Michigan Neurosurgical Institute

9400 S. Saginaw Suite A
Grand Blanc, MI 48439

Phone (810) 606-7200
Fax (810) 606-7115
www.michiganneurosurgicalinstitute.com

New Patient Information (Please Print)

Patient Name:	First:	Middle:	Last:
Date of Birth:	Age:		
Street Address: ☐ Permanent ☐ Temporary		City and State:	Zip Code:
Home Phone Number:	Cell Number:	Emergency Contact: Number: Relationship:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated		Social Secuirty Number:
Race: Ethnicity:	Preferred Language:	Email:	
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone Number:	
Describe Problem:			
How did you hear about us?	☐ Family Member ☐ Friend	☐ Primacy Care Physician	☐ Other:
Family Doctor:	Address:	Number:	
Employer:	Address:	Retired/Disabled Date:	
Describe Your Job Duties:			
Was this an Injury? ☐ Yes ☐ No	Injury Date:	Explain How Injury Occurred:	
Were you Injured on the job? ☐ Yes ☐ No	Responsible Party:		
Comp. Carrier Address:	City and State:	Zip Code:	
Were You Injured in an Auto Accident? ☐ Yes ☐ No	Date of Accident:	Auto Ins. Name:	
Policy Holder Name:	Claim Number:	Name of Attorney:	

Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees. ALL CHARGES ARE DUE AT THE TIME OF SERVICE! If surgery is indicated, the patient is responsible for furnishing insurance claim forms to the office PRIOR to surgery.

I hereby authorize MICHIGAN NEUROSURGICAL INSTITUTE to furnish information to insurance carriers concerning my illness and treatments. I understand I am responsible for any amount not covered by insurance.

Date: ______________ Signature: ____

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Office/Financial Policy Agreement

Thank you for choosing Michigan Neurosurgical Institute, P.C. for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this **Office/Financial Policy Agreement.** By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Except as indicated below, ***payment is required at the time services are provided,*** unless other arrangements have been made in advance. We accept cash, personal in-state checks, VISA, and MasterCard. There is a **$25.00** service charge for returned checks.

OFFICE HOURS (By Appointment Only):

- Monday through Thursday: 8:30 am to 5:00 pm
- Friday: 8:30 am to 3:00 pm

As a courtesy to other patients, we request you arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule. For afterhours/weekend emergencies, please call the office. The answering service will guide your call to the on-call clinician.

INSURANCE: We participate in most managed care plans and will bill your insurance plan if necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is ***your*** responsibility; please contact customer service at your insurance company for questions you may have regarding your coverage. ***You are responsible for any charges not covered by your plan.***

Proof of Insurance. All patients must complete and/or update our Patient Information Form at each office visit. You must provide valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information, you will be responsible for the balance of the claim. Please **notify us of any changes in insurance coverage prior to time of service.** Insurance denials for termination of coverage will be automatically billed to you.

Co-payments and Deductibles. All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductible and non-covered services.

Claim Submission. We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Michigan insurance law requires your insurance company to provide timely payment.

Worker's Compensation/Auto Claim. I understand that Michigan Neurosurgical Institute, P.C. will bill my workers' compensation or auto carrier for any authorized services. By authorization, we mean that your employer is aware of your visit, approved services and has also notified the insurance carrier of your claim of work injury. **The policy of this office is that all services billed to a Worker's Compensation carrier must be prior authorized and that it is the patient's responsibility to obtain that authorization.** If I do not have health insurance or in the event that my health insurance does not subrogate work related claims, I understand that I will be responsible for payment of those services. If I was in an auto accident and did not file a claim, I understand that this provider will bill my health insurance carrier. I understand that if my health insurance denies payment of this claim, I will be responsible for all services that were rendered.

OUT-OF-NETWORK CARE/SELF PAY: Please be aware that you have an option to seek care from Physicians, even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. As a courtesy to your out-of-network patients, we will file your insurance claim if desired. Your out-of-pocket expense will be due at the time services are rendered.

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PRE-PAYMENT FOR SURGICAL PROCEDURES: Please be aware of your out-of-pocket expenses for copay and/or deductible will be collected prior to scheduled surgical procedure. Our office will verify that your insurance is active and determine what copay and/or deductible is remaining for the calendar year. We will notify you of the balance due and the payment due date. Failure to provide payment for your out-of-pocket expense could result in the cancellation of your surgical procedure.

ADMINISTRATIVE SERVICES, CHARGES AND PATIENT RESPONSIBILITIES: ***Due to the continued decline in reimbursements from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility.*** Our practice is committed to providing the highest quality of service to our patients, while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

- **Missed appointments.** Broken appointments represent not only a cost to us, but an inability to provide services to others who could have been seen in the time set aside for you. We require a 24-hour notice of cancellation to avoid a ***$75.00 cancellation fee for a follow up appointment***.

  If you do not show for an appointment, a ***$75.00 missed appointment fee for a follow up appointment, or a $250.00 missed appointment fee for a new patient appointment*** would apply as well. Your insurance will not cover these charges, and they must be paid prior to your next visit. It is your responsibility to remember your appointment.

- **Requests for medical records.** In accordance with Michigan law, written requests are required for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on current Michigan law and is dependent on the number of pages requested and our administrative fees. Please take this into consideration when requesting copies of your medical records.

- **Completion of forms.** We do not fill out any forms until the day of or after surgery is performed. This includes any off-work forms, disability, insurance, or any miscellaneous forms. FMLA forms can be filled out prior to surgery with a pending surgery status. There are fees associated with completion of these forms in which the amount is determined based on requirements of such paperwork. All fees in association with such documents are due and to be paid in full prior to form completion.

I have read, understand, and agree to comply with the terms of your Office/Financial Policy.

____________________ ________________________________

Date **Signature**

____

Printed Name

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Medical Record Access Permission Form

Protected Health Information

Please indicate below any persons that are permitted to have access to your protected medical information (e.g. lab results, medical records, x-ray reports, billing records, etc.). Also, please note any exceptions to medical information that can be released. (For example, "Do not release information about lab tests.")

☐ I do not wish to list any individuals.

NAME:____

RELATIONSHIP:______________________________________

PHONE NUMBER: _____________________________________

EXCEPTIONS:____

NAME:____

RELATIONSHIP:______________________________________

PHONE NUMBER: _____________________________________

EXCEPTIONS:____

NAME:____

RELATIONSHIP:______________________________________

PHONE NUMBER: _____________________________________

EXCEPTIONS:____

____

PATIENT SIGNATURE DATE:

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Cancellation/No Show Policy

Attention Patients:

Effective January 1, 2013, Michigan Neurosurgical Institute, P.C. will assess a fee for all missed appointment as well as any appoints cancelled with less than 24 hours notice

If you do not show for your appointment or if you cancel your appointment with less than 24-hour notice, your account will be charged a fee of $75 if you are an established patient or a fee of $250 for a new patient appointment. Your insurance will not cover this charge and it must be paid prior to your next visit.

Please remember to inform us of your need to cancel or reschedule any appointments as soon as possible. This will allow us to utilize the time for other patients who may need to be seen urgently.

Your cooperation is sincerely appreciated

Michigan Neurosurgical Institute, P.C.

Date: _______________

Patient Signature: ____

Parent or Guardian: ____

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Authorization to Release Records

To

Michigan Neurosurgical Institute

- I hereby authorize **MICHIGAN NEUROSURGICAL INSTITUTE** to request the release of my medical records from any hospital or other facility at which I have been treated.
- You have the right to terminate this authorization at any time by submitting a written request ot our practice manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

____

Signature of Patient; or Guardian   Date

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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient Name: ________________________________

DOB:

SSN:

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Michigan Neurosurgical Institute's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the office.

____

Signature of Patient   Date

Signature of Parent, Guardian or Personal Representative*   Date

____

***If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)**

☐ Patient refuses to Acknowledge Receipt:

Signature of Staff Member   Date

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Health History, please fill out every field, Thank you.

Name: ______________________ Date: ______________

☐ Male ☐ Female Age: ________

Instructions: This health history is a confidential document between you and your doctor. It is intended to help you and your doctor. Your doctor may ask you more questions about some of these items to pinpoint problems you may have. Please answer each question in the space provided.

Eyes and Ears
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Sinus Pain
- ☐ Increase or decrease in tearing

Cardiovascular
- ☐ Chest Pain
- ☐ Chest Discomfort
- ☐ Heart Pounding

Urinary
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Difficulty in passing urine
- ☐ Blood in urine

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Rectal Bleeding
- ☐ Black, tarry stools
- ☐ Stomach Pain
- ☐ Food intolerance
- ☐ Abdonminal Bloating

Respiratory/Nose/ Thorat/Mouth
- ☐ Cold (influenza)
- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Hay Fever
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Pain when breathing

Radiology Screening. Please fill out completely.

Yes	No		Yes	No	
☐	☐	Pacemaker	☐	☐	Metal in eyes
☐	☐	Implants	☐	☐	Cardiac Defibillator
☐	☐	Ear surgery	☐	☐	Abdominal aortic aneurysm surgery?
☐	☐	History of Cancer	☐	☐	Kidney Disease GFR=_____ Dialysis? ______
☐	☐	Cerbral anurysm clips	☐	☐	Pregnant? How many weeks?
☐	☐	Are you claustrophobic?			

General Symptoms

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Restlessness
- ☐ Insomnia/trouble sleeping
- ☐ Headache
- ☐ Decrease in weight
- ☐ Weakness
- ☐ Irritabillity
- ☐ Tension
- ☐ Sweating
- ☐ Skin rash
- ☐ Easy bruising
- ☐ Decrease in appetite
- ☐ Increase in appetite
- ☐ Decrease in sex drive
- ☐ Dizziness/lightheadedness
- ☐ Fainting or feeling faint
- ☐ Seizures
- ☐ Tremors, trembling or shakie
- ☐ Memory problems
- ☐ Agitation
- ☐ Nervousness
- ☐ Trouble concentrating
- ☐ Jumpiness
- ☐ Keyed up/on edge
- ☐ Repetitive, senseless thoughts
- ☐ Repetitive, senseless behavior
- ☐ Violent behavior
- ☐ Constant worry
- ☐ Fearful feelings
- ☐ Helpless feelings
- ☐ Fear of losing control
- ☐ Feeling in a dreamlike state
- ☐ Sad/depressed/down in the dumps
- ☐ Fear of doing something uncontrollable
- ☐ Lack/loss of interest in things
- ☐ Trouble making decisions
- ☐ Excessive feelings of guilt
- ☐ Fear of dying
- ☐ Fear of going crazy
- ☐ Hopeless feelings
- ☐ Feeling life is not worth living
- ☐ Frequent thoughts of death or suicide
- ☐ Worthless feelings
- ☐ Excessive negative thinking
- ☐ Frequent crying or weeping
- ☐ Seeing or hearing things that are not real
- ☐ Sleeping too much

Patient Medical Information

Are you allergic to: Medication: ____________ Food: ____________ None: ____________

Please list all allergies here:

____

____

____

Medications

Please list all current medications and dosages (include over the counter medications)

	MG		Times per day:			MG		Times per day:	
______	MG	______	Times per day:	______	______	MG	______	Times per day:	______
______	MG	______	Times per day:	______	______	MG	______	Times per day:	______
______	MG	______	Times per day:	______	______	MG	______	Times per day:	______
______	MG	______	Times per day:	______	______	MG	______	Times per day:	______
______	MG	______	Times per day:	______	______	MG	______	Times per day:	______
______	MG	______	Times per day:	______	______	MG	______	Times per day:	______

Habits

Please circle one

Are you a current smoker? Yes or No
If yes, how much? ________ # Years ________ How often? ________

Are you a former smoker? Yes or No
When did you quit? ________ # Years ________ How often? ________ If yes, how much? ________

Do you smoke Marijuana? Yes or No
If yes, how much? ________ #Years ________ How often? ________

Do you drink alcohol? Yes or No
If yes, how much? ________ #Years ________ How often? ________

Do you drink caffeine? Yes or No
If yes, how much? ________ # Years ________ How often? ________

Medical/Surgical History

Medical History: (Diabetes, Hypertension, Heart issues, Cancer etc.)

____

____

____

Please List your Doctors Here:

- ☐ Cardiologist: ______________
- ☐ Pulmonologist: ______________
- ☐ Vascular: ______________
- ☐ Nephrologist: ______________
- ☐ Neurologist: ______________
- ☐ Oncologist: ______________
- ☐ Endocrinologist: ______________
- ☐ Infectious Disease: ______________

Surgical/ Hospitalization History

(Please list all hospitization including Emergency Room Visits)

Surgery/Hospitalization	Year	Reason

Family History (Please circle one)

Father: Alive or Deceased

Any medical problems/conditions: ______________ Cause of Death: ______________

Mother: Alive or Deceased

Any medical problems/conditions: ______________ Cause of Death: ______________

Sisters: Alive or Deceased

Any medical problems/conditions ______________ Cause of Death: ______________

Sisters: Alive or Deceased

Any medical problems/conditions ______________ Cause of Death: ______________

Brothers: Alive or Deceased

Any medical problems/conditions ______________ Cause of Death: ______________

Brothers: Alive or Deceased

Any medical problems/conditions ______________ Cause of Death: ______________

I have read and answered the above questions to the best of my knowledge. I authorize the release of any and all medical records/imaging studies/films to Michigan Neurosurgical Institute, P.C.

______________________________ Signature

______________________________ Date