CNI California Neurosurgical Institute * Neurosurgical Associates of Los Angeles
23929 McBean Parkway Suite 215 Valencia, Ca. 91355 P 661-799-2542 F 661-253-0248
8307 Brimhall Road Suite 1706 Bakersfield, Ca. 93312 P 661-414-9100 F 661-735-3960
16260 Ventura Blvd. Suite 700 Encino, Ca. 91435 P 747-206-5424 F 747-206-5422

PATIENT REGISTRATION FORM PATIENT IDENTIFICATION

◯ Male ◯ Female ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Domestic Partner

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone _____ Cell Phone_____ E-Mail _____ _____

Social Security # _____ _____ Driver's License # _____DOB: _____ _____ Age _____

If child, Parent's Name_____

Patient Occupation _____ Employer _____

Emergency Contact _____ Phone _____
(Name and Phone # of Relative or Friend not residing with you)

Referring Physician _____ **Referring Physician Phone** _____

Primary Care Physician (PCP) _____ **PCP Phone** _____

Pharmacy _____ **Phone Number** _____

Do you have an Advanced Directive on file __ Yes ___ No Where _____?

Is this a accident or work related injury ◯ Yes ◯ No
Date of Injury _____ Claim # _____

Adjuster's/ Attorney Name _____ Adjuster's/ Attorney Pone_____

Workers Comp Carrier _____ Worker's Comp Phone _____

For Workers compensation claims, please ask for additional form during your office visit.

INSURANCE INFORMATION- MUST BE FILLED OUT IN FULL ALONG WITH A COPY OF YOUR INSURANCE CARD

Please present your insurance card to the receptionist at the beginning of your office visit.

Primary Insurance Company _____ Subscriber ID _____

Group ID _____ Subscriber name _____ Date of Birth ___/ ___/_____

Relationship to the patient _____

Secondary Insurance Company _____ Subscriber ID _____

Group ID _____ Subscriber Name _____ Date of Birth ___/___/ _____

Relationship to the patient _____

How did you hear about our office _____

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MEDICAL INFORMATION

Please describe the medical problem or reason for today's visit.

_____

_____

_____

Current Medications:

_____

_____

Allergies to Medications:

_____

_____

Do we have your permission to run your Prescription Eligibility? ___ Yes ___ No

Other Physicians currently treating you _____

Please list any previous surgeries or hospitalizations, including live births and miscarriages.

_____

_____

Are you pregnant o Yes o No planning a pregnancy o Yes o No Nursing a child o Yes o No

Do you Smoke o Yes o No o Cigarettes o Pipe o Cigars
If yes how many years _____ how much per day _____
Interested in quitting o Yes o No **WE DO ASK OUR PATIENTS TO STOP SMOKING PRIOR TO SURGERY**

Do you drink alcohol o Yes o No If so how many ounces/drinks per day _____

PERSONAL MEDICAL HISTORY- CHECK ALL THAT APPLY TO YOU

o AIDS/HIV	o Asthma	o Kidney Disease
o Hypertension	o Endocrine Disorders	o Osteoarthrosis
o Heart attack	o Cancer _____	o TB or other lung disorders
o Stroke	o Diabetes	o Ulcers
o Headaches	o Arthritis	o Skin Disorders
o Glaucoma	o Difficulty hearing	o Hepatitis
o Allergies or Eczema	o Anemia	o Coronary Artery Disease
o Depression	o Hemophilia	o Ulcers
o Liver Disease	o High Cholesterol	o Urinary Tract infections

Please list any other conditions

_____

FAMILY MEDICAL HISTORY CHECK ALL THAT APPLY TO YOUR FAMILY

	Father	Mother	Siblings	Children
High blood pressure				
Epilepsy				
Cancer				
Heart attacks				
Stroke				
Diabetes				
Asthma				

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INTAKE QUESTIONS

Why are you here today? ____ Back pain ___ Neck pain ___ Brain Disorder

Describe your symptoms

___ sharp ___ aching ___ tingling ___ burning ___ cramping ___ electric like

___ numbing

When did your symptoms begin? ____ Days ago ___ Months ago ___ Years ago

Have your symptoms increased Yes No

What worsens your symptoms _____

PREVIOUS CONSERVATIVE TREATMENT OF THE SPINE

NSAIDs/ASA/Acetinomphen only	Yes	No
Chiropractic	Yes	No
Corset/Brace	Yes	No
Any narcotic use	Yes	No
Anti-Inflammatory Agents	Yes	No
Physical Therapy	Yes	No
Epidural Injections	Yes	No

How many injections in the last 12 months? _____ Date of most recent injection _____

Did you get any relief from the injections?	Yes	No
Prior surgeries on the spine or/and brain?	Yes	No
Acupuncture	Yes	No

PREVIOUS SERGICAL TREATMENT OF THE SPINE

___ Discectomy ___ Fusion ___ IDET

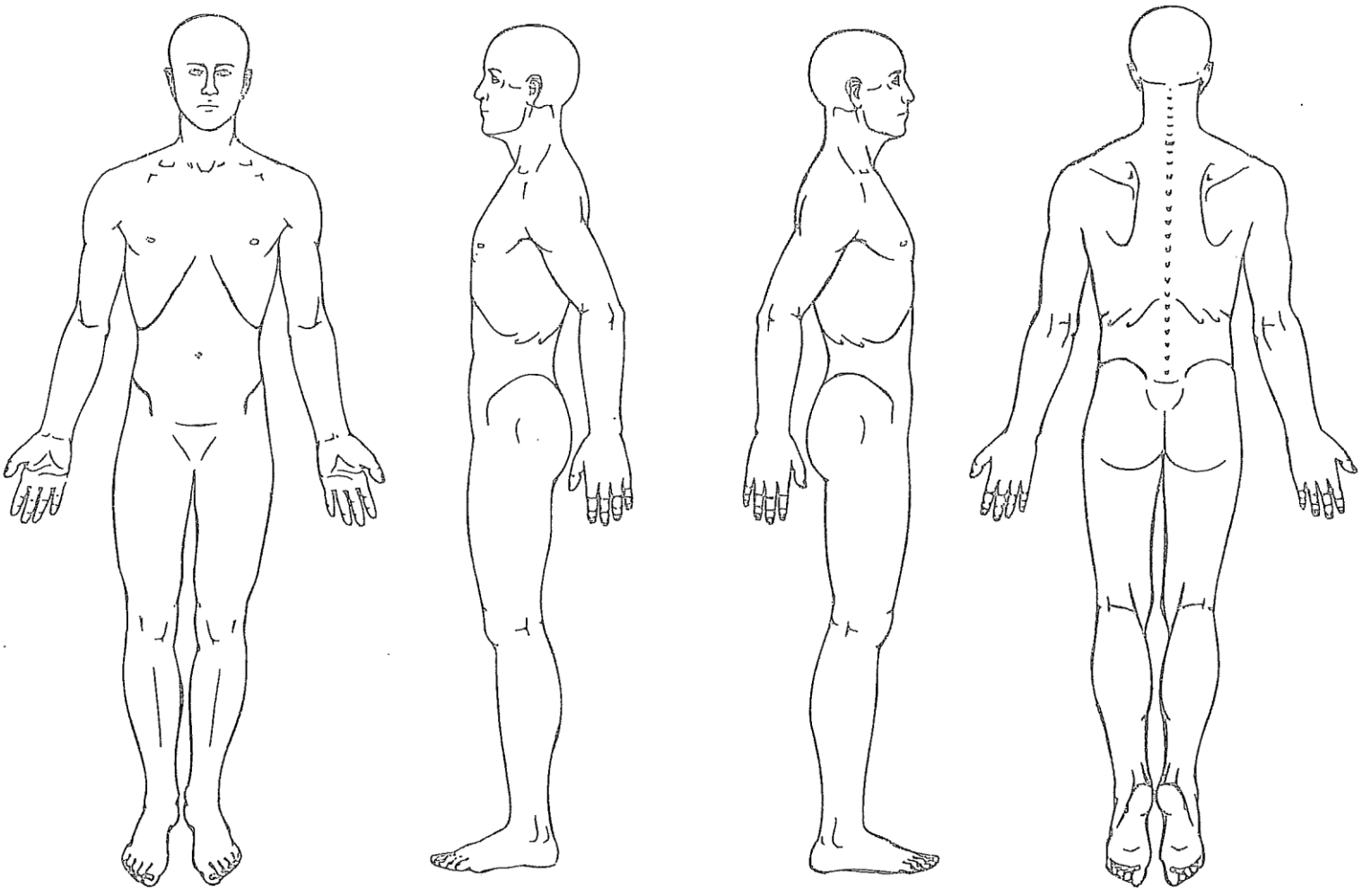
___ Laminotomy ___ Other _____

PAIN ASSESSMENT

Name: _____ Date: _____

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below.



3. Next to each area marked above, please note the intensity of pain.

No Pain		Minimal		Tolerable, but hinders activities		High - 50% of activities impaired		Extreme - most activities impaired		Unbearable
0		1	2	3	4	5	6	7	8	9

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PATIENT RESPONSIBILITY POLICY

Patient Responsibility Policy **Patient Initial** _____

Patients are responsible for knowing which facility is participating with their insurance carrier in regards to hospitals, outpatient testing, labs and etc. The purpose of this policy is to ensure all patient financial responsibilities are collected in a timely manner. We expect our patients to know their financial responsibilities.

Authorizations **Patient Initial** _____

Prior authorization to see our physician for consultations and evaluations are required before seeing our physicians. If you are a NEW PATIENT, it is your obligation to request an authorization from your primary care physician (PCP) or designated workers comp. case manager before making an appointment. Authorizations to see our physicians as follow up care will be obtained by our office staff. IF you are an existing patient and would like to see our physicians for a NEW HEALTH PROBLEM, we require that you contact your PCP to obtain a new authorization under your current health condition. All surgery or procedures authorizations will be obtained by our clinic staff before any services are rendered.

Copayments **Patient Initial** _____

If you are not prepared to make your copay, your appointment will be rescheduled. If your insurance does not pay 100% you are responsible for paying the balance before each visit and or surgery. If you are self- pay, all visits will require payment at them time services are rendered. No surgery will be scheduled until financial arrangements have been made. All balances after your insurance have been processed will be due in full after 30days. Any patients placed in collections must pay any prior balance owed to the practice and the collection agency fee in cash or cashier's check before the practice will see you again.

Return Checks **Patient Initial** _____

All returned checks are subject to a processing fee of $35.00 per transaction. This fee, along with the original amount of the check, will be due within 10 business days of the official notification given from Neurosurgical Associates of Los Angeles, Inc. A returned check, against a closed account or an account with non-sufficient funds (NSF), is in violation of civil law and, in certain situations (e.g. checks written over $100), criminal law.

Eligibility **Patient Initial** _____

In the event you seek medical care at Neurosurgical Associates of Los Angeles, Inc. and are not eligible with your insurance carrier or medical group at the time of service, you will be held financially responsible for all charges.

Paperwork **Patient Initial** _____

Disability paperwork and other forms will not be filed out by Neurosurgical Associates of Los Angeles, Inc. unless the patient has had a surgery performed. If you would like paperwork completed, this can be arranged: However, a fee will be assessed of $20.00-$35.00, depending on the complexity of the forms and medical records to be assessed by our physicians and or staff.

Missed/Cancelled Appointments **Patient Initial** _____

A $25.00 charge will be applied to missed appointments and appointments cancelled without 24 hours' notice. Appointment reminders are done as a courtesy only and do not constitute a timely phone call or failure to appear.

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PATIENT RESPONSIBILITY POLICY CONTINUED

Phone Calls **Patient Initial** _____

Phone calls should be limited to urgent matters and questions. Please allow 24-48 hours for a response from our office. If you feel that this time is not soon enough. Call 911 or go to your local urgent care center or emergency room. Office staff can neither answer medical questions nor give test results. A follow-up appointment must be scheduled for results. If extensive care is needed, including multiple or extended phone calls from our practice, a charge may be applicable.

Refills on Medications **Patient Initial** _____

Our office will not continue to fill your medications if you have not had a surgery or procedure with us. We must be seeing you on a routine basis to refill medications. If it has been over a month since we have seen you, we will ask you to schedule a clinic appointment.

Narcotic Medications **Patient Initial** _____

For narcotics, a written prescription must be made. Theses can not under any circumstances be called into your pharmacy. For all other medications, please call our office or ask your pharmacy to fax refill request to our office.

We Do Not call medications into the pharmacy. For all medications, please allow 48 hours for our office to process your request. It is your responsibility to ensure you have enough medication until your refill is processed. Refills will not be filled on weekends or holidays. We must see you for follow-up in clinic at least once a month to refill narcotic medications, to re-evaluate your pain and the effectiveness of your medication and to make changes as needed.

Physician-Patient Arbitration Agreement **Patient Initial** _____

By signing the Physician-Patient arbitration agreement you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

Images

Please bring your most recent images on a CD to your appointment. If you do not have your images your appointment will be rescheduled.

Patient Initial _____

_____ _____

Patient or Patient Representative's Signature Date

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Neurosurgical Associates of Los Angeles
Brain & Spine Center

PHYSICIAN-PATIENT ARBIRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both Parties to this contract, by entering into it are giving up their constitution rights to have any such dispute decided in court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the other and the mother's expected child or children.

All claims for monetary damages damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator)shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party of such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action and upon such intervention and joinder and existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree to provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of of civil procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California stature of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence With respect to any matter not herein expressly provided for , the arbitrators shall be governed by the California Code of civil Procedure provisions relating to arbitration.

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Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of the arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MEALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Date: _____
Patient's or Patient Representative's Signature

By: _____
Print Patients Name

By: _____ Date: _____
Physicians or Authorized Representatives Signature

By: _____
Print Physician or Representatives Name

A signed copy of this document is to be given to the Patient. Original is to be filed in the Patients medical records

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MEDICAL PRACTICE POLICY & HIPAA INFORMATION

Thank you for choosing California Neurosurgical Institute as your healthcare provider. We are committed in providing you the highest quality and efficient health care. Please familiarize yourself with our policies and procedures to ensure you know your responsibility as a patient.

INSURANCE Plans
To meet the needs of our patients, we participate in various insurance programs. Each insurance company has its own specific guidelines regarding the level of care and patient financial responsibility. Please understand that insurance billing can be a long and difficult process for our office. Please read and initial next to your category of insurance listed.

HMO Plans
All co-pays must be satisfied each and every visit. This is due to contracting and compliance rules. You are responsible for getting proper co-pay information in advance of your appointment.

PPO Plans
We have agreed to accept the discounted rate from your Insurance plan, however all co-insurance is your responsibility. After your primary insurance has paid, we will send you a statement for the remainder applied to your responsibility by your insurance carrier.

MEDICARE
After your insurance has cleared we will send you a statement for the co-payment you are responsible for.

SECONDARY INSURANCE
Having more than one insurance, does not necessarily mean that your services are covered 100%. As a courtesy we will bill your secondary insurance carrier. You are responsible for any balances after your insurance has paid.

OUT OF NETWORK PPO Plans
We will bill your insurance carrier as a courtesy. In the event charges are applied to your responsibility by your insurance carrier, we will bill you directly.

Please be sure to tell us when any of the following occur

- You change insurance companies
- You change plans with the same insurance company
- You change your home address and phone number

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HIPAA

The federal government has mandated that every patient in the practice sign a form acknowledging that they know that a privacy policy is available. This privacy policy is known as the Health Insurance portability and accountability act of 1996 (HIPAA), and it details how we can use your medical information. The office staff has training in medical privacy matters and we make every possible effort to ensure that your medical information is kept private and is used appropriately.

Please be assured patient privacy will be regarded with the utmost importance. Our employees signed a statement of confidentiality before they began working at California Neurosurgical Institute. It is our intention to abide according to the Federal Government Regulation known as HIPAA.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Neurosurgical Associates of Los Angeles to convey to any physician and/or any medical facility directly involved with my care, my medical history, laboratory reports, x-ray, and any other material services, consultations and treatments which I received while under his/her care.

Patient name (please print) _____

Signature _____ Date _____

The signature below indicates patient above received the HIPPA notice of privacy practices of Neurosurgical Associates of Los Angeles.

Patient signature _____ Date _____

Person Financially Responsible if Patient is a Minor

Name _____ DOB _____ Phone _____

Address _____ City _____ State ____ Zip _____

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PATIENT RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

a. I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
b. Co-payments are due at time of service.
c. If my plan requires a referral, I must obtain it prior to my visit.
d. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to **Neurosurgical Associates of Los Angeles, Inc.** on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize **Neurosurgical Associates of Los Angeles, Inc.** to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

MEDICARE REQUEST FOR PAYMENT

I Request payment of authorized Medicare benefits to me on my behalf for any services furnished me by or in **Neurosurgical Associates of Los Angeles, Inc.** I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Date

CNI California Neurosurgical Institute
Brain & Spine Center * Neurosurgical Associates of Los Angeles
Valencia Bakersfield Encino
www.calneuro.org

Informed Consent for Telemedicine Services

Patient Name:_____ Date:_____

Date of Birth:_____

Physician Name:_____

I understand the telemedicine is the use of electronic information and communication technologies by health care provider to deliver services to an individual when he/she is located at a different site that the provider: and I hereby consent to **Neurosurgical Associates of Los Angeles, Inc.** providing health care services via telemedicine. I understand that the laws that protect privacy and the confidentiality of the medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/Audit. I understand that I will be responsible for co-payments or co-insurance that apply to telemedicine visit. I understand I have the right to withhold or withdraw my consent to the use of telemedicine visit. I understand that I at any time without affecting my right to future care or treatment. I may revoke my consent in writing by contacting **Neurosurgical Associates of Los Angeles, Inc.** 23929 McBean Parkway Suite 215, Valencia, Ca. 91355. As long as this consent is in force Neurosurgical Associates of Los Angeles, Inc. may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient or Person authorized to sign for

patient_____ Date:_____

If authorized signer, relationship to patient:_____

CNI California Neurosurgical Institute

Neurosurgical Associates of Los Angeles, Inc. **Appointment Date** _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ DOB : _____

OVER THE LAST 2 WEEKS HOW OFTEN HAVE YOUR BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS

1. **Little interest or pleaser in doing things**
   - **0. Not at all**
   - **1. Several Days**
   - **2. More than half the days**
   - **3. Nearly everyday**
2. **Feeling down, depressed, or hopeless**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly everyday**
3. **Trouble falling or staying asleep, or sleeping too much**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**
4. **Feeling tired or having little energy**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**
5. **Poor appetite or over eating**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**
6. **Feeling bad about yourself – or that you are a failure or have let yourself or your family down**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**

CNI California Neurosurgical Institute

Neurosurgical Associates of Los Angeles, Inc. **Appointment Date** _____

Patient Health Questionnaire (PHQ-9)

7. **Trouble concentrating on things, such as reading the newspaper or watching television**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**
8. **Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**
9. **Thoughts that you would be better off dead or of hurting yourself in some way**
   - **0. Not at all**
   - **1. Several days**
   - **2. More than half the days**
   - **3. Nearly every day**

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

- **Not difficult at all**
- **Somewhat difficult**
- **Very difficult**
- **Extremely difficult**

FOR OFFICE CODING:

Total score of 1's	Total score of 2's	Total Score of 3's	Overall score
_____	_____	_____	_____