

## 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? ( <u>Please initial</u> ): 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? ( <u>Please initial</u> ): 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: \_\_\_\_\_

## 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.
- \_\_\_\_\_ There is a \$15 administrative fee and \$.50 per page for up to 50 pages/ \$0.25 per page thereafter for medical records requests and letters.
- \_\_\_\_\_ There is \$15 fee for a letter from providers
- \_\_\_\_\_ There is \$35 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 Cancellation:** 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: \_\_\_\_\_

## HIPAA Privacy Act

### Patient Authorization to Use and Disclose Protected Health Information

Patient name: \_\_\_\_\_

Date: \_\_\_\_\_

Family Member or Physician Name  
Number

Relationship

Address/Phone

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*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: \_\_\_\_\_

## 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**?

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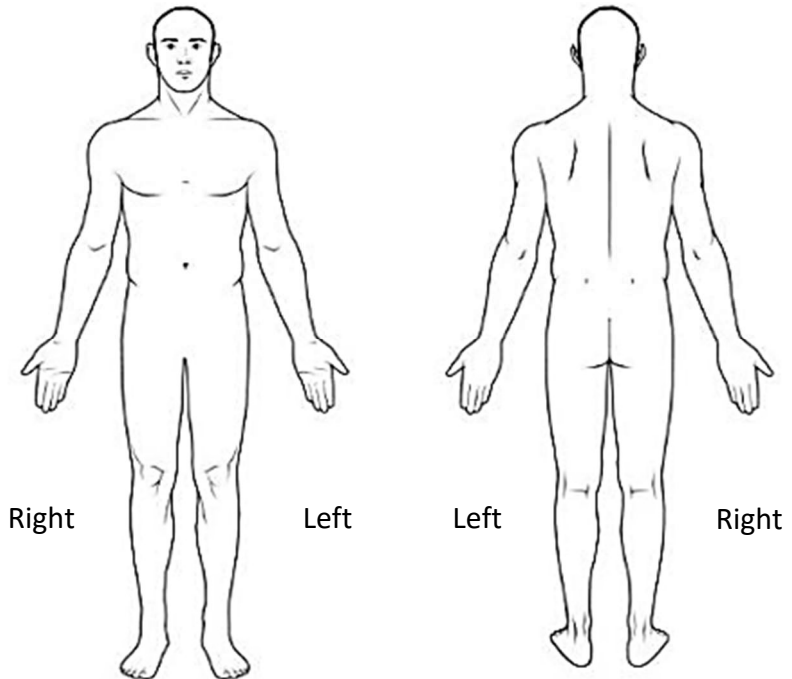


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Please **draw** where you are feeling these symptoms on images to the right.



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

### Medical History

*Check all that apply and add details below:*

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

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: \_\_\_\_\_