Thank you for completing this packet prior to your appointment at Midwest Neurosurgery & Spine Specialists.

PLEASE COMPLETE – The enclosed forms:

- **Patient Registration Form,**
- **Past Medical History Form** &
- **Privacy Policy, Billing Authorization & Financial Policy Forms** that need your ***Signatures.***

Please have all of these completed and bring them with you to your appointment.

REMINDER - Please be sure to bring:

- **Insurance Card**
- **Photo ID**
- **Co-pay**
- **Xrays, CT, and/or MRI Films or CD and reports**
- **This packet of completed information**

Failure to provide the above information could result in rescheduling your visit.

If you need to request scans from a radiology department located in a hospital or other facility make sure to request the scans at least 2 days prior to the day of your appointment.

We look forward to being involved with your medical care. If you have questions prior to your appointment, please contact us at the number below.

Sincerely,

Midwest Neurosurgery & Spine Specialists

(402) 398-9243

Please use BLACK ink only. *Checked-in:* ________

Date: ________ __________ *Updated*: ________

SSN: _______-_______-_______ **Age**: ___________ **Race**: ________________

First Name: _________________________**M**: _________ **Last**: ______________________________

Sex: ____________ **DOB**: _________-_________-__________ **Marital Status**: _________

Employment Status: Yes / No / Retired **Employer**: ______________________________________

Home Address: ____
(Street) (City) (State) (Zip)

____
(PO BOX/ APT)

Email: _____________________________________ **Home Phone:** ________-________-________

Work: _________-_________-__________ **Cell**: ________-________-________

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Requesting/Referring Physician: ____

Family Physician: ____

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Nearest relative or friend, not living with you that we may contact in case of emergency or if we need to change an appointment and cannot reach you?

Name: ____ Relationship: _______________________

Phone #: _______-_______-________

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Health Insurance Information:

Primary **Insurance Carrier Name**: ____ Co-pay: ______

Policy (ID) #: ____________________________________ Group#: __________________________

****Primary Card Holder Name**: ____

****Relationship to Patient**: ____

SSN: _______-_______-_______ DOB: _______-_______-________

Employer: ____ Work # ________________________

Patient Name: ___________________________________

Secondary **Insurance Carrier Name**: _______________________________________ Co-pay: _____

Policy (ID) #: ___________________________________ Group #: _________________________

****Primary Card Holder Name**: ____

****Relationship to patient**: ____

SSN: _______-_______-_______ DOB: _______-_______-________

Employer: ____ Work # _________________________

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Auto Insurance Name ***(if due to an accident)***________________________________

Name of Policy Holder_______________________Claim #_____________________

Address of Insurance Company_______________City________State_______Zip__________

Phone # ( )__________________________Accident Date__________________________

Name of person handling claim____

Do you have an attorney or legal action current or pending for the condition for which you a re seeking legal consultation? _______

- If so, name of attorney ________________________ Attorney phone #: _________________

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Work Comp Information *(if applicable):*

Name of Work Comp Carrier____

Address___________________________City________________State_______Zip_________

Claim #_______________________Name of Person Handling Claim______________________

Phone # ( )__________________ Ext. #_____________Fax # ( )____________________

Date of Injury_________________________Case Manager____________________________

Do you have an attorney or legal action current or pending for the condition for which you a re seeking legal consultation? _______

- If so, name of attorney ________________________ Attorney phone #: _________________

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SELF PAY: Please read & ***sign*** **our Financial Policies & ask to meet with a Financial Counselor** ***within our office. This is required prior to your clinic visit.***

Patient Name: ____

I hereby authorize MIDWEST NEUROSURGERY, P.C. to furnish third party payors with any information concerning the medical care, treatment and billings. I hereby assign to MIDWEST NEUROSURGERY, P.C. all payments for medical services to be rendered to me or my dependents, and I authorize direct payment for such benefits to MIDWEST NEUROSURGERY, P.C. by any third party payor. I understand that I am responsible for all medical fees and costs regardless of the insurance coverage and that Medicare and insurance plans require that all co-pays and deductibles be collected. To the extent there is multiple coverage by third party payors such benefits shall be coordinated and the collection of any deductibles, co-insurance or co-payments up to the full amount of the account balance shall be permitted, and I shall remain responsible for the said amount. I agree to pay a late charge at the rate of 1 1/3 percent per month on any amounts due from and after the 31st day following the invoice date until paid in full if there is no applicable insurance coverage. If a claim is pending with a third party payor, no interest shall accrue until such time as the third party payor denies all or part of the claim, in which case I agree to pay a late charge at the rate of 1 1/3 percent per month on any unpaid amounts from and after the 31st day following the date MIDWEST NEUROSURGERY, P.C. or I receive notice of the same, whichever is earlier. I also agree that if any dispute arises between MIDWEST NEUROSURGERY, P.C. and me, the laws of the State of Nebraska shall govern, and all disputes between MIDWEST NEUROSURGERY, P.C. and me must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

______________________________________ ____________
Patient or Guarantor Signature **Date**

Midwest Neurosurgery & Spine Specialists owns & operates MRI, CT, XR Imaging services located at 8005 Farnam Drive, Suite 202, and provides these services for the convenience of our patients. Effective January 1, 2011, we are required to provide you with the name of five alternate suppliers within a 25 mile radius of our location. In accordance with this requirement, the following suppliers who are not affiliated with our practice offer MRI, CT, XR services:

1. Village Point Imaging Center, 302 N 168th Circle, Ste 202, Omaha, NE, 402-502-7226
2. Northwest Imagine Center, 3606 N 156th St, Ste 104, Omaha, NE, 402-717-1177
3. West Dodge Medical Plaza, 515 N 162nd Ave, Omaha, NE, 402-354-4001
4. Midwest Medical Imaging Center, 6901 N 72nd St, Omaha, NE, 402-572-3131
5. Gold Circle Imaging Center, 13918 Gold Circle, Omaha, NE, 402-330-6550

FINANCIAL POLICY

Thank you for choosing Midwest Neurosurgery and Spine Specialists. The following is a statement of our FINANCIAL POLICY. All patients must accept our financial policy guidelines before receiving treatment. Please understand that full payment of your bill is considered a part of our treatment.

REGARDING YOUR INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. **Any balance after processing of our claim by your carrier is your responsibility.** Your insurance policy is a contract between you and your insurance company. **You are responsible for verifying if providers are in-network with your insurance company**. We cannot bill your insurance company unless you give us your complete insurance information for commercial insurance, Medicare and Nebraska & Iowa Medicaid. It is your responsibility to know your insurance benefits; it may not cover all of the services provided to you.

WHEN SURGERY IS RECOMMENDED: You will be contacted by our Financial Consultant to discuss possible out of pocket costs, if you have a high deductible or if your insurance is out of network, we will help you make the necessary payment arrangements. Post operative visits will be at no charge to you within the first 90 days. This does not apply to radiological services. After the initial 90 days, you will be responsible for co-pays, co-insurance, or deductible if applicable.

SELF-PAY PATIENTS: We **require $150 down payment at the initial consultation**. Financial arrangements will need to be made PRIOR to any other services provided, including any radiological exams or surgical procedures. Failure to pay this will result in cancellation of your appointment.

WORKERS COMPENSATION: All workers compensation visits **must be authorized BEFORE your visit**, if this is not done, **your appointment will be cancelled**. You must provide us with the responsible party's information, including their name, address, phone number, claim number and date of injury. If this information is not provided at the time of service, you are responsible for this balance, which is expected to be paid within 30 days to avoid further collection activity.

PERSONAL INJURY: We require **$250 down payment at the initial consultation**. All radiological services provided by Midwest NeuroImaging will require 50% down payment. If surgery is suggested, we require payment in full prior to the procedure, unless other arrangements have been made prior to your visit here. **We do not bill attorneys**.

METHOD OF PAYMENT: We accept Cash, Check, Visa and MasterCard. Payment plans may be arranged on an individual basis with the Billing Department in our office**. All co-pays are due prior to treatment**. We reserve the right to cancel your appointment if your co-pay is not paid at the time of service.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible. An administrative fee of $10.00 will be applied to your account if it is turned over to collections.

I have read, understand, and agree to the above financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees. My signature also represents knowledge of the attached No Show Policy.

Patient or Guarantor Signature ________________________________**Date:** ________________

DEFINITIONS below are defined by your Health Plan & the financial responsibility of the patient or guarantor.

- **COPAYMENT:** A fixed dollar amount set by your insurance contract that is to be paid at the time of an office visit.
- **DEDUCTIBLE:** An annual dollar amount established by your insurance plan that is deducted from insurance benefit.
- **CO-INSURANCE**: A percent set by your insurance plan that is deducted from insurance benefits. Usually 10%-30%.

Midwest Neurosurgery, PC
(Midwest NeuroSurgery & Spine Specialists)
Notice of Health Information Practices
Notice of Privacy Policies

Acknowledgement of Understanding Statement

I, ________________________________, have had access to the Midwest Neurosurgery's:
Please Print (Patient Name)

Notice of Privacy Policies

I understand:

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

- Basis for planning my care and treatment,
- Means of communication among the many health professionals who contribute to my care,
- Legal document describing the care I received,
- Means by which I 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 Midwest Neuosurgery's planning and marketing,
- A tool which Midwest Neurosurgery can assess and continually work to improve the care rendered and the outcomes achieved.

I understand that Midwest Neurosurgery is only allowed to release medical information to the individual patient with the exception of minors, Worker Compensation cases, and any patient signing a consent form giving permission to another individual to access his/her medical records. This includes picking up medication, prescriptions, DME products and x-rays. I give permission to the following individual/s to have access to this information. Proof of ID must be shown any time information is received.

Name	Relationship

I can change this information at anytime by notifying Midwest Neurosurgery, PC, in writing, of the changes.

________________________________ ________________
Patient / Responsible Party Signature Date

Patient Name:_________________________________ **Date of Birth**__________

Height ________________ **Weight**_______________ **Current Age**__________

Reason for today's visit____

<u>Current problem</u> is the result of a(n): ***Check all that apply***:

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other________________________

Date of Accident____

Past Medical History

Surgeries/Hospitalizations	**Year**	**Complications**

Have you ever had problems with anesthesia: ☐ Yes ☐ No

Malignant Hyperthermia: ☐ Yes ☐ No

Are you on a blood thinner ☐ Yes ☐ No

Allergy to Latex? ☐ Yes ☐ No
If Yes - explain____

Do you have any of the following?

☐ Hepatitis ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease

☐ Asthma ☐ Ulcer ☐ Lung Disease ☐ Liver Disease

☐ Kidney Disease ☐ Pulmonary Embolism / Blood Clot ☐ Stroke/CVA

☐ Cancer/Type___________ ☐ Other illnesses and/or injuries____________________

Current Medication(s)	**Dose**	**Frequency**

Allergies to Medications:

Medication	**Reaction**

Patient Name:____

Review of Systems

Have you currently or recently experienced problems with the following:

Constitutional	***Circle One***	
Unexplained Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Eyes Date of Last Exam:________________________		
Glaucoma	Yes	No
Cataracts	Yes	No
Double or blurred vision	Yes	No
Ear, Nose, Throat and Mouth		
Hearing Loss	Yes	No
Ringing In Ears *Circle*: Left Right Both	Yes	No
Balance Disturbance (e.g., Vertigo, Spinning)	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sore Throat	Yes	No
Mouth Sores	Yes	No
Cardiovascular Date of Last **EKG**:___________________		
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Hand Swelling	Yes	No
Feet Swelling	Yes	No
Endocrine		
Diabetes	Yes	No
Thyroid Disease	Yes	No
Excessive Thirst	Yes	No
Frequent Urination	Yes	No

Patient Name:___________________________________

Respiratory	***Circle One***	
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis (in last 6 months)	Yes	No
Pneumonia (in last 6 months)	Yes	No
Tuberculosis	Yes	No
Integumentary		
Skin Disease / Skin Cancer *(circle one or both)*	Yes	No
Breast Pain / Tenderness / Nipple Discharge *(circle one)*	Yes	No
Date of last mammogram___________________________		
Gastrointestinal		
Indigestion	Yes	No
Pain *with eating*	Yes	No
Nausea / Vomiting *(circle one or both)*	Yes	No
Abdominal Pain	Yes	No
Change in Your Bowel Habits	Yes	No
Genitourinary		
Urinary Tract Infections	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Musculoskeletal		
Broken Bones (If Yes) – Please list: ________________________	Yes	No
Arm Pain (If Yes – circle: Left, Right or Both)	Yes	No
Arm Weakness (If Yes – circle: Left, Right or Both)	Yes	No
Leg Pain (If Yes – circle: Left, Right or Both)	Yes	No
Leg Weakness (If Yes – circle: Left, Right or Both)	Yes	No
Lower Back Pain	Yes	No
Upper Back Pain	Yes	No
Neck Pain	Yes	No
Joint Pain (If Yes) – Please list: ________________	Yes	No
Joint Swelling (If Yes) – Please list: ________________	Yes	No
Arthritis (rheumatoid or degenerative)	Yes	No

Patient Name: ________________________________

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder/Treatment:______________________	Yes	No

Neurological

Headache or headache disorder*	Yes	No

*(If Yes – please describe: Location – Duration – Frequency – Sensitivity to Lights, Etc.)

____

____

Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Problems with Your Memory	Yes	No
Problems with Disorientation	Yes	No
Difficulty with Your Speech	Yes	No
Face Weakness	Yes	No
Coordination in Arm (If Yes – circle: Left, Right or Both)	Yes	No
Coordination in Legs (If Yes – circle: Left, Right or Both)	Yes	No
Risk for Creutzfeld-Jacob Disease (i.e., prior craniotomy with dura or tissue transfer, eye transplant, or growth hormone)	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Bleeding Tendencies	Yes	No
Hemophilia / Clotting disorder *(circle one or both)*	Yes	No
Blood Transfusion-If yes, when?___________________________	Yes	No

Family History

Family member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Patient Name:____

Family History/Social History

Occupation: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Do you live alone? ☐ Yes ☐ No Who lives with you?_____________

Do you have children? ☐ Yes ☐ No How many?___________________

Do you smoke?

☐ No, I have never smoked

☐ No, I quit ____ years ago. At that time I was smoking ____ packs per day for _____ years

☐ Yes, I've smoked _____ packs of cigarettes per day for _____ years

☐ Yes, I smoke cigars or a pipe *(circle one or both)*

Do you drink alcohol?

☐ Yes ☐ Daily ☐ More than once per week ☐ Social Drinker

☐ No ☐ Never Drank ☐ No, but I used to ☐ No, and I quit_______years ago

Do you have a history of narcotic drug abuse? ☐ Yes ☐ No

Are you at risk for AIDS? (e.g. sexual orientation, drug abuse, previous blood transfusion)?

☐ **Yes** ☐ **No** IF YES, please explain:_________________________________

____

The above information is accurate to the best of my knowledge.

_____________________________________ _________________

Patient or Guarantor Signature ***Date***

I have reviewed the above information with the patient.

_____________________________________ _________________

Physician Signature *(Midwest Neurosurgery)* ***Date***

NO SHOW POLICY

Below is our "NO SHOW" policy for office appointments. An increasing number of patients not showing up for their appointments necessitate the need for a policy addressing patients who do not show up or call at least 24-hours in advance to cancel appointments.

Patients who "No-Show" at their appointment result in a number of efficiency issues, but most of all, they keep another patient who may have needed an appointment from being seen at that time.

We hope that we can count on you in the future to cancel or reschedule your appointments at least 24 hours in advance. We look forward to continuing to serve you in the future.

1st NO SHOW: A letter is mailed to the patient to remind them.

2nd NO SHOW: Patient charged $50.00*

3rd NO SHOW: Patient will be charged $150 for an office visit.*

4th NO SHOW: Patient is dismissed from the practice.

* NO SHOW penalties <u>must be paid before patient can be seen</u>.

NO SHOW is any missed appointment, or any appointment that is <u>not cancelled 24 hours in advance</u>.

This policy applies to a 12-month period and not a calendar year.

Penalties must be paid before patient can be seen.

**MWNS provides an interpreter for our patients. In the event one of these patients no shows for their visit, any balance owed to the interpreter will be the responsibility of the patient.