

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: Brain _____ Neck _____ Spine _____

Primary Care Physician:

Primary Care Address:

Pharmacy Name & Address: _____

Pharmacy Phone: _____

How did you hear about our practice? _____

Please check all that apply

Review of Symptoms

General:	<input type="checkbox"/> Fever	Eyes:	<input type="checkbox"/> Blurring
	<input type="checkbox"/> Chills		<input type="checkbox"/> Irritation
	<input type="checkbox"/> Sweats		<input type="checkbox"/> Discharge
	<input type="checkbox"/> Anorexia		<input type="checkbox"/> Vision Loss
	<input type="checkbox"/> Fatigue		<input type="checkbox"/> Eye Pain
	<input type="checkbox"/> Weight Loss		<input type="checkbox"/> Photophobia
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Double Vision
			<input type="checkbox"/> Other _____

Ears/Nose/Throat:	<input type="checkbox"/> Earaches	Cardiovascular:	<input type="checkbox"/> Chest Pain
	<input type="checkbox"/> Ear Discharge		<input type="checkbox"/> Palpitations
	<input type="checkbox"/> Ringing in ears		<input type="checkbox"/> Fainting
	<input type="checkbox"/> Decreased Hearing		<input type="checkbox"/> Leg Swelling
	<input type="checkbox"/> Nasal Congestion		<input type="checkbox"/> Other
	<input type="checkbox"/> Nose Bleed		
	<input type="checkbox"/> Sore Throat		
	<input type="checkbox"/> Hoarseness		
	<input type="checkbox"/> Difficulty Swallowing		
<input type="checkbox"/> 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
 - Arm Pain L or R
 - Leg Pain L or R
 - Other _____

- Skin:**
- Rash
 - Itching
 - Dryness
 - Suspicious Lesions
 - Other _____

- Neurologic:**
- Temporary Paralysis
 - Weakness
 - Numbness
 - Seizures
 - Tremors
 - Tingling
 - Dizziness
 - Fainting
 - Headache
 - 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 _____

Family History

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

<input type="checkbox"/> Heart Disease	Mother	Father	Sibling
<input type="checkbox"/> Hypertension	Mother	Father	Sibling
<input type="checkbox"/> Diabetes	Mother	Father	Sibling
<input type="checkbox"/> Stroke	Mother	Father	Sibling
<input type="checkbox"/> Hyperlipidemia (High Cholesterol)	Mother	Father	Sibling
<input type="checkbox"/> Hematologic (Bleeding)	Mother	Father	Sibling
<input type="checkbox"/> 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