Please download the forms, fill them out and bring them to your appointment. Do not submit the forms to us online.

# Metropolitan Neurosurgery, PA
# Patient Registration Form

Patient Name______________________________________________Birthdate______________
Last First MI

Address______________________________________________________________________
Street City State Zip

Home Phone______________________ Work Phone______________________ Cell Phone______________________

Email Address____________________________ Social Security # ______-_____-______

Referred by__________________________ Primary Doctor____________________________________

Race: White Asian Black or African American Hispanic Other________________________________

Marital Status: S M D W Separated___ Spouse Name____________________ Preferred Language____________

Emergency Contact____________________Relationship__________________Phone #_________________

**Responsible Party**
**(If Other Than Above)**

Name________________________________________________________Relationship____________
Last First MI

Birthdate __________ Social Security # ______________Employer ______________Work Phone ____________

Home Address ____________________________________________________ Home Phone ____________
Street City State Zip

**Insurance Information**

**A copy of your insurance card will be taken at the time of your appointment.**

**Primary:**
Health Auto Work Comp Liability (circle one)
Insurance Company Name____________________
Address ______________________________
Adjuster ______________________________
Phone #________________ Date of Injury ______
Policy Holder __________________________
Claim or ID # __________________________
Group #______________________________

**Secondary**
Health Auto Work Comp Liability (circle one)
Insurance Company Name____________________
Address ______________________________
Phone # ______________________________
Policy Holder __________________________
ID # ______________ Group # ______________

**Attorney Information**

Attorney Firm ________________________Attorney Name ______________________________
Address ____________________________Phone # __________________________________

**Assignment/Release of Information Authorization**

I, the undersigned, hereby authorize payment of medical/surgical benefits directly to Metropolitan Neurosurgery, P.A. I authorize the release of my records to my insurance if required for claims submissions. I realize that all medical/surgical charges and accrued interest incurred by me, or my dependents, for services rendered at Metropolitan Neurosurgery, P.A. are my financial responsibility. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary. A photo copy of this original may be used in lieu of the original.

Signature ______________________ Relationship to Patient ______________________ Date ____________

**METROPOLITAN NEUROSURGERY, PA**
**PATIENT HEALTH HISTORY FORM**

Today's Date: ______

**PLEASE ANSWER ALL QUESTIONS:.**

Patient Name: ____________________ Birth Date: ____________ Weight: ________

Requesting Physician: ____________________ Family Doctor/Clinic: ____________________

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Why are you seeing the doctor today? ________________________________________
Was this condition related to a WORK injury? YES NO
If yes, what date did the injury occur? ____________
Was this condition related to an AUTO accident? YES NO
If yes, what was the date of the accident? ____________
Was this related to any OTHER type of injury? YES NO What was the date of injury? ________
Describe the injury. ________________________________
Have you been treated elsewhere for this condition? Yes NO
If yes, where? ________________________________

**Past Medical History:**
List all previous hospitalizations or surgeries:

________________________________ Date: ________
________________________________ Date: ________
________________________________ Date: ________

**List all Medical problems and Conditions that you have had or currently have:**

________________________________ Date: ________
________________________________ Date: ________
________________________________ Date: ________

**Medications:**
List any medications you are currently taking:

| Name: | Dosage (Milligrams) | Frequency (# times per day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**INCLUDING OTC MEDICATION SUCH AS ASPIRIN OR VITAMIN E**
**Allergies:**
Are you allergic to any medications? If yes list:
________________________________
Type of reaction: ____Rash _____Hives _____Severe Reaction _____ Intolerance ____ anaphlaxis ____ Other__________
**ARE YOU ALLERGIC TO LATEX?** ___________
**Health Habits:**
Do you use tobacco in any form? YES NO If yes, how much? ____________________ Type:__________________
Do you drink alcohol? YES NO If yes, how much? ____________________
Have you ever used IV drugs? YES NO
Do you use herbs, vitamins or nutritional supplements? YES NO
If yes, please list: ________________________________

**PLEASE CIRCLE IF YOU HAVE A: DEFIBRILLATOR OR PACEMAKER**

**Family History:**

Do you have a family history of arthritis or disease of the muscles, bones or nervous system? YES NO
If yes, please describe: ____________________________________________________________

Do you have a family history of cancer? YES NO
If yes, please describe: ____________________________________________________________

Do you have a family history of bleeding/clotting problems? YES NO
If yes, please describe: ____________________________________________________________

Do you have a family history of any other diseases you would like your doctor to know about? YES NO
If yes, please describe: ____________________________________________________________

**Employment/Social History:**

Are you currently employed? YES NO If yes, what is your occupation? ____________________
How long? ____________________________ Employer: ___________________________________
Is your work ___Heavy ____ Medium ____ Light ____ Sedentary
Do you have any current work restrictions? YES NO
If yes, please describe: ____________________________________________________________
What is your marital status?
(circle one) Single Married Widowed Divorced Separated
Who lives with you? _________________________________ Pets? _____________________

**Review of Systems:**

Do you currently have any problems in the following areas? If yes, please provide additional information.

| | YES | NO | Details |
|---|---|---|---|
| GENERAL (fever, heat stroke, wt loss/wt gain, fatigue, difficulty sleeping) | | | |
| EARS, NOSE, THROAT (hearing, sinus, earache, cough, dry mouth) | | | |
| EYES (vision problems, blind spots, glaucoma, eye pain) | | | |
| CARDIOVASCULAR (High BP, racing pulse, blood clots) | | | |
| RESPIRATORY (congestion, wheezing, shortness of breath, COPD) | | | |
| URINARY, KIDNEY, BLADDER (painful urination, frequency, incontinence, ect) | | | |
| MUSCLE, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, gout, etc) | | | |
| DIGESTIVE (heart burn, nausea, indigestion, abdominal pain, bloating) | | | |
| SKIN (rashes, growths, warts, etc) | | | |
| NEUROLOGICAL (numbness, headache, seizures, paralysis, etc) | | | |
| PSYCHIATRIC (anxiety, depression, insomnia) | | | |
| ENDOCRINE (diabetes, thyroid, etc) | | | |
| BLOOD/LYMPH (bleeding, enlarged lymph nodes, problems with blood transfusions) | | | |
| ALLERGIC/IMMUNE (sneezing, swelling, redness, itching, hives, lupus, etc) | | | |

Patient Signature: ___________________________________________________ Date: _______________

Physician Signature: _________________________________________________ Date: _______________

1/20/17

# METROPOLITAN NEUROSURGERY FINANCIAL POLICY

To all Patients:

The intent of this document is to inform you of Metropolitan Neurosurgery, P. A.'s (referred to in this policy as MET) Financial Policy. It is the philosophy of MET that all of our patients receive the best possible care and service; therefore, your complete understanding of our financial policy as it relates to your financial obligations is an essential part of our philosophy. Please read this document thoroughly and sign and date the bottom indicating you understand and agree to comply with these policies.

- Payment for all services provided by our practice is due in full at the time of service. Exclusions to this policy are those patients who are members of a health care organization that MET participates with, Medicare, Medicaid, or confirmed Workman's Compensation patients.
- You are responsible for your deductible and any other charges for services not covered by your insurance policy such as routine care, preventive services, etc.
- Patients with no insurance coverage will be required to remit a $200 deposit before their appointment. This is the average cost of a first consult. If the charged amount is less than $200 the patient will be promptly refunded.
- If you are covered under an insurance policy that MET has a participating contract with, we will file your claims with that organization. You will be expected to pay your co-payment at the time you arrive for your appointment. All other balances not covered by your plan will be billed to you after your insurance company settles your claims. If you have questions or disputes on claims settlements done by your insurance company, we encourage you to contact them for satisfactory resolution.
- If MET does not have a contractual agreement with your insurance carrier, our insurance department will bill available insurance carriers as a courtesy to you, the patient. However, you are still responsible for the full payment of the services if we have not received payment from your insurance company within 90 days.
- All patients will receive a monthly statement when there is an appropriate patient balance due. Balances left after we have received payment from your insurance carrier OR communication that your health plan has deemed services to be non-covered, are appropriate patient balances. All patient balances are payable in full within 30 days after receipt of your statement unless other acceptable arrangements have been set up with our Business Office.
- In the event you are hospitalized, we will bill all services rendered by MET physicians to your health plan provided we have correct insurance information. Prior authorizations that may be required by your insurance company for hospitalization are your responsibility to obtain.
- It is the policy of MET that any patient at the age of eighteen years or older will be financially responsible for all charges incurred by them. MET does not get involved with divorce or separation. For any patient under the age of eighteen, the parent who accompanies the minor for their visit will be financially responsible for all charges incurred.
- MET accepts Cash, Personal Checks, Visa/MasterCard, or Money Orders as payment for services rendered.
- A $25.00 Returned Check Fee will be assessed to the account for every check returned to MET for insufficient funds or closed accounts.
- If refunds are warranted, they will be sent to you in the form of a check regardless of the form of payment used by the patient.
- There may be additional charges applied to your account if MET is asked to participate in a Deposition, Phone consultation or producing of Medical Records for the purpose of Insurance Verification.
- MET reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy.

I, ________________________________________have read and understand the above Financial Policy of Metropolitan Neurosurgery, P. A. I agree to the terms outlined in this policy and understand that if I do not adhere to this policy; my account may be turned over to a collection agency for payment of debt.

SIGNATURE:_______________________________________________ DATE:_____________________________

# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## INTRODUCTION

At Metropolitan Neurosurgery, PA, we are committed to treating and using protected health information about you responsibly. We are required by law to provide patients with a notice of our legal responsibilities and privacy practices. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

## UNDERSTANDING YOUR HEALTH RECORD INFORMATION

Each time you visit Metropolitan Neurosurgery, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- a source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for planning and marketing, and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may Access your health information, and make more informed decisions when authorizing disclosure to others.

## YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Metropolitan Neurosurgery, PA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

## OUR RESPONSIBILITIES

Metropolitan Neurosurgery, PA, is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will give you a new copy at the first scheduled appointment time following the change.

## FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below:

***Office for Civil Rights***
U. S. Department of Health and Human Services
200 Independence Avenue, S. W.
509 F, HHH Building
Washington, DC 20201

***We will use your health information for treatment.***

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from this facility.

***We will use your health information for payment.***

For example: A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

***We will use your health information for regular health operations.***

For example: Members of the medical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

***We will use your health information for communication with family.***

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care

***Business Associates:*** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contacted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associated to appropriately safeguard your information.

***Notification of Appointments:*** The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or, a brief non-specific message may be left on your answering machine.

***Research/ Teaching/Training:*** We may use your information for the purpose of research, teaching, and training.

***Funeral Directors:*** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

***Organ Procurement Organizations:*** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and implant.

***Law Enforcement:*** We may disclose health information to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

***Public Health:*** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

***Marketing:*** We may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you

***Food and Drug Administration (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

***Workers Compensation:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

***Inmates:*** We may use or disclose your protected health information if you are an inmate of a correction facility and your physician created or received your protected health information in the course of providing care to you

***Health Oversight:*** Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

***Other Uses and Disclosures:*** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you object to any of the above, notify this office in writing, within 30 days of receiving this notice. However, your decision to revoke authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

## AUTHORIZATION AND CONSENT FORM

**Please initial highlighted areas**

__________ **General Release of Information & Assignment of Benefits:**
**I authorize METROPOLITAN NEUROSURGERY, P.A., on behalf of myself and/or my dependents, to furnish medical records, including films and other information related to health care services provided by METROPOLITAN NEUROSURGERY, P.A., to Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hereby assign all authorized medical and surgical benefits to which I am entitled and I request payment of all such authorized benefits be made on my behalf to METROPOLITAN NEUROSURGERY, P.A. for any services furnished by METROPOLITAN NEUROSURGERY, P.A.**

__________ **Release of Information by Payers and Networks:**
**I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from METROPOLITAN NEUROSURGERY, P.A. or any other provider, with METROPOLITAN NEUROSURGERY, P.A., other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.**

__________ **Payment Agreement:**
**I understand that I am financially responsible and agree to pay for any charges for the care and treatment rendered to me not covered by my insurance plan or if I do not have active insurance coverage. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary.**

__________ **Release/Retrieval of Information to/from Health Care Facilities, Pharmacy Benefit Payers and Providers: I authorize the release or retrieval of my medical treatment information, including films, prescription medication history and other information related to such services for health care operations to or from third party pharmacy benefit payers, other health care facilities, and other providers who may be involved in my medical treatment.**

__________ **Messages:**
**I authorize METROPOLITAN NEUROSURGERY, P.A. to use and disclose medical information to contact me in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to me. METROPOLITAN NEUROSURGERY, P.A. may call me and, if necessary may leave messages on my answering machine.**

- **In addition, the following people may have access to my health information:**

________________________________________________________________________

__________ **Patient Information:**
**By initialing, I acknowledge that I have received the Notice of Privacy Practices from METROPOLITAN NEUROSURGERY, P.A.**

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**I understand all of the above and I have had the chance to ask questions and all of my questions have been answered to my satisfaction. This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at anytime and that my revocation shall have no effect on any actions taken prior to my revocation.**

| ______________________________ | ______________________________ |
|---|---|
| **Patient's Name** | **Date** |
| ______________________________ | ______________________________ |
| **Signature of Patient or Personal Representative** | **Relationship to Patient (if patient unable to sign)** |