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: (H) _____(C)_____(W)_____

S.S.N: _____Date of Birth: _____ Male / Female

Race: _____Ethnicity: _____Primary Language: _____

Employer: _____

Address: _____

Phone Number: _____

Please Circle One: Single / Married / Divorced / Widowed / Other

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

Name: _____Date of Birth: _____

Relationship to you: _____Phone Number: _____

Address: _____

Primary Pharmacy: _____ Phone Number: _____

Address: _____

How did you hear about our office (Please check one of the following):

___ Referring Physician ___ Newspaper/Online/Google ___ Friend/Relative ___Other

Referring Physician: _____ Phone Number: _____

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

## Primary Insurance Information

Insurance Carrier: _____

Address: _____ Phone: _____

Name of Policy Holder: _____ D.O.B: _____

Policy/Claim Number: _____ SS#: _____

## Secondary Insurance Information

Insurance Carrier: _____

Address: _____ Phone: _____

Name of Policy Holder: _____ D.O.B: _____

Policy/Claim Number: _____ SS#: _____

Is your visit today related to an auto accident? (Please circle) Yes / No

Is your visit today related to a work-related injury? (Please circle) Yes / No

If yes: Date of Injury: _____

Case Manager: _____ Email: _____

Phone Number: _____ Fax Number: _____

Attorney: _____ Phone Number: _____

Patient Signature: _____ Date: _____

Printed: _____ D.O.B: _____

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 the account will be considered for discharge from the practice.

In the event the account is turned over for collections, the person is financially responsible for the account and will be responsible for all collection 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 services rendered in our office. Our office will not bill any other personal party.

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

Cancellation & No-Show Policy

We understand that "Life Happens" and we will do our best to accommodate your scheduling needs. To best serve all our patients, it is important that our appointment schedule be as accurate as possible. The following policies were instituted with that goal in mind.

Cancellation/No Show Policy: We understand that there are times when you must miss appointments due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, this can result in preventing another patient from getting much needed treatment. Conversely, the situation may happen where another client fails to cancel, and we are unable to schedule you for a visit in a timely manner.

For this reason, we ask that you give at least 24 hours' notice when cancelling an appointment. Failure to do so will result in a $25.00 charge for a regular office visit or an $100.00 charge for an EMG appointment.

Delayed Appointments: We understand that delays can happen, however we must try to keep the patients and the doctor on time.

We do allow a 15-minute window to attend your appointment. If you arrive over 15 minutes late for your appointment, we will do our best to accommodate the situation, but a reschedule of the appointment may be required.

By signing below, I acknowledge that I have read and understand the Cancellation and No Show Polices of Neuro Spinal and Headache Center.

Patient's Name (Printed): _____

Signature: _____ Date: _____

# HIPAA Disclosure Form

Patient Name: _____ Date: _____

Address: _____

Alternate Address: _____

Primary Phone Number: _____ Alt Phone Number: _____

E-Mail Address: _____

Would you like our correspondence with you to be marked "Confidential"? Yes No

May we identify ourselves over the phone? Yes No

May we leave medical information and appointment information via voicemail? Yes No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following individuals:

Name:_____ D.O.B: ___/___/____ Relationship: _____

Name:_____ D.O.B: ___/___/____ Relationship: _____

Name:_____ D.O.B: ___/___/____ Relationship: _____

Name:_____ D.O.B: ___/___/____ Relationship: _____

Patient Signature: _____ D.O.B: _____

Name (Printed): _____ Date: _____

## 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 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 ay patient information changes.

### Co-Pay's

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the 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 part 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 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-Authorization's

Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider before visiting a specialist. If your insurance company requires a referral and/or re-authorization, you are responsible for obtaining it. Failure to obtain the referral and or pre-authorization may result in a lesser or complete lack of 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 $385 at the initial/New Patient 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.

### Worker's Compensation

It is the patient's responsibility to provide our office staff with employer authorization and contact information regarding a worker' compensation claim. If the claim is denied by 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 denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

### Returned Checks

The charge for a returned check is $35.00 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/are responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Print:_____ Signature: _____

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

# Patient History Form

Patient: _____ Age: _____ Date: _____

Chief Complaint: _____

Primary Care Physician: _____

Medications (Name, Strength, and Dose)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Drug Allergies: _____

## Past Medical History (Please Circle All That Apply)

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

Other: _____

Operations: _____

_____

Family Medical history (Diseases or cause of death):

Mother: _____ Father: _____

Grandparents: _____

Siblings: _____

Children: _____

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

# New Patient Questionnaire

1. Have you had any falls recently? Yes No

   If yes, When? _____ Did you injure yourself? Yes No

   If Yes. Describe: _____

   Have you ever had a flu shot? Yes No If yes. When: _____

   Do you use Tobacco Products? Yes No

   If Yes. How many packs per day? (Please circle) 1 2 Other: _____

   Do you use Alcohol Products? Yes No

   If Yes. How many drinks per month? (Please circle) 1 2 Other: _____

   When was your last mammogram? Month: _____ Year: _____

   Where was it performed? _____

   Have you had any of the following? (Please Circle)
   Colonoscopy or CT Colonography? Yes No Date: _____

   Where and Results: _____

   Flexible Sigmoidoscopy? Yes No Date: _____

   Where and Results: _____

   Fecal Occult or Cologuard? Yes No Date: _____

Tel. 512.264.9999 Fax. 512.264.8099

# *AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION*

**I hereby authorize** _____ **to disclose the following information from the health records of:**

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

_____

**Covering the period(s) of healthcare:**

From: _____ to: _____

**Information to be disclosed:**

[ ] Complete health records
[ ] History & Physical Examination
[ ] Consultation Reports
[ ] Radiology Reports
[ ] Discharge Summary
[ ] Progress Notes
[ ] Laboratory Tests
[ ] Other: _____

**I understand that this will include information related to (check if applicable):**

[ ] Acquired Immunodeficiency Syndrome (AIDS) human immunodeficiency virus (HIV)
[ ] Behavioral health service/ psychiatric care
[ ] Treatment for alcohol and/or drug abuse

**This information is to be disclosed to:** Neuro Spinal and Headache Center
**For the purpose of:** Evaluation and treatment

**I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date:**

_____

**The facility, its employees, officers and physicians are hereby released form any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**

Signed: _____ Date: _____
(patient)

_____

or (legal representative) (relationship to the patient) (date)

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

# New Patient Questionnaire

Where and Results: _____

Have you recently been admitted into the hospital or any inpatient facility?

If yes. Please answer the following?

Admission Date: _____ Discharge Date: _____

Reason for Admission: _____

Did you follow up with your primary doctor?

If so, who? _____

Over the past two weeks have you been bothered by any of the following problems?

Little interest or pleasure in doing things (please check all that apply):

Not at all ____

Several days ____

More than half the days ____

Nearly every day ____

Feeling down depressed or hopeless?

Not at all ____

Several days ____

More than half the days ____

Nearly every day ____

NEURO SPINAL & HEADACHE CENTER
Stephen G. Pappas, MD
2600 Parkwood Drive
Brunswick, GA 31520
Tel: 912.264.9999 Fax: 912.264.8099

## *AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION*

**I hereby authorize** _____ **to disclose the following information from the health records of:**

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

_____

**Covering the period(s) of healthcare:**

From: _____ to: _____

**Information to be disclosed:**

[ ] Complete health records
[ ] History & Physical Examination
[ ] Consultation Reports
[ ] Radiology Reports
[ ] Discharge Summary
[ ] Progress Notes
[ ] Laboratory Tests
[ ] Other: _____

**I understand that this will include information related to (check if applicable):**

[ ] Acquired Immunodeficiency Syndrome (AIDS) human immunodeficiency virus (HIV)
[ ] Behavioral health service/ psychiatric care
[ ] Treatment for alcohol and/or drug abuse

**This information is to be disclosed to:** Neuro Spinal and Headache Center
**For the purpose of:** Evaluation and treatment

**I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date:**

_____

**The facility, its employees, officers and physicians are hereby released form any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**

Signed: _____ Date: _____
(patient)

_____

or (legal representative) (relationship to the patient) (date)