

Neurosurgery

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MEDICATION POLICY

Effective October 6, 2014 the Department of Justice and Drug Enforcement Administration (DEA) has changed the classification of Hydrocodone. **Each** prescription for this medication must be personally signed by your healthcare provider; therefore this medication **cannot** be called into your pharmacy.

As a result of the DEA change, our office has implemented the following policy:

The providers at Neuroscience **may** or **may not** prescribe pain medication as part of your treatment plan. In the event you are prescribed pain medication you will be required to follow and sign our office policy. *Please Note:* Policy is subject to change.

- There will be a **3 business day** turn around for pain medication refills. You will be notified when your refill can be picked up if it is authorized. <u>Multiple calls OR</u> <u>walking into the office for status OR requesting refills, will not be acceptable.</u>
- You must follow the treatment plan ordered by your provider. Refills will not be authorized if there is a delay or non-compliance of the treatment plan.
- You must follow the directions on your prescription. Running out of pain medication is not an emergency; therefore not taking it as directed may result in you being out for a period of time. Early refills will not be authorized.
- You must safeguard your pain medication from loss or theft. Lost or Stolen medications will not be replaced.
- You will be responsible for picking up your prescription; however you may authorize someone else to pick it up for you. The office *will not* be responsible once a prescription has been signed for.

By signing below, I understand and agree to comply with the above policy.

Signature	Printed Name	Date of Birth	Date of Signature

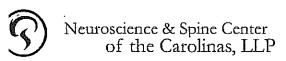


Neuroscience and Spine Center of the Carolina, LLP CURRENT AND PAST MEDICAL HISTORY

Provide us with a current and past history of your medical condition

OUR NAME:		AGE:	SEX: Today's D	ate:
IT: WT: C	CCUPATION:		EMPLOYER:	···
lame of Spouse:	or	Parent:	or Frien	d:
Family Physician:	C		Telephone #:	r' o 1
Address:	C	ity:	State:	Zip Code:
Referring Physician:	C	*	Telephone # :	7in Code
Address:		ıty:	State.	_ Zip code
How did you hear about us?	NT 3		Friends/family	
Doctor Self referral	Website Newspaper		Other	
	• •		\$	
ist all physicians you are see		3		
		4.		
re you right handed or left ha	anded?			
CURRENT PROBLEM:				
JURKENT I ROBLEM.	m, how it began, and when it bega	n:		
lease describe earreit proble				
Was this problem work relate ALLERGIES TO MEDIO	CINE: Codeine, Penicillin, Iodine	Is this a We, Sulfa, anti-inflated.	at is your attorney's name? _ orker's Comp claim? YES mmatory, contrast dye, etc.	NO
CIRRENT MEDICATIO	ONS: Name, dosage, how many t	imes a day?		
1	Doce: Frequency:	6.	Dose:	Frequency:
2, 1	Dose: Frequency:	7.	Dose:	
				Frequency:
	Dose: Frequency: Dose: Frequency: Frequency:			Frequency:
Do you smoke? YES NO	If YES, how much?		II NO, For	mer or Never
Do you drink? YES NO	How much?	ES NO		
Do you use street arugs? (Mi Do you have any of the follo	arijuana, Cocaine, Heroin, etc.) Yl wing illnesses? (Circle Yes or No)	Hepatitis: YES	NO / HIV: YES NO / TB: Y	ES NO / MRSA: YES N
-				
SURGICAL HISTORY:		ta1	Date	Surgeon
Type of Surgery	Hospi			Dargoon
_				
Do you have any bleeding pr	roblems because of surgery or whe	n you shave?		
	h infections?			
,				

Anxiety	AL HISTORY: Check any m	edical problems you have t		
Arrhythmi	ia		Glaucoma Headaches	
Asthma	iu.		Heart attack/MI	
	illation (A-fib)	-	Hyperlipidemia/High chol	esterol
Bipolar dis			Hypertension/High blood	
Bleeding d		 -	Kidney disease	pressure
	f yes, what type?)	Liver disease	
	e heart failure (CHF)		Lung disease	
	artery disease		Osteoporosis	
	ascular accident (CVA/stroke)	-th-A ¹¹⁰ -quilty-sche-sche-sche-sche-sche-sche-sche-sche	Osteoarthritis	
Depression		<u></u>	Parkinson's disease	
Diabetes	•		Rheumatoid arthritis	
	thrombosis (DVT)/Blood clots		Sleep apnea	
Emphysen			Thyroid disease	•
Fibromyal			Peripheral neuropathy	
	phageal reflux (GERD)		Peripheral vascular disease	e (PVI))
	al problems not listed above?		Torrpriorar vaccurar discuss	• •
is there anything	else about your health we should	l know?		
REVIEW OF	SYSTEMS: Have you had any	problems with the followin	g? Circle if present	
General	Appetite loss Unintentional weight gain	Fatigue	Night sweats	Unintentional weight loss
<u>HEENT</u>	Headaches Ringing in the ears Hoarseness	Blurred vision Nasal congestion Difficulty swallowing	Loss of vision Frequent nose bleeds	Hearing loss Sore throat
Respiratory	Shortness of breath	Wheezing	Chronic cough	
Cardiovascular	Chest pain	Palpitations/Racing heart	Leg swelling/Edema	
Gastrointestinal	Abdominal pain Change in bowel habits	Nausea Constipation	Vomiting Diarrhea	Heartburn
Genitourinary	Urinary frequency Frequent UTI's	Incontinence	Difficulty urinating	Blood in the urine
<u>Neurological</u>	Problems with speech Memory loss	Dizziness	Tremor	Balance problems
WOMEN ONLY				
Any serious men	l you be pregnant? YES NO strual problems or endometriosis MEN: Number of children/ages	:		
for the members Alcohol/Drug ab	in your family who had/have the use Depression	following illnesses Kidney	disease	or Other (O) in the spaces below
Bleeding disorde	er Diabetes	Liver d	isease	D 1 11
Cancer	Heart disease	Rheum	atoid arthritis	
If yes, what kind	? High blood press	sure Vascula	ır disease	
lf other, please sp	pecify:			
				NSSC USE ONLY
The abovemention	oned is my complete medical hist	ory and I consent for treatr	ment by signing below.	-
	ATURE		· · · ·	
			DATE_	
PRINT NAME			DATE OF BIRTH	

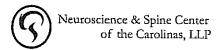


Signature

PATIENT REGISTRATION SHEET

Date

Social Security #	Title (Mr., Mrs., Ms.)	Last Name	·	First Name		MI
Mailing Address	City	State	Zip Code	Em	ail Addr	eess
Primary Phone #	2 nd Phone #	Date of I	Birth	Age	Se	x (M/F)
Marital Status: Single (S) Married (M) Divorced	(D) Widowed	l (W) Separate	d (X) Pr	eferred I	Language:
	merican Indian or Alaska l hite Refuse to Report		n Black or Af	rican American	Native	Hawaiian or Other Pacific Islander
Ethnicity: (Please Circl	e) Hispanic or Latino N	lot Hispanic o	r Latino Refu	se to Report Un	defined	
Employment: Full (F)	Part Time (P) Retired (R)	None (N)	Student: Full (F) Part Time (P)	Name	of School:
Employer Primary Insurance		supation		Work Phone	and Exte	nsion
Primary Insurance Insured's Information (if	other than patient)	Insured'	s Name		Self(S)	Spouse (SP) Child (CH) Other (O) Insured's Relationship to Patient
Social Security #	Title (Mr., Mrs., Ms.)	Last Name		First Name		MI
Mailing Address	City	State	Zip Code			
Home Phone #	Cell Phone#		Date	of Birth		Sex (M/F)
Employer Secondary Insura	nce Information:		Work Phone a	nd Extension		
Secondary Insurance Insured's Information (if	other than patient)	Insured	's Name		Self (S)	Spouse (SP) Child (CH) Other (O Insured's Relationship to Patient
Social Security #	Title (Mr., Mrs., Ms.)	Last Name		First Name		MI
Mailing Address	City	State	Zip Code			
Home Phone #	Cell Phone #		Date	of Birth		Sex (M/F)
Employer Emergency Conta	cts:		Work Phone a	nd Extension	***************************************	
Name	Relationship	to Patient	***************************************	Address		3
Home Phone #	Wo	ork Phone #		Cell Phone #	ļ	
2Name	Relationship	to Patient		Address		
Home Phone #	We	ork Phone #		Cell Phone	#	



Financial Policy

Neuroscience & Spine Center of the Carolinas, LLP, believes that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

- 1. Payment is expected at the time of your visit. We accept cash, check, Visa, or MasterCard.
- Payment will include any unmet deductible, coinsurance, co pay amount, or charges that are not covered by your insurance company.
- 3. We are participating providers for several insurance carriers. We will file all these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.
- 4. Credit Occasionally an established patient incurs unusually high charges for services provided by our physicians. We will work with these patients to establish an appropriate payment plan and obtain a signed financial agreement.
- 5. Pre-payment for Surgery. Our office policy is to collect the anticipated patient responsibility for surgery at the pre-operative appointment. If payment in full is not possible, a <u>Payment Agreement MUST</u> be made with the Billing Department prior to your surgery date except in the case of an emergency.
- 6. Returned checks will incur \$35 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.
- 7. Accounting principles Payments and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges.
- 8. Refunds will not be issued automatically for \$10.00 or less. Patient or patient's representative must contact our billing department and request such a refund.
- 9. Disability forms, insurance forms, copies of medical records, etc require office staff time away from patient care for the doctors. We require prepayment for completing forms, copying medical records and for extra transcription by the doctors. The charge is determined by the length and complexity of the form/letter.
- 10. Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including reasonable attorney fees. To be reinstated as a patient in our practice, there is a \$25.00 re-activation fee. Patients are responsible for any commission we pay to a collection agency.

If you have any questions after reviewing our policy, please call our office to avoid any misunderstanding. By signing my name below, I agree:

- A. I have read and understand the Neuroscience & Spine Center of the Carolinas' financial policy
- B. I hereby authorize the release of medical information to my insurance carriers concerning any medical condition and treatment.
- C. I assign to Neuroscience & Spine Center of the Carolinas all payments from my insurance carrier for medical services rendered to myself and/or my dependants.
- D. I fully understand that I am financially responsible for any co pays, deductibles, coinsurance, or services that are not covered as determined by my insurance carrier.

Payment will be collected at the time the services are rendered.

Signature: I	Date:
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