Neuroscience and Spine Center
of the Carolinas, LLP

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. ***Multiple calls OR walking into the office for status OR requesting refills, will not be acceptable.***
- 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

2555 Court Drive, Suite 400 Gastonia, NC 28054 (704) 864-5550 Fax (704) 864-7448

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

YOUR NAME: ______________________ AGE:______ SEX: ______ Today's Date: ______________
HT: ______ WT: ________ OCCUPATION: ______________________ EMPLOYER: ______________

Name of Spouse: ______________________ or Parent: ______________________ or Friend:______________

- Family Physician: ______________________ Telephone #: ______________
  Address: ______________________ City: ______________ State: ________ Zip Code: ____________
- Referring Physician:______________________ Telephone # : ______________
  Address:______________________ City:______________ State: ________ Zip Code ____________

How did you hear about us?
Doctor _________ Website _________ Friends/family _________
Self referral _________ Newspaper _________ Other _________

List all physicians you are seeing below:
1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Are you right handed or left handed? ______________________

CURRENT PROBLEM:

Please describe current problem, how it began, and when it began: ____

____

____

____

____

Physical therapy /chiropractic care in the last 12 months? YES NO How many treatments?______________
Have you had cortisone-like injections in back or neck? YES NO From whom? ______________ When? ______________
Was the problem accident related? YES NO Is this a personal injury claim? YES NO
Do you name an attorney? YES NO If yes, what is your attorney's name? ______________
Was this problem work related? YES NO Is this a Worker's Comp claim? YES NO

ALLERGIES TO MEDICINE: Codeine, Penicillin, Iodine, Sulfa, anti-inflammatory, contrast dye, etc.
1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Do you have any food allergies? ____

CURRENT MEDICATIONS: Name, dosage, how many times a day?
1. ______________ Dose: ________ Frequency: ________ 6. ______________ Dose: ________ Frequency: ________
2. ______________ Dose: ________ Frequency: ________ 7. ______________ Dose: ________ Frequency: ________
3. ______________ Dose: ________ Frequency: ________ 8. ______________ Dose: ________ Frequency: ________
4. ______________ Dose: ________ Frequency: ________ 9. ______________ Dose: ________ Frequency: ________
5. ______________ Dose: ________ Frequency: ________ 10. ______________ Dose: ________ Frequency: ________

Do you smoke? YES NO If YES, how much? ______________ If NO, Former or Never
Do you drink? YES NO How much? ______________
Do you use street drugs? (Marijuana, Cocaine, Heroin, etc.) YES NO
Do you have any of the following illnesses? (Circle Yes or No) **Hepatitis:** YES NO / **HIV:** YES NO / **TB:** YES NO / **MRSA:** YES NO

SURGICAL HISTORY:

	Type of Surgery	Hospital	Date	Surgeon
1.				
2.				
3.				
4.				

Do you have any bleeding problems because of surgery or when you shave? ______________________________
Have you had a problem with infections? ______________________________

PAST MEDICAL HISTORY: Check any medical problems you have below

____	Anxiety	____	Glaucoma
____	Arrhythmia	____	Headaches
____	Asthma	____	Heart attack/MI
____	Atrial fibrillation (A-fib)	____	Hyperlipidemia/High cholesterol
____	Bipolar disorder	____	Hypertension/High blood pressure
____	Bleeding disorder	____	Kidney disease
____	Cancer (If yes, what type? ________________)	____	Liver disease
____	Congestive heart failure (CHF)	____	Lung disease
____	Coronary artery disease	____	Osteoporosis
____	Cerebral vascular accident (CVA/stroke)	____	Osteoarthritis
____	Depression	____	Parkinson's disease
____	Diabetes	____	Rheumatoid arthritis
____	Deep vein thrombosis (DVT)/Blood clots	____	Sleep apnea
____	Emphysema/COPD	____	Thyroid disease
____	Fibromyalgia	____	Peripheral neuropathy
____	Gastroesophageal reflux (GERD)	____	Peripheral vascular disease (PVD)

Any other medical problems not listed above? ____

____

Is there anything else about your health we should know? ____

REVIEW OF SYSTEMS: Have you had any problems with the following? Circle if present

General	Appetite loss Unintentional weight gain	Fatigue	Night sweats	Unintentional weight loss
HEENT	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
Neurological	Problems with speech Memory loss	Dizziness	Tremor	Balance problems

WOMEN ONLY:

Are you or could you be pregnant? YES NO Number of pregnancies: __________

Any serious menstrual problems or endometriosis: ____

MEN AND WOMEN: Number of children/ages ____

FAMILY MEDICAL HISTORY: Please indicate Mother (M), Father (F), Sister (S), Brother (B), or Other (O) in the spaces below for the members in your family who had/have the following illnesses

Alcohol/Drug abuse ______	Depression ____________	Kidney disease ____________
Bleeding disorder ______	Diabetes ____________	Liver disease ____________
Cancer ____________	Heart disease ____________	Rheumatoid arthritis ________
If yes, what kind? ______	High blood pressure ______	Vascular disease ________

If other, please specify: ____

____

Reviewed by:

NSSC USE ONLY

The abovementioned is my complete medical history and I consent for treatment by signing below.

PATIENT SIGNATURE ______________________________ DATE ______________

PRINT NAME ______________________________ DATE OF BIRTH ______________

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PATIENT REGISTRATION SHEET

Social Security # Title (Mr., Mrs., Ms.) Last Name First Name MI

Mailing Address City State Zip Code **Email Address**

Primary Phone # 2nd Phone # Date of Birth Age Sex (M/F)

Marital Status: Single (S) Married (M) Divorced (D) Widowed (W) Separated (X) **Preferred Language:** ____________________

Race: (Please Circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Refuse to Report Undefined

Ethnicity: (Please Circle) Hispanic or Latino Not Hispanic or Latino Refuse to Report Undefined

Employment: Full (F) Part Time (P) Retired (R) None (N) Student: Full (F) Part Time (P) Name of School:____________________

Employer Occupation Work Phone and Extension

Primary Insurance Information:

Self (S) Spouse (SP) Child (CH) Other (O)

Primary Insurance Insured's Name Insured's Relationship to Patient

Insured's Information (if other than 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 Work Phone and Extension

Secondary Insurance Information:

Self (S) Spouse (SP) Child (CH) Other (O)

Secondary Insurance Insured's Name Insured's Relationship to Patient

Insured's Information (if other than 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 Work Phone and Extension

Emergency Contacts:

1.____________________

Name Relationship to Patient Address

Home Phone # Work Phone # Cell Phone #

2.____________________

Name Relationship to Patient Address

Home Phone # Work Phone # Cell Phone #

Signature Date

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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.
2. **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 Payment Agreement MUST 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: ______________________________ Date: ____________________