Neurosurgical & Spine Institute

THANK YOU FOR CHOOSING THE INSTITUTE

At the Neurosurgical & Spine Institute of Savannah, our doctors specialize in conditions and injuries related to the brain and spine. Thank you for choosing us and trusting our team with YOUR brain and spine health. We promise to provide quality care and cutting- edge treatment options from top doctors and experts in the field, delivered with the compassion you deserve.

This new patient packet is designed to help you prepare for your upcoming appointment. Please take some time to review in detail so you know what to expect before, during, and after your visit with your surgeon's team.

This packet can be filled in and printed to bring with you on the day of your appointment. Patients are also welcome to print as a PDF and email a completed packet to referrals@neurosav.com in advance of their appointment.

WHAT TO EXPECT: BEFORE YOUR VISIT

Upon receiving your referral, your surgeon's team will take time to review any available office notes, operative reports, and imaging provided by your referring physician. This ensures we have what we need to build your patient chart and schedule the right appointment type and resources for your specific condition. Once these items are received and imported, a scheduler will reach out with a date, time and location for your appointment. **NOTE:** Your first appointment may be with your surgeon's designated nurse practitioner or physician assistant. These individuals are highly qualified and trained by our surgeons to assess each patient's individual condition. They are able to order additional tests and prescribe any medications or conservative treatments needed to advance your plan of care.

If you are a new patient and we received a mobile number as part of your referral or registration packet, you will receive a text message inviting you to complete your new patient forms online approximately 5 days prior to your scheduled appointment time. Alternatively, you can review and complete the following pages and bring them with you to your appointment.

You will receive two additional text messages to confirm your appointment, including a reminder the day before.

WHAT TO BRING

- ☐ A copy of your current **insurance card(s)**
- ☐ **Photo identification,** such as a driver's license
- ☐ **A written list of your current medications** (including vitamins and supplements) including the dosages you are currently taking
- ☐ Any radiology films and CDs **(X-rays, CT scans, and MRIs)** you have that pertain to your current problem
- ☐ New Patient Forms

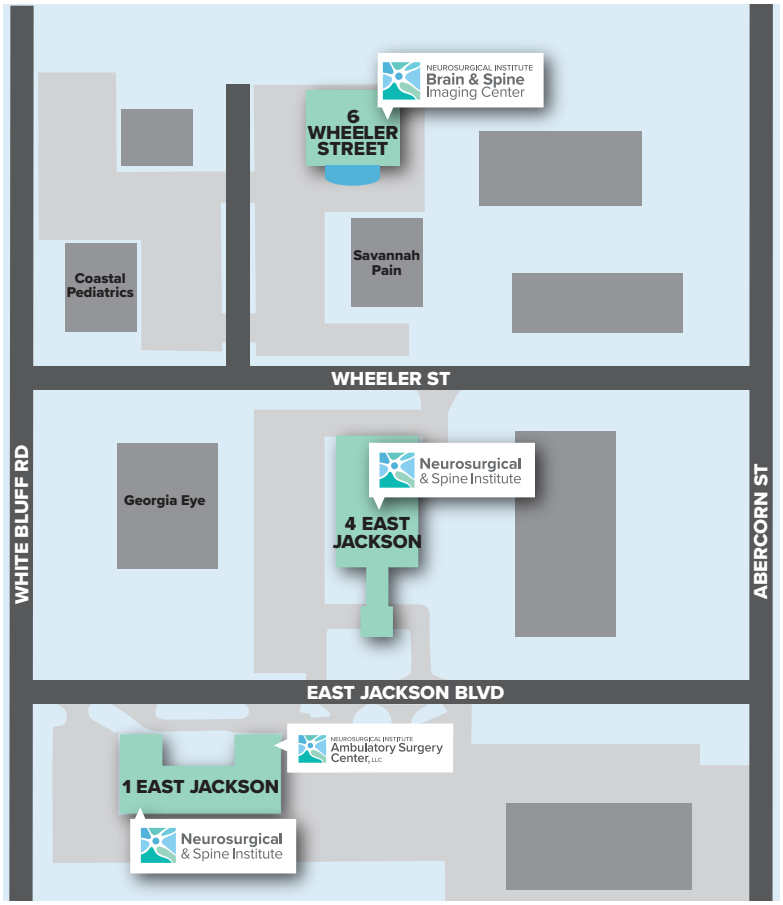
Neurosurgical & Spine Institute

OUR LOCATIONS

SAVANNAH
1 EAST JACKSON BLVD
Kevin Ammar, MD | Louis Horn IV, MD
Jay Howington, MD | James Lindley, Jr., MD
Daniel Y. Suh, PhD, MD
Ambulatory Surgery Center

4 EAST JACKSON BLVD
Roy Baker, MD | Matthew Helton, MD | Ryan Lingo, MD
Davis Reames IV, MD | Willard Thompson, Jr., MD
Jeffrey Wessell, DO

6 WHEELER STREET
X-Ray, MRI, CT, Ultrasound, Lab, Angiograms,
Myelograms & Kyphoplasty



FROM I-16
- Stay on I-16 to 516 toward Savannah heading East.
- Take Exit 164A; this street will turn into Derenne Ave.
- Turn right onto Abercorn St.; Jackson Blvd. will be the 4th traffic light.
- Turn right onto Jackson Blvd.

FROM I-95
- Turn onto GA Highway 204.
- Take Exit 94 (Abercorn Expwy. to Abercorn St.).
- Continue on Abercorn St. for approximately 12 miles.
- Turn left onto Jackson Blvd.

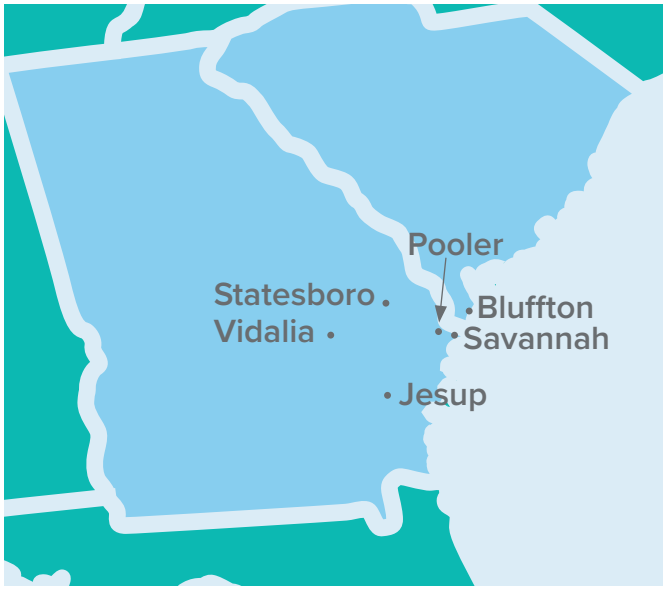
BLUFFTON
12B Arley Way (Ste 103)
Daniel Y. Suh, PhD, MD | Jeffrey Wessell, DO

JESUP
1907 Sunset Blvd
Kevin Ammar, MD | Matthew Helton, MD
Louis Horn IV, MD

POOLER
101 St. Joseph's Candler Drive, Suite 340
Kevin Ammar, MD | Ryan Lingo, MD | Davis Reames IV, MD
Daniel Y. Suh, PhD, MD

STATESBORO
2A Ed Moore Court
Kevin Ammar, MD | Jeffrey Wessell, DO

VIDALIA
1707 Meadows Lane, Suite E
Ryan Lingo, MD



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WHAT TO EXPECT: UPON ARRIVAL

When you arrive for your appointment, our Patient Services Team will be available to guide you through the check in process. If you prefer to not use Mobile Check In, please plan to arrive 15-20 minutes early for your first visit so we can review and scan any forms and documents needed from this packet.

At check in, our Patient Services Team will request any imaging you were instructed to bring and share it with your clinic team in advance. Depending on the reason for your visit, they may also provide you with an intake form to complete while you are waiting for your team's Patient Care Coordinator to call you back for your appointment.

Once your Patient Care Coordinator gets you settled into your exam room, they will take your vitals, review and input your list of current medications, make copies of any films you have brought with you and collect any additional information your provider has requested. Next, they will notify your provider that you have arrived and are ready to be seen.

Appointment Policies & Reminders

Our clinic team aims to set aside enough time to provide each patient with the highest quality care. We will make every effort to schedule your appointments as efficiently as possible. In return, it is your responsibility to keep your scheduled appointments and to arrive at your specified time. Below are some of our practices policies and procedures related to patient appointments. Please review these carefully.

Suggested Arrival Time: Patients are asked to arrive before their scheduled appointment time as this allows enough time for the patient to check in and update their records before the actual appointment time. We strongly suggest that new patients arrive 15-20 minutes before their scheduled appointment time. Established patients should plan to arrive 5-10 minutes before their scheduled appointment time.

Late Arrivals: A grace period of 10 minutes will be permitted for any unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their scheduled appointment, and cannot be seen by the provider on the same day, they will be rescheduled for the next available opening.

No Show/Late Cancellation Policy

We do realize that unanticipated events can occur and may prevent you from keeping your appointment. We request that you notify our office immediately when you realize you will not be able to keep your appointment as this gives us the ability to accommodate other patients who may be waiting for a neurosurgery consult. A patient who does not show up for a scheduled appointment or does not provide twenty-four (24) hours notice prior to cancelling an appointment will be charged a $40.00 No Show/Late Cancellation Fee. We require these fees be paid prior to any future appointments.

Non-Compliance Policy: Patients who do not arrive for their scheduled appointments on three occasions may be discharged from the practice for non-compliance.

Multiple Providers: We have multiple providers caring for our patients within the same treatment area; therefore, some patients may be called before others who have been waiting longer because they are seeing a different provider. All patients will be seen in the order they have been scheduled. Patients who arrive before their scheduled appointment time will not be seen early unless there has been a cancellation.

Wait Times: While we strive to keep all scheduled appointment times, our goal is to provide the necessary time and treatment to ensure every patient understands their diagnosis and treatment options. Some patients may require more time than others depending on the variety of complex neurosurgical conditions your surgeon is seeing on the day you are scheduled. For this reason, we suggest each patient plan to be here for up to two hours following their scheduled appointment time.

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WHAT TO EXPECT: AFTER YOUR VISIT

Your Patient Care Coordinator will help you arrange for additional tests or referrals ordered by your provider.

We provide advanced imaging services (i.e. MRI & CT) as part of our practice for the convenience of our patients. However, please be advised that you have the right to obtain the above services at a provider of your choice. A list of alternative providers of advanced imaging services is as follows:

Bluffton
MRI at Belfair: 843-815-9700

Brunswick
American Health Imaging
in Brunswick: 912-267-6736

Jesup
Wayne Memorial Hospital:
Memorial Satilla Health:
Liberty Regional Medical Center:

Pooler
Pooler Imaging: 912-330-5170
St. Joseph's/Candler Imaging Services: 912-748-0068

Rincon
Effingham Hospital (CT only): 912-826-1400
Effingham Hospital (MRI only): 912-826-6015
Rincon Imaging: 826-1400

Savannah
Coastal Imaging Center: 912-355-6255
Open MRI/Savannah (MRI only): 912-355-6736
Trident Medical Imaging (CT only): 912-355-7523

Statesboro
OPI of Statesboro: 800-4674
Statesboro Imaging: 912-764-5656

Vidalia
Meadows Regional: 912-535-5555

Regardless of where you choose to go, most insurances require pre-authorization for advanced imaging like MRI or CT scans. It can take up to 14 days to secure approval depending on your insurance plan. Our team will likely schedule your CT or MRI with this in mind and will often schedule a follow up appointment to occur the same or next day.

Disability and FMLA Forms
If you have disability insurance or are eligible for leave under the Family Medical Leave Act (FMLA), you may drop these forms off at your physician's receptionist.

Completing this paperwork requires additional time and attention to ensure complete and accurate information is provided. This paperwork cannot be billed to your insurance company. Therefore, it is our office policy to charge $35 for the completion of each form.

If the form to be completed is sent to us by an outside organization, we will notify you of the exact amount that is due. We may also request completion of the Authorization to Disclose My Health Information.

Please allow us 7 to 10 business days after receipt of payment to complete these forms. We suggest that you call our office before making a trip to pick up the completed forms. Alternatively, you may provide a fax number and the forms can be sent for you.

Please note: You may be able to avoid being charged by requesting a copy of your office visit note if your insurance company or employer will accept the note in lieu of a completed form.

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PATIENT RIGHTS & RESPONSIBILITIES

YOUR RIGHTS

* You have the right to considerate, safe, respectful and responsive care. You have the right to medical treatment regardless of your age, sex, race, religion, disability or national origin.
* You have the right to respectful consideration of your psychosocial, spiritual and cultural values, needs and preferences.
* You have the right to be involved in all aspects of your care.
* You have the right to discuss with your physician the available information about your condition and treatment options so you may understand the potential risks, alternatives and possible results before making informed decisions about your treatment.
* You (or a family member/friend who is authorized to speak on your behalf) have the right to call for, and participate in, appropriate discussions of ethical concerns/issues. To arrange such discussions, speak with the nursing personnel caring for you or your loved one, or call administration at 912-355-1010.
* You have the right to refuse treatment to the extent permitted by law and be informed of the consequences of your refusal. In accordance with its philosophy, the Neurological Institute of Savannah's Ambulatory Surgery Center is opposed to, and will not cooperate in, suicide, assisted suicide and/or active euthanasia.
* You have the right to an explanation of treatments and procedures you are receiving, including the name of the physician who has primary responsibility for your care and the identity and status of professionals responsible for authorizing and performing treatments.
* You have the right to a reasonable response to your requests for any services within the available resources of our surgery centers and based on priority of need. This includes discharge-planning services.
* You have the right to confidentiality of information relating to your care in either the form of discussions or written records.
* You have the right to security and personal privacy, including access to protective services (e.g. guardianship and advocacy services).
* You have the right to information from surgery center staff in all matters relating to surgery center charges, payment of your bill, completion of insurance forms and explanation of utilization review procedures.
* You have the right to know rules and regulations that apply to your conduct and that of your family and your visitors while you are a patient at one of our surgery centers.
* You have the right to be provided with, upon written request, access to all information contained in your medical record.
* You have the right to be advised of participation in a medical care research program or donor program and to give your consent prior to participation in such a program. A patient may also refuse to continue in a program that they have previously given informed consent to participate in.
* You have the right to exercise your rights without being subjected to discrimination or reprisal.
* You have the right to voice grievances regarding treatment or care that is (or fails to be) furnished.
* You have the right to accurate information regarding the competence and capabilities of the organization.
* You have the right to change providers if other qualified providers are available.

YOUR RESPONSIBILITIES

* You have the responsibility to exercise your right to make informed decisions about your healthcare. This includes seeking and considering the information provided by your physician and other caregivers.
* You have the responsibility to follow treatment plans and instructions recommended by your physician. This includes your responsibility to ask questions when you do not understand the plan or instructions.
* You have the responsibility to report any changes in your condition to your physician and/or nurse.
* You have the responsibility to cooperate with the surgery center staff caring for you.
* You have the responsibility to provide, to the best of your knowledge, accurate and complete information about all matters relating to your health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
* You have the responsibility to consider and abide by the rules that apply to your conduct and that of your family and visitors while you are a patient at one of our surgery centers.
* You have the responsibility to provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if anesthesia/sedation is provided.
* You have the responsibility to follow surgery center rules and regulations, including respect for surgery center property and that of other patients.
* You have the responsibility to cooperate with surgery center staff to provide information for processing insurance and payment forms.
* You have the responsibility to leave valuables at home or send valuables with your family/friends while you are a patient.
* You have the responsibility to contact a nurse or physician, or call administration, to receive answers to questions about your care in one of our surgery centers.
* You have the responsibility to accept personal financial responsibility for any charges not covered by your insurance.
* You have the responsibility to inform your provider about any living will, medical power of attorney or other directive that could affect your care.

If you have any concerns, questions or need to file a grievance, please contact:
Carrie Bennett, Administrator
(912) 721-0191
carrie.bennett@neurosav.com

Other patient support resources:
Department of Community Health
Complaints Division
www.dch.georgia.com
(800)878-5728

US Department of Health and Human Services
Office of Civil Rights
www.hhs.gov/office/file/index.html
(800) 368-1019 | (800) 537-7697 (TDD)

Office of the Medicare Beneficiary Ombudsman
www.medicare.com/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Neurosurgical & Spine Institute

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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

If you have any questions about this notice, please speak with our Reception Staff.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Carrie Bennett. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Carrie Bennett.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Carrie Bennett.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Carrie Bennett. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific ite m or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Carrie Bennett. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.neurologicalinstitute.com. To obtain a paper copy of this notice, please ask our Reception Staff.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services.

To file a complaint with our office, please submit your complaint in writing and mail or bring it to:
Carrie Bennett, Practice Administrator
4 Jackson Blvd.
Savannah, Georgia 31405
Telephone: (912) 355-1010

To file a written complaint with the federal government, please use the following contact information:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Toll-Free Phone: 1-(877) 696-6775
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

Neurosurgical & Spine Institute

PATIENT INFORMATION FORM

PATIENT INFORMATION

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

NAME _____ ☐ MALE ☐ FEMALE
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

HOME PH (_____) _____ CELL PH (_____) _____ DATE OF BIRTH ____ /____ / _____

SOCIAL SECURITY # _____ /____ / _____

RACE: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Hispanic/Latino ☐ Hawaiian/Pacific

EMAIL _____ EMPLOYER _____

PHONE (____) _____

GENERAL INFORMATION

Who referred you to our office? (Doctor/Friend/Internet) _____ PHONE (____)_____

Nearest relative (not living with you) _____ PHONE (____)_____

In case of emergency notify: _____

RELATIONSHIP _____ PHONE (____)_____

SPOUSE/PARENT INFORMATION

NAME _____ ☐ MALE ☐ FEMALE
LAST FIRST MI

PHONE (_____) _____ DATE OF BIRTH ____ /____ / _____ SOCIAL SECURITY # _____ /____ / ____

ADDRESS _____
CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN_____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ PHONE (____) _____

SECONDARY INSURANCE PLAN_____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ PHONE (____) _____

VISIT DUE TO: ☐ Auto Accident ☐ Worker's Comp. DATE OF ACCIDENT ____ /____ /_____

CLAIM# _____ BILLING ADDRESS_____

HIPAA INFORMATION Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at ☐ Home ☐ Work ☐ Cell

The office may leave a message at ☐ Home ☐ Work ☐ Cell

I authorized the office to leave detailed messages about appointments/phone calls ☐ Yes ☐ No

Patient (or Parent/Guardian) Signature _____ DATE ____ /____ /_____

Neurosurgical & Spine Institute

YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following: (Circle All That Apply)

- Alcohol Use
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defects
- Bladder Problems
- Bleeding Disease
- Blood Clots
- Blood Transfusion
- Bowel Disease
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Depression
- Growth/Development Disorder
- Heart Attack
- Heart Disease
- Heart Pain/Angina
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- Hives
- Kidney Disease
- Liver Cancer
- Lung/Respiratory Disease
- Lung Cancer
- Liver Disease
- Mental Illness
- Migraines
- Osteoporosis
- Prostate Cancer
- Rectal Cancer
- Reflux/ GERD
- Seizures/Convulsions
- Severe Allergy
- Sexually Transmitted Disease
- Skin Cancer
- Stroke/ CVA of the Brain
- Suicide Attempts
- Thyroid Problems
- Ulcer
- Other Disease, Cancer, or Significant Illness

YOUR SURGICAL HISTORY

Please indicate if **YOU** have had any of the following neurosurgeries: (Circle All That Apply)

- Aneurysm Repair
- Angioplasty
- Brain Surgery
- Neck Surgery
- Back Surgery
- Spinal Fusion
- Carpal Tunnel Surgery
- Ulnar Nerve Release

Please indicate if **YOU** have had any of the following surgeries: (Circle All That Apply)

- Abdominal Surgery
- Appendectomy
- Breast Surgery
- Cardio Pacemaker Insertion
- Cholecystectomy
- Colectomy
- Coronary Artery Bypass Graft
- Cystectomy
- Defibrillator Implant
- Sinus Surgery
- Gastric Bypass
- Heart Transplant
- Heart Valve Surgery
- Hernia Repair
- Hip Replacement, Total
- Knee Replacement Total
- Liver Transplant
- Lung Transplant
- Nephrectomy
- Parathyroidectomy
- Prostate Surgery
- Renal Transplant
- Sinus Surgery
- Thyroidectomy
- Tonsillectomy

Neurosurgical & Spine Institute

OTHER PERTINENT HEALTH & SOCIAL HISTORY

Please circle any of the following symptoms you are **CURRENTLY** experiencing:

Visual Disturbances	Change in Bowel Habits	Urinary Urgency
Wear Glasses/Contacts	Urinary Frequency	Change in Urinary Stream
Painful Urination	Impotence	Easy Bruising
Excessive Bleeding	Fainting	Decreased Memory
Numbness	Trouble Walking	Seizures
Headaches	Joint Pain	Muscle Pain
Muscle Weakness		

TOBACCO USE

1. What is your smoking status? (Select One)

   ☐ Current (every day) ☐ Current (some days) ☐ Previous ☐ Never

   If you answered Never, skip to the Alcohol Use section.
2. At what age did you begin smoking? _____
3. If you quit smoking, at what age did you quit? _____
4. How many cigarettes do you currently smoke or did you previously smoke per day? _____
5. How many cigars or pipes do you smoke per week? _____
6. How many cans of smokeless/chewing tobacco do you use per week? _____
7. Are you exposed to passive (second hand) smoke? ☐ Yes ☐ No

ALCOHOL USE

1. How often do you use alcohol? (Circle The Number of Times)

   Never 1 2 3 4 5 6 7

   Per: Day Week Month Year

   If you answered Never, skip to the HIV High Risk Behavior section.
2. What type(s) of alcohol do you drink?

   ☐ Beer ☐ Wine ☐ Liquor
3. How many drinks do you have per occasion? _____
4. How often do you have more than five (5) drinks per occasion?

   ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

HIV HIGH RISK BEHAVIOR

1. Do you engage in HIV high risk behavior? (HIV risk factors include: IV drug use, more than one sexual partner, sex with a prostitute, unprotected sexual contact, contact with contaminated injection equipment)

   ☐ Yes ☐ No ☐ Prefer to discuss with Physician

Neurosurgical & Spine Institute

CURRENT MEDICATIONS

NAME _____ DATE OF BIRTH ____ /____ / _____
LAST FIRST MI

HEIGHT _____ WEIGHT _____

PREFERRED PHARMACY _____ PHONE (_____) _____

PHARMACY ADDRESS _____
CITY STATE ZIP

CURRENT MEDICATION(S)	DOSE	FREQUENCY

ALLERGIES TO MEDICATIONS/OTHER	REACTION

Are you currently taking a blood thinner? ☐ Yes ☐ No

Are you taking any medications for diabetes? ☐ Yes ☐ No

Have you had any problems with imaging contrast in the past? ☐ Yes ☐ No

Have you ever had problems with Anesthesia? ☐ Yes ☐ No

Do you have any implants (pacemaker, stimulator, etc.)? ☐ Yes ☐ No

Neurosurgical & Spine Institute

MEDICATION AGREEMENT

Medication refills should be requested Monday through Thursday between 9 am and 4 pm. No refills will be authorized on Friday-Sunday, after 4 pm on weekdays or any holidays where the practice is listed as closed. Our surgeons and advanced practitioners are only in clinic 2-3 days a week depending on their surgical and emergency call schedule, we require at least 1 business day to respond to all medication requests.

The purpose of this agreement is to promote understanding about certain medicines you may be prescribed or may already be taking. This is to help you and your physician comply with the law regarding prescription drugs. This agreement is essential to the trust and confidence necessary in the physician/patient relationship.

The use of narcotic medications has inherent risks with adverse effects including chemical dependency, addiction, CNS depression, hypotension, seizures, constipation, nausea, vomiting, dizziness, headache, confusion, respiratory arrest, somnolence, coma and death. Narcotic medication alone, or in combination with muscle relaxants, sleeping pills, anxiety medications, antihistamines, decongestants, or alcohol can cause cognitive impairment and delayed reaction time.

These guidelines are in place for your safety and well-being. Our hope is that you consider that pain medicine is provided as adjunctive therapy and not as long term management of symptoms while under neurosurgical care.

Please read carefully before signing

1. **I will receive medications from one prescribing physician only.** This means, if you are obtaining medications (pain meds/muscle relaxants) from your following physician, or from ER physicians, you are to continue receiving medications from their office. If our physician assumes your care, and at any time you obtain the above listed medications from any other physician, our physician reserves the right to discontinue further prescriptions for you.
2. **I will not share, sell, or trade my medications with anyone.**
3. **Lost or stolen medicines will not be replaced.** Once the prescription is in your trust, it may not be refilled until time allowed.
4. **I will use my medicine at no greater rate than prescribed.** A greater rate will result in my being without medicine for a period of time.
5. I understand that if I am pregnant or become pregnant while taking opioid medications, my child could become physically dependent on opioid medications, and withdrawals can be life threatening for a baby.
6. If at any time I break the law with regards to my pain medicine, I am aware that the appropriate **law enforcement department may be notified and my records could be released to them.** It is illegal to sell, trade, or share prescription medication. It is illegal to obtain controlled substances from more than one doctor without telling the other doctor. It is illegal to obtain alter or fabricate prescriptions.
7. If I break this agreement, my doctor may stop prescribing these pain control medicines and, if recommended, submit to an evaluation by an addictionologist, or discharge if necessary.

The acceptance of this document authorizes the physician and your pharmacy to cooperate fully with any city, state, or federal law enforcement agents, including this state's Board of Pharmacy in regards to the actions listed above. I authorize the physician to provide a copy of this agreement to my pharmacy.

This agreement has been reviewed and signed on the _____ day of _____ in the year of _____.

PATIENT NAME _____ PATIENT SIGNATURE _____

Neurosurgical & Spine Institute

AUTHORIZATION FOR TREATMENT

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the healthcare providers and staff of Neurosurgical and Spine Institute to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I also hereby authorize Neurosurgical and Spine Institute to release information requested by insurance company and/or its representatives to process my insurance claim. I fully understand this agreement and consent will continue until cancelled by me in writing.

SIGNATURE _____ DATE _____ /_____ / _____

Responsible/Authorized Representative (Guarantor) _____

Relationship to Patient _____

Neurosurgical & Spine Institute

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby authorize The Neurosurgical & Spine Institute together with its employees, agents and contractors, to use or disclose my protected health information (covered under Privacy and Security Regulations to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) as specified in this authorization. I understand that protected health information includes my medical and billing information and other records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health diagnosis, treatment or related communications, or information relating to diagnosis, testing or treatment for AIDS, HIV, or other communicable diseases (collectively referred to herein as "PHI")).

Recipient(s) of Use or Disclosure
This information may be used by or disclosed to names listed below and its subsidaries, employees, agents and contractors.

Information to be Used or Disclosed
I understand the information to be enclosed shall include all information in my medical record unless specific items have been submitted in writing.

Expiration
This authorization will remain in effect until a written notice is provided to The Neurosurgical & Spine Institute.

Revoking Authorization
I understand that I may revoke this authorization by submitting a written request for revocation to The Neurosurgical & Spine Institute, provided that such revocation shall not be effective with respect to any use or disclosure made in reliance on this authorization prior to the date of The Neurosurgical & Spine Institute receipt of my revocation.

Authorization as a Condition to Treatment
I understand that The Neurosurgical & Spine Institute cannot require me to sign this authorization in order to receive medical treatment from them.

Potential Re-Disclosure
I understand that the PHI used or disclosed by The Neurosurgical & Spine Institute pursuant to this authorization may be subject to re-disclosure by the recipient who may or may not be subject to the HIPAA Privacy Rule and may not be subject to other state or federal privacy laws.

Compensation
I understand that I will not receive compensation from the recipient for the use/disclosure of my PHI. I understand that The Neurosurgical & Spine Institute will not receive compensation for the disclosure of my PHI.

Below are the individuals authorized to discuss my care:

AUTHORIZED NAME LIST

NAME_____ RELATION _____

NAME_____ RELATION _____

NAME_____ RELATION _____

NAME_____ RELATION _____

(If additional space is needed please attach additional pages.)

I have read and understood this authorization and my questions have been answered. I certify that I am the patient listed above or a person authorized to permit release of records on the patient's behalf. I hereby release The Neurosurgical & Spine Institute and recipient and its officers, trustees, employees, agents and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this authorization. I understand that if this authorization is being requested by The Neurosurgical & Spine Institute they must provide me with a copy of the signed authorization.

PATIENT SIGNATURE _____ DATE ____ /____ / _____

Signature of Patient's Authorized Representative _____

Print Patient's Authorized Representative Name _____

Basis of Authority to Sign for Patient _____

Neurosurgical & Spine Institute

FINANCIAL POLICY

The Neurosurgical and Spine Institute is committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, however, we need your assistance and your understanding of our financial payment policy.

a. Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangement must be made before you see the physician. We accept the following forms of payment: cash, check, American Express, MasterCard, Visa, and Discover.

b. As a courtesy to you, we will file your insurance claim form for reimbursement. However, in order to do this, we must have current insurance information. Charges not paid by your insurance company within 90 days will become due and payable by you. Patients who do not provide current insurance information will be treated as self-pay (see above).

c. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization number before you see our physicians. If you are unable to obtain the authorization, you can sign a medical waiver and pay us directly for the services we provide you, and we will refund you when we receive the proper authorization for those services.

d. Surgical procedures **will require** a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts are required at the time of scheduling you for your procedure.

e. Parents, a designated family member, or a legal guardian are responsible for payment for services rendered to children.

f. We will bill for Workers' Compensation services that have been authorized by your employer or Workers' Compensation insurance carrier.

g. We charge additional fees for (a) insurance, FMLA, or disability forms; (b) images on disc; (c) medical records review; and (d) medical depositions.

h. Please be aware that any balance on your account over 90 days is subject to collection procedures and may result in denial of future care until overdue balances are paid in full.

i. If you have insurance, the company considers your plan a contract with you to pay for a portion of any covered services. We similarly have a contract on file to participate as an in-network provider. Both contracts stipulate that our practice cannot waive any copays, coinsurances, or deductibles due at time of service as well as any prior balances that are considered patient responsibility according to your plan. For those insurance plans with real time adjudication, payment will be collected at check-out for charges incurred that day. For insurance plans that do not provide immediate patient responsible information, a deposit may be required on the date of service and the balance can be settled within 30 days of statement.

PAYMENT AGREEMENT

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree to pay within 90 days of receipt of notice all balances due such as non-covered services, coinsurance, deductibles and co-payments not paid by my insurance company.

I _____, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPT THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

SIGNATURE _____ DATE ____ /____ / _____

Responsible/Authorized Representative (Guarantor) _____

Relationship to Patient _____

Neurosurgical & Spine Institute

ASSIGNMENT OF BENEFITS

I hereby authorize benefits to be assigned to Neurosurgical & Spine Institute ("NIOS") and, if applicable, its subsidiary Neurosurgical Institute Ambulatory Surgery Center, LLC, ("NIASC"), for healthcare services provided to me by NIOS and/or NIASC. I hereby certify that the insurance information that I have provided the NIOS and/or NIASC is true and accurate as of the date of service and that I am responsible for keeping it always updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance may not pay 100% of the amount of the medical claim and I am responsible for payment of all amounts not paid by my insurance company within 90 days, including for any services which my insurance company has determined not to be covered by my policy.

I hereby authorize NIOS and/or NIASC to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided the NIOS and/or NIASC. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by NIOS and/or NIASC, including exclusive and irrevocable right to receive payment for such services, make demands in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize NIOS and/or NIASC to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by NIOS and/or NIASC.

I hereby irrevocably designate, authorize and appoint NIOS and/or NIASC as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by NIOS and/or NIASC. This power of attorney shall automatically terminate, without formal action being taken, as soon as NIOS and/or NIASC has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me.

I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby instruct and direct my insurance company to pay NIOS and/or NIASC directly for medical services and care provided by NIOS and/or NIASC, and to provide to NIOS and/or NIASC all relevant information and documentation in connection with such payments and claims for payment.

I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to NIOS at 4E Jackson Blvd., Savannah, GA 31405 or NIASC at 1E Jackson Blvd, Suite 101, Savannah, GA 31405, for the any medical benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by NIOS and/or NIASC. Upon receipt of said check, I authorize NIOS and/or NIASC to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by NIOS and/or NIASC will be immediately signed over and sent directly to NIOS and/or NIASC. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to NIOS and/or NIASC, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to NIOS and/or NIASC C pursuant to this assignment of benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize NIOS and/or NIASC to be my personal representative, which allows NIOS and/or NIASC to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of NIOS and/or NIASC's billed charges within ninety (90) days of all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to NIOS and/or NIASC for acting as my personal representative.

Patient Account # _____

PARENT/GUARDIAN SIGNATURE _____ DATE ____ /____ / _____