Pacific Neurosurgery
45 Castro Street, Suite 437
San Francisco, CA 94114

PATIENT REGISTRATION		
Last Name	First Name	MI
Date of Birth	Social Security #	Gender □ M □ F
Address		
City	State	Zip
Home Phone #	Cell Phone #	
Work Phone #	Email	
Preferred Phone Number: □ Home □ Cell □ Work		
Employer	Occupation	
Employer Address		
City	State	Zip
DEMOGRAPHIC INFORMATION		
Preferred Language	Height	Weight
Ethnicity	Race	Marital Status
EMERGENCY CONTACT		
Last Name	First Name	MI
Home Phone #	Cell Phone #	Relationship

Referred by
Primary Care Physician

ADVANCED DIRECTIVES

An advanced directive is a document that you complete to be used in a situation when you can't speak for yourself and make your own decisions regarding the healthcare you want. It can do two things: (1) name the person you want to make decisions on your behalf when you can't and (2) provide that person and your health care team with information on the decision you would make if you could speak for yourself.

Do you have any type of Advanced Directive: □ Yes □ No

If yes, which type of Advanced Directive do you have:

□ Durable Power of Attorney for Health Care   □ Living Will   □ POLST

PRIMARY INSURANCE INFORMATION

Primary insurance

Policy Number or Medicare ID Number	Effective Date	Policy Type □ HMO □ PPO

Your Relationship to Insurance Holder: □ Self   □ Child □ Spouse □ Other

Name of Insured (If Different from Patient)	Date of Birth (If Different from Patient)

SECONDARY INSURANCE INFORMATION

Secondary Insurance (if applicable)

Policy Number or Medicare ID Number	Effective Date	Policy Type □ HMO □ PPO

Your Relationship to Insurance Holder: □ Self   □ Child □ Spouse □ Other

Name of Insured (If Different from Patient)	Date of Birth (If Different from Patient)

AUTHORIZATION

I hereby authorize Pacific Neurosurgery to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctors all payments for medical services rendered. I understand that I will be responsible for any legal costs and attorney's fees incurred for collection of any past due account. I further understand that I am financially responsible for all charges whether or not covered by insurance.

Signature	Date

If Minor, name of responsible party	Relationship	Phone #

PATIENT INFORMATION AND MEDICAL HISTORY

Current Medications &
Dosage (mg): _____

Allergies (Drug and/or
Medical): _____

Previous Surgical
Procedures & Approx.
Date: _____

Previous Significant
Injuries & Approx. Date: _____

Do You Drink Alcohol: □ Yes   □ No   □ Occasionally

Do You Smoke: □ Yes   □ No   □ I did smoke, but I do not smoke currently
If yes, do you smoke: □ *Everyday*   □ *Occasionally*

Do you experience any of the following?

□ Back Pain	□ STD	□ High Blood Pressure	□ Kidney Problems
□ Neck Stiffness	□ Blood Clots	□ Irregular Pulse	□ Hepatitis/Jaundice
□ Heart Problems	□ Thyroid Problems	□ Chest Pain/Angina	□ Heartburn
□ Asthma	□ Numbness/Weakness	□ Ulcers	□ Transfusions
□ Cancer/Malignancy	□ Seizure/Epilepsy	□ Bleeding Problems	□ Anemia
□ Alcohol/Drug Addiction	□ Tuberculosis	□ Diabetes	□ Difficulty Urinating
□ Arthritis	□ Stroke	□ HIV Positive/Risk	

Explanation of above/
other medical problems: _____

REVIEW OF SYSTEMS

Below, please indicate any symptoms you are currently experiencing (within the last month):

General, Constitutional	□ Good general health	□ Fever	□ Fatigue	□ Weight change

Musculoskeletal	□ Neck Pain	□ Weakness of muscles	□ Cold extremities
	□ Muscle pain/cramps	□ Lower back pain	□ Difficulty walking
	□ Joint Stiffness/Swelling		

Psychiatric	□ Nervousness	□ Depression	□ Sleep problems
	□ Anxiety or panic attacks		

Ears, Nose & Throat	□ Ringing in the Ears	□ Nose bleeds	□ Swollen glands in neck
	□ Hearing Loss	□ Earaches/drainage	□ Mouth sores
	□ Sinus Problems	□ Sore throat/voice change	

Neurological	□ Stroke	□ Paralysis	□ Memory Loss or confusion
	□ Head Injury	□ Lightheaded/dizzy	□ Migraines
	□ Numbness/ tingling	□ Convulsions/ seizures	□ Frequent headache

Heart & Cardiovascular	□ Chest pain	□ Sudden heartbeat changes	□ Swelling of feet, ankles, hands

Respiratory	□ Spitting up blood	□ Shortness of breath	□ Asthma
	□ Frequent coughing		

Eyes & Vision	□ Wear glasses or contact lenses	□ Eye disease/injury
	□ Blurred/Double Vision	

Gastrointestinal	□ Change in bowel movements	□ Nausea or vomiting	□ Frequent diarrhea
	□ Painful bowel movements	□ Constipation	□ Loss of appetite
	□ Stomach pain	□ Blood in stool	

Genitourinary	□ Sexual difficulty	□ Kidney stones	□ Painful urination
	□ Blood in urine	□ Strain with Urination	□ Incontinence
	□ Frequent urination		

Endocrine	□ Thyroid disease	□ Diabetes	□ Excessive thirst or urination
	□ Temp. intolerance	□ Glandular/hormone problem	
	□ Change in skin color	□ Rash or itching	

Skin & Breasts	□ Varicose veins	□ Breast pain	□ Breast lump
	□ Breast discharge	□ Change in hair or nails	□ Dry skin

Hematologic/Lymphatic	□ Easily bruise or bleed	□ Anemia	□ Phlebitis
	□ Transfusion	□ Slow to heal after cuts	□ Swollen glands

PATIENT'S RIGHTS

This letter is a notice of privacy practices under current HIPAA regulations. We request that you review these rights and sign below as an acknowledgement of the fact that you've reviewed them.

1. Patients have the right to access their medical records. You may request to inspect your medical records at any time. There is a fee to produce the copies.

2. You have the right to request an amendment or addendum to your medical records as you see fit. Please speak to our office staff if you have questions regarding making such an amendment or addendum upon review of your medical records.

3. You have the right to an accounting of disclosures of your medical records as requested from appropriate parties such as state or federal disability agencies, worker's compensation agencies, or referring physicians. Should you request that your medical records be sent to any other parties, such as attorney's or third parties, you must place in your medical records a release which you sign that allows such release of records to that particular party to take place.

4. You have the right to request restrictions on how we release or communicate information in your medical records. Generally we will make every effort to accommodate reasonable requests for restrictions in release of your medical records to appropriate other parties, such as referring physicians.

5. You have the right to complain about your privacy if you feel that your rights have been violated.

We will make every effort to comply with the HIPAA regulations and respect your privacy regarding your medical records. Please contact me or my staff should you have any further questions regarding this matter.

I acknowledge receipt and review of the above-noted Patient's Right.

Signature   Date

PACIFIC NEUROSURGERY OFFICE & PATIENT FINANCIAL POLICY

I agree that in return for services provided to me by Pacific Neurosurgery, I will pay any account balances at the time of service or will make financial arrangements with Pacific Neurosurgery. If co-payments, deductibles, out-of-network balances, non-covered services and/or past balances are designated by my health plan, I agree to pay those balances directly to Pacific Neurosurgery. I understand that if my account is delinquent and all efforts to collect any balances have been exhausted, it may be turned over to a collection agency.

Non-Participating Insurance Accounts

A patient who is insured by an insurance carrier with which the practice does not participate, is considered a self-pay patient. It is the patient's responsibility to inform the practice of any insurance coverage changes, to confirm the practice's participation and to verify their eligibility before each visit. I understand and agree that I am obligated to pay the full charge(s) of all services rendered to me by Pacific Neurosurgery if I belong to a plan in which Pacific Neurosurgery does not participate.

Self-Pay Patients

Self-pay patients are those who are covered by an insurance carrier with which the practice does not participate or patients without insurance at the time of service. I understand and agree that, as a self-pay patient, I am individual responsible to pay the full charges at the time of service.

HMO Referrals and Authorizations

If your insurance is an HMO (has a designated primary care physician), you are required to inform the office of this at the time of scheduling your appointment so an authorization may be obtained. If this information is not provided at the time of scheduling, you will be asked to reschedule your appointment.

Non-Covered Services

I understand that my insurance plan may not pay for all of my medical services and costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. It is the patient's responsibility to understand what your plan covers and does not cover. You will be responsible for all non-covered charges/services.

Missed Appointments

Failure to arrive for a scheduled appointment and/or failure to cancel an appointment within 24 hours will result in a missed appointment fee of $50 for each occurrence. The patient is fully responsible for this payment.

I HAVE READ AND UNDERSTAND THE POLICIES WRITTEN ABOVE

Signature   Date

CREDIT CARD ON FILE POLICY

Pacific Neurosurgery requires that all patients keep a credit card or debit card on file as a convenient way to pay for any outstanding patient balances. This is due to an increasing amount of deductibles and co-payments required by insurance companies, and to decrease the number of delinquent accounts.

We will bill your credit card, <u>ONLY</u>, in the following situations:
1. Your balance is 90+ days old and/or we have sent you at least 3 statements
2. You instruct us to bill your credit card for any outstanding balance
3. If you set up a payment plan with us

Should you decline to provide a credit card or debit card number, you will be responsible for paying any outstanding balance upon receiving a billing statement. Should you not pay your balance due after three statements, your balance will be sent to collections without further notice, and you will no longer be able to receive services by Pacific Neurosurgery until this balance is paid in full.

Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been processed by your insurance company, and the insurance portion of your claim has been paid and posted to your account.

I authorize Pacific Neurosurgery to charge the portion of my bill that is my financial responsibility to the following credit card or debit card:

Credit Card Number	
Expiration Date	CVV
Cardholder Name	
Billing Address	

I (we), the undersigned, authorize and request Pacific Neurosurgery to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. The authorization relates to all payments not covered by my insurance company for services provided to my by Pacific Neurosurgery. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Pacific Neurosurgery in writing and the account must be in good standing.

Patient Name (Print)

_____

Patient Signature   Date

_____