NSH Neuro Spinal & Headache Center
Of Southeast Georgia • Stephen G. Pappas M.D.
Expert solutions for complex neurological & pain problems

Patient Registration

Patient Name: ____
Last First Middle Initial

Address: ____

City: ___________________________ State: _____________ Zip Code: _______________

Phone: (____)_______________ (____)__________________ (____)__________________
Home Work Cell

SSN: ________________________ Date of Birth:_____/_____/________ Male / Female

Race: ______________ Ethnicity: ______________ Preferred Language: ________________

Employer: ____

Address: ____

Phone: _____________________________________

Spouse's Name: ______________________________ Date of Birth: ___________________

Emergency Contact (someone who does not live at your address):

Name: ____

Relationship: ____________________________Phone: _____________________________

Address: ____

****

Pharmacy Name:______________________________ Phone: _______________________

Address : ____

How did you hear about us:

___Referring Physician __Newspaper ___Website ____Friend/Relative ___Other: _____________

Referring Physician: ____________________________ Phone: _______________________

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Is this visit related to an auto accident? YES / NO

A work-related injury? YES / NO

Time and Date of Injury: ____

Attorney Name: ____________________________________

****

Staff Initials______________ Date: ________________

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Patient History

Patient Name: ____

Date: ______________________ Age: ______________________

Chief Complaint: ____

Medications (name and dose):

1.______________________ 6. ______________________

2.______________________ 7.______________________

3.______________________ 8. ______________________

4______________________9. ______________________

5.______________________10.______________________

Drug Allergies: ____

Past Medical History (circle):

High Blood Pressure
Cancer
Thyroid disease
Rheumatic Fever
Heart Problems
Arthritis
Depression
Anemia
Lung Problems
Kidney Disease
Stomach Ulcers
Asthma
Sleep Problems
Diabetes
Trauma

Other: ____

Operations: ____

____

____

Family Medical History (diseases or cause of death):

Mother: ______________________ Father: ______________________

Grandparents: ____

Brothers/Sisters: ____

Children: ____

Smoke? Y/N _____ packs/day

Alcohol Use: Y/N _____ drinks/day

Patient Information Release

The physician and staff of Neuro Spinal and Headache Center recognize and respect a patient's right to privacy of their medical records and billing matters. Your medical and/or billing matters will not be discussed with anyone without your permission. This includes your spouse, family members, friends and others. In order for us to speak with anyone regarding you, even in the event of an emergency, you must specify to whom we may speak.

If you wish for us to be able to release information regarding you, please indicate below.

I give permission for the physicians and staff of Neuro Spinal and Headache Center to discuss information indicated, regarding myself to:

Name	Relationship	Type of Information To Be Released
________________________	______________________	Medical / Financial / Appt Information
________________________	______________________	Medical / Financial / Appt Information
________________________	______________________	Medical / Financial / Appt Information

Patient Name____ DOB ________________________

Signature ____ Date_________________________

We ask that you update this information annually or as circumstances change.

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Financial Policy

Thank you for choosing Neuro Spinal and Headache Center as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Pre-authorizations
Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us.. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring $295 at the initial appointment. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Missed Appointments
NSH requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of $25.00.

Returned Checks
The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent three statements. If payment is not made on the account, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Primary Insurance Information:
Name of Insurance Company: ______________________________ Phone: __________________
Address: ____
Name of Policy Holder: _______________________________ Birth Date: ____/____/______
Insurance Policy#:__________________________________ Group#: ______________________
Social Security Number: _____________________________

Secondary Insurance Information:
Name of Insurance Company: ______________________________ Phone: __________________
Address: ____
Name of Policy Holder: _______________________________ Birth Date: ____/____/______
Insurance Policy#:__________________________________ Group#: ______________________
Social Security Number: _____________________________

Do you have an Attorney for the problem you are here for today? □ Yes □ No
Attorney Name: _________________________ Phone: __________________________

By signing below I acknowledge that all the information on this document is true and complete to the best of my knowledge. Also, I agree to the financial policy of this office and will abide by it.

Signature: ____ Date: _____________________________

Print Name: __________________________________