PRINCETON BRAIN & SPINE CARE

Date: _____

Dear Patient:

Welcome to our Practice and our Family. Our Mission Statement is: **"Princeton Brain and Spine Care is committed to expert patient care and compassion for our patients."** All of us are dedicated to the important concept that at all times, no matter what, the most important person in our office is you!

In order to make your visit with us a great experience we request the following:

1. Please fill out your forms before your visit. We need the requested information in order to communicate with your referring and primary care physicians about your care. We also need your insurance information in case we need to get pre-certification for any testing or procedures that you may need. Please bring all your insurance cards to your visit so that we may copy them for our files.

2. We ask that you bring your actual films and/or disks, as well as the reports for any x-rays or scans that you have had. You should bring any medical records which are pertinent to your condition. By having all your records with you at the time of your visit gives the doctors a clearer picture of what is wrong and how we can help you.

3. For our new patients, especially, we ask that you arrive at least 15 minutes before your appointment. This will give us time to register you in our computer and have your medical records ready for the doctor to review. If you are going to be delayed for your appointment please call us. We might have to reschedule your visit so the doctor will be able to give you all the time you need to discuss your issues.

Your appointment has been reserved for you on_____ at _____am/pm with:

☐ Mark R. McLaughlin, MD
☐ Nirav K. Shah, MD
☐ Prithvi Narayan, MD
☐ Seth S. Joseffer, MD

At the following office:

☐ 1203 Langhorne-Newtown Road, Suite 138, Langhorne, PA 19047 – 215-741-3141
☐ 731 Alexander Road, Suite 200, Princeton, NJ 08540 – 609-921-9001
☐ 190 Route 31 North, Suite 300 B, Flemington, NJ 08822 – 908-229-6627
☐ PBSC @ St. Francis Medical Center, 601 Hamilton Avenue, The Neuroscience Center, Third Floor, Trenton, NJ 08629 – 609-921-9001

We look forward to helping you. Please visit our website at www.princetonbrainandspine.com. We have information concerning many medical conditions, our doctors, our practice policies and links to other sites which may be of interest to you.

The Staff at Princeton Brain and Spine Care, LLC

Patient Registration Form

Today's Date:_____

Patient Name: _____ Social Security #:_____
Last Name
First Name: _____MI_____ Date of Birth: ___/___/_____ Sex: M F
Address 1:_____ Home Phone: (_____) _____
Address 2:_____ Cell Phone: (_____) _____
City, State Zip: _____ Marital Status: S M W D
Home E-mail: _____
Occupation:_____
Emp Status: Full Time Part Time Employer:_____
Unemployed Disabled Addr1: _____
Retired Student Addr 2:_____
Emergency Contact:_____ City, State, Zip:_____
Relationship to patient:_____ Work Phone Number: (____)_____
Phone Number: (____)_____

How did you hear of our practice? Friend Family Physician Self Referred Local Presentation
Emergency Room Newspaper/Magazine Brochure Radio Word of Mouth Internet

Insurance Information

Please complete all fields in order to ensure proper billing.
A separate form is required for workers' compensation, automobile liability, or legal services.

Primary Carrier:_____ Subscriber's Name:_____
Address:_____ Relationship to Patient:_____
Telephone#:_____ ID#:_____
Effective Date:_____ Group #:_____
Subscriber's DOB:_____

Secondary Carrier:_____ Subscriber's Name:_____
Address:_____ Relationship to Patient:_____
Telephone#:_____ ID#:_____
Effective Date:_____ Group #:_____
Subscriber's DOB:_____

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for the patient's bill.)

Guarantor:_____ Relationship to Patient:_____
Addr1:_____ Home Phone: (___)_____
Addr2:_____ Work Phone: (___)_____
City, St, Zip:_____ Social Security#:_____

Primary Care Physician/Referring Physician

Referring Physician:_____ Phone Number:(____)_____
Family Physician:_____ Phone Number:(____)_____

Assignment of Benefits/Financial Agreement

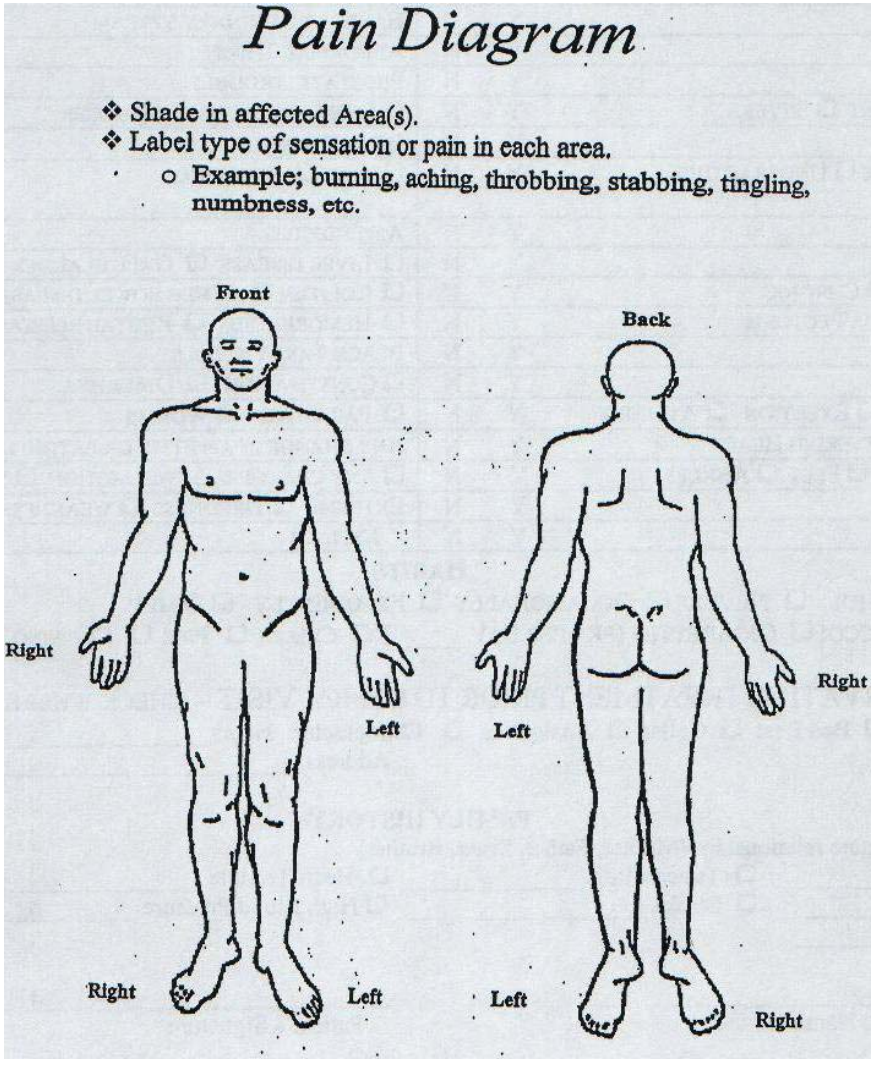
I hereby authorize Princeton Brain & Care LLC to disclose to my insurance company(s) copies of my medical record(s) to obtain payment for services or as part of payment review of medical services. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Additionally, I authorize Princeton Brain & Spine Care, LLC to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose such information.

_____ ___/___/_____
Patient Signature Date

PRINCETON BRAIN & SPINE CARE

Patient Name _____

Date of Birth _____



Patient Volunteered Medical Information

STATEMENT OF CURRENT PROBLEM_____

_____

_____

DATE FIRST STARTED:_____

PAST MEDICAL HISTORY_____

_____

OPERATIONS_____

_____

_____

ALLERGIES TO MEDICATIONS OR FOOD_____

_____

HISTORY OF HIGH BLOOD PRESSURE Y N HISTORY OF DIABETES Y N
PREVIOUS REACTION TO TRANSFUSIONS Y N
HISTORY OF CANCER Y N PREVIOUS REACTION TO ANESTHESIA Y N

CURRENT REVIEW OF SYSTEMS

(PLEASE CIRCLE Y OR N)

ANY ❑ EYE DISEASE ❑ EYE INJURY ❑ IMPAIRED SIGHT	Y	N	KIDNEY ❑ DISEASE ❑ STONES	Y	N
ANY ❑ EAR DISEASE ❑ EAR INJURY ❑ IMPAIRED HEARING	Y	N	BLADDER DISEASE	Y	N
ANY TROUBLE WITH ❑ NOSE ❑ SINUSES ❑ MOUTH ❑ THROAT	Y	N	❑ BLOOD ❑ ALBUMIN ❑ SUGAR ❑ PUS. ETC. IN URINE	Y	N
FAINTING SPELLS	Y	N	DIFFICULTY IN URINATION	Y	N
CONVULSIONS	Y	N	NARROWED URINARY STREAM	Y	N
PARALYSIS	Y	N	ABNORMAL THIRST	Y	N
DIZZINESS	Y	N	PROSTATIC TROUBLE	Y	N
HEADACHES ❑ FREQUENT ❑ SEVERE	Y	N	❑ STOMACH TROUBLE ❑ ULCER	Y	N
ENLARGED GLANDS	Y	N	INDIGESTION	Y	N
THYROID ❑ OVERACTIVE ❑ UNDERACTIVE ❑ ENLARGED	Y	N	❑ GAS ❑ BELCHING	Y	N
ENLARGED GOITER	Y	N	APPENDICITIS	Y	N
SKIN DISEASE	Y	N	❑ LIVER DISEASE ❑ GALL BLADDER DISEASE	Y	N
COUGH: ❑ FREQUENT ❑ CHRONIC	Y	N	❑ COLITIS ❑ OTHER BOWEL DISEASE	Y	N
❑ CHEST PAIN ❑ ANGINA PECTORIS	Y	N	❑ HEMORRHOIDS ❑ RECTAL BLEEDING	Y	N
SPITTING UP BLOOD	Y	N	BLACK TARRY STOOLS	Y	N
NIGHT SWEATS	Y	N	❑ CONSTIPATION ❑ DIARRHEA	Y	N
SHORTNESS OF BREATH ❑ EXERTION ❑ AT NIGHT	Y	N	❑ PARASITES ❑ WORMS	Y	N
❑ PALPITATION ❑ FLUTTERING HEART	Y	N	ANY CHANGE IN APPETITE OR EATING HABITS	Y	N
SWELLING OF ❑ HANDS ❑ FEET ❑ ANKLES	Y	N	❑ ANY CHANGE IN BOWEL ACTION ❑ STOOLS	Y	N
VARICOSE VEINS	Y	N	EXTREME ❑ TIREDNESS ❑ WEAKNESS	Y	N
CANCER	Y	N	EXPLAIN		

HABITS

DO YOU USE : ALCOHOL: ❑ NEVER ❑ OCCASIONALLY ❑ FREQUENTLY ❑ DAILY
TOBACCO: ❑ CIGARETTES (PKS PER DAY _____) ❑ CIGARS ❑ PIPE ❑ CHEWING TOBACCO ❑ NON SMOKER ❑ NEVER SMOKED

CONSERVATIVE TREATMENT PRIOR TO OFFICE VISIT – CHECK WHERE APPLICABLE

❑ Physical Therapy ❑ Bed Rest ❑ Collar ❑ Analgesics ❑ Chiropractor: Name_____
Address: _____

FAMILY HISTORY

Check if applicable and state relationship: (Mother, Father, Sister, Brother)

❑ Cancer_____ ❑ Tuberculosis_____ ❑ Heart Trouble _____
❑ Diabetes _____ ❑ Stroke _____ ❑ High Blood Pressure _____
❑ Epilepsy_____

_____ _____ ___/___/___
Print Patient's Name Patient's Signature Today's Date

Acknowledgement of Receipt of the HIPAA Privacy Notice

Princeton Brain and Spine Care is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosure of your protected health information and your privacy rights.

The delivery of your health care service will in no way be conditioned upon your signed acknowledgement.

If you decline to provide a signed acknowledgement, we will continue to provide you treatment, and we will use and disclose your protected health information for treatment, payment, and healthcare operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for Princeton Brain & Spine Care.

Name of Patient

Signature of Patient

Date

Princeton Brain & Spine Care, LLC Financial Agreement

We have put our financial policy into writing so that there is no misunderstanding regarding the fees and payment process that will be associated with your surgery. Please feel free to discuss this policy with our Billing Manager, Karyn Leasher at any time. It is the policy of PBSC to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- If we do not participate in your insurance, you are responsible for payment of all charges.
- Payment for your consultation is due in full at the time of service.
- If you are having surgery, we will submit your claim and work with your insurance carrier for 90 days. After the 90 days you will be required to make payments, or payment arrangements.
- If an appeal is required, we ask that you work with our billing department on the appeal. This is a much more efficient way to approach your carrier. It also keeps you informed of how the claim is being handled by them. Again, after 90 days regardless of the insurance situation, you will be required to make payments even if it is in appeals.
- Our Neurosurgeons often work with an assistant. If the assistant is another surgeon in our group this will be billed to your insurance. If the carrier does not pay those charges, you will be billed directly. If you are concerned about this, please discuss it with the physician before your surgery.
- We do not wait for secondary insurance to pay on your claim. We bill you for the balance directly after your primary carrier makes payment. Secondary payments will be sent directly to you from your carrier. This often takes many months.
- We do not accept lien letters or promissory notes from attorneys for any accounts. This includes Motor Vehicle and Workman's Comp claims. We would still expect payment to come from you after 90 days.
- If you do not have insurance at all, we will need you to make payment arrangements directly with the Billing Manager prior to your surgery.
- If you have a "Charity Care" card from any hospital, it will cover only your hospital charges. We require you to submit an application to us in order for us to give you "charity care". It is based on proof of income and financial need.
- We cannot write off any co-insurance, co-payments, or deductibles. This is against our compliance program and in some instances against the insurance regulations in our state. In the case of Medicare it is against federal law. Regardless of the financial arrangements that we make with you, please do not expect these fees to be waived.
- Our practice does not give professional courtesies. This is a business decision based on fairness to everyone that comes here.

Your signature indicates that you understand & agree to the terms stated.

_____ _____

Patient signature Date

☐ A copy of this form was given to the patient. Initialed by: _____

PRINCETON BRAIN & SPINE CARE

Date_____

Workers' Compensation /Automobile Liability/Legal Registration Form

Please complete this form in order to ensure proper billing of your services. Please Print.

Patient Name: _____
Insurance Company Name: _____
Address 1: _____
Address 2: _____
City, State _____
Zip: _____
Adjustor's Name: _____
Phone: _____
Injury Type:
Please Circle One: ***Workers' Comp*** ***Automobile*** ***Other***
Injury Date: _____
Claim Number: _____
Policy Number: _____
State Accident Occurred: _____

Insured's Name: _____
Insured's Address 1: _____
Insured's Address 2: _____
Insured's City, State: _____
Insured's Zip: _____
Insured's Phone: _____
Patient Relationship to Insured:
(Circle one) ***Self*** ***Spouse*** ***Child*** ***Other*** ***Employer***
Insured's Sex: _____
Insured's DOB: _____

If a legal Case, please complete the following:

Attorney's Name: _____
Attorney's Address: _____
_____
Attorney's Phone Number: _____

Release of Information I hereby authorize Princeton Brain & Spine Care, LLC to disclose to my insurance company(s) copies of my medical record(s) to obtain payment for services or as part of a payment review of medical services, or in the case of Workers Compensation or Motor Vehicle claims, to my present or past employer(s). Additionally, I authorize Princeton Brain & Spine Care, LLC to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose such information.

_____ ___/___/_____
Patient Signature Date

Medicare Signature on File

I request that payment of authorized Medicare Benefits be made on my behalf to Princeton Brain & Spine Care, LLC for any services furnished to me by the listing provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the provider of service.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

Princeton Brain & Spine Care LLC agrees to accept the charge determination of the Medicare carrier as the full charge. **I am responsible for any deductible and/or co-insurance deemed payable by Medicare.**

Medigap (Medicare Secondary Insurance)
I request that payment of authorized Medigap benefits be made either to me or on my behalf to Princeton Brain & Spine Care, LLC for any services furnished to me by that physician. I authorize information about me to release Medigap Coverage needed to determine benefits payable for related services.

_____	_____
Patient's Name (printed)	Medicare ID Number
_____	_____
Patient's Signature	Date

PRINCETON BRAIN & SPINE CARE

Patient Medication List

*Please list below **all** medications you are currently taking. Enter the name of each medication, the dosage (ie: how many milligrams) and the frequency (how many times a day you take each medication). In addition, please include the date you started taking the medication.*

Medication	*Dosage*	*Frequency*	*Date Started*	*Date Sopped*

Please provide the name and phone number of the pharmacy where your prescriptions are filled. Pharmacy Name: _____

Pharmacy Phone Number: _____

Patient Name: _____Date:_____

Patient Signature: _____

PRINCETON BRAIN & SPINE CARE

Patient Medication List (Page 2)

Medication	*Dosage*	*Frequency*	*Date Started*	*Dated Stopped*

Patient Name: _____Date:_____

Patient Signature: _____

Dear Patient:

Please read below Princeton Brain and Spine Care's policies regarding the following:

PRESCRIPTION/REFILL POLICY:

Please allow at least 48 hours for one of our physicians/physician assistants to call back in response to your request for a prescription/refill for medication.

FILM/DISK POLICY:

Please allow two weeks for our physician to review your films/disks and contact you with an interpretation. We cannot mail your films/disks back to you. You must pick them up. If you cannot pick them up within three months they will be destroyed according to office policy.

FORMS/CLAIMS:

Please allow at least one week for our physicians to complete paperwork related to your treatment. When you submit forms/claims, please also include instructions for their disbursement.

Thank you,
The Staff of Princeton Brain and Spine Care