICES TO BE MADE DIRECTLY TO THE PROVIDER.

- TO RELEASE ANY INFORMATION ABOUT ME TO ANY REFERRING PHYSICIAN OR OTHER PROVIDER OR TO ANY INSTITUTION OR PROVIDER AS NECESSARY TO PROVIDE TREATMENT OR DIAGNOSIS FOR ME.

- AND MY PHYSICIAN OR OTHER PROVIDER TO RELEASE INFORMATION ABOUT ME AS NECESSARY TO PROCESS CLAIMS FOR PAYMENT FOR SERVICES PROVIDED FOR ME, INCLUDING HEALTH AND LIABILITY INSURANCE COMPANIES, AGENCIES PROCESSING MEDICARE, MEDICAID, OR WORKER'S COMPENSATION CLAIMS, MEDICAL BENEFITS PLANS, CASE MANAGERS OR REVIEWERS, OR THIRD PARTIES RESPONSIBLE FOR PAYING CLAIMS FOR SERVICES PROVIDED TO ME.

THIS AUTHORIZATION EXPIRES **ONE (1) YEAR** AFTER THIS DATE, EXCEPT AS DISCLOSURE IS NECESSARY AFTER THAT DATE TO PROCESS FINANICAL CLAIMS OR IS REQUIRED OR PERMITTED BY LAW. I UNDERSTAND THAT THIS AUTHORIZATION COVERS SERVICES I MAY RECEIVE TODAY OR WITHIN **ONE (1) YEAR** FROM TODAY. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRIITEN NOTIFICATION ADDRESSED TO RALEIGH NEUROSURGICAL CLINIC, 5838 SIX FORKS RD, STE. 100 RALEIGH, NC 27609. THIS REVOCATION WILL BE EFFECTIVE FOR FUTURE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

I RELEASE RALEIGH NEUROSURGICAL CLINIC, INC., IT'S EMPLOYEES, OFFICERS, AGENTS AND PHYSICIANS FROM ANY LEGAL LIABILITY FOR DISCLOSURE AUTHORIZED HEREIN.

Signature:_____ **Date:**_____

PATIENT OR RESPONSIBLE PARTY IF A MINOR

RALEIGH NEUROSURGICAL CLINIC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have a received a copy of the Notice of Privacy Practices and understand that the notice describes certain rights I have under federal and state law and discusses how my medical information may be used by Raleigh Neurosurgical Clinic. I have been given an opportunity to ask questions about the Notice.

_____ _____

Signature Date

Please list the names of people we may communicate with regarding your medical care:_____
_____
_____
_____

_____ _____

Signature Date

RALEIGH NEUROSURGICAL CLINIC, INC.

FINANCIAL POLICY

We accept various methods of payment including:
CASH, CHECK, MC, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT CARDS

Thank you for choosing us as your health care provider. We are committed to providing you with the finest health care available and a courteous and helpful staff. In order to make this process as smooth as possible for our clients, we offer this brochure outlining some of the policies followed by
RALEIGH NEUROSURGICAL CLINIC.

All patients must complete check-in forms before seeing the doctor. Please bring any x-rays or MRI films related to your problem to the appointment. Also, bring your insurance card(s) and a photo ID to **every** visit.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY BELOW. I ALSO UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE CARRIER. I FURTHER UNDERSTAND ANY BALANCES SHOULD BE PAID WITHIN 60 DAYS, UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE _____ **DATE** _____

OFFICE VISITS Payment in full for all office visits is expected on the day of your appointment unless you have applicable insurance that will be filed for your visit. Co-pays, deductibles and co-insurance amounts will be collected before being seen by the physician. **Failure to pay your co-pay or co-insurance will result in your appointment being rescheduled.**

Authorization for office visits: If your insurance requires authorization to see a specialist it is your responsibility to make sure this is received in our office prior to your appointment. Your visit will be rescheduled or a wavier must be signed making you responsible for payment if authorization is not obtained prior to seeing the physician.

Workers Compensation Cases: If you are visiting as a patient under Workers Compensation we must have a documented referral at the time of your visit or have your adjuster call and give information about your case prior to your appointment. Failure to provide this information will result in your visit being rescheduled.

Third Party Payors: Raleigh Neurosurgical Clinic does **not** file medical liens for personal injury claims. If you are being represented by an attorney as a result of an accident or injury and are expecting reimbursement from a third party, you are still responsible for your bill at the time services are rendered. No arrangements will be made based on prospective third party payments.

Self Insured: If you are a non-insured patient you will be required to pay the full amount before being seen by the physician. On average, office visits range from **$70.00 to $285.00** depending on if you are an existing patient or a new patient. **Your appointment will be rescheduled, if you are unable to pay for your visit at the time of service.**

No Show Policy: As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Cancellations must be received 24 hours in advance, so that we may accommodate patients who need to be seen. Patients who do not contact us prior to their appointment will be charged a $50.00 cancellation fee that **MUST** be paid prior to the appointment being rescheduled.

SURGICAL PROCEDURES If after consultation with the doctor, your condition requires surgery, the procedure will be scheduled at the facility of your choice and our office will contact your insurance company to obtain benefits and preauthorization. However, verification of benefits is not a guarantee of payment from your insurance company. It is **YOUR** responsibility to contact your insurance company regarding your coverage, any required second surgical opinions, and preadmission certification. **Failure to keep your scheduled surgery or procedure date will result in a $50.00 charge, payable before your surgery will be rescheduled.**

Managed Care and PPO Plans : If your insurance is through a Managed Care or PPO plan that RALEIGH NEUROSURGICAL CLINIC participates with, you are expected to pay the co-payment or out of pocket costs as directed by your policy. **No scheduled procedure will be performed, until the full co-payment or out-of-pocket cost is paid in full.**

Other Insurance Plans: Insurance companies that we do not participate with or non-managed care plans will be treated as a commercial plan. They generally only pay a portion of the total bill. **You will be responsible for any unpaid portion; before any scheduled procedure will be performed.**

Self Insured: If you are a non-insured patient the Financial Coordinator will estimate the cost of your surgery. At that time you are required to pay at least 50% of the estimated charge. The surgery will be scheduled after the deposit has been received. Upon making your down payment, the balance should be paid within 60 days or a monthly payment arrangement made.

BILLING PROCEDURES As a courtesy, our office will submit your insurance claim on your behalf. Therefore, it is essential that we have complete and accurate information about your insurance carrier. Please remember that your insurance policy is an agreement between you and the insurance company. No insurance company attempts to cover all medical costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any balance not paid or covered by your insurance. If your insurance carrier sends you payment for our services, please sign over the check to RALEIGH NEUROSURGICAL CLINIC or you will be billed for the balance.

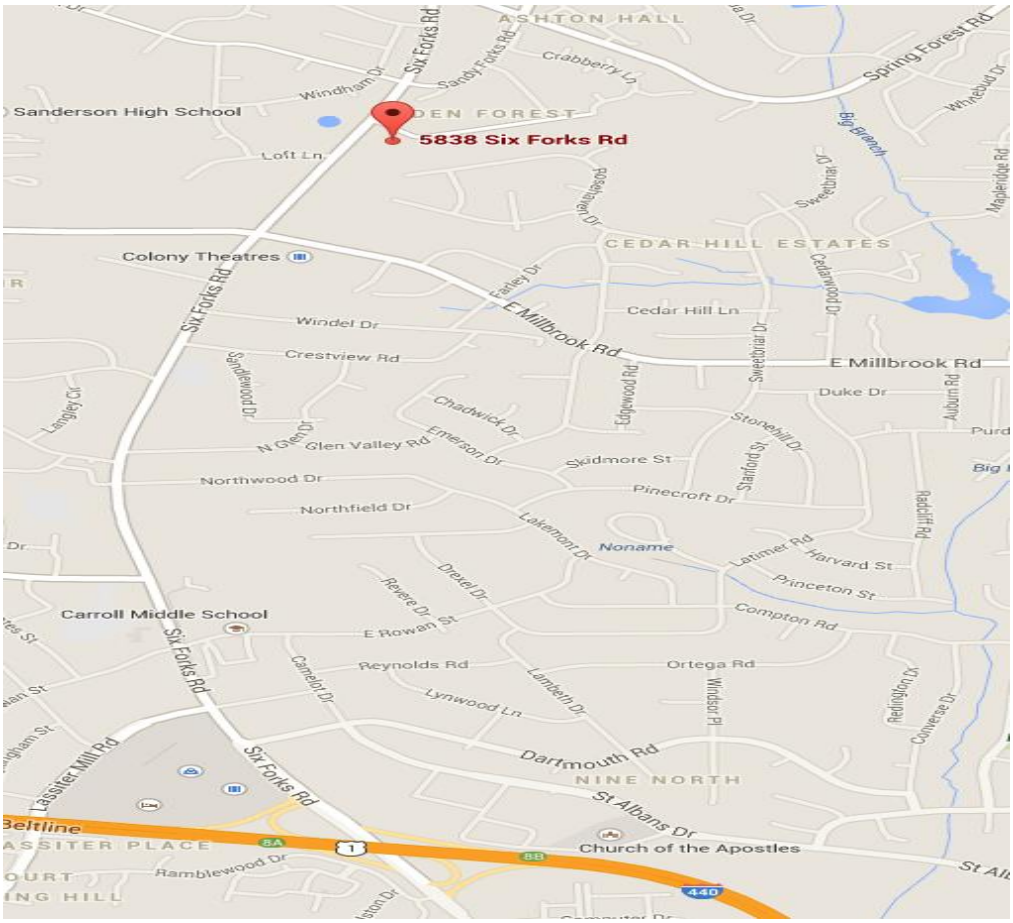
Collection Process: Our Billing and Collections Department is able to help you with any questions you may have. You may contact them anytime between 9 AM and 5 PM at (919) 785-3400. You will receive a monthly statement from our office. It notes any insurance/patient balances and payments made within the last 30 days. Please review the statement for accuracy and contact your insurance company regarding any outstanding claims. Please understand that our services are separate from the hospital therefore you will receive a statement from us as well as the hospital.

Delinquent Accounts: Any outstanding patient balances with no payment or activity for 60 days will result in your account being turned over to an outside collection agency. We will make every effort to negotiate a payment arrangement with you prior to this action taking place.

FORMS AND MEDICAL RECORDS If you require our office to complete any forms for disability or out of work purposes there will be a $10.00 charge to be collected prior to the form being completed and allow at least 2 weeks for completion. If you require a copy of your medical records you must sign a Medical Records Release of Information form and a payment of $10.00 will be required. A form may be obtained by visiting our website at www.raleighneurosurgical.com.

Appointment Date:_____ Appointment Time:_____ Doctor: _____

We look forward to seeing you at your appointment. Please complete all the following paperwork front and back. **Do Not** mail back your completed paperwork just bring it with you to your appointment along with your MRI and/or x-ray or CD. Failure to bring your films or copay will result in your appointment being rescheduled. Please see "What To Bring" on our website. Thank You!



Directions: Take I-440 Beltline to Six Forks Road North, Exit # 8B. Continue on Six Forks Road thru 9 stoplights (9th stop light is Millbrook Rd), approximately 1.7 miles from the beltline. We are the 4TH driveway on the right at 5838 Six Forks Road.

FOR MORE DETAILED DIRECTIONS AND INFORMATION PLEASE VISIT OUR WEBSITE AT
www.raleighneurosurgical.com

OFFICE HOURS
Open Monday-Thursday 9:00 am – 5:00 pm (except holidays)
Fridays 9:00 am – 2:00 pm
24 hour on-call Neurosurgeon

RALEIGH NEUROSURGICAL CLINIC INC

5838 Six Forks Road, Suite 100
Raleigh, NC 27609
Phone: 919-785-3400
Fax: 919-783-7778