Vascular Neurosurgery
Movement Disorder Surgery
Epilepsy Surgery
Brain Tumor Surgery
Gamma Knife Radiosurgery

SMITH | D'ALISE
NEUROSURGERY LLP

Complex and Reconstructive
Spine Surgery
Spinal Tumor Surgery
Neurotrauma

Patient Information

Last_____ **First** _____ **MI**_____

Date of Birth: ____/____/____ **Social Security:**____-____-____ **Sex:**☐**Male** ☐**Female**

Home Phone:(____)_____ **Cell**(____)_____ **Work**(____)_____

Address:_____ **Apt#**____ **City:**_____ **St**_____ **Zip:**_____

Race: **Caucasian** **Hispanic** **African American** **Asian** **American Indian** **Other**

Employer:_____**Business Phone**_____

(Insurance)
Name of Insurance:_____

Policy ID Number_____**Group Number**_____

Subscriber's Name_____ ☐**Self** ☐**Spouse** ☐**Other**

DOB____/____/____ **Social Security** _____-_____-_____

(Secondary Insurance)

Name of Insurance_____

Policy ID Number_____ **Group Number**_____

Subscriber's Name_____ ☐**Self** ☐**Spouse** ☐**Other**

(Additional Information)

Pharmacy_____ **Phone #** (____)_____

Referring Doctor_____**Primary Doctor**_____

Emergency Contact:

Name:_____ **Relationship:**_____

Home Phone:(____) ____-_____ **Cell:**(____) ____-_____ **Work:**(____) ____-_____

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Office Agreement

Welcome to our practice. We are excited to meet you! This is a specialty practice and it is important that you understand the following:

- Appointments for new patients are accepted by physician referral only
- Information can not be released without written authorization by the patient or parent/guardian.
- Surgery scheduling could be as far out as 3 or more weeks. Please be patient as we care for each patient as an individual.
- Patients could be referred to another specialist, such as pain management or neurology, for treatment or certain testing. Please understand that it may take several weeks to arrange such appointments.
- Due to the number of patients seen in each clinic, patients will be seen at appointment time, not arrival time.
- We do not prescribe any medications, except for during the immediate postoperative period. Please allow 72 hours for any requested medication refill.
- Work restrictions will only be written after surgery has been completed.
- All forms pertaining to being out of work (e.g. FMLA, AFLAC, etc.) can take up to approximately 7 days to be completed.
- In order to provide optimal care each physician is occupied in clinic on certain days of the week and is not available by phone on these days.
- Finally, be aware that we only have one goal, and that is to offer the care that we would want for our family members.

******All scheduling may be subject to change due to the nature of our practice. Our doctors are on call 24 hours for trauma and other emergencies. We apologize for any inconvenience this may cause you. Your understanding and cooperation with rescheduling will be appreciated. ******

Please sign below indicating that you have read and agree to the above.

Thank you.

Patient Name:_____ **Phone:**_____

Patient Signature:_____ **Date:**_____

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HIPPA

(Health Information Portability& Accountability Act)

I understand that at any time I may contact Smith D'Alise Neurosurgery to obtain a current copy of the Notice of Privacy Practices as it pertains to my treatment with Dr. Smith or Dr. D'Alise.

1) **I authorize my doctor and his clinic staff to release my private medical information to: (Example: Family members, attorney, friends, or social security administration.)**

Name **Relationship**

_____

_____

_____

_____

2) **I authorize my doctor and his clinic staff to leave messages with myself or others on recording devices at the following numbers:**

YOUR Primary Phone Number:_____

YOUR Secondary Phone Number:_____

I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

I understand I have the right to the request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of Smith D'Alise Neurosurgery. Smith D'Alise Neurosurgery is required to agree to any restriction that I may request. If, however, Smith D'Alise Neurosurgery agrees to any restriction requested by me, such restriction shall be binding on Smith D'Alise Neurosurgery. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Smith D'Alise Neurosurgery has taken action in reliance on this consent.

☐ **I consent to the terms of this agreement.**

☐ **I do not consent to the terms of this agreement.**

Signature:_____ **Date:**_____

Printed Name:_____ **Date:**_____

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Medical History

Name:_____ **Date of Birth:**_____ **SS#:**____-____-____

Height: _____ **Weight:** _____ **Drug Allergies:**_____

Food Allergies:_____ **Location of Pain:**_____

Are you working now?	**Yes**	**No**	**Retired**	**Disabled**
Is today's visit a result of some type of injury?		**Yes**	**No**	
Did your injury happen on the job?		**Yes**	**No**	
Are you here related to a Worker's compensation Claim?		**Yes**	**No**	
Are you here related to a motor vehicle accident?		**Yes**	**No**	
Are you currently taking Aspirin?		**Yes**	**No**	
Are you currently taking Fish Oil?		**Yes**	**No**	

MEDICATIONS: (***Please list all the medications you take including supplements, vitamins and over the counter medications***)

Name	**Dose (Strength)**	**Schedule Taken**

Surgeries/Hospitalizations	**Year**	**Complications**

Past History: (*Please circle any prior major illnesses and/or injuries)*

Asthma	COPD	Heart Murmur	Hypothyroidism
Autoimmune Disease	Coronary Artery Disease	Hepatitis	Myocardial Infraction
Bleeding Disorder	Depression	Hyperlipidemia	
Cancer	Diabetes Mellitus	Hypertension	
CHF	GERD	Hyperthyroidism	

Other:_____

Have you ever had problems with Anesthesia or Sedation? Yes No

Allergies/Reactions to Medications, Anesthetics, or Materials:_____
_____
_____

Social History:

Marital Status: Single Married Divorced Widowed

Number of Children: _____Occupation: _____

Do you live...? Nursing Home Senior Facility Long-term Care Facility Assisted Living

Illicit Drug use? Yes No

Do you drink alcohol? Yes No

If yes, how often? Daily 1 or more times a week 1 or more times a month

Do you smoke? Yes No

If yes, _____packs of cigarettes per day for _____ years.

Yes, I smoke cigars or pipes

No I have never smoked.

No I quit _____ years ago. At that time I was smoking_____ packs per day for _____ years.

Family History

Do you have a family history of trouble with Anesthesia? Yes No

Do you have a family history of easy bleeding? Yes No

Other family history:

Father: _____Mother:_____

Sister: _____Brother:_____

Maternal Grandmother/Father: _____
Paternal Grandmother/Father: _____

Review of Systems

Are you currently, or have you had problems with:

	Circle One	
Constitutional		
Weight gains	Yes	No
Weight loss	Yes	No
Night Sweats	Yes	No
Insomnia	Yes	No
Eyes		
Double vision	Yes	No
Visual loss	Yes	No
Ear, Nose, Throat and Mouth		
Hearing Loss	Yes	No
Noise/ringing in ears	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Sore Throat	Yes	No
Trouble Swallowing	Yes	No
Hoarseness	Yes	No
Cardiovascular		
Chest pain or angina	Yes	No
Heart trouble	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
Neurological		
Numbness	Yes	No
Weakness	Yes	No
Stroke	Yes	No
Headache	Yes	No
Psychiatric		
Depression	Yes	No
Allergic/Immunologic		
Sneezing	Yes	No
Itchy eyes/nose	Yes	No
Itchy throat	Yes	No

Respiratory		
Asthma	Yes	No
Cough up Blood	Yes	No
TB	Yes	No
Pneumonia	Yes	No
Trouble Breathing	Yes	No
Snoring	Yes	No
Gastrointestinal		
Indigestion	Yes	No
Heartburn	Yes	No
Ulcer	Yes	No
Hepatitis	Yes	No
Jaundice	Yes	No
Blood in stools	Yes	No
Black, tarry stools	Yes	No
Genitourinary		
Bladder trouble	Yes	No
Prostate disease	Yes	No
Kidney disease	Yes	No
Musculoskeletal		
Arthritis	Yes	No
Endocrine		
Diabetes	Yes	No
Thyroid disease	Yes	No
Hematologic		
Bleeding disorder	Yes	No
Easy bleeding	Yes	No
Skin rash	Yes	No
HIV	Yes	No

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SPINAL TUMOR SURGERY
NEUROTRAUMA

Referrals: Insurance Authorizations

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. It is the patient's responsibility to make sure insurance authorizations are on file and up to date for each visit. Failure to obtain the referral may result in your appointment being cancelled and rescheduled.

Please sign below indicating that you have read and agree to the above.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Worker's Compensation

Employer: _____ **Phone:** _____

Adjuster: _____ **Phone:** _____

Fax: _____ **Compensable Injury:** _____

Claim #: _____ **DOI:** _____

Patient Name: _____ **Date:** _____

Patient Signature: _____

Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by Cash, Check, Visa, or MasterCard.

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Which Plans Do You Contract With?

Please contact your individual insurance company for contractual agreements.

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of patient responsibility for all office visits, x-ray, injection, and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable co-pays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	File an insurance claim on your behalf as a courtesy.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	File an insurance claim on your behalf as a courtesy.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.	File an insurance claim on your behalf as a courtesy.

If You Have...	You Are Responsible For...	Our Staff Will...
Medicare	If you have Regular Medicare, and have not met your $100 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap</u>: No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% co-pay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable co-pays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation	<u>If we have verified the claim with your carrier</u> No payment is necessary at the time of the visit. <u>If we are not able to verify your claim</u> Payment in full is requested at the time of the visit.	Verify information given by referring physician and file your claim on your behalf as a courtesy.
Motor Vehicle Accident	All charges incurred will be the responsibility of the patient. Please make arrangements with our business office for payment prior to seeing the doctor.	**We will not bill third party insurance companies, such as PIP.**
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our billing supervisor if you need assistance.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Surgery Policy

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Business Office may request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Business Office.