WELLSTAR NEUROSURGERY

PLEASE PRINT & FILL IN COMPLETELY **ACCT #**_____

Personal E-Mail Address _____ **Cell phone #** _____

Name: _____ Sex: _____ Marital Status: _____
(First) (Middle) (Last) (F or M) M S W D

Address: _____
(Street) (City) (State) (Zip)

Phone # ( )_____ Soc. Sec. #: _____-_____-_____ Birth date: _____ Age: _____

Your Employer: _____ Wk Address: _____

Work Phone # ( )_____-_____EXT _____

Referred By:
_____

List any drug allergies:_____
_____

If married, SPOUSE NAME: _____ Birth date: _____ SS#_____

Spouse Employer: _____ Phone # ( )_____ - _____

IF A STUDENT, Full Time or Part Time? (Circle one) **Parent Name:** _____ Day Time Phone # ( )_____ - _____

** Birth Date of **Parent:** ____/____/_____ SS # of **Parent:** ____-_____-_____ **Parent** Employer: _____

Nearest Relative (not living with you): _____

Address: _____Daytime Phone: ( )_____-_____

Primary Insurance Name: _____ Are Referrals required for you to see a specialist? Yes NO

Current Insurance ID Card Provided to Receptionist? Yes NO (*If No, you will be considered Self Pay for today's visit.)

Secondary Insurance Name: _____ Are Referrals required for you to see a specialist? Yes NO

Current Insurance ID Card Provided to Receptionist? Yes NO

I hereby authorize WELLSTAR NEUROSURGERY to furnish my medical information to insurance carriers concerning my illness and treatment and I hereby assign all medical and/or surgical benefits rendered to myself or my dependent to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to WellStar Neurosurgery for service provided. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

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 intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____

I certify that all information provided is current and correct and understand that it is my responsibility to notify my physician's office were any of the above information to change.

_____ _____
Patient/Guardian Signature Date

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

WellStar Medical Group

WellStar Neurosurgery
61 Whitcher St., Suite 3110
Marietta, GA 30060
770-422-2326

Patient Name: _____ **Date of Birth:** _____

Patient Account No: _____ **Initial Encounter Date:** _____ **Statement Term Date** _____

Please check one of the following:

[ ] **I have presented evidence of valid insurance coverage, as of this date below, to WellStar Medical Group.**

_____

Insurance Identification Number / Insurer's Name / PCP Name on Card

**** Verification of benefits from your Insurance Company is not a guarantee services are covered or will be paid by your insurance company. You, as the patient, are responsible for knowing and understanding your insurance benefits as related to any service provided and billed by WellStar Neurosurgery. Benefits verified by WellStar Neurosurgery are based upon estimates given by your insurance company and are subject to change upon adjudication of your claim.***

[ ] **Self-Pay. I have not presented any evidence of insurance coverage. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time services are rendered and I possess the means to tender payment today.**

Please circle intended method of payment: **Cash** **Check** **Credit Card**

In consideration of the services provided at the Facility identified above:
I, the undersigned, hereby assign all hospital and medical provider benefits payable (i.e. "Payor": Insurance Coverage, Medicare, Medicaid, Social Security, etc.) and related rights existing under the Payor coverage that I have identified or will identify in connection with the services provided directly to the Group and acknowledge this includes my permission to submit all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.
I understand that any payment received by the Group for this period may be applied to any unpaid bill(s) for which I am liable.
I understand that different Payor's have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary.
I understand that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled.
I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the Group the full balance that is not reimbursed by my medical provider benefits (certain regulations and exceptions apply for Medicare Beneficiaries).
Additionally, if the Group elects to pursue an appeal of any denials by my Payor of the payment for services rendered, this Statement constitutes written consent that Facility and/or its agents have the authority to pursue any and all appeals, including arbitration, on my behalf. This financial responsibility is hereby affirmed and acknowledged by my signature below.
I understand that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the three major credit bureaus if not paid in a timely manner.

_____ _____

(Patient/Guarantor Signature) **(Date)**

** **NOTE**: If you provided us with insurance information today, you are obligated to pay all co-payments, deductibles and any non-covered out-of-network/reduced benefits at the time services are rendered. You will subsequently be invoiced for any additional amounts which are not paid by your Insurer. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the Group for reimbursement of services provided. ** Please contact the number above for more information regarding financial assistance or payment plan options that may be available to you.*

WELLSTAR Medical Group

Patient Authorization for Use and Disclosure of Protected Health Information

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly)*:

_____ _____ _____ _____

Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____

Street Address *Apt. #/P.O. Box # (Please include complete mailing address)* *Medical Record #/Social Security# (optional)*

_____ _____ _____ _____

City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

_____ _____ _____

Business Number *Cell Phone Number* *Other Phone Number*

I authorize the WellStar Medical Group to disclose Protected Health Information to the following persons:

☐ Spouse: _____ _____

Name *Phone Number*

☐ Child(ren): _____ _____

Name *Phone Number*

_____ _____

Name *Phone Number*

☐ Other: _____ _____

Name *Phone Number*

Information to be disclosed

☐ All Medical Information ☐ Laboratory Results ☐ All Billing/Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature/Date: *(date authorization signed by patient or Legal Guardian/Personal Representative)* _____

Month/Day/Year

_____ _____

Print Patient Name or Name of Legal Guardian/Personal Representative *Signature of Patient or Legal Guardian/Personal Representative*

_____

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

WELLSTAR Medical Group

Acknowledgment of Receipt of "Notice of Privacy Practices" for Protected Health Information

I acknowledge that I have received a copy of WellStar Health System's "Notice of Privacy Practices" for protected health information on the date set forth below.

_____
Date of Receipt

Patient Information *(please print clearly)*:

_____ _____
Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____
Print Patient Name or Legal Guardian/Personal Representative *Relationship to Patient*

_____
Signature of Patient or Legal Guardian/Personal Representative

Release and Assignment:

The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform the WellStar Medical Group of any changes in my address, phone number or insurance. I understand that I am financially responsible for any amounts not covered by my insurance. _____

For use by WellStar Personnel Only *(complete this section if patient acknowledgement is **not** received)*:

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication/language or other barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other: *Please indicate reason* _____

Signature of WellStar Representative: _____ Date: _____

WELLSTAR NEUROSURGERY

Chart # _____
Date: _____

PATIENT HISTORY FORM

Name: _____ Birth Date: _____ Age: _____

Marital status: Single Married Divorced

Handedness: Right Left Ambidextrous

Referring physician for this visit:
(address, telephone number and fax):

Primary care physician
(address, telephone number and fax):

Other physicians/specialists involved in your care
(address, telephone number and fax):

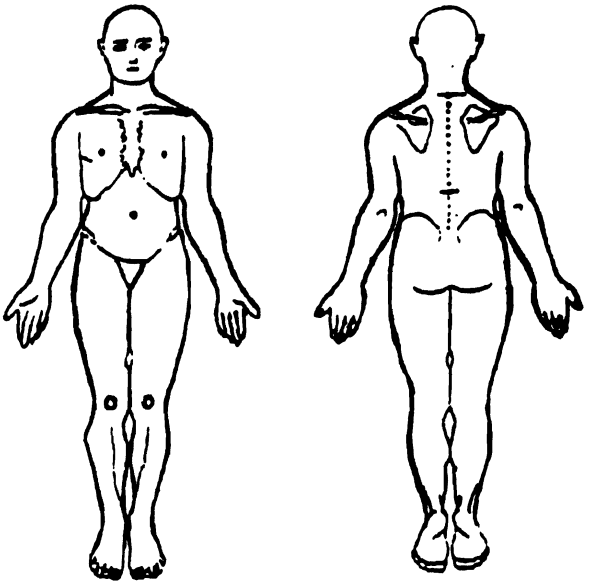
Is your visit today the result of a **Car Accident**? Y N
Attorney's name and contact information:

CHIEF COMPLAINT (REASON FOR VISIT):

Is your visit today the result of a **Worker's Comp** Injury? Y N
Is your visit today approved by your adjuster? Y N
Adjuster's Name and Contact Information:

Duration of pain or complaint, how long it has been present, does the pain or problem move or radiate anywhere?

Illustrate where your pain is located (if any).
Show areas of numbness, tingling, weakness.



Pain score (0-no pain, 10-worse pain of your life)

What makes your pain or problem worse (i.e. standing, sitting, lying down)?

What makes your pain or problem better?

REVIEW OF SYSTEMS

Constitutional complaints

Have you had any recent unintended weight loss (how much over how long)? _____

_____

_____

Do you experience fevers, chills, or night sweats? _____

_____

Check yes or no on all, if yes, please describe:

HEENT

Yes	No	
☐	☐	Scalp masses or injuries
☐	☐	Vision problems (circle): blurred vision, double vision, visual loss
☐	☐	Nasal drainage
☐	☐	Sinus disease
☐	☐	Oral lesions, sore throat
☐	☐	Difficulty swallowing
☐	☐	Hoarseness of voice
☐	☐	Hearing loss
☐	☐	Tinnitus
☐	☐	Vertigo
☐	☐	Neck masses, lymph nodes, or nodules
☐	☐	Thyroid masses or disease

RESPIRATORY

Yes	No	
☐	☐	Shortness of breath
☐	☐	Dry cough
☐	☐	Productive cough
☐	☐	Blood in sputum
☐	☐	Wheezing
☐	☐	Shortness of breath
☐	☐	Chest pain

CARDIAC

Yes	No	
☐	☐	Chest pain
☐	☐	Heart palpitations
☐	☐	Shortness of breath with exertion
☐	☐	Need to sleep on pillows at night to breath easily
☐	☐	Urinary frequency at night
☐	☐	Ankle swelling

GASTROINTESTINAL

Yes	No	
☐	☐	Abdominal pain
☐	☐	Nausea or vomiting
☐	☐	Blood in stool
☐	☐	Heart burn (reflux)
☐	☐	Diarrhea

GENITO-URINARY

Yes	No	
☐	☐	Testicular or lower abdominal pain
☐	☐	Irregular periods
☐	☐	Abnormal or absent menses (periods)
☐	☐	Unusual bleeding or discharge
☐	☐	Genital masses or lesions
☐	☐	Erectile dysfunction
☐	☐	Blood in urine

HEMATOLOGIC

☐	☐	Easy bruising or bleeding
☐	☐	Fatigue
☐	☐	Nodules or masses under arms, along groin, above collar bones, or other locations

ENDOCRINE

Yes	No	
☐	☐	Fatigue
☐	☐	Hyperactivity
☐	☐	Swelling of arms or legs
☐	☐	Frequent urination
☐	☐	Discharge from breasts
☐	☐	Change in appearance of face
☐	☐	Unusual weight gain or loss
☐	☐	Purple lines along abdomen or thighs

NEUROLOGIC

Yes	No	
☐	☐	Headache
☐	☐	Seizures
☐	☐	Memory impairment
☐	☐	Walking disturbance
☐	☐	Weakness of the arms or legs
☐	☐	Numbness or tingling (arms, legs, or face)
☐	☐	Behavior change
☐	☐	Muscle weakness, or loss of muscle mass

PSYCHIATRIC

Yes	No	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Bipolar disorder
☐	☐	Schizophrenia
☐	☐	Psychosis
☐	☐	Hallucination

ALLERGIES (MEDICATION OR IV DYES)

_____

_____

_____

MEDICATIONS (dosages and frequency)

_____

_____

_____

_____

_____

_____

_____

_____

DO YOU TAKE (CIRCLE): PLAVIX (CLOPIDOGREL) COUMADIN (WARFARIN) ASPIRIN

PAST MEDICAL HISTORY

Yes	No	
☐	☐	Fatigue
☐	☐	Hypertension (high blood pressure)
☐	☐	Heart disease/heart attack
☐	☐	Diabetes
☐	☐	High cholesterol
☐	☐	Peripheral vascular disease
☐	☐	Carotid artery disease
☐	☐	Stroke
☐	☐	COPD (type of lung disease) _____
☐	☐	Seizures
☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Psychiatric disease _____
☐	☐	Headaches (type) _____
☐	☐	Cancer (type) _____
☐	☐	_____
☐	☐	_____

PAST SURGICAL HISTORY

Yes	No	
☐	☐	Cardiac bypass
☐	☐	Lung surgery
☐	☐	Vascular surgery (carotid or other vascular)
☐	☐	Brain surgery (Please describe type of surgery, surgeon, location, date)

_____

_____

_____

Yes	No	
☐	☐	Spine surgery (Please describe type of surgery, surgeon, location, date)

_____

_____

_____

Yes	No	
☐	☐	Orthopedic procedures (Describe)

_____

_____

_____

Yes	No	
☐	☐	Other surgical procedures

_____

_____

_____

DO YOU HAVE AN ADVANCE DIRECTIVE IN PLACE? _____NO _____ YES (PROVIDE A COPY TO OUR OFFICE)
ON YOUR ADVANCE DIRECTIVE OR LIVING WILL, HAVE YOU CHOSEN *"DO NOT RESUSCITATE"?* YES NO
DO YOU HAVE A (IF YES, PROVIDE A COPY TO OUR OFFICE): ____DURABLE POWER OF ATTORNEY FOR HEALTH CARE
____HEALTH CARE PROXY ___LIVING WILL

SOCIAL HISTORY

Smoking/tobacco use (packs of cigarettes per day)_____

Alcohol use (drinks/day) _____

Illicit drug use _____

FAMILY HISTORY (living/deceased, major illnesses)

	Living (Y/N)	Age of death	Major illnesses
Mother			
Father			
Siblings			

Children (Ages/living/deceased/major illnesses)

_____

_____

_____

Is there a history of stroke, brain tumors, cerebral aneurysms, or other neurologic disorders in your family?

_____

_____

_____

PATIENT/ LEGAL GUARDIAN SIGNATURE _____

DATE _____/_____/_____

Legal Guardian Printed Name: _____ Relationship: _____