Atlantic
NeuroSurgical
Specialists

Brain, Spine and
Neurovascular Surgery

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Dear Patient,

You must fill out all of the attached forms prior to your first office appointment. We are providing these so you can complete them at your leisure. This will save time when you get to the office. You should have your insurance card in front of you when you are completing the forms.

When you come to our office, you will need to bring your films along with any/all reports, your insurance card and the completed forms that are attached. Also, we would like to remind you that your payment is due at the time of service.

If you need to cancel or reschedule your appointment, we would appreciate 24 hours advance notice. Also, if you have any other questions regarding the forms, feel free to contact us. We look forward to meeting you.

Sincerely,

The Physicians and Staff of Atlantic Neurosurgical Specialists

310 Madison Avenue Morristown, NJ 07960 Tel 973.285.7800 Fax 973.285.7839 www.atlanticneurosurgical.com

WELCOME TO OUR PRACTICE

Welcome to Atlantic Neurosurgical Specialists. It means a great deal to us that you have chosen us to serve as your professional neurosurgical specialists. We want to assure you that our doctors and staff will constantly strive to earn your continued confidence and satisfaction.

In order to provide you with the best medical care, we will need your comprehensive medical history. You can assist us, and save time during your first visit, by completing the enclosed medical history form in advance. Please bring these completed forms when you come to our office, and be prepared to spend at least one hour with us for your complete and thorough examination. Remember that our doctors sometimes have emergencies to deal with that may effect your appointment time or require that we reschedule.

Payment for your consultation is expected at the time of your visit, unless other arrangements have been made with our staff in advance of your appointment. Please make sure that you have your insurance card with you. If you have an insurance that requires an authorization or referral, you must have it with you at the time of the visit. Please understand that we do not participate in any HMO plans. This does not; by any means indicate that you cannot have a consultation with our doctors! It simply means that you will have to have an out of network referral from your Primary care physician in order to be reimbursed for your office visit. If surgery is indicated, we will work with you to get approval from the carrier. Regarding other insurances such as PPO plans or POS and traditional plans, we are more than happy to negotiate with them and work towards getting the best possible reimbursement for you. Please do not hesitate to talk to us about your insurance. For surgical cases, we will submit your insurance. We then wait 90 days for your claim to be paid. If they do not pay the claim within that 3 month period, then you will be responsible for any open balance. If you have financial problems that indicate your need to be on a payment plan, our billing department will work with you. We feel an obligation to tell each and every patient our financial policy before the services are provided in an effort to avoid any miscommunication later.

Having said this, please consider our experience and dedication to each and every one of our patients. Nothing is more important to us. We look forward to meeting you and your family.

Please visit our website before your appointment at: www.atlanticneurosurgical.com

ATLANTIC NEUROSURGICAL SPECIALISTS

REGISTRATION FORM

PATIENT NAME:__________________________ __________________________SEX: M F SS NUMBER:__________-__________-__________

LAST NAME FIRST NAME

ADDRESS:____ ___________________________________ __________ ______________

STREET CITY STATE ZIP

HOME PHONE: ( )______________________WORK PHONE:________________________BIRTHDATE:_____________________AGE:______

EMPLOYER:____________________________ ADDRESS:____

NAME STREET CITY STATE/ZIP

NAME OF EMERGENCY CONTACT:____PHONE:_________________________________

REFERRING PHYSICIAN:________________________________PHONE: ( )______________________FAX: ( )___________________

ADDRESS____

STREET CITY STATE ZIP

PRIMARY CARE PHYSICIAN:______________________________PHONE: ( )______________________FAX: ( )__________________

ADDRESS:____

STREET CITY STATE ZIP

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE__________________________________ID#________________________________GROUP/POLICY #_________________

ADDRESS:______________________________________PHONE: ( )_________________________RELATION TO PATIENT:________________

POLICYHOLDERS NAME:__________________________________BIRTHDATE:______________________________SS # :____________________

SECONDARY INSURANCE:______________________________ID#________________________________GROUP.PLOICY #_________________

ADDRESS______________________________________PHONE ( )__________________________RELATION TO PATIENT:_______________

POLICYHOLDERS NAME:__________________________________BIRTHDATE:______________________________SS #:____________________

NO FAULT/PIP OR WORKER'S COMPENSATION INFORMATION

ACCIDENT OR INJURY DATE:_____________________

IS THIS VISIT RELATED TO : ________________WCOMP ________________PIP

LOCATION OF ACCIDENT: ______________________STATE:_______________________

INSURANCE:_______________________________CLAIM #:__________________________________POLICY #:____________________________

ADDRESS:____

STREET CITY STATE ZIP

INSURED:____________________________CLAIM ADJUSTER:_________________________PHONE: ( )_____________________________

ATTORNEY'S NAME:____PHONE: ( )_______________________________

I have reviewed all previously documented information on the registration form and acknowledge that it is complete and accurate.

Signature:____________________________ Print Name:____________________________Date:______________

ASSIGNMENT OF BENEFITS

I hereby authorize Atlantic Neurosurgical Specialists to apply for Medicare/Medigap, and other health insurance benefits (if applicable No-Fault and Worker's Compensation) on my behalf. I request that payment of all Medicare/Medigap and commercial insurance carriers be made directly to the Atlantic Neurosurgical Specialists. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information and records about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, and any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medicare/Medigap AND/OR commercial insurance carrier benefits be made on my behalf to Atlantic Neurosurgical Specialists. I release any holder of Medicare/Medigap information about me to my insurance carrier(s) necessary to determine benefits payable for related service(s). I hereby authorize this medical provider and its associates to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, claims adjuster, or attorney if applicable,

Signature of Patient or Guardian:____

Print Name:____Date:_______________

FINANCIAL POLICY/AGREEMENT

You will be responsible for payment of any and all services provided to you by the Physicians/ Nurse Practitioners/Registered Nurse First Assist at Atlantic Neurosurgical Specialists regardless of your insurance coverage. If surgery is necessary, a claim will be submitted to your insurance company with the medical insurance information you have provided to Atlantic Neurosurgical Specialists at the time of service and Atlantic Neurosurgical Specialists will wait 3 months for the insurance carrier to make payment. **At the end of 3 months, you are responsible for the payment of the account in full.** You will be responsible for all co-payments, coinsurance and deductibles not met for the year as well as any non-covered services under your health plan. With the exception of payments which are payable at the time of service, you will be billed for any of the aforementioned fees and payment is due upon receipt of a billing statement. If the correct insurance information is not presented at the time of service, you will be responsible for the full amount of charges incurred. If you do not have medical insurance, financial agreements can be made prior to services rendered; otherwise, full payment is expected at the time of service. Atlantic Neurosurgical does not accept lien letters from attorneys in lieu of payment. We will attempt to resolve all past due balances amicably, but non-payment will be subject to the collection process after 3 months from the date of service. Atlantic Neurosurgical Specialists is an independent private practice and our policies, procedures, and billing process is completely separate from all/any hospitals, surgical centers, facilities or entities. All charges other than Medicare or Medicaid will be submitted to your insurance carrier as an Out of Network provider. You further agree to relinquish all/any checks or correspondence that you receive from your insurance carrier to Atlantic Neurosurgical Specialists within five (5) business days of receipt to properly reflect on your account. **Failure to comply will result in delinquent account and further collection actions. By signing below, you fully understand and agree to the above and take full financial responsibility for your account.**

Signature of Patient or Guardian:____

Print Name:____Date:__________

PRIVACY NOTICE/ACKNOWLEDGEMENT (HIPAA)

Atlantic Neurosurgical Specialists assures each patient the safety of protecting their healthcare information. The plan is in a binder in the waiting area and is available for reading. This plan describes how Atlantic Neurosurgical assures the safety of my protected health information and explains my rights and their responsibilities to my privacy in regard to the medical care that I am seeking. I understand that I have the right to limit access of my protected health information at any time of service. Below I have listed the name of anyone that I would like denied access. I also understand that any questions that I have regarding my privacy can and will be answered by the Director of Operations. By signing this acknowledgement form, I agree to the Atlantic Neurosurgical Specialists privacy policy as stated here and in their plan. In addition, I give Atlantic Neurosurgical Specialists permission to leave voicemails on my home or cellular phone and use email if necessary in regard to appointment and scheduling.
Please state any specific requirements:

____

Signature of Patient or Guardian:_______________________**Print Name:**______________________**Date:**_____________

Atlantic Neurosurgical Specialists

Health History
Confidential

Name: ____ **Date:** _____/______/_____

Age: _____ **Date of Birth:** ____/____/_____ **Date of last physical exam:** ____/____/_______

Reason for visit: ____

Primary Care Physician: ____

Primary Care Address: ____

How did you hear about our practice?____

Please check all that apply

Review of Symptoms

General:
- [ ] Fever
- [ ] Chills
- [ ] Sweats
- [ ] Anorexia
- [ ] Fatigue
- [ ] Weight Loss
- [ ] Other ____________

Eyes:
- [ ] Blurring
- [ ] Irritation
- [ ] Discharge
- [ ] Vision Loss
- [ ] Eye Pain
- [ ] Photophobia
- [ ] Double Vision
- [ ] Other ___________

Ears/Nose/Throat:
- [ ] Earaches
- [ ] Ear Discharge
- [ ] Ringing in ears
- [ ] Decreased Hearing
- [ ] Nasal Congestion
- [ ] Nose Bleed
- [ ] Sore Throat
- [ ] Hoarseness
- [ ] Difficulty Swallowing
- [ ] Other ___________________

Cardiovascular:
- [ ] Chest Pain
- [ ] Palpitations
- [ ] Fainting
- [ ] Leg Swelling
- [ ] Other

Respiratory:
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Excessive Sputum
- [ ] Coughing of Blood
- [ ] Other___________________

Gastrointestinal:
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Change of Bowel Habits
- [ ] Blood in Stool
- [ ] Jaundice
- [ ] Other____________________

Genitourinary:
- [ ] Pain on Voiding
- [ ] Blood in Urine
- [ ] Discharge
- [ ] Urinary Frequency
- [ ] Urinary Hesitation
- [ ] Incontinence
- [ ] Genital Sores
- [ ] Decreased Libido
- [ ] Awakening at night to void
- [ ] Other__________________________

Musculoskeletal:
- [ ] Back Pain
- [ ] Joint Pain
- [ ] Joint Swelling
- [ ] Muscle Cramp
- [ ] Muscle Weakness
- [ ] Neck Pain
- [ ] Stiffness
- [ ] Arthritis
- [ ] Other ________________________

Skin:
- [ ] Rash
- [ ] Itching
- [ ] Dryness
- [ ] Suspicious Lesions
- [ ] Other ___________________________________

Neurologic:
- [ ] Temporary Paralysis
- [ ] Weakness
- [ ] Numbness
- [ ] Seizures
- [ ] Tremors
- [ ] Tingling
- [ ] Dizziness
- [ ] Fainting
- [ ] Other______________________________

Psychiatric:
- [ ] Depression
- [ ] Anxiety
- [ ] Memory Loss
- [ ] Paranoia
- [ ] Mental Disturbance
- [ ] Suicidal Ideations
- [ ] Hallucination
- [ ] Other _______________________

Endocrine:
- [ ] Cold intolerance
- [ ] Heat intolerance
- [ ] Increased appetite
- [ ] Increased urination
- [ ] Increased thirst
- [ ] Weight changes
- [ ] Other ___________________________

Heme/Lymphatic:
- [ ] Abnormal bruising
- [ ] Bleeding
- [ ] Enlarged lymph nodes
- [ ] Other_____________________

Allergic/Immunologic:
- [ ] Seasonal Allergies
- [ ] Persistent Infections
- [ ] HIV Exposure
- [ ] Other ____________________

Women Only:
- [ ] Abnormal Pap smear
- [ ] Bleeding between periods
- [ ] Breast Lumps
- [ ] Extreme Menstrual Pain
- [ ] Hot Flashes
- [ ] Nipple Discharge
- [ ] Painful Intercourse
- [ ] Vaginal Discharge
- [ ] Other________________________

Date of last Menstrual Period ___/___/_____ Date of last Pap Smear ___/___/_____

Have you had a Mammogram? Y / N

Are you Pregnant? Y / N

Conditions

Please check **ONLY** those that apply

[ ] Aids
[ ] Alcoholism
[ ] Anemia
[ ] Aneurysm
[ ] Anorexia
[ ] Arthritis
[ ] Asthma
[ ] Bleeding Disorders
[ ] Breast Lump
[ ] Bronchitis
[ ] Bulimia
[ ] Cancer Type___________________
[ ] Cataract
[ ] Chemical Dependency
[ ] Childhood Diseases
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Glaucoma
[ ] Goiter
[ ] Gonorrhea
[ ] Gout
[ ] Heart Disease
[ ] Hepatitis Type___________________
[ ] Herpes
[ ] High Cholesterol
[ ] HIV Positive
[ ] Hypertension (High Blood Pressure)
[ ] Kidney Disease
[ ] Migraine Headaches
[ ] Miscarriage
[ ] Multiple Sclerosis
[ ] Pacemaker
[ ] Pneumonia
[ ] Polio
[ ] Prostate Problems
[ ] Psychiatric Care
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Stroke
[ ] Suicide Attempts
[ ] Thyroid
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Typhoid Fever
[ ] Ulcers
[ ] Vaginal Infection
[ ] Venereal Disease

Current Medications with dosage & directions including Aspirin & Vitamins	Allergies Please include FOOD and LATEX

Family History

Please check and circle **ONLY** those that Apply

[ ] Heart Disease	**Mother**	**Father**	**Sibling**
[ ] Hypertension	**Mother**	**Father**	**Sibling**
[ ] Diabetes	**Mother**	**Father**	**Sibling**
[ ] Stroke	**Mother**	**Father**	**Sibling**
[ ] Hyperlipidemia (High Cholesterol)	**Mother**	**Father**	**Sibling**
[ ] Hematologic (Bleeding)	**Mother**	**Father**	**Sibling**
[ ] Cancer	**Mother**	**Father**	**Sibling**

Type of Cancer____

Social History

Please check and circle **ONLY** those that apply

Marital Status **[ ] Single** **[ ] Married** **[ ]Divorced** **[ ] Widowed**

Number of Children: ______

Type of Employment ______________________________________

Litigation Pending **[ ] Yes** **[ ] No**

Handedness **[ ] Right** **[ ] Left** **[ ] Ambidextrous**

Caffeine Intake: **[ ] Coffee** **# of cups per day ____**

[ ] Tea **# of cups per day ____**

[ ] Soda **# of cups per day ____**

[ ] Other_______________________

Alcohol Use: **Yes or No** **Beer / Wine /Hard Liquor # per day _____ or #per week ____**

Tobacco Use: **Yes or No** **Pipe / Cigars / Cigarettes # packs per day _____# of yrs quit___**

Drug Use: **Yes or No** **Drug Type: _________ Date last used: __/___/____**

HIV Tested ______________________ **date**_________________ **result**____________

Exercise: **[ ] Sedentary** **[ ] Mild Exercise** **[ ] Occasional Vigorous Exercise**

[ ] Regular Vigorous Exercise

Directions to:

Atlantic Neurosurgical Specialists
Corner of (310) Madison Avenue & Punch Bowl Road
Morristown, NJ 07960
Phone: (973) 285-7800

<u>From the Garden State Parkway: (North & South)</u> Take the Parkway to Route 78 West, which is near the Union toll. Follow Rt. 78West (stay in local lane). Get onto Route 24 West. Follow Rt. 24 West to exit 2A (Morristown), which will pull you onto Columbia Turnpike. At the traffic light, turn left onto Park Avenue. Go to the second light and turn right onto Punch Bowl Road. We are at the end of Punch Bowl Road on the left side of the street (black glass building, #310). This is the corner of Punch Bowl Road and Madison Avenue.

<u>From Route 287: (North & South)</u> Take Route 287 to Exit 35 (Madison Avenue). Follow the signs "H" to Morristown Memorial Hospital. You will be on Madison Avenue heading towards Madison. Go past the hospital and follow Madison Avenue for about one mile. You will pass Friendly's Restaurant on your left and Jersey Central Power & Light. Turn left onto Punch Bowl Road. We are the first (black glass) building on the corner (#310).

<u>From Route 80:</u> Follow Route 80 East or West to Route 287 and proceed as above.

<u>From Summit, Chatham, and local towns:</u> Take Main Street in Chatham through Main Street in Madison. Main Street turns into Park Avenue. Keep going past Verizon, past the Hamilton Park Conference Center, to the light at Punch Bowl Road. Make a left on to Punch Bowl and we are at the end of Punch Bowl Road on the left side of the street.
OR You can follow Main Street to Madison Avenue, and we are about half a mile past the Madison Hotel and Rod's Steakhouse. (#310 on your right, black glass building).

Parking:

You may park in the front of the building. Come in the front doors and walk straight ahead to the elevators which are on your left. Take the elevators to the second floor. You may also park under the building and enter through the glass doors, taking the elevators to the second floor.