PATIENT REGISTRATION FORM

Formulario de registracion del paciente

PATIENT INFORMATION

LAST NAME_____ (APELLIDO) FIRST NAME_____ (PRIMER NOMBRE) MI_____ (INITIAL)

SOC. SEC. #_____ (NUMERO DEL SEGURO SOCIAL) DATE OF BIRTH_____ (FECHA DE NACIMIENTO) GENDER: (SEXO) ☐ MALE (MASCULINO) ☐ FEMALE (FEMENINO)

ADDRESS_____ (DOMICILIO) CITY_____ (CIUDAD) STATE_____ (ESTADE) ZIP_____ (ZONA)

TELEPHONE (Home) _____ (TELEFONO DE CASA) MARITAL STATUS: (ESTADO CIVIL) ☐ Single (SOLTERO) ☐ Married (CASADO) ☐ Separated (SEPARADO)

TELEPHONE (Mobile) _____ (TELEFONO DE CONTACTO DIARIO) ☐ Divorced (DIVORCIADO) ☐ Widowed (VIUDO)

EMAIL: _____

PREFERRED LANGUAGE: ☐English ☐Spanish ☐French ☐Other: _____

ETHNICITY: ☐Hispanic ☐Black/ African American ☐Asian ☐Native American ☐Caucasian ☐Other

IN CASE OF EMERGENCY CONTACT: _____ (NOMBRE DE LA PERSONA EN CASO DE EMERGENCIA) **TELEPHONE:** _____ (TELEFONO)

INSURANCE INFORMATION

PRIMARY INS. CO. NAME_____ (NOMBRE DEL SEGURO PRIMARIO)
ID# _____ (NUMERO DEL ASEGURADO) GRP. PLAN#_____ (NUMERO DEL PLAN)
ADDRESS_____ (DOMICILIO)
CITY_____ (CIUDAD) STATE_____ (ESTADO) ZIP_____ (ZONA)

SECONDARY INS. CO. NAME_____ (NOMBRE DEL SEGURO SECUNDARIO)
ID#_____ (NUMERO DEL ASEGURADO) GRP PLAN#_____ (NUMERO DEL PLAN)
ADDRESS_____ (DOMICILIO)
CITY_____ (CIUDAD) STATE_____ (ESTADO) ZIP_____ (ZONA)

EMPLOYMENT STATUS: (SU SITUACION LABORAL) ☐ FULL TIME (TIEMPO COMPLETO) ☐ PART TIME (PARTE DE TIEMPO) ☐ RETIRED (RETIRADO) ☐ NOT EMPLOYED (DESOCUPADO)

EMPLOYER_____ (NOMBRE DE LA COMPAÑIA DONDE TRABAJA) TELEPHONE_____ (TELEFONO DE LA COMPAÑIA)

RESPONSIBLE PARTY INFORMATION: (INFORMACION DEL RESPONSABLE) ☐ SELF (YO) ☐ SPOUSE (ESPOSA (O)) ☐ OTHER _____ (OTRO)

NAME (Last, First) _____ (APELLIDO, PRIMER NOMBRE) D.O.B: ____/____

PRIMARY CARE PHYSICIAN

(SU MEDICO PRINCIPAL)

NAME_____ (NOMBRE)

ADDRESS_____ (DOMICILIO)

TELEPHONE (W/ AREA CODE) _____ (TELEFONO CON EL CODIGO DE ZONA)

REFERRING PHYSICIAN (MD WHO SENT YOU HERE)

(QUIEN LE REFIRIO A NOSOTROS)

NAME_____ (NOMBRE)

ADDRESS_____ (DOMICILIO)

TELEPHONE (W/ AREA CODE) _____ (TELEFONO CON EL CODIGO DE ZONA)

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I AUTHORIZE THE RELEASE OF INFORMATION.

(YO VEREFICO LA VERACIDAD DE ESTA INFORMATION Y AUTORIZO SU DIFUNDACION)

* _____ PATIENT (or authorized signature) (FIRMA DEL PACIENTE OR PERSONA AUTORIZADA)

* _____ DATE (FECHA)

WORKERS COMPENSATION INFORMATION

ATTENTION: PLEASE PROVIDE THE COMPLETE INFORMATION REQUESTED BELOW IN ORDER FOR OUR OFFICE TO EXPEDITE THE HANDLING OF YOUR CASE.

PATIENT INFORMATION

PATIENT NAME: _____

*DATE OF INJURY: _____/_____/_____

DESCRIBE HOW INJURY OCCURRED:

_____

_____

_____

_____

_____

_____

EMPLOYER INFORMATION

*EMPLOYERS NAME: _____

*ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

*PHONE: (_____) _____-_____

COMPENSATIONS INSURANCE:

*NAME: _____

*ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

*PHONE: (_____) _____-_____

*WCB#: _____

*CARRIER CASE#:_____

*CARRIER ID#: _____

ADJUSTOR/ NURSE CASE MANAGER CONTACT INFORMATION

NAME: _____

PHONE: (_____) _____-_____ FAX: (_____) _____-_____

LAWYERS CONTACT INFORMATION

NAME: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PHONE: (_____) _____-_____ FAX: (_____) _____-_____

WORKMEN'S COMPENSATION QUESTIONNAIRE

1) Are you currently working? ☐ YES ☐NO

2) Have you missed any days of work because of your injury?
If yes, please provide dates:

_____
_____
_____

3) At the time of the accident, what was your job title or description?

_____
_____
_____

4) On the day of injury, what were your usual work activities?

_____
_____
_____
_____

5) Did another healthcare provider treat this injury? ☐YES ☐ NO
If yes, please provide details:

_____
_____
_____
_____

NeuroAxis Neurosurgical Associates, P.C.
8002 Kew Gardens Rd, Kew Gardens, NY 11415
(718) 459-7700

PATIENT HEALTH HISTORY

PATIENT NAME_____ **DATE OF BIRTH**_____
(NOMBRE DEL PACIENTE) (FECHA DE NACIMIENTO)

CURRENT PROBLEM IS THE RESULT OF: ***CHECK ONE***
(QUE CAUSO SU PROBLEMA) (MARQUE UNO)

☐ MOTOR VEHICLE ACCIDENT ☐ WORK ACCIDENT ☐ NO WORK / MOTOR VEHICLE ACCIDENT
(ACCIDENTE DE CARRO) (ACCIDENTE DE TRABAJO) (NO ACCIDENTE DE TRABAJO O DE CARRO)

_____
PATIENT SIGNATURE

CHIEF COMPLAINT
(PROBLEMA PRINCIPAL)

REASON FOR TODAY'S VISIT?_____
(CUAL ES LA RAZON DE SU VISITA HOY)

PAST HISTORY

PLEASE LIST ANY PRIOR MAJOR ILLNESSES AND/OR INJURIES: _____
(LISTE POR FAVOR ALGUNA ENFERMEDAD Y/O LAS HERIDAS MAYORES PREVIAS)

SURGERIES / HOSPITALIZATIONS (OPERACIONES / HOSPITALIZACIONES)	YEAR (AÑO)	COMPLICATIONS (COMPLICACIONES)

HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA? ☐ YES (SI) ☐ NO (NO)
(HA TENIDO USTED PROBLEMAS CON ANASTESIA?)

PATIENT NAME_____ DATE OF BIRTH_____
(NOMBRE DEL PACIENTE) (FECHA DE NACIMIENTO)

CURRENT MEDICATION(S) (MEDICACIONES QUE ESTA TOMANDO)	DOSE (DOSIS)	FREQUENCY (FREQUENCIA)

LIST ANY ALLERGIES TO MEDICATIONS:
(LISTE CUALQUIER ALEGIA A MEDICIAS):

_____

_____

PHARMACY: _____
(NAME)

_____
(ADDRESS) (CITY) (ZIP)

PHONE#: _____

DO YOU SMOKE?: ☐ YES, I SMOKE ____ PACKS OF CIGARETTES PER DAY FOR_____YEARS
(USTED FUMA) (SI, FUMO) (PAKETES DE CIGARRILLOS POR DIA POR) (AÑOS)

____ CIGARETTES PER DAY FOR_____YEARS
(CIGARRILLOS POR DIA POR) (AÑOS)

☐ NO, I HAVE NEVER SMOKED.
(NO, YO NUNCA FUME)

☐ NO, I QUIT _____ YEARS AGO
(NO, DEJE DE FUMAR) (AÑOS ATRAS)

-AT THE TIME I WAS SMOKING _____ PACKS PER DAY FOR _____ YEARS
(EN ESE TIEMPO ESTABA FUMANDO) (PAKETES POR DIA POR) (AÑOS)

DO YOU DRINK ALCOHOL?:
(USTED TOMA ALCHOL?)

☐ NO, NEVER (OR RARELY)
(NO, NUNCA O RARA VEZ)

☐ NO, BUT I USED TO
(NO, PERO TOMABA)

☐ YES: ☐DAILY ☐ 1 OR MORE TIMES/WEEK ☐SOCIALLY
(SI) (DIARIAMENTE) (UNA O MAS VECES A LA SEMANA)

REVIEW OF SYSTEMS
(REVISION DE SYSTEMAS)

ARE YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH: (TIENE, O HA TENIDO USTED PROBLEMAS CON):	YES	NO
GENERAL/ CONSTITUTIONAL		
FEVER (FIEBRE)		
WEIGHT LOSS (PERDIDA DE PESO)		
EYES/ EARS/ NOSE/ THROAT (OIDOS, NARIZ, GARGANTA Y BOCA)		
EAR PAIN (DOLOR DE OIDO)		
RINGING IN EARS (TIENE RUIDOS EN SUS OIDOS)		
BALANCE PROBLEMS (DISTURBIOS EN SU BALANCE; EJEMPLO VERTIGO, MAREO		
SINUS PROBLEMS (PROBLEMAS SINOSOIDALES)		
CARDIOVASCULAR/ HEMATOLOGIC (CARDIO VASCULAR)		
CHEST PAIN (DOLOR DE PECHO OR ANGINA)		
HIGH BLOOD PRESSURE (ALTA PRESSION)		
HEART ATTACK (INFARTO)		
ANEMIA (ANEMIA)		
BLEEDING PROBLEMS (PROBLEMAS SANGRIENTOS)		
RESPIRATORY (RESPIRATORIO)		
ASTHMA (ASMA)		
SHORTNESS OF BREATH (CORTO DE RESPIRACION)		
CHRONIC COUGH (TOSE CONTINUAMENTE)		
GASTROINTESTINAL (GASTRONOMICO)		
NAUSEA (NAUSIA)		
VOMITING (VOMITANDO)		
ABDOMINAL PAIN (DOLOR ABDOMINAL)		
CHANGE IN BOWEL HABITS (CAMBIOS EN EL HÁBITO DE IR AL BAÑO)		
ULCERS (ULCERAS)		
GENITOURINARY (URINARIO)		
URINARY TRACT INVECTIONS (INFECIONES EN EL CANAL URINARIO)		
DIFFICULTY STARTIN OR STOPPING STREAM (DIFICULTAD EMPENZANDO O PARAR URINA)		
INCONTINENCE (INCONSISTENCIA EN URINAR)		
MUSCULOSKELETAL (ESTRUCTURAL)		
BROKEN BONES (HUESOS ROTOS)		
WEAKNESS IN ARM OR LEG (DEVILIDAD EN LOS MUSCOLOS DE BRAZO O PIERNA)		
JOINT PAIN (DOLOR OR INCHASON DE LAS COYONTURAS)		
ENDOCRINE (ENDOCRINOLOGO)		
DIABETES (DIABETIS)		
THYROID DISEASE (ENFERMEDAD DE LA TIROIDE)		
HORMONE PROBLEMS (PROBLEMAS HORMONALES)		
INTEGUMENTARY (DE LA PIEL)		
SKIN DISEASE (ENFERMEDAD DE LA PIEL)		
SKIN CANCER (CANCER DE LA PIEL)		
MAMMOGRAM: DATE OF MOST RECENT		
NEUROLOGICAL (NEUROLOGICO)		
FAINTING SPELLS/ BLACKOUTS (DESMAYOS O IRSE EN BLANCO)		
SEIZURES (ATEQUES EPILECTICOS)		
HEADACHES (DOLOR DE LA CABEZA)		
DOUBLE VISION (DOBLE O NUBOSIDAD EN SU VISION)		
FACE WEAKNESS (DEVILIDAD EN LOS MUSCOLOS DE SU CARA)		
PROBLEMS WITH YOUR MEMORY (PROBLEMAS CON SU MEMORIA)		
COORDINATION IN ARM AND/OR LEGS (CORDINACION DE BRAZOS O PIERNAS)		

PATIENT SIGNATURE

DATE

NeuroAxis Neurosurgical Associates, P.C.

8002 Kew Gardens Rd. Suite 703, Kew Gardens, NY 11415 Phone (718) 459-7700 Fax (718) 286-1140

John Miller, M.D., F.A.C.S.
Richard W. Johnson, M.D., F.A.C.S.
Harrison T. Mu, M.D., F.A.C.S.
Nicholas Post, M.D.
Rick Madhok, M.D.
David Chen, M.D.

I hereby authorize as follows:

I hereby authorize and direct NeuroAxis Neurosurgical Associates, P.C. and its physicians having treated me, to release to Medicare, Medicaid, government agencies, insurance carriers, or others who are financially liable for medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I hereby guarantee payment to NeuroAxis Neurosurgical Associates, P.C. and my physician(s) of all charges and fees incurred for services rendered to the patient. I understand that if an insurance company (non-participating) fails to pay all or part of this claim, that I am responsible, upon notice, for payment. In consideration of the physician's services which have been or will be provided to the patient. I hereby assign to NeuroAxis Neurosurgical Associates, P.C. and to any physicians providing services, all of the medical insurance benefits to which I may be entitled from Medicare, Medicaid, government agencies, insurance carriers, no-fault carriers, or others that are financially liable for my care.

I request that payment of authorized benefits be made on my behalf to NeuroAxis Neurosurgical Associates, P.C.

INSURANCE GRIEVANCE CONSENT FORM

I _____ hereby request and authorize the administrative representative, physician,
(Print Name)
hospital, facility or other licensed health care provider of NEUROAXIS NEUROSURGICAL ASSOCIATES, P.C. to file a grievance on my behalf. The denial, termination or other limitation of covered health care services is as set forth this grievance. I further consent that the filing of this grievance constitutes an exercise of my rights under my benefits agreement.

* _____ * _____

Signature of Patient **Date**

_____ _____

Signature of person/guarantor (other then patient) **Witness**

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that information given by me in applying for payment under title XVIII of the social security act is correct. I authorize any holder of medical or other information about me to release to the social security administration and Health Care Financing Administration or its intermediates of carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to claim to Medicare for payment to me.

_____ _____

Date **Signature of Insured or Authorized Representative**

HIPPA PRIVACY NOTICE

Neuroaxis Neurosurgical Associates, P.C.
8002 Kew Gardens Road
Kew Gardens, NY 11415
(718) 459-7700

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION:

Neuroaxis Neurosurgical Associates, P.C. understands that your medical information is private and confidential. We are required by law to maintain the privacy of "protected health information." This includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the use and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our must current privacy notice. Any disclosures of your health information that are not indicated below or for which the law does not require a written authorization will require a written authorization from you. You may, pursuant to law revoke that authorization, but the information may have been disclosed by the time you revoke the authorization. You may also request to inspect and/or copy certain medical and billing information contained in medical records held by us.

PERMITTED USES AND DISCLOSURES:

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of use and disclosures, we have provided a description. You may request restrictions of certain disclosures of your health information, though we are not required to agree to such restrictions, except as required by law and as indicated below.

TREATMENT:

Means the provision, coordination or management of your health care, including consultation between healthcare providers regarding your care and referrals for health care from one healthcare provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because this may slow the healing process. The doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

PAYMENT:

Means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections and claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your third party payer about your medical condition to determine whether the proposed course of treatment will be covered. When we bill the third party payer for the services rendered to you, we can provide them with information regarding your care if necessary to obtain payment. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sing a release when necessary under applicable law. You may request that we make no disclosure to your health insurer if you agree to pay for the treatment out of your pocket in full and will not seek insurance reimbursement for it.

HEALTH CARE OPERATIONS:

Means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are needed and whether certain new treatments are affective. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and healthcare delivery without learning who you are.

AMENDMENT:

You have the right to request an amendment to your protected health information, but we may deny your request if we determine that the information i:

1) Was not created by us, unless you provide a reasonable basis to believe that the originator of that information is no longer available to act upon your request for an amendment;
2) The information is not part of the medical or billing records used to make decisions about you;
3) The information is not available for our inspection;
4) The information is accurate and complete.

RELEASE OF INFORMATION

* I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

(CHECK ALL THAT APPLY)

- O Information is not to be released to anyone.
- O Spouse: _____
- O Chil(dren): _____
  _____
- O Other: _____

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

If unable to reach me:

(CHECK ONE)

- O You may leave a detailed message.
- O Please leave a message asking me to return your call.

Please call:

(CHECK ALL THAT APPLY)

- O Home: _____
- O Cell: _____
- O Work: _____

PRINT NAME: _____

DATE: _____/_____/20_____

SIGN: _____

(Signature of patient or personal representative.)

CONTACT OR COMPLAINTS

If you believe that your privacy rights have been violated, or have a questions about the ways in which your protected health information is created, used or disclosed, please contact our Privacy Officer at (718) 459-7700.

NEURO- AXIS

NEUROSURGICAL ASSOCIATES, P.C.

80-02 KEW GARDENS ROAD · KEW GARDENS, NY 11415
TEL: 718.459.7700 · FAX: 718.286.1140

JOHN I. MILLER, M.D., F.A.C.S
Diplomate American Board of Neurological Surgery
American Board of Pediatric Neurological Surgery

RICHARD W. JOHNSON, M.D., F.A.C.S
Diplomate American Board of Neurological Surgery
Member of the North American Spine Society

HARRISON T. MU, M.D., F.A.C.S
Diplomate American Board of Neurological Surgery

NICHOLAS H. POST, M.D.

RICK MADHOK, M.D.

DAVID CHEN, M.D.

PLEASE ALLOW A MINIMUM OF 7-10 BUSINESS DAY FOR FORMS TO BE PROCESSED AND A MINIMUM OF 14 BUSINESS DAYS FOR MEDICAL RECORD REQUESTS.

All paper work, forms, and letters which are requested to be completed or signed by the doctor will be at a cost of:

- One Page Form/Letter $15.00
- Two Page Form/Letter $30.00
- Three Page Form/Letter $50.00
- Four Page Form/Letter $100.00
- FMLA / Attending Physician Statement $25.00

We are only responsible to complete the section on forms that are directly related to neurosurgical matters.

PAYMENT MUST BE MADE PRIOR TO THE RELEASE OF RECORDS OR FORMS. PAYABLE BY CASH, CREDIT OR CHECK.