

Please – It is very important that the ENTIRE FORM is COMPLETED.



**Child Registration Form (5-14 years)
MIDWEST NEUROSURGERY, P.C.
8005 Farnam Drive, Suite #305
Omaha, NE 68114**

Checked-in: _____
Updated: _____

Please Use Black Ink Only

Date: _____

Age _____

Referring Physician _____

(The physician who requested your consultation with our office)

Family Physician _____

Patient's Name _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Date of Birth _____ SS# _____ Sex: M / F

Guarantor's Information (person financially responsible for patient):

Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Relation to Pt: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Email Address: _____

Sex: _____ Marital Status: _____

Employer: : _____

Emp. Address: _____

Insured's Name (if different than above) _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

Insured's Employer _____ Phone # () _____

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Patient's Name _____

Emergency Contact, not living with you, that we may contact in case of emergency or if we need to change an appointment and are unable to reach you:

Name: _____ Relationship: _____

Phone #: _____

Mother's Information (if different than guarantor):

Name: _____ Date of Birth: _____

Address: _____ Employer: _____

Home: () _____ Work: () _____

Cellular: () _____ Email: _____

Social Security # _____

Employer's Address: _____

Father's Information (if different than guarantor):

Name: _____ Date of Birth: _____

Address: _____ Employer: _____

Home: () _____ Work: () _____

Cellular: () _____ Email: _____

Social Security # _____

Employer's Address: _____

INSURANCE INFORMATION

Primary Insurance Carrier Name _____

Policy # _____ Group # _____

Secondary Insurance Carrier Name _____ Policy # _____

_____ Group # _____

Please – It is very important that the ENTIRE FORM is COMPLETED.

Patient's Name: _____

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 are seeking legal consultation? _____ (If so), name of attorney _____ Attorney phone #: _____

Do you have Co-Pay with your insurance plan for office visits? _____

If yes, what is the amount? _____

COPAYS ARE TO BE TAKEN CARE OF AT THE TIME OF SERVICE.

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.

Signature _____

Date _____

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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%.

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Midwest Neurosurgery, P.C.
(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

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 Neurosurgery'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
_____	_____
Name	Relationship
_____	_____
Name	Relationship

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

_____	_____
Patient / Responsible Party Signature	Date

Please – It is *very important* that the ENTIRE FORM is COMPLETED.

Child's Name: _____

Date of Birth: _____

Birth Weight: _____

APGAR Score: _____
(if known)

What **symptom** or **problem** brings you to our office: (Please be specific – do not leave blank) _____

Primary Care Doctor / Pediatrician: _____

Complications with pregnancy: none / hypertension / drug use / alcohol use

Was the baby born prematurely? No Yes If yes, how early? _____

Did the baby stay in the intensive care? No Yes If yes, How long? _____

Was the baby on a ventilator No Yes If yes, how long? _____

Did the baby have any bleeding in the brain? No Yes

Any birth trauma: Skull Fracture / Cephalohematoma / Brachioplexus Nerve Injury

At what age did your child start walking? _____

At what age was your child "potty" trained: _____

Does your child have any of the following?

- Hydrocephalus? No Yes Lung Problems
- Diabetes Heart Murmur or Defects High Blood Pressure
- Asthma Cancer/Type_____ Spina Bifida
- Cerebral Palsy History of Meningitis (if yes) when?_____
- Genetic disorders/syndromes? *Please list:* _____
- Other illnesses and /or injuries_____

Please list any other ***chronic health problems*** of your child? _____

Please list any ***other specialists*** who care for your child: _____

Past Surgeries &/or Hospitalizations	Date	Complications

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Child's Name: _____

CURRENT MEDICATIONS:

Name of Medication	Dose	Times given

Medication or other ALLERGIES _____

Allergy to Latex: **No** **Yes**

Are **immunizations** up to date? **Yes** **No** (*if No – please explain*) _____

Most recent: Height _____ Weight _____

Diet: ___ Normal for age ___ by mouth ___ by tube

Family History: *Please circle those conditions present in siblings, parents and grandparents*

- High Blood Pressure Heart Disease Cancer Diabetes
 Liver Disease Bleeding Problems Birth Defects Kidney Disease

If yes, explain _____

Have you been told your child has any delays in developing skills? No Yes

- Motor** **Speech/Language** **Social**

If yes, explain _____

Do you use child safety seats or seat belts? No Yes

Are any of the following *used in the home*? Tobacco Alcohol Recreational Drugs

Is there a history of *domestic violence*? No Yes

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Child's Name _____

Review of Systems: Please circle **Yes** or **No** for the following conditions or symptoms your child has currently or had in the past.

Constitutional

Unexplained fever (**recent**) Yes No

Weight loss Yes No

Eyes

Eye infections Yes No

Eyes crossing Yes No

Vision loss Yes No

Ear, Nose, Throat and Mouth

Ear infections Yes No

Hearing loss Yes No

Sinus infections Yes No

Throat infections Yes No

Trouble swallowing or chewing (**circle one or both**) Yes No

Choking Yes No

Mouth sores Yes No

Neck pain Yes No

Respiratory

Turning blue Yes No

Bronchitis Yes No

Pneumonia Yes No

Shortness of breath Yes No

Mechanical ventilation – history of / currently use Yes No

Tracheostomy – history of / currently use Yes No

BPD Yes No

Cardiovascular

Heart abnormality or defect Yes No

Endocrine

Growth problems Yes No

Excessive thirst or urination Yes No

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Child's Name _____

Integumentary

Skin rashes	Yes	No
Skin sores	Yes	No
Birthmarks	Yes	No
Sacral or other spinal dimple	Yes	No

Gastrointestinal

Stomach reflux	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Vomiting	Yes	No
Bowel incontinence	Yes	No
Feeding tube	Yes	No

Musculoskeletal

Back pain	Yes	No
Arm pain	Yes	No
Arm stiffness	Yes	No
Trouble using arms	Yes	No
Arm numbness	Yes	No
Leg pain	Yes	No
Leg stiffness	Yes	No
Trouble using legs	Yes	No
Leg numbness	Yes	No
Scoliosis	Yes	No

Genitourinary

Kidney or urinary infections	Yes	No
Bladder reflux	Yes	No
Urinary incontinence	Yes	No
Urethral straight catheterization (non-balloon)	Yes	No

Neurological

Headaches	Yes	No
Dizziness	Yes	No
Seizures	Yes	No

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Child's Name _____

Hematologic/Lymphatic

Bleeding tendencies/Hemophilia/Clotting disorder Yes No

Jaundice Yes No

Anemia Yes No

Allergic/Immunologic

Swollen glands Yes No

Social Development

Problems in school Yes No

Needs special help in school Yes No

Performs at or above grade level Yes No

Form completed by _____ **Date** _____

Relationship to child _____

I have reviewed the above information with the patient's parent &/or care giver.

Medical Staff - *Signature*

Date _____

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NO SHOW POLICY

Below is our “NO SHOW” policy for office appointments. An increasing number of patients not showing up for their appointments necessitates 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 must be paid before patient can be seen.

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

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

Penalties must be paid before patient can be seen.