Palm Beach Neurosurgery, LLC

Specializing in Surgical Diseases of the Brain, Spine and Nerves

PATIENT REGISTRATION & INFORMATION

PLEASE PRINT

Name: ____
Last First Middle

Date of Birth: ____________ SS#: ____________________ Marital Status: __________

Gender: ___ Language: __________ Race: ________ Ethnicity: Hispanic/Non-Hispanic/Other

Address: ____

City: ____________________ State: ________ Zip Code: ____________

Home #: ________________ Cell #: ____________________

Occupation: ________________________ Work #: ____________________

***Please choose one** – Do you live in FL: ☐ Full Time or ☐ Seasonal

Seasonal Address: ____

Emergency Contact (**Name, Relation, & Phone**):

____

Primary Dr.: ________________________________ Phone #: ______________

Referring Dr.: ______________________________ Phone #: ______________

Is this visit due to an Auto Accident? _______ Work Injury? _______ Slip or fall? _______

Second Opinion? _______ Do you or will you have a Legal Case? _______ Due to: _________

____
Patient (or Responsible Party) Signature

____
Date

3319 State Road 7
Suite #313
Wellington, FL 33449

4560 Lantana Road
Suite #120
Lake Worth, FL 33463

601 University Blvd
Suite #203
Jupiter, FL 33458

Tel. 561-433-4444 **www.pbneurosurgery.com** **Fax. 561-433-8877**

Palm Beach Neurosurgery, LLC

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Steven A. Dutcher, DO,
PhD, FAANS, FACOS
Diplomate, American Board of Neurological Surgery
Diplomate, American Board of Osteopathic Surgery

Ramin M. Abdolvahabi,
MD, PhD, FAANS
Diplomate, American Board of Neurological Surgery

John D. Cantando, DO
Diplomate, American Board of Osteopathic Surgery

Brett A. Schlifka, DO,
FACOS
Diplomate, American Board of Osteopathic Surgery

Megan Ginter, PA-C
Hana Korb, PA-C
Kelly Meyer, PA-C
Vanessa Vieda, PA-C
Kelli Griffiths, PA-C

Dear Patient,

Name: ______________________________

As part of our Electronic Medical Record (EMR) system you will be receiving an email from Palm Beach Neurosurgery, this is not SPAM. Using the link sent to you, you will create a username login and password. Using a secure server you will be able to view your demographic information on file as well as your allergies, medications, problems/diagnosis, family history, and vital signs recorded during your appointments. **There will be no communication to or from the office through this system other than appointment reminders.** If you have any questions please do not hesitate to contact our office at 561-433-4444.

EMAIL- PLEASE PRINT:

____

Thank You for Your Cooperation.

Ramin Abdolvahabi, MD, PhD, FAANS

Steven Dutcher, DO, PhD, FACOS, FAANS

John Cantando, DO

Brett A. Schlifka, DO, FACOS

Tel. 561-433-4444 | **3319 State Road 7, Suite #313, Wellington, FL 33449** | **4560 Lantana Rd., Suite #120, Lake Worth, FL 33463** | **601 University Blvd., Suite #203, Jupiter, FL 33458** | **Fax. 561-433-8877**

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PHARMACY INFORMATION

Patient Name: ______________________________ Date: _________

Date of Birth: ____________________________

Pharmacy Name: ____

Pharmacy Phone #: ____

Pharmacy Address or Cross Streets: ___________________________

____

____

Please list any Advanced Directives you have, (i.e. ok to give blood, DNR, etc.) if none please write none:

____

____

____

Authorization for Release of Information

Name of Patient ______________________________ **Date of Birth** __________

Palm Beach Neurosurgery, LLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you Approve to receive information	**Description of Information to be released** Check each that can be given to person/entity
☐ Voice Mail	☐ Results of Labs/Imaging ☐ Other:
☐ Spouse (Name & phone #)	☐ Financial ☐ Medical as follows:
☐ Parent (Name & phone #)	☐ Financial ☐ Medical as follows:
☐ Other (Name & #)	☐ Financial ☐ Medical as follows:

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

______________________________ Date __________

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

____

Revised January 2010

Patient Name: ______________________________ Are you allergic to contrast dye? __________

Medication Allergies: __________________________ Food Allergies: ____________________

LIST ALL CURRENT MEDICATIONS & DOSAGE:_________________________________

____

____

____

MEDICAL HISTORY

			Date Started				Date started
AIDS	Yes	No	________	Alcohol Depend.	Yes	No	________
Alzheimer's	Yes	No	________	Anemia	Yes	No	________
Arrhythmias	Yes	No	________	Asthma	Yes	No	________
B Prost. Hyper.	Yes	No	________	Bladder Infection	Yes	No	________
Cancer Benign	Yes	No	________	Cataracts	Yes	No	________
Cancer Malig.	Yes	No	________	Concussion	Yes	No	________
Specify Type of cancer: ________________				Cirrhosis	Yes	No	________
COPD	Yes	No	________	Depression	Yes	No	________
Diabetes	Yes	No	________	Diverticulitis	Yes	No	________
Drug Depend.	Yes	No	________	Eye Problems	Yes	No	________
Fibromyalgia	Yes	No	________	Gall Stones	Yes	No	________
GERD	Yes	No	________	Glaucoma	Yes	No	________
Gout	Yes	No	________	Headache any	Yes	No	________
Hearing impaired	Yes	No	________	Heart disease	Yes	No	________
Hemorrhoids	Yes	No	________	Hepatitis- A, B, C	Yes	No	________
High Cholesterol	Yes	No	________	HIV	Yes	No	________
Hydrocephalus	Yes	No	________	Hypertension	Yes	No	________
IBS	Yes	No	________	Kidney Stones	Yes	No	________
Meningitis	Yes	No	________	Osteo. Arthritis	Yes	No	________
Osteoporosis	Yes	No	________	Paralysis	Yes	No	________
Parkinson's	Yes	No	________	Peptic Ulcer	Yes	No	________
Pneumonia	Yes	No	________	Psych Disorder	Yes	No	________
Rheum. Arthritis	Yes	No	________	Seizure Disorder	Yes	No	________
Sleep apnea	Yes	No	________	STD's	Yes	No	________
Stroke	Yes	No	________	Thyroid Disease	Yes	No	________
Tuberculosis	Yes	No	________	Urinary Infection	Yes	No	________

ARE YOU EXPERIENCING ANY OF THE FOLLOWING AT THIS TIME?

Shortness of breath	yes	no	Chest pain	yes	no
Blood in stool	yes	no	Numbness	yes	no
Blood in urine	yes	no	Headaches	yes	no
Uncontrolled bladder	yes	no	Nausea	yes	no
Uncontrolled bowel	yes	no	Tingling	yes	no
Vomiting	yes	no	Ringing in ears	yes	no
Weakness	yes	no	Abnormal Vision	yes	no
Paralysis	yes	no	Abn. Weight Gain	yes	no
Hearing loss	yes	no	Abn. Weight Loss	yes	no

Have you fallen in the last year? YES NO If yes, did it result in an injury? Please specify:

____

____

PATIENT NAME: ______________________________ DATE: ___________________

LIST ALL SURGERIES. PLEASE BE SPECIFIC AS TO TYPE OF SURGERY & YEAR:

____

____

____

____

Do you have any Metal or Implants in your body? ____________________________

Previous treatment Brain or Spine and Dates: ________________________________

Epidurals __________________________

Physical Therapy ____________________

MRI/CT SCAN/X-RAYS (location and date) ___________________________

Family History

Members	Status	Year of Birth	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Other Please List
Father	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Mother	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Siblings	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Paternal grandfather	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Paternal grandmother	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Maternal grandfather	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	
Maternal grandmother	Alive, Deceased, Unknown		Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	Yes or No Unknown	

How many -- Sisters _________ Brothers: ________ Daughters: ________ Sons: _________

Do you smoke: yes no What, How much & how often: ______________

Have you ever smoked: _________ When did you quit: ____________

Do you drink: yes no How much & how often: ________________

Do you use any recreational drugs: yes no Specify type: ______________________

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Main Complaint for your visit today: ____

When did this begin: ______________________

Where Is Your Pain?

Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol and mark the areas radiation also, include all affected areas.

Ache ^^^	Numbness OOO	Pins/Needles ***	Radiating Pain ///
^^^	OOO	***	///
^^^	OOO	***	///

Please indicate the percentage (%) of pain that you have in the following areas, to be equal to 100%:

Neck Pain ______%
Arm Pain ______%
Back Pain ______%
Leg Pain ______%

LEFT LEFT

How bad is your pain now?

1-----------2-----------3-----------4-----------5----------6-----------7-----------8------------9--------------10

No Pain Intermediate Pain Worst Pain

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

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Diplomate, American Board of Osteopathic Surgery

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Diplomate, American Board of Osteopathic Surgery

Kelly Meyer, PA-C
Megan Ginter, PA-C
Julie Sacerdote, PA-C
Hana Korb, PA-C

I, ______________________ DOB: __________

GIVE PERMISSION TO RELEASE MY

MEDICAL RECORDS TO:

PALM BEACH NEUROSURGERY, LLC
3319 STATE ROAD 7
SUITE 313
WELLINGTON, FL. 33449
PHONE: 561-433-4444
FAX: 561-433-8877

FOR THE PURPOSE OF CONTINUED MEDICAL CARE.

PATIENT SIGNATURE: ________________________

DATE: ____________________________________

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HEALTH INSURANCE INFORMATION:

PRIMARY INSURANCE

Name of Insured: ______________________________ Relationship to Insured: __________

Insurance Company: ____

Insurance Member ID #: ____________________________ Group #: _________________

Effective Date of Coverage: __________________________ Co-pay $: _________________

SECONDARY INSURANCE

Insurance Company: ____

Insurance Member ID #: ____________________________ Group #: _________________

Effective Date of Coverage: __________________________ Co-pay $: _________________

TERTIARY INSURANCE

Name of Insured: ______________________________ Relationship to Insured: __________

Insurance Company: ____

Insurance Member ID #: ____________________________ Group #: _________________

Effective Date of Coverage: __________________________ Co-pay $: _________________

I HEARBYAGREE THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

____ _______________

Patient (or Responsible Party) Signature Date

****IF INJURY RELATED PLEASE ALSO FILL OUT ACCIDENT FORM****

PATIENT RESPONSIBILITIES:

Please read the following carefully as they are your responsibilities.

** To inform office of any changes in insurance coverage.

** To inform office of any changes to address, phone number, or doctor's.

** To inform office if your visit is due to an accident related injury.

** **IT IS YOUR RESPONSIBILITY to provide us with your current insurance plan and referral if needed from your Primary Care Physician at the time of your visit. _______** (please initial that you understand, even if it does not apply at this current time to you)

** If your insurance requires a referral and you are seen without a valid referral, you understand that you will be responsible for any costs incurred for the visit.

** **To pay any applicable co-pays or balances due on the day of your visit.**

** **To provide the Doctor with any diagnostic films or discs requested**: Note: when you have a diagnostic test (such as MRI, X-RAY, CT SCAN) it is **YOUR RESPONSIBILITY** to bring your films or discs along with the reports to your next visit. **YOUR PICTURES ARE NOT DELIVERED TO US NO MATTER WHAT THEY TELL YOU!!!! __________** (initials)

** I understand there is a $ 25.00 fee for any and all forms (e.g. Disability Forms) that may need to be filled out by the Doctor/staff on my behalf.

I, the patient, have read and understand the above responsibilities:

Signature: ____________________________ Date: ______________

Patient Consent Form
Please read and sign.

I am voluntarily seeking health care and hereby consent to medical treatment, procedures, diagnostic imaging, laboratory tests, and other health care services. The attending physician is responsible for the patients care. I, the Patient/Patients legal representative, understand that I have the right to refuse specific treatments or procedures; however, by signing below, I agree in general, to permit diagnostic imaging, laboratory tests, routine medical and mental health treatment, emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physician assisting in the care of the patient. By signing this I verify that I am at least 18 years of age.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand the Palm Beach Neurosurgery, LLC may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Drs. Dutcher, Abdolvahabi, Cantando, and Schlifka will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practiced.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or it's intermediaries for my Medicare claims. I assign the benefits payable for services to Palm Beach Neurosurgery, LLC/ Drs. Dutcher, Abdolvahabi, Cantando, or Schlifka

To obtain a copy of the Palm Beach Neurosurgery, LLC Notice of Privacy Practices please visit our website @ https://www.pbneurosurgery.com. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________________ ________________
Patient (or Responsible Party) Signature **Date**

Palm Beach Neurosurgery, LLC
Financial and Office Policies

Thank you for choosing Palm Beach Neurosurgery, LLC as your healthcare provider. We are committed to your successful treatment and optimal experience in our office. Please familiarize yourself with our policies and procedures to ensure the highest quality of care.

FINANCIAL POLICY

Insurance

Please understand that your insurance policy is a contract between you and your insurance company. Please ensure that we have updated information about your insurance at all time. We bill your insurance as a courtesy to you when provided with current information and an assignment of benefits, but the patient will be responsible for verifying their coverage and participating facilities, obtaining authorizations/referrals and ultimately paying the bill if the insurance company denies payment for services provided.

If your insurance requires a co-pay, it must be paid the day of your appointment or the appointment will be rescheduled. If your deductible hasn't been met, you will be required to make a payment the day services are provided. If your insurance cannot verify your coverage or you do not have insurance, you will be expected to pay in full the day of the services.

Patient Balances: All balances after insurance has processed will be due in full within 30 days. Any patient that has been placed on collections must pay any prior balance owed to the practice and the collection agency fee and/or attorney fees before the practice can schedule any future appointments. Patients sent to collections might have their debt reported to credit score agencies. **If your account is turned over to our collection agency Collection Information Bureau, Inc, patient will be responsible to pay the collection fee which is 25% of total patient responsible balance.**

Surgery Deposit: Self pay patients who are scheduled for an elective surgery will be asked to make a deposit of 75% of balance with our office prior to scheduling procedure. This allows us to reserve the operating time. Payment arrangements must be discussed with the billing office prior to surgery. Payments are not to exceed 3 installments after deposit.

HMO Plans: If you are required to have a PCP, please obtain a referral to see our providers. You are responsible for getting proper co-pay information in advance of your appointment.

PPO Plans: If we are in your network, we have agreed to accept the discounted rate from your plan, however all co-insurance, co-payments and deductible are your responsibility.

Medicare: After your insurance or secondary insurance has cleared we will send you a statement for the co-payment you are responsible for. Having more than one insurer does not necessarily mean that your services are covered 100%. As a courtesy we will bill your secondary insurance carrier, if they do not pay after 60 days you will be responsible for balance.
Out of network PPO plans: We will bill your insurance carrier as a courtesy. In the event charges are applied to your responsibility by your insurance carrier, we will expect payment at the time of service.
Payment Plans: Patients who have financial hardship to fulfill their financial obligation and whose balance is over $500.00, might be eligible for a payment plan. Payment plans will not exceed 3 payments.

OFFICE POLICIES

Returned Checks: All returned checks are subject to a processing fee of $25.00 per transaction. This fee along with the original amount of the check will be due within 10 business days of the official notification given from Palm Beach Neurosurgery. A returned check, against a closed account or an account with non-sufficient funds (NSF), is in violation of civil law and, in certain situations (checks written over $100), criminal law.
Patient Forms: Disability paper work will be filled out as a courtesy for patients during the post op period and whose balance has been paid. We also provide this service for patients for a fee of $25.00 or more depending on complexity, to the patient.
Missed/Canceled Appointments: A $50.00 charge may apply to missed appointments and appointments cancelled without 24 hours of notice. Appointment reminders are done as a courtesy and do not constitute a timely phone call or failure to appear.

I read and understand all of the financial and office policies. I agree to comply with these policies:

____

Printed Name **Signature** **Date**

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Kelly Meyer, PA-C
Megan Ginter, PA-C
Hana Korb, PA-C
Julie Sacerdote, PA-C

Auto/WC/Liability Intake

Patient Name: ______________________________

Phone: ________________

Carrier Name: ______________________________

Carrier Address: ______________________________

Carrier Phone: ________________

Claim #: ______________________________

Date of Accident: ____________________

Adjuster Name: ______________________________

Adjuster Phone: ________________

Attorney Name: ______________________________

Attorney Address: ______________________________

Attorney Phone: ______________________________

I understand Palm Beach Neurosurgery does not accept outside letters of protection. ________________________ (Sign & Date)

I understand that when my benefits become exhausted, I assume financial responsibility. ____________________ (Sign & Date)

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PALM BEACH NEUROSURGERY, LLC

TO: ______________________ RE: ______________________

______________________ PATIENT'S NAME

______________________ SS# ______________________

LETTER OF PROTECTION

I, (PRINT NAME)______________________ DO HEREBY AUTHORIZE and direct my attorney, ______________________ to pay Palm Beach Neurosurgery, LLC and or its assignees any such sums as may be due and owing for professional services rendered to me by reason of the accident dated ____________ and to withhold such sums from any settlement, judgment or verdict which may be necessary to adequately protect Palm Beach Neurosurgery, LLC as a result of the injuries for which I have been treated or injuries in connection therewith. I FULLY UNDERSTAND that I am directly and fully responsible to Palm Beach Neurosurgery, LLC for all bills submitted by Palm Beach Neurosurgery, LLC for services rendered to me and that this agreement is made solely for Palm Beach Neurosurgery, LLC'S additional protection in consideration of awaiting payment. Furthermore, I HEREBY AGREE to otherwise consent to Palm Beach Neurosurgery and/or its assignee's entitlement to intervene in any such actions, suit of claim which may be filed by patient or his/her attorney for the injuries treated by Palm Beach Neurosurgery, LLC. In addition, patient hereby acknowledges that the covenants and agreements made herein supersede any health or managed care contracts between patient's health care provider and Palm Beach Neurosurgery, LLC by which patient may be a direct or third beneficiary. I further understand and agree that payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I FINALLY UNDERSTAND that such payment for medical services rendered is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

______________________ ______________________

Patient or Responsible Party Date

______________________ ______________________

Witness Date

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above, including Palm Beach Neurosurgery's and/or its assignee's entitlement to intervene in any action, suit or claim, and furthermore agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Palm Beach Neurosurgery.

______________________ ______________________

Attorney's Signature Date

ALTERATIONS TO THIS DOCUMENT WILL BE DEEMED AS NULL AND INVALID