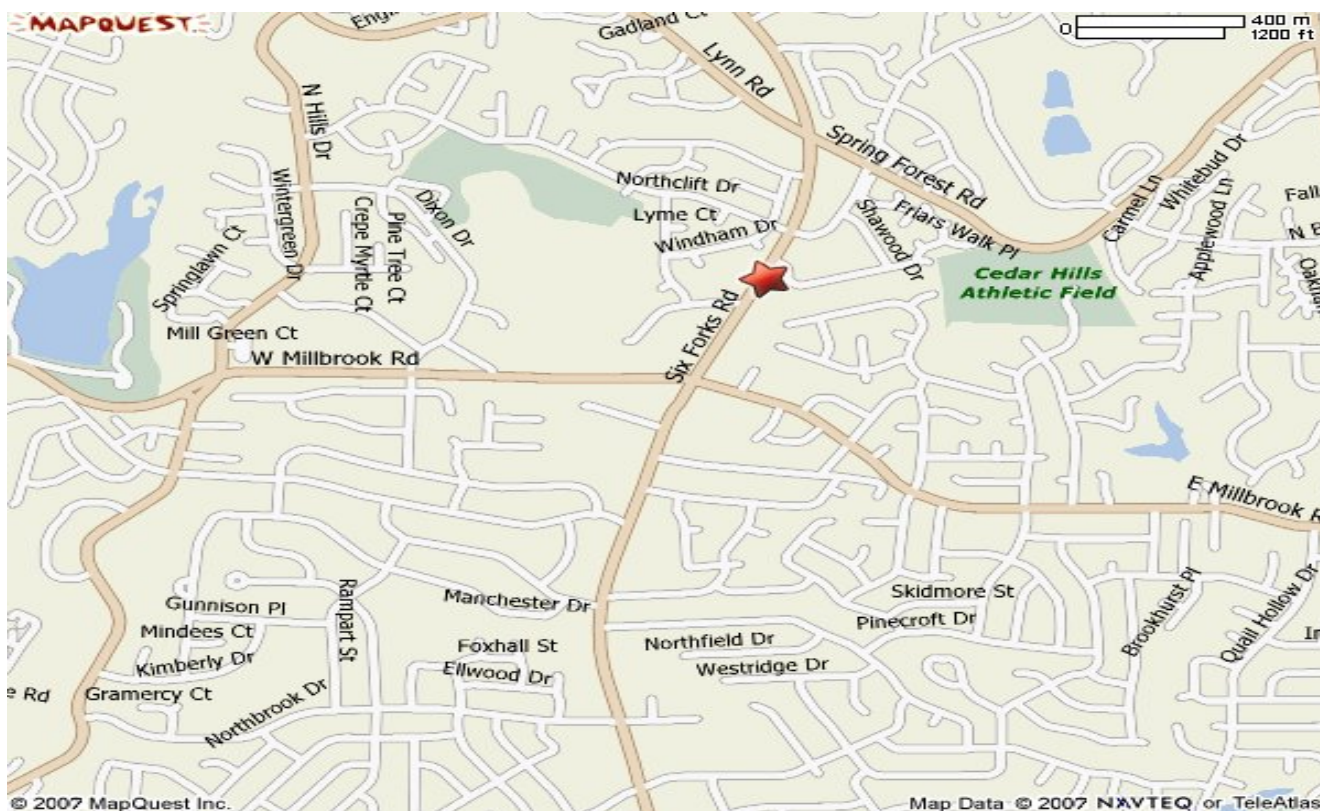


Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_ Doctor: \_\_\_\_\_

We look forward to seeing you at your appointment. Please complete all the following paperwork front and back. **Do Not** mail back your completed paperwork just bring it with you to your appointment along with your MRI and/or x-ray or CD. Failure to bring your films or copay will result in your appointment being rescheduled. Please see "What To Bring" on our website. Thank You!



**Directions:** Take I-440 Beltline to Six Forks Road North, Exit # 8B. Continue on Six Forks Road thru 9 stoplights (9<sup>th</sup> stop light is Millbrook Rd), approximately 1.7 miles from the beltline. We are the 4<sup>th</sup> driveway on the right at 5838 Six Forks Road.

FOR MORE DETAILED DIRECTIONS AND INFORMATION PLEASE VISIT OUR WEBSITE AT  
[www.raleighneurosurgical.com](http://www.raleighneurosurgical.com)

#### OFFICE HOURS

Open Monday-Friday 9:00 am – 5:00 pm (except holidays)  
24 hour on-call Neurosurgeon



5838 Six Forks Road, Suite 100  
Raleigh, NC 27609  
Phone: 919-785-3400  
Fax: 919-783-7778

# RALEIGH NEUROSURGICAL CLINIC, INC.

## **PATIENT INFORMATION**

Age: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Other

Work Status:  Employed  Retired  Disabled  Self-Employed  Unemployed Other \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

In Case of Emergency, Notify \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Emergency contact Phone (\_\_\_\_) \_\_\_\_\_  Cell  Home  Work

Spouse Name \_\_\_\_\_ Spouse Phone (\_\_\_\_) \_\_\_\_\_  Cell  Home  Work

Spouse DOB \_\_\_\_\_ Social Security # \_\_\_\_\_ Spouse Employer \_\_\_\_\_

## **INSURANCE INFORMATION**

Responsible Party (check one)  Self  Other \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID/Policy # \_\_\_\_\_

Subscriber Name \_\_\_\_\_  Self  Spouse  Parent Subscriber Employer \_\_\_\_\_

Subscriber Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID/Policy # \_\_\_\_\_

Subscriber Name \_\_\_\_\_  Self  Spouse  Parent Subscriber Employer \_\_\_\_\_

Subscriber Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Group # \_\_\_\_\_

## **ACCIDENT INFORMATION**

Is Your Visit Related To An Accident?  Yes  No If So, Date of injury/Accident \_\_\_\_\_

Type of Accident  Job\*  Automobile  Other Brief Description of Accident \_\_\_\_\_

Are you represented by an attorney?  Yes  No Name \_\_\_\_\_ Phone \_\_\_\_\_

*If your visit is due to a Worker's Compensation Claim, you must have a referral and your visit must be pre-approved  
\*Failure to provide this information will result in your appointment being rescheduled \**

## **REFERRING INFORMATION**

How did you hear about our practice?  Internet  Yellowpages

Prior Patient  Friend/Family member  Your Physician  Insurance Carrier  Other \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Family Doctor \_\_\_\_\_ Address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

**ACCEPTANCE OF FINANCIAL RESPONSIBILITY**

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL MEDICAL EXPENSES, REGARDLESS OF INSURANCE COVERAGE AND WHETHER OR NOT THERE IS A JOB RELATED ACCIDENT OR AN ACCIDENT WITH ANOTHER PERSON AT FAULT

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I HEREBY AUTHORIZE RALEIGH NEUROSURGICAL CLINIC, INC.:

- TO FILE INSURANCE CLAIMS FOR ALL SERVICES PROVIDED TO ME, AND I AUTHORIZE PAYMENT FOR THOSE SERVICES TO BE MADE DIRECTLY TO THE PROVIDER.
- TO RELEASE ANY INFORMATION ABOUT ME TO ANY REFERRING PHYSICIAN OR OTHER PROVIDER OR TO ANY INSTITUTION OR PROVIDER AS NECESSARY TO PROVIDE TREATMENT OR DIAGNOSIS FOR ME.
- AND MY PHYSICIAN OR OTHER PROVIDER TO RELEASE INFORMATION ABOUT ME AS NECESSARY TO PROCESS CLAIMS FOR PAYMENT FOR SERVICES PROVIDED FOR ME, INCLUDING HEALTH AND LIABILITY INSURANCE COMPANIES, AGENCIES PROCESSING MEDICARE, MEDICAID, OR WORKER'S COMPENSATION CLAIMS, MEDICAL BENEFITS PLANS, CASE MANAGERS OR REVIEWERS, OR THIRD PARTIES RESPONSIBLE FOR PAYING CLAIMS FOR SERVICES PROVIDED TO ME.

THIS AUTHORIZATION EXPIRES **ONE (1) YEAR** AFTER THIS DATE, EXCEPT AS DISCLOSURE IS NECESSARY AFTER THAT DATE TO PROCESS FINANCIAL CLAIMS OR IS REQUIRED OR PERMITTED BY LAW. I UNDERSTAND THAT THIS AUTHORIZATION COVERS SERVICES I MAY RECEIVE TODAY OR WITHIN **ONE (1) YEAR** FROM TODAY. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION ADDRESSED TO RALEIGH NEUROSURGICAL CLINIC, 5838 SIX FORKS RD, STE. 100 RALEIGH, NC 27609. THIS REVOCATION WILL BE EFFECTIVE FOR FUTURE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

I RELEASE RALEIGH NEUROSURGICAL CLINIC, INC., IT'S EMPLOYEES, OFFICERS, AGENTS AND PHYSICIANS FROM ANY LEGAL LIABILITY FOR DISCLOSURE AUTHORIZED HEREIN.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**PATIENT OR RESPONSIBLE PARTY IF A MINOR**

**RALEIGH NEUROSURGICAL CLINIC, INC.**

Name \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY** Chief Complaint (Describe your problem and what treatment you have had)  
\_\_\_\_\_

When Did your Symptoms Begin? \_\_\_\_\_  
What doctors have you seen for this problem and what tests have you had? \_\_\_\_\_

**PAST MEDICAL HISTORY** (ex: High Blood Pressure, Heart Disease, Diabetes) List all major illnesses and conditions you have ever been diagnosed with \_\_\_\_\_

Past Surgeries \_\_\_\_\_

**FAMILY HISTORY** Please list any serious medical conditions that run in your family \_\_\_\_\_

**SOCIAL HISTORY** Do you smoke?  Yes  No Amount/How often? \_\_\_\_\_  
Do you drink alcohol?  Yes  No Amount/How often? \_\_\_\_\_  
Current Occupation \_\_\_\_\_ Last day worked \_\_\_\_\_ Right\_\_ or Left\_\_ handed

**REVIEW OF SYSTEMS** (Have you had or are you having problems with any of the following?)

- |                        |                              |                        |                              |
|------------------------|------------------------------|------------------------|------------------------------|
| <u>General</u>         | <u>Skin</u>                  | <u>Eyes</u>            | <u>Respiratory</u>           |
| __fevers               | __rash                       | __blurry vision        | __cough                      |
| __chills               | __itching                    | __blindness            | __wheezing                   |
| __sweats               | __dryness                    | __eye pain/discharge   | __coughing up blood          |
| __fatigue              | __suspicious lesions         | __sensitivity to light | __shortness of breath        |
| __weight change        | <u>Gastrointestinal</u>      | <u>Genitourinary</u>   | __asthma                     |
| __sleep disturbance    | __constipation               | __urinary frequency    | <u>Reproductive</u>          |
| <u>Cardiovascular</u>  | __indigestion                | __painful urination    | __abnormal menstrual period  |
| __palpitations         | __nausea/vomiting            | __blood in urine       | __pain with intercourse      |
| __chest pain           | __change in bowel habits     | __bladder control      | __sexual dysfunction         |
| __fainting             | __abdominal pain             | __pelvic pain          | __sexual transmitted disease |
| __ankle swelling       | __bloody stool               | <u>Neurologic</u>      | <u>Ear/Nose/Throat</u>       |
| __breathing difficulty | __jaundice                   | __numbness             | __hearing loss               |
| <u>Musculoskeletal</u> | <u>Hematologic/Lymphatic</u> | __paralysis            | __earache                    |
| __joint pain/swelling  | __abnormal bruising          | __seizures             | __ringing in ears            |
| __muscle pain/weakness | __bleeding                   | __migraines/headaches  | __nosebleeds                 |
| __trauma/fractures     | __enlarged lymph nodes       | __memory loss          | <u>Other</u> _____           |

**MEDICATIONS** Also include non-prescription drugs with dosages NONE \_\_\_\_\_  
1. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 6. \_\_\_\_\_  
3. \_\_\_\_\_ 7. \_\_\_\_\_  
4. \_\_\_\_\_ 8. \_\_\_\_\_

**DRUG ALLERGIES** Allergic to shellfish or x-ray dye?  Yes  No Reaction: \_\_\_\_\_  
{ PLEASE LIST REACTIONS } Latex allergy?  Yes  No Reaction: \_\_\_\_\_  
1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

**Do religious beliefs prevent you from receiving blood or blood products?**  Yes  No

(For office use only) Updated: \_\_\_\_\_ Updated: \_\_\_\_\_ Updated: \_\_\_\_\_ Updated: \_\_\_\_\_  
MD Sign: \_\_\_\_\_ MD Sign: \_\_\_\_\_ MD Sign: \_\_\_\_\_ MD Sign: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_ Date: \_\_\_\_\_

# RALEIGH NEUROSURGICAL CLINIC, INC.

## FINANCIAL POLICY

We accept various methods of payment including:  
CASH, CHECK, MC, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT CARDS

Thank you for choosing us as your health care provider. We are committed to providing you with the finest health care available and a courteous and helpful staff. In order to make this process as smooth as possible for our clients, we offer this brochure outlining some of the policies followed by RALEIGH NEUROSURGICAL CLINIC.

All patients must complete check-in forms before seeing the doctor. Please bring any x-rays or MRI films related to your problem to the appointment. Also, bring your insurance card(s) and a photo ID to **every** visit.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY BELOW. I ALSO UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE CARRIER. I FURTHER UNDERSTAND ANY BALANCES SHOULD BE PAID WITHIN 60 DAYS, UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### OFFICE VISITS

Payment in full for all office visits is expected on the day of your appointment unless you have applicable insurance that will be filed for your visit. Co-pays, deductibles and co-insurance amounts will be collected before being seen by the physician. **Failure to pay your co-pay or co-insurance will result in your appointment being rescheduled.**

**Authorization for office visits:** If your insurance requires authorization to see a specialist it is your responsibility to make sure this is received in our office prior to your appointment. Your visit will be rescheduled or a waiver must be signed making you responsible for payment if authorization is not obtained prior to seeing the physician.

**Workers Compensation Cases:** If you are visiting as a patient under Workers Compensation we must have a documented referral at the time of your visit or have your adjuster call and give information about your case prior to your appointment. Failure to provide this information will result in your visit being rescheduled.

**Third Party Payors:** Raleigh Neurosurgical Clinic does **not** file medical liens for personal injury claims. If you are being represented by an attorney as a result of an accident or injury and are expecting reimbursement from a third party, you are still responsible for your bill at the time services are rendered. No arrangements will be made based on prospective third party payments.

**Self Insured:** If you are a non-insured patient you will be required to pay the full amount before being seen by the physician. On average, office visits are **\$110.00** for established patients and **\$220.00** for new patients. **Your appointment will be rescheduled, if you are unable to pay for your visit at the time of service.**

**No Show Policy:** As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Cancellations must be received 24 hours in advance, so that we may accommodate patients who need to be seen. Patients who do not contact us prior to their appointment will be charged a \$50.00 cancellation fee that **MUST** be paid prior to the appointment being rescheduled.

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## **SURGICAL PROCEDURES**

If after consultation with the doctor, your condition requires surgery, the procedure will be scheduled at the facility of your choice and our office will contact your insurance company to obtain benefits and preauthorization. However, verification of benefits is not a guarantee of payment from your insurance company. It is **YOUR** responsibility to contact your insurance company regarding your coverage, any required second surgical opinions, and preadmission certification. **Failure to keep your scheduled surgery or procedure date will result in a \$50.00 charge, payable before your surgery will be rescheduled.**

**Managed Care and PPO Plans :** If your insurance is through a Managed Care or PPO plan that RALEIGH NEUROSURGICAL CLINIC participates with, you are expected to pay the co-payment or out of pocket costs as directed by your policy. **No scheduled procedure will be performed, until the full co-payment or out-of-pocket cost is paid in full.**

**Other Insurance Plans:** Insurance companies that we do not participate with or non-managed care plans will be treated as a commercial plan. They generally only pay a portion of the total bill. **You will responsible for any unpaid portion; before any scheduled procedure will be performed.**

**Self Insured:** If you are a non-insured patient the Financial Coordinator will estimate the cost of your surgery. At that time you are required to pay at least 50% of the estimated charge. The surgery will be scheduled after the deposit has been received. Upon making your down payment, the balance should be paid within 60 days or a monthly payment arrangement made.

## **BILLING PROCEDURES**

As a courtesy, our office will submit your insurance claim on your behalf. Therefore, it is essential that we have complete and accurate information about your insurance carrier. Please remember that your insurance policy is an agreement between you and the insurance company. No insurance company attempts to cover all medical costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any balance not paid or covered by your insurance. If your insurance carrier sends you payment for our services, please sign over the check to RALEIGH NEUROSURGICAL CLINIC or you will be billed for the balance.

**Collection Process:** Our Billing and Collections Department is able to help you with any questions you may have. You may contact them anytime between 9 AM and 5 PM at (919) 785-3400. You will receive a monthly statement from our office. It notes any insurance/patient balances and payments made within the last 30 days. Please review the statement for accuracy and contact your insurance company regarding any outstanding claims. Please understand that our services are separate from the hospital therefore you will receive a statement from us as well as the hospital.

**Delinquent Accounts:** Any outstanding patient balances with no payment or activity for 60 days will result in your account being turned over to an outside collection agency. We will make every effort to negotiate a payment arrangement with you prior to this action taking place.

## **FORMS AND MEDICAL RECORDS**

If you require our office to complete any forms for disability or out of work purposes there will be a \$10.00 charge to be collected prior to the form being completed and allow at least 2 weeks for completion. If you require a copy of your medical records you must sign a Medical Records Release of Information form and a payment of \$10.00 will be required. A form may be obtained by visiting our website at [www.raleighneurosurgical.com](http://www.raleighneurosurgical.com).

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
FOR RALEIGH NEUROSURGICAL CLINIC, INC.  
(to be filed in patient's medical record)**

**I have been made aware of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.**

**Print Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship ( if not signed by patient )** \_\_\_\_\_

**PLEASE GIVE THE NAME OF ANY PERSONS WITH WHOM WE CAN DISCUSS YOUR MEDICAL CARE AND/OR PRESCRIPTIONS (OTHER THAN PHYSICIANS)**

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**Internal Use Only**

A patient/ patient's representative refuses to sign acknowledgement. Please document date and time policy was presented to patient and sign below.

Presented (date and time) \_\_\_\_\_

By (name and title ) \_\_\_\_\_