PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ Marital Status: _____ E-Mail Address: _____

INSURANCE INFORMATION

Primary Insurance

Subscriber's Name: _____ SSN: _____ DOB: _____

ID#: _____ Group#: _____ Co-Pay Amount: _____

Secondary Insurance

Subscriber's Name: _____ SSN: _____ DOB: _____

ID#: _____ Group#: _____ Co-Pay Amount: _____

WORKER'S COMPENSATION INFORMATION

Worker's Comp Carrier: _____ Claim#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Name: _____

Copies to: _____

Responsible Party:

Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship to Patient: _____

Your signature confirms that all of the above information is correct and authorizes *ARCH Neurosurgery* to correspond with the physicians listed above. I authorize the release of information to my insurance company, including Medicare, I also authorize insurance benefits to be paid directly to ARCH Neurosurgery. I understand I am responsible for all deductibles, co-insurance, and non-covered services that may be required. In addition, I agree to pay for any additional charges related to the cost of collection in the event I fail to pay my bill. If signed by a guardian or parent, this is also an authorization for medical treatment of a minor. A photocopy of this document is to be considered as valid as the original.

Patient Signature: _____ Date: _____

Name:_____ **Date:**_____

Referring MD:_____ Primary Healthcare Provider:_____

Date of onset/injury:_____ Were you in an auto accident? YES or NO

Work related injury? YES or NO Caseworker:_____

Area of Concern: Please describe injury/complaint & how long condition has been present

_____

What makes your symptoms better (ie. Rest, medication)_____

What makes your symptoms worse (ie. Walking, bending)_____

Have you had any prior treatment for this problem? Describe._____

Have any MRI, CT Scans or X-Rays been performed? YES or NO

Name of test:_____

Date:_____ Location:_____

Current Medical Status (please circle all that apply to you)

General good health
Recent weight change
Fever
Eye disease/injury
Glasses/contacts
Blurred/double vision
Hearing loss/ringing
Chronic sinus problems
Nose bleeds
Difficulty swallowing
Shortness of breath
Chest pain
Palpitations
Faintness
Breathing problems
Chronic/frequent coughs

Wheezing
Spitting up blood
Change in bowel habits
Nausea/vomiting
Diarrhea
Constipation
Indigestion
Burning/painful urination
Frequent urination
Bloody urine
Joint pain
Back pain
Difficulty walking
Muscle weakness
Leg cramps
Rashes

Dry skin/itching
Chronic skin ulcers
Varicose veins
Numbness/tingling
Blackouts
Tremors
Paralysis
Memory loss/confusion
Nervousness
Insomnia
Slow to heal after cuts
Bruising tendency
Transfusions
Excessive thirst
Excessive sweating

Prior Surgeries or Hospitalizations:_____

_____

Allergies

Known **drug** allergies? YES NO
Known **food** allergies? YES NO
Known **latex** allergies? YES NO

If yes, please list below:

_____
_____
_____

Name:_____ **Date:**_____

Past Medical History (please circle all that apply to you)

Heart Attack	Psychiatric history	Ulcerative Colitis
Angina	Anxiety	Irritable bowels
Congestive heart failure	Depression	Diverticulitis
Mitral valve prolapse	Schizophrenia	Osteoporosis
High Blood Pressure	Headaches	Rheumatoid arthritis
High cholesterol/Triglycerides	Lung Disease	Osteoarthritis
Heart Disease	Emphysema (COPD)	Hepatitis
Arrhythmia	Pneumonia	Liver Problems
Anemia	Chronic Bronchitis	Diabetes-Insulin Yes/No
Stroke	Blood clot in lung	Thyroid disease
Bleeding disorder	Tuberculosis	Kidney Stones/Disease
Blood clots (DVT)	Hiatal Hernia	Urologic problems
Peripheral vascular disease	Reflux	Stress incontinence
Peripheral neuropathy	Stomach or intestinal ulcers	Enlarged prostate
Cancer	Peptic ulcer disease	HIV+
Frequent urinary infections (UTI)	Fractures	Crohn's disease
Sleep Apena	Problems with anesthesia	Intestinal bleeding
Asthma	Fibromyalgia	A-fib

Family History (please circle any conditions present in your biological mother, father or siblings)
*Use the Key to indicate which member of your family
Mother (M) Father (F) Brother (B) Sister (S) Grandmother (GD) Grandfather (GF)

Heart disease	Cancer	Stroke
High blood pressure	Lung Disease	Liver disease
Kidney disease	Diabetes	Osteoporosis
Arthritis	Rheumatoid arthritis	Psychiatric disease
Anesthesia difficulties	Bleeding disorders	

Please list any additional conditions that are not listed above:_____

Social History

Occupation:_____
Work status (circle one) Working Retired Disabled Other
Work demands (circle one) Sedentary Moderate Active Heavy Labor
Marital Status (circle one) Single Married Separated Divorced Widowed
Tobacco use: YES NO Packs per day ___ for ___ years (is stopped when _____)
Alcohol use: YES NO Amount ____ drinks per day week month year
Have you used illegal drugs? YES NO
Do you exercise regularly? YES NO Describe_____

The above information is correct and accurate to the best of my knowledge. I understand the need to inform my provider of any changes in my medical condition.

Signature:_____ Date:_____

Name:_____ **Date:**_____

Pharmacy Information:

Pharmacy Name:_____ Phone number:_____

Address:_____ Fax number:_____

Please list **ALL** medications including over-the-counter, vitamins and supplements which you may be taking routinely and/or as needed:

Medication	Dosage	Frequency	Route of Administration	Prescribed by:

Please use the back of this sheet, if you need additional space

CONSENT TO RELEASE INFORMATION

PATIENT'S NAME_____

Patients' date of birth_____

You may leave a message on my answering machine at my home. YES_____ NO_____

You may leave a message on my voice mail at my work. YES_____ NO_____

I understand that it is my responsibility to provide authorization to Arch Neurosurgery in order to release any medical information regarding my care. I hereby authorize Arch Neurosurgery to release medical information to the following:

_____ (Spouse)

_____ (Significant other)

_____ (Parent)

_____ (Sibling)

_____ (Friend)

_____ (Employer)

_____(Other)

By signing this release I am authorizing any employee of Arch Neurosurgery to either provide verbal or written information regarding my medical condition to the above named individual(s). This authorization may be canceled by me at any time written notification.

_____ _____

Patient's signature Date

ARCH Neurosurgery
Dr. Joseph Yazdi

Cancellation Policy/No Show Policy for Doctor Appointments

Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctors on time.

If a patient is 30 minutes past their scheduled time we will have to reschedule the appointment.

Account Balances

We will require that patients with self-pay balances do pay their account balances to zero ($0) prior to receiving further services by our practice.

Patients who have questions about their bill or who would like to discuss a payment plan option may call and ask to speak to a billing representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ (___/___/___)

Patient Signature Date

_____

Print Patient Name

Arch Neurosurgery, LLC

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Arch Neurosurgery, LLC, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the Notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will provide me with a copy of any revised notice.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions request.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I requested on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

(PATIENT'S NAME PRINTED) (DATE)

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) (DATE)