NASHVILLE NEUROSURGERY ASSOCIATES

Date of visit: _____ Email Address: _____

Patient Name: _____

Date of Birth: _____ SS#: _____ Sex: ___Female ___Male

Address: _____

City:_____ State:_____ Zip_____

Phone Numbers: (H) _____ (W) _____(C) _____

Check all that apply: Message can be left on [ ] H [ ] W [ ] C Message may be: [ ] Brief [ ] Extended

Height: _____ ft. _____in. Weight: _____ lbs. Hand Dominance: □ Right Handed □ Left Handed

RACE: Please check one (optional)

__American Indian or Alaska Native
__Asian
__Native Hawaiian or other Pacific
__Black or African American
__White
__Hispanic or Latino
__Other_____
__Declined to Answer

PRIMARY LANGUAGE:

__English __Spanish
__Arabic __Chinese
__French __Italian
__Other:_____

Marital status: [ ] Married [ ] Widowed [ ] Separated [ ]Divorced [ ] Single [ ] Partnership

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____ Policy #:_____

Address: _____ Group #:_____

Phone: _____ Name of Insured: _____ DOB _____SSN_____

Employer of Policyholder: _____

Secondary Insurance: _____ Policy #:_____

Address: _____ Group #:_____

Phone: _____ Name of Insured: _____ DOB _____SSN_____

Employer of Policyholder: _____

------OR------

Are your symptoms due to a work-related accident? [ ] Yes [ ] No

WORKER'S COMPENSATION INFORMATION:

Insurance Carrier: _____ Claim #:_____Date of Injury: _____

Address: _____ Employer: _____

Phone: _____ Adjustor's Name: _____ Phone: _____

Patient Name: _____ DOB: _____

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: _____ Specialty: _____

Address: _____

Phone Number: _____ Fax Number: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?
[ ] SAME AS REFERRING DOCTOR ABOVE

Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:
[For Example: Cardiologist, Endocrinologist, Oncologist or Pulmonologist]

(1) Name: _____

Address: _____

Phone: _____

Fax: _____

(2) Name: _____

Address: _____

Phone: _____

Fax: _____

PLEASE LIST ANY OTHER PERSONS YOU WISH TO HAVE ACCESS TO YOUR MEDICAL INFO:
[For Example: Family, Friends or Attorney]

I authorize Nashville Neurosurgery Associates to contact and discuss my Personal Health Information with the following persons:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

X_____ _____
Patient Signature Date

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS:

Please check all conditions that applies to you now OR in the past 6 months:

GENERAL:

- O Weight loss or gain
- O Chest pain
- O Change in appetite
- O Altered taste or smell
- O Heart murmur
- O Chest pressure
- O Angina
- O Fainting
- O Excessive sleepiness
- O Low blood pressure
- O Unable to sleep
- O Fatigue
- O Leg swelling

EARS, NOSE & THROAT:

- O Mouth sores
- O Sinus disease
- O Sore throat
- O Ringing in ears
- O Hearing loss
- O Cataracts
- O Blurred vision
- O Double vision

RESPIRATORY:

- O Shortness of breath
- O Trouble breathing
- O Emphysema
- O Tuberculosis
- O Chronic cough

GENITOURINARY:

- O Sexual dysfunction
- O Impotence
- O Kidney stones
- O Urinary incontinence
- O Urinary urgency
- O Vaginal bleeding
- O Frequent urination
- O Painful urination
- O Blood in urine

PSYCHIATRIC:

- O Anxiety
- O Depression
- O Trouble concentrating

GASTROINTESTINAL:

- O Ulcer
- O Vomiting
- O Constipation
- O Diarrhea
- O Bowel Incontinence
- O Hiatal hernia
- O Reflux
- O Rectal bleeding

NEUROLOGICAL:

- O Headache
- O Seizure
- O Memory loss
- O Loss of consciousness
- O Weakness
- O Falling down
- O Vertigo
- O Concussion

MUSCULOSKELETAL:

- O Low back pain
- O Neck pain
- O Joint pain
- O Trouble walking
- O Joint swelling
- O Numbness

HEMATOLOGICAL:

- O Blood disorder
- O HIV
- O Enlarged lymph nodes
- O Hepatitis
- O Tingling leukemia
- O Sickle cell disease

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY:

- O GERD/Heartburn
- O Colon Polyps
- O Pancreatitis
- O Ulcerative Colitis
- O Hypertension
- O Coronary Artery Disease
- O Congestive Heart Failure
- O Atrial Fibrillation
- O Pacemaker
- O AICD (Defibrillator)
- O COPD
- O Diabetes
- O Thyroid Problems
- O Elevated Cholesterol
- O Stroke
- O Fibromyalgia
- O Arthritis
- O Chronic Back pain
- O Cancer
- O Kidney Failure
- O Heart Attack
- O Seizures
- O Glaucoma
- O Pneumonia
- O Aneurysm

PAST SURGICAL HISTORY:

- O Colonoscopy
- O EGD (Upper endoscopy)
- O Ulcer Surgery
- O Colon Surgery
- O Cholecystectomy
- O Appendectomy
- O Hemorrhoidectomy
- O Bypass Surgery
- O Heart Valve Replacement
- O Hysterectomy
- O Ovaries Removed
- O Breast Cancer Surgery
- O Spinal Cord Stimulator
- O Prostate Surgery
- O Back Surgery
- O Neck Surgery
- O Hip Surgery
- O Knee Surgery
- O Weight Loss Surgery
- O Brain Surgery
- O Intrathecal Pain Pump
- O Other: _____

Have you ever had a problem with anesthesia? O Yes O No

If yes, please explain:

Have you ever had a blood transfusion? O Yes O No

If yes, why?

FAMILY HISTORY:

- O Arthritis
- O Heart Attack
- O Heart Disease
- O Peripheral Vascular Disease
- O Hypertension
- O High Cholesterol
- O Diabetes Mellitus
- O Stroke
- O Cancer
- O Aneurysm
- O Other:_____

Patient Name: _____ DOB: _____

SOCIAL HISTORY:

Do you drink alcohol? O Yes O No

If yes, approximately how many drinks per week? _____

Do you smoke or vape? O Yes O No

If yes, how often? O every day O some days **If yes,** how many a day? _____

How soon after you wake do you smoke? _____

Are you interested in quitting? O Yes O No O Undecided

If you are a former smoker, how long has it been since you last smoked?

[ ] 1-3 months [ ] 3-6 months [ ] 6-12 months [ ] 1-5 years [ ] 5-10 years [ ] 10+ years

Work Status: O Full Time O Part Time O Retired O Homemaker O Student O Unemployed O Disabled

Occupation:_____

MEDICATIONS:

Please list all medications and dosage you are currently taking, including over the counter medications.
Please also include the length of time you have been taking any narcotic medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you take aspirin or any medicines that contain aspirin such as Ibuprofen or Motrin? If yes, please specify:
_____

PHARMACY:

Please provide the name and phone number of your pharmacy so that we may keep this information on file if needed.

Name: _____City:_____Phone:_____

Patient Name: _____ DOB: _____

PAIN MANAGEMENT:

Are you currently in Pain Management or receiving pain medications from another physician? O Yes O No

If yes, please list below the name and address this physician:

Name: _____ Address: _____

Phone: _____ Fax: _____

ALLERGIES:

Please list any known drug and/or food allergies.

Medication / Food	Type of Reaction

Patient Agreement for Prescribed Medications

I will submit to random pill counts and urine and/or blood drug tests as requested by my provider in order to monitor my treatment. I understand that the presence of any unauthorized substances may prompt referral for assessment of addiction and could result in discontinuation of further opioid and all other prescriptions. I also understand that failure to follow these rules may lead to dismissal from care by my provider.

I will not share, sell or otherwise permit others to have access to my medication and I will keep it in a secure location as I understand that medications reported as lost or stolen will not be refilled early.

By signing this document either in person or electronically, I voluntarily give my consent to prescription medication therapy and fully understand my responsibilities.

X_____ _____

Patient Signature Date

Patient Name: _____ DOB: _____

HISTORY OF PRESENT ILLNESS:

What is the reason for your visit today?

_____

How long have you had the problem?

_____

How severe is the problem?

_____

What type of symptoms are you experiencing?

_____

How often do your symptoms occur?

_____

How long do your symptoms last?

_____

Is there anything that makes the problem worse?

_____

Does anything make the problem better?

_____

Have you ever had treatment or surgery for this problem?

_____

Please rate your pain on a scale from one to ten. (1 being minor and 10 being severe)

1 2 3 4 5 6 7 8 9 10

PREVIOUS TREATMENT: (Check all that you have tried)

- ☐ Previous Surgery
- ☐ Physical Therapy
- ☐ Exercise Programs
- ☐ Chiropractor
- ☐ Brace or Wrist Splints
- ☐ Narcotic Pain Medication (Lortab, Percocet, Vicodin, Etc.)
- ☐ Anti-Inflammatory Medications (Motrin, Naproxen, Aspirin, Etc.)
- ☐ Steroidal Anti-Inflammatory Medications (Medrol Dose Pak, Depo-Medrol, Solu-Medrol, Etc.)
- ☐ Epidural Steroid Injections:

  How many times (number of injections)? _____ These provided relief for:

  - ☐ No Relief
  - ☐ 1 – 4 weeks relief
  - ☐ 5 – 8 weeks relief
  - ☐ 8+ weeks relief

Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #_____

I request and authorize _____

to release healthcare information of the patient named above to:

NASHVILLE NEUROSURGERY ASSOCIATES – The office of:

	Provider	Fax Number	Phone Number
	Arthur J. Ulm, MD	615-902-3980	615-320-0007
	Robert A. Mericle, MD	615-902-3982	
	Robbi L. Franklin, MD	615-902-3983	
	Chine Sp. Logan, DO	615-320-3183	
	James M. Barry, MD	615-526-6477	
	Christopher M. Storey, MD	615-383-6329	

	Provider	Fax Number	Phone Number
	L. Brett Babat, MD	615-320-3186	615-986-1256
	Khan W. Li, MD	615-320-4178	
	William R. Schooley, MD	615-320-4106	
	Rex E. Arendall, MD	615-327-8975	
	D. Timothy Lockney, MD	615-329-3044	

This request and authorization applies to:

☐ ALL healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

☐ Other:

_____

_____

_____ _____

Patient Signature **Date Signed**

Nashville Neurosurgery Associates
FINANCIAL & ADMINSTRATIVE POLICIES

- ✓ **Insurance Billing:** As a service to our patients, Nashville Neurosurgery Associates is more than willing to directly billyour insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from Nashville Neurosurgery Associates. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing Nashville Neurosurgery Associates with the most current insurance information (.i.e. Insurance card, Spouse's information, etc.). This includes patients providing their insurance with the appropriate information needed inorder to process your bills accordingly (.i.e. coordination of benefits, pre-existing information requested, surveys needed, etc.). Patients who do not bring their insurance card for their appointment may be asked to pay for the services rendered. If and when the insurance is billed and payment has been received, Nashville Neurosurgery Associates will gladly refund any credits due the patient.

- ✓ **Patient Balances** are due 30 days after the first statement has been sent out. Alternatively, the patient must make acceptable payment arrangements by contacting the Billing Department at Nashville Neurosurgery Associates. Balances may be paid by via cash, check, money order, Visa, or MasterCard.

- ✓ **Unpaid Balances**: If for any reason the patient cannot make scheduled payments, the patient must immediately contact the Office Manager at Nashville Neurosurgery Associates to make acceptable arrangements. Nashville Neurosurgery Associates reserves the right to refer all unpaid accounts to collection agencies. Any fees associated with collection, including contingency fees and court costs, will be added to the patient's account balance. After accounts are placed with collection agencies, all patient visits and procedures will be on a cash only basis. Nashville Neurosurgery Associates reserves the right to discharge a patient from our practice if balances are not paid.

- ✓ **Service Charge**: Nashville Neurosurgery Associates reserves the right to assess a 35% service charge to a patient account, if sent to a collection agency, for any unpaid patient balance over 30 days after the insurance coverage has paid. No service charges will be assessed to a patient account where the patient has made payment arrangements with the Billing Department and payments are being made as agreed.

- ✓ All insurance co-pays are due at time of service; patients may be re-scheduled if the co-pay is not made.

- ✓ Patients who are not on time for their scheduled appointment may be re-scheduled to a later date.

- ✓ Nashville Neurosurgery Associates will charge the patient account $35.00 for any returned checks to cover the cost of the associated bank charges.

Authorization for Treatment & Financial Agreement:

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received in writing within 30 days of statement date. I agree to pay all charges within 30 days of statement date. I agree to assign my insurance benefits to Nashville Neurosurgery Associates if applicable.

I have read and understand these policies and hereby acknowledge receipt of a copy of this form.

_____

Signature and Date

ALL QUESTIONS CONCERNING THESE POLICIES SHOULD BE DIRECTED TO THE ADMINISTRATOR

NEUROSURGICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES

This Notice is effective May 4, 2011

THIS NOTICE SUMMARIZES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

1. **Treatment**
2. **Payment**
3. **Healthcare Operations**
4. **Persons Involved in Your Care**
5. **Required by Law**
6. **National Priority Uses and Disclosures**
   - **Law enforcement**
   - **Coroners and others**
   - **Workers' compensation**
   - **Research organizations**
   - **Certain government functions**
7. **Authorizations**

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

1. **Right to a Copy of This Notice**
2. **Right of Access to Inspect and Copy**
3. **Right to Have Medical Information Amended**
4. **Right to an Accounting of Disclosures We Have Made**
5. **Right to Request Restrictions on Uses and Disclosures**
6. **Right to Request an Alternative Method of Contact**

Signing this form indicates that you have reviewed the full Notice of Privacy Practices for Neurosurgical Associates that was provided to you either in an electronic, laminated or printed format at the time of your appointment. A copy of the full Notice of Privacy Practices for Neurosurgical Associates is available upon request. This notice is effective for all medical information that we maintain that pertains to your care and does not expire.

_____

PATIENT SIGNATURE & DATE