NEW PATIENT PACKET

Instructions

- Please complete highlighted sections only.
- For "starred"(*) pages, you must complete entire page.
- Make sure to read and understand all forms.
- Please complete all pages with most current information.
- Please return all completed forms to receptionist.
- ***Notice of Privacy Packet*** is information for you to keep.

Southern California Institute of Neurological Surgery

REFERING M.D.: _____
(Referido por)

NAME: _____ DATE OF BIRTH: _____ AGE: _____
(Nombre) (Fecha de Nacimiento) (Edad)

ADDRESS: _____ CITY: _____ ZIP: _____
(Dirección) (Ciudad) (Código)

SSN: _____ PHONE NO.: _____ CELL NO.: _____
(Seguro Social) (Número de Teléfono) (Numero de Celular)

SPOUSE NAME: _____ SSN: _____ DATE OF BIRTH: _____
(Esposo o Esposa) (Seguro Social) (Fecha de Nacimiento)

EMERGENCY CONTACT: _____ PHONE NO.: _____
(Contacto de Emergencia) (Número de teléfono)

EMPLOYER: _____ PHONE NO.: _____
(Compañía de Trabajo) (Número de Teléfono)

ADDRESS: _____ CITY: _____ ZIP: _____
(Dirección) (Ciudad) (Código)

INSURANCE INFORMATION
(INFORMACION DE SEGURO MEDICO)

PRIMARY INSURANCE: _____ ID NO.: _____
(Seguro Médico Primario) (Número de Identificación)

SECONDARY INSURANCE: _____ ID NO.: _____
(Seguro Médico Secundario) (Número de Identificación)

SUBSCRIBER: _____ SSN: _____
(Suscriptor) (Seguro Social)

WORKERS COMPENSATION INFORMATION
(INFORMACION DE COMPENSACIÓN A TABAJADORES)

INSURANCE NAME: _____ PHONE NO.: _____
(Nombre de Seguro Médico) (Número de Teléfono)

ADDRESS: _____ CITY: _____ ZIP: _____
(Dirección) (Ciudad) (Código)

ADJUSTER'S NAME: _____ PHONE NO.: _____
(Nombre de Ajustador) (Número de Teléfono)

CLAIM NO.: _____ DATE OF INJURY.: _____
(Número de Reclamo) (Fecha de Lesión)

EMPLOYER AT THE TIME: _____

ATTORNEY INFORMATION
(INFORMACION DEL ABOGADO)

NAME OF ATTORNEY: _____ PHONE NO.: _____
(Nombre del Abogado) (Número de Teléfono)

ADDRESS: _____ CITY: _____ ZIP: _____

FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Southern California Institute of Neurological Surgery and any assistant physician for services rendered. I am financially responsible for all charges whether or not they are covered by insurance or rejected by worker's compensation. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize the physician to release all information necessary to secure the payment of benefits. I hereby authorize The California Institute of Neurological Surgery to provide medical record information pertaining to the care rendered to any other Health Care provider, Hospital, Insurance Carrier and/or Worker's Compensation Carrier for the purpose of evaluation, treatment, and/or reimbursement of medical services. I further agree that a photocopy of this agreement shall be as valid as the original. This agreement will remain in effect until revoked by patient in writing.

INSURANCE

In most cases we will accept your insurance benefits. Your portion of the bill (also known as copayments/co-insurance) is to be paid at the time of service. We cannot waive or discount this fee due to our contracts with insurance companies. If not paid, we reserve the right to charge an interest of 1.5% to any unpaid balance unless other arrangements are made.

We cannot file a claim to your insurance company unless you give us your insurance information. Please present your insurance card at the of check-in. It is necessary for us to keep a copy of the card in your medical records chart.

All patients are responsible for their insurance benefits and Eligibility. We are not responsible to notify you when your insurance changes. We must be notified in to get any necessary authorization for the visit and/or procedure. If you do not notify us in a reasonable amount of time, you will be responsible for the visit and/or procedure.

Your insurance policy is a contact between you and your insurance company. We are not a party to that contract. Please be aware that some, and sometimes all, of the services provided may not be covered by your insurance.

In the event that a charge is not covered by your plan, you will be billed the balance after we obtain an Explanation of Benefits (EOB) from your insurance carrier. Outstanding charges are due upon receipt. Accounts with unpaid charges, 120 days from the original date a claim has been filed, are placed with a collection agency. You will be responsible for any collection cost.

MISSED APPOINTMENTS

We understand that schedules sometimes change with short notice, but we would appreciate the courtesy of a 24 hour notice if you need to cancel an appointment. If the appointment is not cancelled 24 hours in advance or you do not show up for a schedule appointment, you will receive an invoice with a missed appointment fee. We reserve the right to charge $25.00 for missed appointment and $250.00 for missed in-office procedures. Please help us serve you better by keeping your scheduled appointment. We try to confirm all appointments the day before; however this is a courtesy. Not receiving a reminder from our office does not release a patient from responsibility of remembering an appointment.

_____

PLEASE INITIAL

MEDICAL RECORDS REQUEST

Copies of records will be released with written patient authorization in a timely manner. Please allow us one week to complete your request. Outside request service fee is $25.00

DISABILITY/DMV FORMS

There will be a charge of $60.00 to complete an initial disability form and $25.00 for DMV forms.

RETURNED CHECKS

There will be a $25.00 service charge for all returned checks.

PRESCRIPTION REFILLS

If you need a medication refill, please contact your pharmacy and have them fax a refill request to the office. All Medication refills will be addressed within three business days of contacting the office of Dr. Mark stern. Please Give your pharmacy enough time to fax and receive an answer BEFORE you run out of your medication.

If you have not received a call back within three business days, please contact your pharmacy to see if your medication has been refilled via phone or fax. If your pharmacy has not received confirmation of your refill please call our office.

If this is a pain emergency you should go to the nearest Emergency Room in your area, Dr. mark Stern will be notified if you are admitted.

CONSENT FOR TREATMENT

I voluntarily consent to medical treatment under the professional judgement of Mark S. Stern, MD and his staff. I understand that the medical treatment performed is necessary or beneficial to my condition.

PATIENT CONFIDENTIALITY

I have read the office's PRIVACY POLICY PRACTICES and have received a copy if I so desire.

_____

PLEASE INITIAL

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

ABOUT US

Dr Mark Stern is the only Board-Certified Neurosurgeon in Northern San Diego County. He is a graduate of the Albany Medical School. Dr Stern completed his internship and residency at Georgetown University and University of Southern California. He is a member of the San Diego Medical Society, American Medical Association, California Neurosurgeons Association, and American Association of Neurosurgeons. Dr Stern has been practicing since 1984.

Dr Berman is a Board-Certified fellowship trained Spinal and Neurological Surgeon. He is a graduate of Western University and completed his fellowship in complex spine and neuro-trauma at Arrowhead Regional medical Center in Colton, CA. He has been in practice since 2004.

They work very closely with Palomar Medical Center and Tri-City Medical Center. Dr Stern is frequently on trauma call at the emergency room in addition to numerous patients at his practice. Also he performs surgeries 1 to 3 days a week.

Because of the overwhelming number of patients from the practice and hospital follow ups, there may by a long wait time for your appointment. The Dr. Stern often has to leave to the hospital between office appointments to tend to our patients that are in critical care or on trauma-call. Also the hospital calls him frequently to obtain orders for his patients that are currently in our care.

We apologize ahead of time for any inconvenience this may cause. We make every effort to notify our patients when a delay and/or reschedule is needed.

Sincerely,

The Staff and physicians at Southern California Institute of Neurological Surgery.

PLEASE INITIAL

Southern California Institute of Neurological Surgery

NAME: _____ **AGE/DOB:** _____ **DATE:** _____

PLEASE MARK ANY PROBLEMS THAT PERTAIN TO YOU

GENERAL
____WEIGHT CHANGES
____TEND TO BE HOT OR COLD
____CHANGE IN APPETITE/THIRST
____FATIGUE
____SLEEPING DIFFICULTIES
____SMOKING - __PER DAY __YEARS
____COFFEE/TEA - ___CUPS PER DAY
____ALCOHOL – AMOUNT ___

MUSCULOSKELETAL
____ACHING MUSCLES & JOINTS
____BACK & SHOULDER PAIN

CARDIOVASCULAR
____HIGH BLOOD PRESSURE
____RACING HEARTBEAT
____CHEST PAIN/HEAVINESS
____SHORTNESS OF BREATH
____DIZZY SPELLS
____SWOLLEN FEET & ANKLES
____LEG CRAMPS
____HEART MURMUR
____HEART ATTACK

SKIN
____SKIN PROBLEMS
____BLEEDS EASILY
____BRUISES EASILY

FEMALE GENITAL
____MENSTRUAL TROUBLE
____VAGINAL DISCHARGE
____PREGNANCY PROBLEMS
LAST PAP SMEAR _____

CURRENT MEDICATIONS
HOW LONG? _____
_____
_____

DRUG ALLERGIES & REACTION
_____
_____
_____
_____

PLEASE INDICATE THE LOCATION OF YOUR PAIN:

MOOD
____LACK OF CONCENTRATION
____POOR MEMORY
____LONELY OR DEPRESSED
____DIFFICULTY RELAXING
____EASILY ANNOYED
____WORK/FAMILY PROBLEMS
____SEXUAL DIFFICULTIES
____DESIRE PSYCHIATRIC HELP

EYES,EARS,NOSE & THROAT
____WORSENING EYESIGHT
____SEEING DOUBLE
____SEEING HALOS
____EYE PAIN/ITCHING
____HEARING DIFFICULTY
____EAR ACHES
____BUZZING/RINGING IN EARS
____MOTION SICKNESS
____NOSE BLEEDS

RESPIRATORY
____WHEEZES
____CHRONIC COUGHING
____COUGH & BLOOD
____CHEST COLDS
____LAST CHEST X-RAY: _____

SOCIAL HISTORY
BIRTHPLACE: _____
____MARITAL STATUS
EDUCATION _____
DAILY ACTIVITIES: _____
_____

HOSPITALIZATION
REASON & DATE:_____
_____
_____
_____
_____

NEUROLOGICAL
___WEAKNESS - ARMS/LEGS
___NUMBNESS
___CONVULSIONS/SEIZURES
___CHANGE IN HANDWRITING
___TREMOR

HEAD & NECK
____FREQUENT HEADACHES
____NECK PAINS
____NECK LUMPS/SWELLING

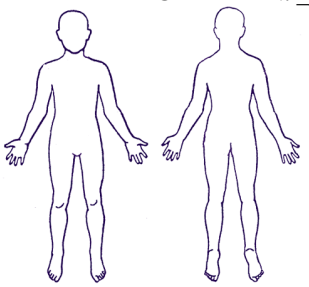
DIGESTIVE
____HEARTBURN
____ABDOMINAL PAIN
____NAUSEA
____VOMITED BLOOD
____SWALLOWING DIFFICULTY
____CHANGE IN BOWEL HABITS
____BLACK STOOLS
____RECTAL BLEEDING

URINARY
____PROSTATE TROUBLE
____BURNING WITH URINATION
____DIFFICULTY IN URINATION
____FREQUENT URINATION

TRAVELS OUT OF USA
DATES/LOCATIONS:
_____
_____
_____
_____

SPECIAL PROBLEMS
_____
_____
_____
_____
_____

PLEASE LIST FAMILY HEALTH PROBLEMS, IF DECEASED ENTER CAUSE OF DEATH AND AGES.
MOTHER: _____
FATHER: _____
SIBLINGS: _____
CHILDREN: _____



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Southern California Institute of Neurological Surgery

QUESTIONS FOR MY DOCTOR

NAME: _____ DATE OF BIRTH: _____

DATE: _____ TIME: _____

CHIEF COMPLAINT TODAY: _____

_____

I DO NOT HAVE ANY QUESTIONS TO ASK MY DOCTOR ABOUT MY CONDITION:

PATIENT'S SIGNATURE: _____

I have the following question(s) to ask my doctor:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Southern California Institute of Neurological Surgery

AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Southern California Institute of Neurological Surgery cannot condition services on whether or not you sign this authorization except under limited circumstances such as for services related to research eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as Worker's Compensation). In these circumstances, Southern California Institute of Neurological Surgery may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information leaves the office of Southern California Institute of Neurological Surgery, we will no longer protect that information, and the recipients of your information may not legally required to protect your information.

AUTHORIZATION: I hereby authorize **Southern California Institute of Neurological Surgery**
705 East Ohio Avenue
Escondido, CA 92025
Phone: (760) 489-9490Fax: (760) 489-7638

☐ to furnish to or ☐ to obtain from:

Name of Facility or Individual: _____

Address: _____

Health Records and information pertaining to medical history, mental or physical condition, services rendered or treatment of patient:_____

Date of Birth: _____ Date of Services: _____

Location of Services ☐ Dr's Office ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Other: _____

I understand that this may include information relating to AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus) Infection, Psychiatric care and/or treatment for alcohol or drug abuse. This authorization is limited to the following medical records and type of information:

☐ Discharge Summary ☐ History & Physical Exam ☐ Consultation Report ☐ Progress Notes
☐ Lab Tests ☐ X-ray Report ☐ Photographs, videotapes, digital images
☐ Other: _____

USES: The requestor may use the medical records and type of information authorized only for:

☐ Continuing Care ☐ Inspection of Record ONLY ☐ Legal matters ☐ Insurance Claim
☐ Personal Copy ☐ Second Opinion ☐ Other: _____

_____

DURATION: I understand that this authorization may be revoked in writing at any time according to the instructions of Southern California Institute of Neurological Surgery's Notice of Privacy Practices, except to the extent that action has been take in reliance on this authorization. Unless otherwise revoked, this authorization will expire within six months from the date of this authorization.

RESTRICTIONS: I understand that Southern California Institute of Neurological Surgery may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Southern California Institute of Neurological Surgery from any legal liability that may arise from the release of this information to the party named above.

ADDITIONAL COPY: I further understand that I have the right to receive a copy of this authorization upon my request. (Civil code S.56.11)

SIGNATURE:

Printed Name: _____ Signature: _____

Date: _____ If signed by other than patient, indicate Relationship: _____

Witness: _____ Date: _____

Southern California Institute of Neurological Surgery

HIPAA NOTICE OF PRIVACY RECEIPT

Southern California Institute of Neurological Surgery
705 East Ohio Avenue
Escondido, CA 92025
Tel: (760) 489-9490

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy practices. I further acknowledge that copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of privacy practices will be available at each appointment.

Signed: _____ Date: _____

Printed Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

____ Parent and Guardian of minor patient

____ Guardian or conservator of an incompetent patient

Patient Name: _____

Address: _____

_____