NEUROSURGERY
of St. Louis

Dear Patient

Welcome to our practice. To simplify the process on your first visit please complete the enclosed patient information forms prior to your arrival. You may also complete these forms through our patient portal if you are registered. Additionally, you will need to present a current insurance card and valid form of identification upon your arrival. If your insurance requires a referral from your primary care physician it is **your responsibility** either to bring it with you, or to ensure that it has been transmitted to us. We strongly encourage you to contact your insurance carrier to determine whether you need a referral for your visit to the Neurosurgeon.

In order to help maintain health care costs we require all co-pays at the time of check-in. **A FEE OF $30 WILL BE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT A 24 HOUR NOTICE. A FEE OF $75 WILL BE CHARGED FOR PROCEDURES CANCELLED WITHOUT A 72 HOUR NOTICE.** If you wish to acquaint yourself with our practice you may visit our website at www.stlbrainandspine.com.

We look forward to seeing you.

Sincerely,

The physicians and staff at Neurosurgery of St. Louis

314.806.1770 phone 314-558-9017 fax
www.stlbrainandspine.com

THE FOLLOWING ARE VERY IMPORTANT FOR YOU TO BRING WITH YOU FOR YOUR APPOINTMENT:

- All CT, MRI or XRAY on CD as well as the written report.

- Patient information forms.

REMINDER: If you have not completed your patient information forms either on-line or mailed to you, it is important to arrive 30 minutes before your appointment to complete all necessary paperwork.

Having this information helps our doctors understand your problem without you having to return for a second office visit. It is possible that we may not be able to see you on your appointment day and reschedule your appointment if the above criteria is not met.

Patient Balance:
Physician:

NEUROSURGERY of St. Louis

PATIENT INFORMATION

Last Name:		First Name:		M.I.	
Address:		City:		State/Zip:	
Home Phone:		Cell:		Marital Status:	
Social Security #:		Date of Birth:		Gender:	
Employer/Occup:		Employer Phone:		**PATIENT #:**	

➔ **Email:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

OTHER INFORMATION

Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding "Notice of Privacy Practices." (HIPAA)

X SIGNATURE: _____ **Date**: _____

AUTHORIZATION TO RELEASE INFORMATION *(Your Signature is Required)*

Do You Authorize Another Person To Receive Your Medical Information? Yes □ No □

If YES, Who _____ Relationship to Patient _____

Do You Authorize Another Person To Receive Your Billing Information? Yes □ No □

If YES, Who _____ Relationship to Patient _____

Do You Authorize Neurosurgery of St. Louis to Leave Patient Test Results on an Answering Machine or Voice Mail: Yes □ No □ If YES, at which phone number(s)? _____

X SIGNATURE:_____ **Date**: _____

Neursurgery of St. Louis complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient Name:

Date of Birth:

NEUROSURGERY of St. Louis

Financial Policy - Payment and Insurance

Health Insurance Information - a copy of your insurance card(s) is required

PRIMARY COVERAGE:

Insurance Company Name: _____ Subscriber (circle one): Self Other

If subscriber is not patient, name of subscriber: _____ Date of Birth: _____

SECONDARY COVERAGE:

Insurance Company Name: _____ Subscriber (circle one): Self Other

If subscriber is not patient, name of subscriber: _____ Date of Birth: _____

- Please contact your insurance company to make sure Neurosurgery of St. Louis is a participating, in-network provider on your plan prior to scheduling an appointment. Some plans may require you to obtain a "referral" from your primary care provider prior to seeing a specialist. If your insurance requires a referral, we will not be able to see you until you obtain that.
- We can still help you even if we are not a participating, in-network provider with your insurance. Your insurance coverage will be determined by any "out of network" benefits you may have as dictated by your plan.
- Applicable copayments will be collected at the time of service. This arrangement is part of our contract with your insurance company, and our failure to collect copayment from you may be considered fraud.
- We will collect any unmet deductible and applicable patient payment responsibility at the time of your visit.
- Fees for services not covered by insurance are collected at the time of visit.
    - If further fees are owed after adjudication of the insurance claim, you will receive a monthly statement.
- Patients who do not have insurance coverage or have a Health Savings Account / Health Reimbursement Arrangement will be required to pay in full at every visit.
- For your convenience, our office accepts cash, debit cards, credit cards (MasterCard™ VISA™, and Discover) and personal checks. We may only allow payment plans in limited circumstances.
- Please contact your insurance plan representative if you have questions regarding coverage for your visit or procedure. Insurance companies are responsible to you, the policyholder, not to the physician. As a courtesy to you, our office will file your claims to your insurance company as long as we are "contracted" with your insurance company. However, we do not determine the amount of coverage

you will receive. Your insurance company determines the amount of your coverage and you should be aware of your benefits prior to all office visits and procedures. Any questions you may have concerning your insurance benefits should be directed to your insurance plan representative. You are ultimately responsible for the payment of all charges.

- For your convenience we will file your claim with your insurance but we must have accurate information at the time of your visit. Claims that are denied for payment because of incorrect information will become the responsibility of the patient. It is very important to let us know immediately of any change in your insurance information. We do file primary and secondary claims but do not file claims to tertiary insurance policies.
- No show appointments or appointments cancelled with less than 24 hour notice will be charged $30 per incident. A fee of $75 will be charged for scheduled procedures such as CT scans, X-rays and Urodynamics Studies cancelled without a 72 hour notice.
- A fee of $150 will be charged for **elective surgeries** cancelled less than 5 days in advance, unless cancelled for medical reasons. The fee may also be charged if you request that your surgery date be rescheduled. Rescheduled surgeries create significant additional work for our staff.
- Please contact our Billing Office at 833-684-0015 should you have any questions.

I have reviewed the Neurosurgery of St. Louis Financial Policy and agree to comply with its guidelines.

_____ _____

Patient or Guarantor Signature **Date**

Patient Name: _____ **DOB**: _____ **Ht.**: _____ **Wt.**: _____

Reason for Visit: _____ **Date Symptoms Began**: _____

PAST MEDICAL HISTORY

	Y	N		Y	N		Y	N		Y	N
Anemia			Depression			Hepatitis			Parkinson's		
Arthritis or DJD			Diabetes			Type:			Seizures		
Asthma			DVT or Blood Clots			Heart Disease			Sleep Apnea		
Bleeding Tendencies			Emphysema			High Blood Pressure			Stroke or TIA		
Cancer			Epilepsy			High Cholesterol			Thyroid Disease		
Type:			GERD / Acid Reflux			HIV			Other:		
Cataracts			Glaucoma			Kidney Disease					
Chronic Infections			Gout			Kidney Stones					
Connective Tissue Dis.			Heart Attack			Multiple Sclerosis					
COPD			Heart Murmur			MRSA					

PAST SURGICAL HISTORY

Surgery/Hospitalization	Date	Surgery/Hospitalization	Date

Notate additional surgeries on back →

SOCIAL HISTORY

Smoker? ❒ Yes ❒ No Packs per Day: _____ Years: _____ Quit: ❒ Yes ❒ No When? _____
Alcohol use? ❒ Yes ❒ No Type(s): _____ Drinks per week: _____
Caffeine? ❒ Yes ❒ No Type(s): _____ How much per day? _____
Recreational drug use? ❒ Yes ❒ No Type(s) & reason: _____ How often? _____

LIST ALLERGIES AND REACTIONS

_____

_____

VACCINATIONS AND TESTING

Date of last pneumococcal vaccination: _____ ❒ N/A Date of last flu vaccination: _____ ❒ N/A
Date of last colonoscopy and/or sigmoidoscopy: _____ ❒ N/A Date of last mammogram? _____ ❒ N/A
Have you EVER had a problem with anesthesia? ❒ Yes ❒ No Explain: _____
Do you require antibiotics prior to dental procedures? ❒ Yes ❒ No

FAMILY HISTORY (Parent, sibling, or child)

	Y	N	FAMILY MEMBER		Y	N	FAMILY MEMBER
Diabetes				Prostate cancer			
Kidney stones				Bladder cancer			
Heart disease				Other:			
High blood pressure				Other:			

Is there any litigation with a MVA or worker's comp involved with this current reason for visit? **NO** **YES**

Have you had imaging done on your brain or spine? **NO** **YES***

*If yes: MRI CT X-RAY MYELOGRAM Location:_____

LUMBAR THORACIC CERVICAL BRAIN When:_____

Patient Name: _____ **DOB**: _____ **Ht.**: _____ **Wt.**: _____

Reason for Visit: _____ **Date Symptoms Began**: _____

REVIEW OF SYSTEMS: **Do you <u>CURRENTLY</u> have any problems related to the following systems?**

GENERAL	**Y**	**N**	**(NEUROLOGICAL CONT.)**	**Y**	**N**	**GASTROINTESTINAL**	**Y**	**N**	**(GENIITOURINARY CONT.)**	**Y**	**N**
Chills			Numbness			Abdominal pain			Urinary urgency		
Difficulty sleeping			Where?			Black / Bloody stool			**MUSCULOSKELETAL**		
Fatigue			Seizures			Constipation			Back pain		
Fever			Severe, frequent headaches			Diarrhea			History of gout		
History of Blood Transfusion			Tingling			Difficulty swallowing			Joint pain		
Night sweats			Where?			Indigestion/heartburn			Joint swelling		
Unintentional weight change			Tremors			**(GASTROINTESTINAL CONT.)**			Muscle weakness		
HEAD			Weakness			Nausea			Neck pain		
Dizziness			Where?			Vomiting			Weakness of arm		
Double vision			**RESPIRATORY**			Vomiting Blood			Weakness of leg		
Ear pain			Coughing up blood			**PSYCHIATRIC**			**HEMATOLOGY**		
Frequent nosebleeds			Chronic cough			Anxiety			Blood clots		
Hoarseness			Shortness of breath			Depression			Swollen glands		
Mouth sores			Snoring			Feeling hopeless			**ENDOCRINE**		
Ringing in ears			Sore throat			Hearing voices			Excessive thirst		
Sinus problems			Wake from sleep w/ wheezing or shortness of breath			**GENIITOURINARY**			Fatigue		
Trouble hearing			Wheezing			Blood in urine			Too hot/cold		
Visual changes (not glasses)			**CARDIOVASCULAR**			Change in sex drive			**SKIN/HAIR**		
NECK			Chest discomfort / tightness			Change in stream			Hair loss		
Persistent sore throat			Episodes of fainting			Flank pain			Major skin problems		
Swollen glands			Irregular heartbeat			Pain with urination			Poor-healing wounds		
NEUROLOGICAL			Leg or ankle swelling			Urinary Frequency > 8x per day			Rash (persistent)		
Difficulty speaking			Lightheaded			Urinary hesitancy			**OTHER**		
Forgetfulness / Confusion			Smothering feeling at night			Urinary incontinence			Have wet / soiled self on way to toilet		
Loss of coordination						Urinary retention			Have fallen in last 3 months		
						UTI					

Medication List

Name: DOB:

Date completed:

Local Pharmacy: Phone:

Mail Order Pharmacy: Phone:

Please list all prescription and non-prescription medications as well as vitamins and supplements that you are currently taking:

Medication Name:	Dose / MG	Frequency

Are you ALLERGIC to or have you had any unusual reactions to medication, radiology contrasts, or an allergy to shellfish? If so, please list the name of the drug and the reaction. If none, please write "NONE".

Neurosurgery of St. Louis
12855 North Forty Drive, Suite 125
St. Louis, MO 63141 * 314-806-1770

Privacy Officer: Diana Whitman
dwhitman@stlurology.com
www.stlbrainandspine.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	· You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. · We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. · We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. · We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	· You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. · If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. · We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. · We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	· You can complain if you feel we have violated your rights by contacting us using the information on page 1. · You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** · We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	· Share information with your family, close friends, or others involved in your care · Share information in a disaster relief situation · Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	· Marketing purposes · Sale of your information · Most sharing of psychotherapy notes
In the case of fundraising:	· We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	· We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	· We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	· We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	· We can share health information about you for certain situations such as: · Preventing disease · Helping with product recalls · Reporting adverse reactions to medications · Reporting suspected abuse, neglect, or domestic violence · Preventing or reducing a serious threat to anyone's health or safety
Do research	· We can use or share your information for health research.
Comply with the law	· We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	· We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	· We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	· We can use or share health information about you: · For workers' compensation claims · For law enforcement purposes or with a law enforcement official · With health oversight agencies for activities authorized by law · For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	· We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

6/1/2019

Privacy Officer: Diana Whitman *dwhitman@stlurology.com*