VIRGINIA NEUROSURGEONS PC

Annual Intake Form

Basic Information

Date:	
Last name:	First name:
Date of birth: Age:	Sex: Gender identity:
Street Address: City: State: Zip:	
Email address:	
Mobile phone:	Alternate phone:
Do you authorize our staff to leave medical and/or administrative information on patient's voicemail or secure email? (Please initial): Yes _____ No_____	
Pharmacy name, location, phone:	
Emergency contact name (Required):	Relationship:
Emergency contact phone(Required):	
Do you authorize our staff to release your medical information to this emergency contact? (Please initial): Yes _____ No _____	

Please list all of the following health care providers that apply to you:

	Name	City	Phone number
Primary care			
Referring physician			
Pain specialist			
Neurologist			
Cardiologist			
Physical Therapist			
Other			

Insurance Information

Primary Insurance Information:

Insurance Company: _____

Obtained on an insurance exchange? □ Yes □ No

ID#: _____ Group#: _____

Subscriber: _____Subscriber DOB: _____

Relationship to patient: □ Self □ Spouse □ Parent □ Other

Insurance Benefits: □ HMO/PPO □ Out-of-Network □ Self-Pay □ Workers Compensation

Secondary Insurance / Workers' Compensation:

Insurance Company: _____

Obtained on an insurance exchange? □ Yes □ No

ID#: _____ Group#: _____

Subscriber: _____ Subscriber DOB: _____

Relationship to patient: □ Self □ Spouse □ Parent □ Other

Insurance Benefits: □ HMO/PPO □ Out-of-Network □ Self-Pay □ Workers Compensation

Assignment and Release

I, the undersigned, certify that the information provided with regards to my insurance coverage is true and accurate. I further authorize the release of any medical information necessary to process this claim. I hereby assign to Virginia Neurosurgeons, PLC those insurance benefit payments for services provided to me. I understand that regardless of this assignment, I remain financially responsible for all charges whether or not paid by insurance.

Signature: _____ **Date:** _____

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Notice of Privacy Practices

Patient Acknowledgment and Consent

I have been given a copy of the Virginia Neurosurgeons, PC Notice of Privacy Practices and consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative: _____ Date: _____

Printed Name: _____

Relationship if other than patient: _____

Office and Financial Policies

Please initial *to acknowledge each of the following office policies:*

_____ For insurance carriers/out of network requiring a referral or visit pre-authorization, it is the patient's responsibility to obtain appropriate insurance approval/authorization before the clinic visit. Failure to do so will require out-of-pocket payment by the patient for services rendered.

_____ There is a $10 fee in addition to my copay amount if not collected at the time of the visit. There is a $45 fee for returned checks. Co-pay and balances are due upon registration and check-in.

_____ **All balances** must be paid in full before appointments can be scheduled.

_____ There is a $50 **no-show fee** if an appointment is not canceled at least 24 hours in advance.

_____ All requests for copies of medical records must be submitted in writing. A medical records fee in accordance with Virginia Law must be received by our office prior to release of the record.

_____ There is $35 fee for a letter from providers

_____ There is $80 fee for completion of forms

_____ **Prescription Medications**: 48-hour notice is required for any refill requests. Refills are given at provider's discretion. No refills will be authorized for patients who have not been seen in over 6 months. Our providers may request that your primary care provider take over refills on medications we prescribe.

_____ **Non-English speaking patients**: We recommend bringing a companion that can translate.

_____ **Chaperone requests**: you may request a second staff member be present during your meeting with the provider.

_____ **Surgery Cancelation**: surgeries canceled within 14 days of the procedure are subject to a **$500** fee.

_____ **Surgery Rescheduling:** surgeries rescheduled within 14 days of the procedure are subject to a **$250** fee.

I have reviewed the Virginia Neurosurgeons PLC Office and Financial Policy. By providing my signature below, I acknowledge that I have read, understand, and approve all of the above.

Signature: _____ **Date:** _____

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HIPAA Privacy Act

Patient Authorization to Use and Disclose Protected Health Information

Patient name: _____ Date: _____

Family Member or Physician Name	Relationship	Address/Phone Number

*I authorize my physician(s) and office staff at Virginia Neurosurgeons to use, retrieve or disclose my protected health information (PHI) to / from the parties (ex**: family members, physician(s), and/or facility**) listed below. This information may pertain to my diagnosis and treatment, laboratory test results, medical history, billing information, ordering and treating physicians, and/ other relate information, including but not limited to HIV and drug testing information.*

Signature of patient or representative: _____ Date: _____

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New Patient Medical History

Welcome to Virginia Neurosurgeons. Please take the time to fill out the entire enclosed packet as providing complete information will allow us to develop a safe and effective treatment plan for you. Please return all forms to the front desk on the day of your visit.

Date:	
Last name:	First name:
Date of birth: Age:	Sex: Gender identity:
Height:	Weight:

Primary Complaint

What is the **reason** for your visit today? _____

What are your **symptoms**?

_____

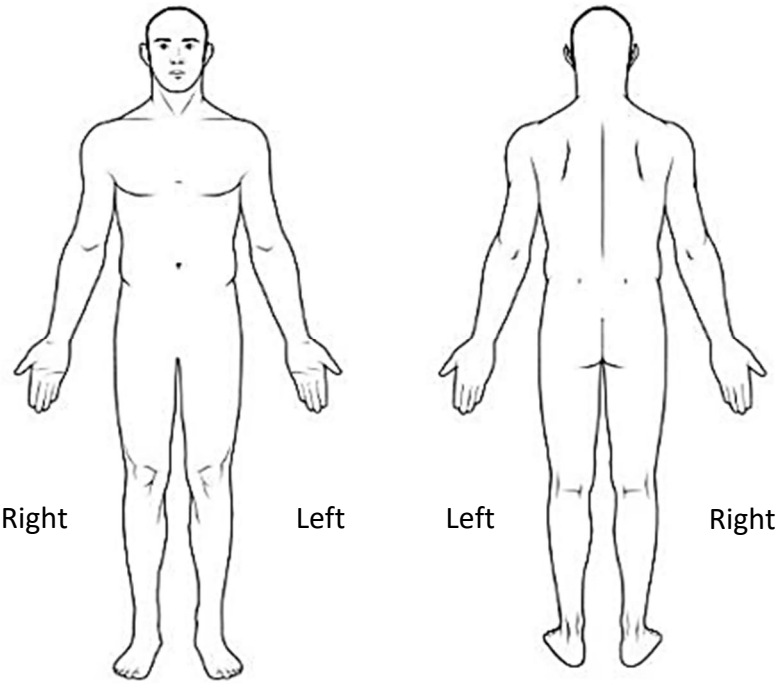
_____

_____

_____

_____

Please **draw** where you are feeling these symptoms on images to the right.



When did this problem begin? _____

Is this problem related to: □ Work injury □ Motor Vehicle Accident □ Other: _____

Please check any of the following **treatments** you have had for this problem:

□ Physical Therapy □ Spinal Injections □ Acupuncture □ Chiropractic manipulation

□ Massage therapy □ Medications (*list*):_____

Have you had any **imaging or diagnostic studies** for this problem in the last 2 years? Please list:

Diagnostic Study	Body Part Studied	Approximate Date	Hospital/Imaging Center
X-ray			
MRI			
CT Scan			
EMG			
Bone Density			
Other			

Please check if you experience any of the following:

Constitutional	□ fever □ chills □ night sweats □ fatigue □ appetite change □ headaches
Eyes/Ear/Nose	□ blurry vision □ double vision □ hearing loss □ ear ringing □ nose bleeds
Cardiovascular	□ chest pain or tightness □ palpitations □ fainting
Respiratory	□ shortness of breath □ cough □ wheezing
Gastrointestinal	□ abdominal pain □ nausea □ vomiting □ diarrhea □ constipation
Genitourinary	□ incontinence (leakage) □ frequent urination □ urine slow/difficult to flow
Musculoskeletal	□ joint pain □ joint swelling □ muscle pain □ leg swelling □ limb weakness
Skin	□ rash □ redness □ itching □ swelling □ skin infection
Neurologic	□ dizziness □ memory loss □ seizures □ speech changes □ numbness
Psychiatric	□ anxiety □ depression □ hallucinations □ excessive stress
Endocrinologic	□ hot/cold intolerance □ recent weight gain □ recent weight loss
Hematologic	□ abnormal bleeding □ easy bruising

Medical History

Check all that apply and add details below:

□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Blood clots
□ Cancer (type):_____
□ COPD
□ Depression
□ Diabetes
□ Epilepsy
□ Glaucoma
□ Heart disease
□ Heart attack
□ Hepatitis
□ HIV/AIDS
□ High cholesterol
□ High blood pressure
□ Irregular heartbeat
□ Liver disease
□ Kidney disease
□ Meningitis
□ Neuropathy
□ Osteoporosis
□ Pacemaker
□ Pancreatitis
□ Peripheral vascular disease
□ Seizures
□ Stroke/TIA
□ Thyroid disease
□ Tired of paperwork

Other: _____

Surgical History

Surgery	Hospital/Surgeon Name	Approximate date

Allergies

□ *Check if no known medication allergies*

Medication or Food Name	Reaction

Allergy to iodine or IV contrast: □ No □ Yes – reaction:_____

Current Medications (including over the counter medications and supplements)

□ *Check if you do not currently take any medications or supplements*

Name	Dose	Frequency	Indication
If more space is needed, use the back of this form and check here: □			

Are you currently taking any medication to prevent blood clots, or *blood thinners*? (ex: aspirin, coumadin/warfarin, Xarelto, Eliquis, Pradaxa)

□ No □ Yes – specify: _____

Social History

Living arrangement: □ Alone □ Roommate □ Spouse □ Children □ Parents/sibling
□ Assisted living □ Other facility: _____

Marital Status: _____

Tobacco use: □ Never □ Current □ Past (quit date: _____)
If yes, how many packs per day? _____ *How many years?* _____
Alcohol use: □ Never □ Occasional/Social □ Daily
If yes, how many drinks per week? _____
Recreational drug use: □ Never □ Current □ Past
If yes, what kind(s)? □ *Prescription drugs* □ *Marijuana* □ *Cocaine* □ *Heroin*
□ *Other:* _____

Occupation: _____
Are you currently working? □ Yes □ Retired □ Unemployed □ Disability
Does your job require lifting? □ Frequent □ Occasional □ Rare □ Never

Family Medical History

Please list major medical conditions or hereditary diseases in relatives including children:

Relation	Condition

I attest that the information provided is complete and accurate to the best of my knowledge.

Signature of patient or representative: _____ Date: _____

VIRGINIA NEUROSURGEONS PC

RICHARD MURRAY, MD | NIKHIL NAYAK, MD | MATTHEW PIAZZA, MD

Out of Network Waiver Form

(Secondary Insurance)

Date of Service: _____

Patient Name: _____ Date of Birth: _____

Insurance: _____

Your signature below signifies that you clearly understand that Virginia Neurosurgeons PC, is **NOT** a member of your managed care plan. Because the doctor is NOT on your plan, the expenses for today's visit will be your responsibility. This means you will have to pay the doctors for any allowed patient responsibility as determined by your primary insurance and this amount will be collected today.

Our office will file a claim to your carrier as a courtesy.

Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is **NOT** part of the plan or network.

Do not sign this form unless you positively understand the consequences of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the non-participating physician today.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

1625 N. George Mason Drive, Suite 445 | Arlington, VA 22205 | Tel: 703.248.0111 | Fax: 703.248.0046