BRAIN AND SPINE CENTER
South Florida

4800 Linton Boulevard • Suite E310 • Delray Beach, FL 33445
Phone: 561.501.7445 • Fax: 561.562.5061
Website: www.brainandspinemds.com

Evan Packer, MD, FAANS, FACS • Lloyd Zucker, MD, FAANS • Ronald Young, MD, FAANS • Martin Greenberg, MD, PhD

NEW PATIENT HISTORY QUESTIONNAIRE

Welcome to our office! Please answer this questionnaire to the best of your knowledge, which will allow the staff and doctor to know more about you and your medical condition. Along with this form you will need to have a picture ID, reports and films if applicable and your insurance information.

Full Name: _____ **DOB**: ___|____|___ **Age**: ____ **Email**: _____

Address: _____ City: _____ State: ___ Zip code: _____

Cell #: _____ Home: _____ Wk: _____ Ext: _____

Emergency Contact: Name _____ Relationship: _____ Ph #: _____

Referral source: ☐ Doctor :_____ PH #: _____ ☐ Internet ☐ Friend: _____

Check applicable selection : ☐ Refuse to answer
Sex: ☐ Male ☐ Female **Ethnicity**: ☐Hispanic ☐ Non Hispanic
Race: ☐White ☐African American ☐ Asian ☐ Pacific Islander ☐ Indian/Alaskan

We are in network and participating with Medicare and Multiplan

Health Insurance:

Primary Insurance Name: _____ ID# _____ Phone_____
Are you the policy holder? ☐ Yes ☐ No, if no check ☐ spouse/other DOB: _____ and Name: _____

Secondary Insurance Name: _____ ID# _____ Phone:_____
Are you the policy holder? ☐ Yes ☐ No, if no check ☐ spouse/other DOB: _____ and Name: _____

Is this related to an ***Auto accident***? ☐ No ☐ Yes, (if yes) accident date: _____ Auto Ins Name: _____
Claim#: _____ Adjuster Name: _____ Adj Ph Number: _____

Workman's Comp injury? ☐ No ☐ Yes, (if yes) injury date: _____ Insurance Name: _____
Claim#: _____ Adjuster Name: _____ Adj Ph Number: _____

*Do you have an **Attorney**?* ☐ No ☐ Yes, pls provide Name: _____ PH: _____

Authorization and release: I authorize release of my information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorization of payment from my insurance benefits to my doctor otherwise payable to me.

Patient Signature: _____ Date: _____

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Patient History

Name: _____ DOB: ___/____/____

Chief complaint (s): _____ _____ Date Began: _____

Is this Visit related to an accident? Y / N (circle one). If YES, check: ○ Auto ○ Work ○ Slip & Fall - Date of injury:_____

Allergies & Reactions: NKDA ☐

_____

_____

Pharmacy Name: _____ Address: _____ Phone: _____

(If you have a List of Medications Please Provide a Copy)

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

(Please include Over the Counter Medications)

Past Medical History: (Circle if Positive)

Epilepsy	Cancer – Type?	Alzheimer's Disease
Prior Seizure	Atrial Fibrillation	Essential Tremor
Stroke	Blood Clots	Parkinson's Disease
Hypertension	Cerebral Aneurysm	Other:
Coronary Artery Disease	Hyperlipidemia(Cholesterol)	Other:
Diabetes	Migraines	Other:
Neuropathy	Headaches	Other:
Chronic Back Pain	Hypothyroidism	Other:

Have you received any of the Following Treatments within the Last Year?

☐ Physical Therapy ☐ Epidural Injections ☐ Traction

Past Surgical History w/Dates & Medical Devices (Please provide all implanted medical device cards)

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Patient Name: _____ DOB: ____/_____/_____

Review of Systems: (Please circle all the following symptoms you are experiencing)

Fatigue	Fever	Chills	Night Sweats
Unexplained Weight Loss	Unexplained Weight Gain	Difficulty Sleeping	Changes in Vision
Dry Eyes	Contact lens or Glasses	Diplopia(Double Vision)	Blurred Vision
Redness	Flashing Lights	Specks	Glaucoma/Cataracts
Headaches	Vertigo/Dizziness	Hearing Loss/Changes	Tinnitus(Ringing in Ears)
Snoring	Dry Mouth	Shortness of Breath	Cough
Dysphagia(Difficulty Swallowing)	Reflux	Loss of Appetite	Nausea
Vomiting	Diarrhea	Constipation	Bowel Incontinence
Urinary Frequency	Urinary Incontinence	Dysuria(Painful Urination)	Decreased Libido
Impotence	Skin Pigmentation Changes	Transient Weakness	Tingling or Numbness
Tremors	Speech Difficulties	Muscular Weakness	Incoordination
Altered Mental Status	Difficulty Concentrating	Seizures	Loss of Balance
Dyskinesia	Morning Slowness	Off Periods	Freezing of Gait
Stiffness	Slowness of Movement	Wearing off	Joint Pain
Muscle Pain	Muscle Cramps	Back Pain	Wrist/Hand Pain
Nocturnal Leg Cramps	Heat Intolerance	Cold Intolerance	Loss of Hair
Anxiety	Depression	Delusions	Excessive Anger
Hallucinations	Stress	Memory Loss	Easy Bleeding/Bruising

Social History: (Circle One) Married Single Widowed Divorced #of children : _____

Occupation: _____ Retired? YES ☐ NO ☐

Alcohol: Regularly Socially Rarely Never

Do you exercise? Regularly Sometimes Rarely Never (Sedentary)

Tobacco: Current Use Never Used If current/former, how many packs per day? _____ Number of years? _____

Drugs (Non-Prescription Drug Use) YES NO Types used and frequency: _____

Family History: (Circle if Positive, Please indicate Relation)

Epilepsy	Cancer – Type?	Alzheimer's Disease
Stroke	Blood Clots	Parkinson's Disease
Hypertension	Cerebral Aneurysm	Dementia
Coronary Artery Disease	Hyperlipidemia(Cholesterol)	Other:
Diabetes	Migraines	Other:

Patient's Signature: _____ Date: _____

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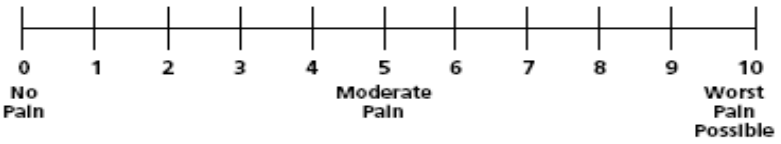
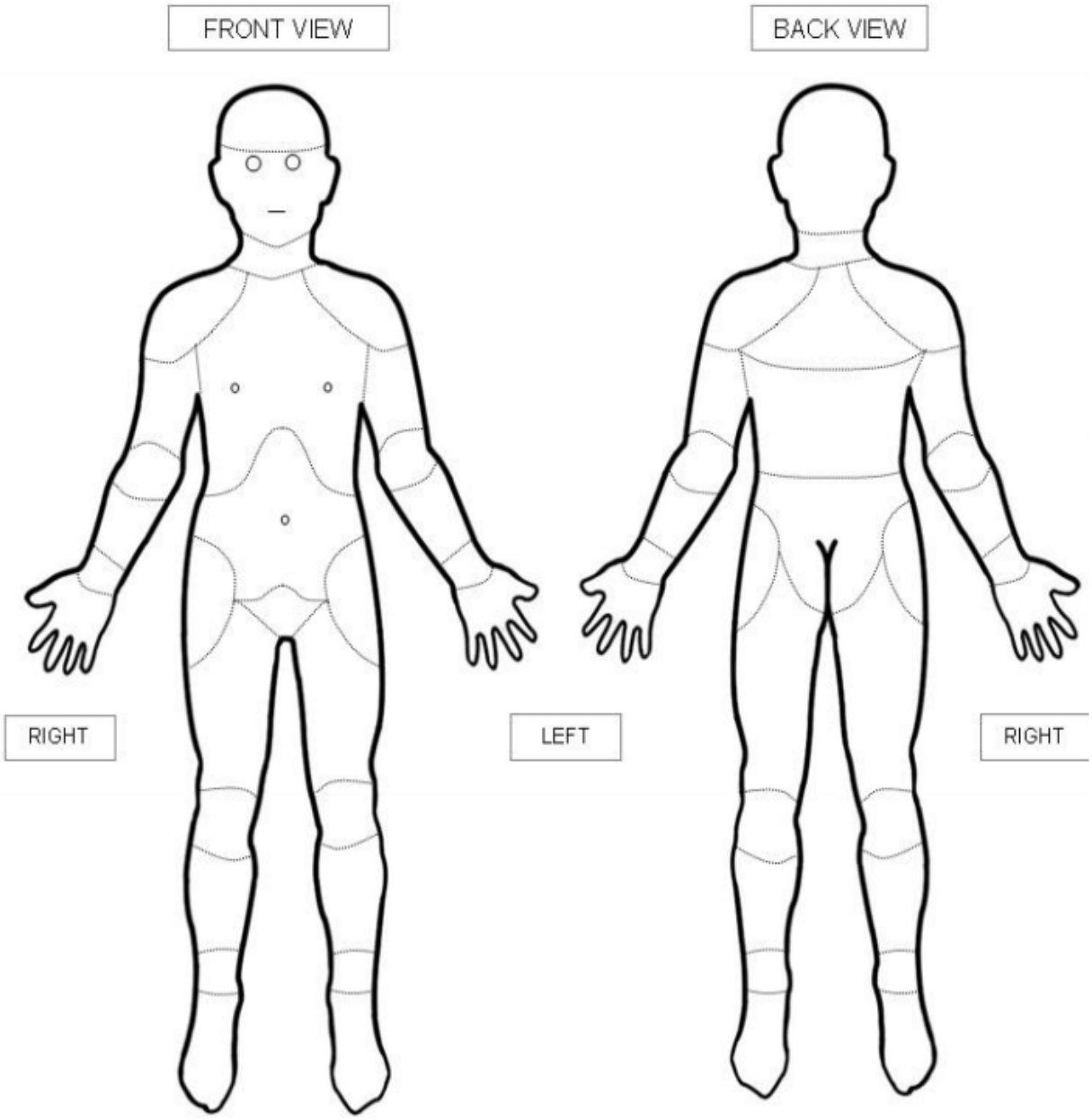
Name: _____ DOB: _____/_____/_____ Date: _____

*0 – 10 Numeric Pain Intensity Scale**



PAIN DIAGRAM - On the diagrams below mark where you are experiencing pain**, RIGHT NOW**!

P - PAIN * N - NUMBNESS * T - TINGLING



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Patient Name: _____ **DOB**: ___/____/____ **Date**: _____

Please provide the names of your physicians and the office phone numbers;

Primary Care/Family Medicine/Internist: _____

Phone: _____

Neurologist: _____

Phone: _____

Cardiologist: _____

Phone: _____

Oncologist: _____

Phone: _____

Physiatrist/Pain Management: _____

Phone: _____

Any other physician or specialist treating you:

_____

_____

_____

_____

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Patient Name: _____ **DOB**: ____/____/____

Authorization to Release Medical Record Information

NCSF will use and disclose your health information only for purposes of treatment, payment, and health care operations, unless you authorize us to use or discuss your health information for other purposes.

*You hereby authorize your physicians, hospitals, and health care facilities to disclose all or any part of your medical record to NCSF in connection with treatment, payment and health care operations for treatment and services provided to you by NCSF.

*This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may affect or limit the insurance coverage for treatment, services, or supplies provided by NCSF.

**** Please list the names of family members or care givers we may speak with regarding your health information. We will not give any information out to anyone not listed on this form. ****

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

OR:

☐ **Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information.**

_____ **Date:** _____

Signature of Patient or Guardian/Representative

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PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

You agree to be responsible for and pay in full all charges by Neurosurgical Consultants of South Florida, L.L.C.'s ("NCSF") for treatment/supplies provided to you. Payment is due upon receipt of our statement for services rendered. NCSF will bill your insurance company (Auto, W/C or health plan) for the medical services/supplies provided. We rely upon the information you provide from your current insurance card or other evidence of valid coverage. If your coverage changes in any way or terminates, please notify NCSF immediately. Unpaid balance on your account will begin to incur an interest charge 45 days after the date of the invoice and will accrue at a rate of 1-1/2% per month.

If your health plan is a HMO, you are only responsible under Florida law for payment of deductibles, co-payments and charges for non-covered services as specified in your plan. You may be required to contact your primary doctor to obtain a prior authorization for medical services. If you do not comply with your health plan's policies and procedures, payment for the services we render could become your responsibility. If you are unsure of your obligations, you can contact your insurance company. We may be able to clarify your obligations as well.

NCSF's efforts to bill and collect on your behalf from your health plan and NCSF's acceptance of payment from your health plan will not relieve you of your obligation to make payment to NCSF in full. The amount your health plan pays NCSF may be less than the full charges or the amount you owe to NCSF. NCSF will credit all payments received from your health plan to your account and will bill you for the balance, unless otherwise provided under Florida law or if NCSF contracts with your health plan to accept the amount paid by them as payment in full. Deductibles and co-payments required by your health plan are expected to be paid and by law this *cannot be waived*. If unpaid balances require NCSF to engage an attorney to assist in collection, you will be responsible for all fees and costs NCSF incurs in connection with its collection efforts which is in addition to the charges and interest accrued on your account.

Advance Payment

If you are required to make an advance payment (Copay/deductible) to NCSF we will collect prior to the provision of any medical services. This will apply to your account and any balances due will be billed to you. If we bill a health plan on your behalf and receive payment, we will credit the payment to your account and send you a statement reflecting the balance due. If at the time of the conclusion of our services there is a credit balance on your account, we will refund the balance to you in a form of a check.

Assignment of Insurance Benefits

You authorize payment to be made directly to NCSF and assign to NCSF all Medicare and other insurance benefits that may be due and payable to you directly. You hereby authorize NCSF and any other holder of medical or other information about you, including any Medigap insurer, to release to the Social Security Administration, the Centers for Medicare and Medicaid Services, and their agents, intermediaries and carriers, any information needed to determine the benefits or benefits payable to you for any claim with respect to NCSF's provision of health care services/supplies. Where Medicare and Medicaid benefits are applicable, you certify that the information given in applying for payment under Title XVIII or XIX of the Social Security Act's is complete and correct. You authorize NCSF to use this Agreement as evidence of your consent to bill and receive payment for health care services/supplies provided to you by NCSF. You further acknowledge that this assignment of benefits does not in any way relieve you of your liability to make payment to NCSF, and that you will remain financially responsible to NCSF until all charges for which you are legally responsible are paid in full. In the event the insurance carrier mistakenly sends payment for the claim directly to me, I agree that I will remit payment in its entirety to NCSF.

Authorization for Appointment of Designated Appeal Representative of Designated Appeal Representative.

I _____, authorize Neurosurgical Consultants of S. FL, LLC to act as my representative in connection with the filing of an appeal on my behalf regarding a denial for the above referenced date(s) of service. I authorize my insurance carrier to release any of my protected health information including benefits and policy information to Neurosurgical Consultants of S. FL, LLC for the purpose of resolving this appeal. I understand that this information is privileged and confidential and will only be released as specified in this authorization or as required or permitted by law.

I understand that I may revoke this authorization at any time by mailing a written notice to my insurance company. I understand that revoking this authorization will not affect any action taken prior to my notice of revocation. My designated appeals representative also has the right to rescind consent at any time. I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand that I am granting my consent for my representative to file an appeal on my behalf.

Please be advised that our doctors do not carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

I have read and understand each of the above paragraphs and I acknowledge and accept these terms and conditions.

X_____ Date: _____ _____

Signature of Patient or Guardian/Representative

Witness of Neurosurgical Consultants of S. FL, LLC

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Patient's Name)

Signature of Patient (Responsible Party): _____Date: _____

Witness: _____ Date: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining the acknowledgment

_____ Other _____