

REGISTRATION FORM

Name: _____ Social Security #: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ___ Q _____ Work Phone: ___ QQ _____ Cell Phone: ___ Q _____

DOB: ___/___/___ Age: _____ Marital Status: M S D W Sex: Male / Female

Race: _____ Ethnicity: Hispanic Non-Hispanic U.S. Citizen: Yes No

Language: _____ Hearing Impaired: Yes No

Employer: _____

Full-Time

Part-Time

Retired

Unemployed/Disabled

Emergency Contact: _____

Relationship: _____ Phone: _____ Q _____

Referred by: _____ Phone: Q _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: ___ Q _____

Address: _____ City: _____ State: _____ Zip: _____

Please give us your insurance card(s) and driver's license so we can make a copy of them.

Primary Insurance: _____ Secondary Insurance: _____

If covered under your spouse's insurance, please provide the following information:

Spouse's Name: _____ Social Security #: _____ - _____ - _____

DOB: ___/___/___ Age: _____ Is insurance: Primary / Secondary / Both

Spouse's Employer: _____ Phone: ___ QQ _____

**All patients MUST provide some form of identification.
Please read and sign the following statements.**

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician or supplier for services described in the insurance claim. I understand that my insurance plan(s) MAY NOT COVER THE TOTAL COST OF TREATMENT (DUE TO THE NATURE OF THE INSURANCE PLAN OR THAT SOME TREATMENT(S) MAY NOT BE CONSIDERED AS MEDICALLY NECESSARY BY THE INSURANCE COMPANY) AND THAT **I AM RESPONSIBLE FOR ANY COPAYMENT, DEDUCTIBLE, COINSURANCE AND OTHER CHARGES NOT COVERED BY MY PRIMARY OR SECONDARY INSURANCE PLAN(S).**
MEDICARE PATIENTS: I understand that I am responsible for the deductible and the coinsurance applied to my Medicare Insurance coverage.

Signature: _____ Date: _____

Patient Name: _____

Date: _____

Check all that apply

Eyes

- Near-sighted **Y** **N**
- Far-sighted
- Do you wear contacts?
- Glaucoma
- Cataracts
- Eye pain
- Double vision
- Floating lights
- Excessive tearing
- Matting

Immunology

- Rheumatoid arthritis **Y** **N**
- Lupus
- Scleroderma

Gastrointestinal

- Chronic abdominal pain **Y** **N**
- Persistent nausea/vomiting
- Heartburn
- Appetite loss
- Vomiting blood
- Diarrhea
- Blood/clay-colored stools
- Hemorrhoids
- Constipation
- Hepatitis
- Gall bladder disease
- Difficulty swallowing liquids
- Difficulty swallowing solids

Genitourinary

- Excessive dribbling **Y** **N**
- Burning upon urination
- Incontinence
- Frequent urination at night
- Blood in urine
- Kidney stones

Reproductive - Male

- Discharge/sore penis **Y** **N**
- Hernias
- Testicular pain or lumps
- History of venereal disease
- Type
- Sexually active

Endocrine

- Thyroid trouble **Y** **N**
- Hot/cold intolerance
- Excessive thirst/hunger
- Diabetes
- If yes, do you take insulin?

Musculoskeletal

- Numbness in arms or legs **Y** **N**
- Tingling in arms or legs
- Problems walking
- Muscle jerking
- Paralysis
- Shaking/tremors
- Limited motion
- Muscle pain

Psychiatric

- Depression **Y** **N**
- Anxiety
- On psychiatric medicine

Ears/Nose/Throat/Mouth

- Hearing loss **Y** **N**
- Ringing in ears
- Pain in ears
- Discharge from ear
- Chronic nose obstruction
- Repeated nosebleeds
- Persistent sore gums
- Dentures
- Prolonged hoarseness
- Dry mouth

Respiratory

- Chronic cough **Y** **N**
- Difficulty breathing
- Asthma
- Emphysema
- Bronchitis
- Sit up to breathe easier?
- Wheezing
- Tuberculosis
- Pneumonia
- Require oxygen? 1/min
- Coughing up blood

Skin

- Lumps or bumps? **Y** **N**
- Color change in moles
- Hives or rashes
- Psoriasis/eczema
- Prior skin cancer
- Shingles

Neurological

- Dizziness/fainting **Y** **N**
- Memory loss
- Seizures
- Speech changes
- Sensory loss or changes
- Weakness in arms or legs

Reproductive - Female

- Breast lumps **Y** **N**
- Nipple discharge
- Hormone therapy
- Last menstrual period ___/___/___
- Sexually active
- History of venereal disease
- Type: _____

Cardiovascular

- High blood pressure **Y** **N**
- Heart disease or defects
- Pacemaker
- Chest pain

Hemo/lymphatic

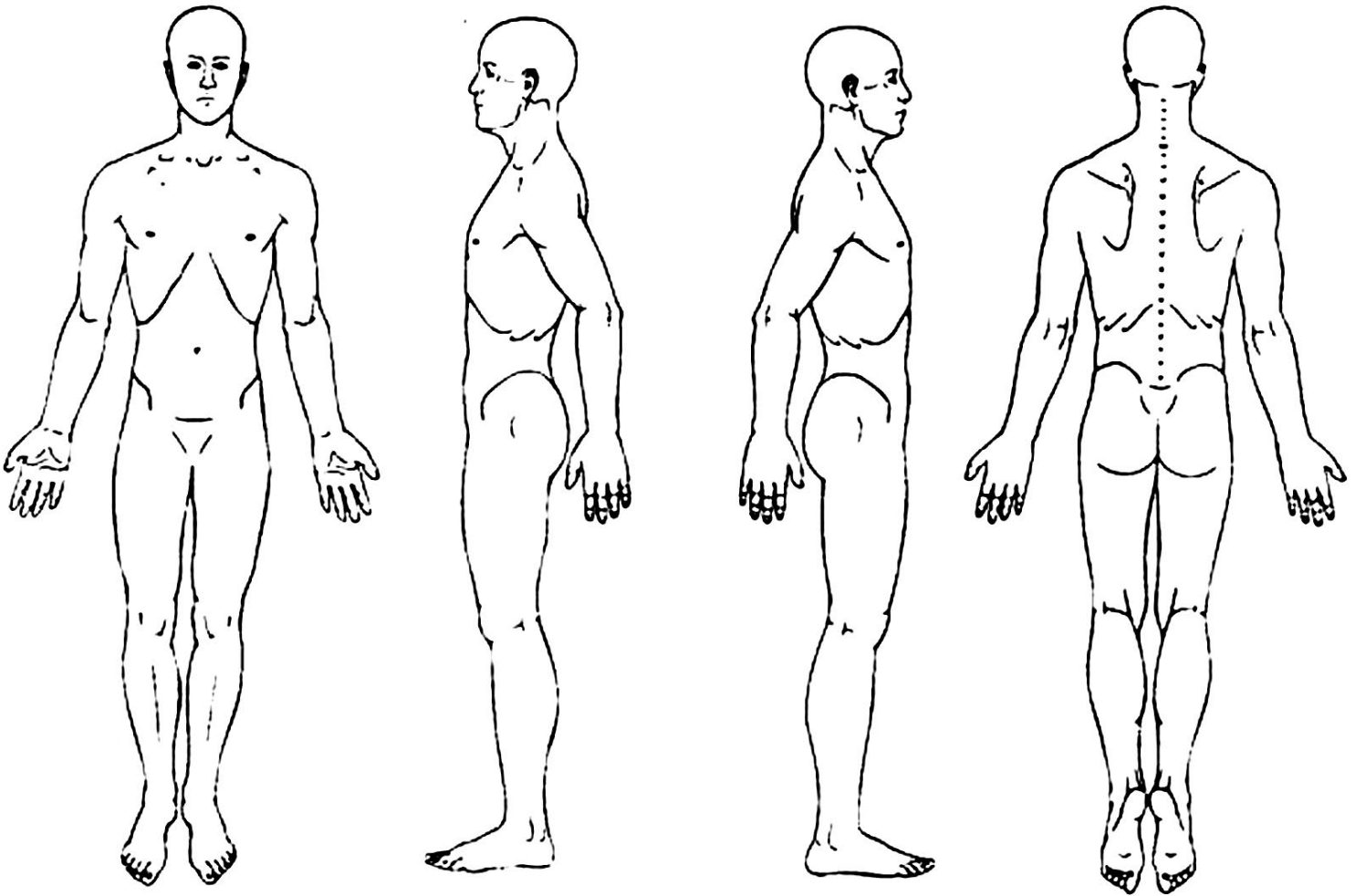
- Anemia **Y** **N**
- Bruising/bleeding
- Swollen lymph nodes
- HIV positive
- If yes, diagnosis date: ___/___/___
- Night sweats
- Frequent infections

Allergies

- Hay fever **Y** **N**
- Molds

Patient Name: _____ Date: _____

Please mark or shade the areas of your body where you feel pain on the diagrams below.



Next to each area marked above, please note the intensity of pain.

No Pain	Minimal	Tolerable, but hinders activities	High 50% of activities impaired	Extreme, most activities impaired	Unbearable
0	1 2	3 4	5 6	7 8	9 10



Stanley H. Kim, MD; Jeff T. Miley, MD; Anant I. Patel, MD
12180 North Mopac; Suite B; Austin, TX 78758

Financial Policy

This document is to inform you of Neurosurgery, Endovascular & Spine Center (NESC) financial policy. It is the philosophy of NESC that all of our patients receive the best possible care and service; therefore, your complete understanding of our financial obligations is an essential part of our philosophy. Please read this document thoroughly, sign and date at the bottom indicating that you understand and agree to comply with these policies.

Payment **FOR ALL SERVICES** by our practice is due in full at the time services are rendered. We reserve the right to charge interest on any accounts deemed past due. Exclusions to this policy include those patients who are a member of a Health Maintenance Organization (HMO).

If you are a member of an insurance company that NESC participates with, we will file your claims. Co-payment, co-insurance and deductible are due at the time services are provided REGARDLAESS if NESC is participating **OR NOT** participating with your insurance company.

Medicare patients are responsible for their co-insurance, deductible and any items deemed Medically Unnecessary by Medicare. If you have insurance that covers your co-insurance and deductible we will file on your behalf.

Patients will receive a monthly statement itemizing the services rendered, claims submitted on their behalf, payments received and appropriate balances due. All patient balances are payable in full, within fourteen (14) days of date on statement **unless prior arrangements are made** with our billing office.

It is the policy of NESC that any patient eighteen (18) years of age or older will be financially responsible for all charges incurred. NESC does not get involved with divorce or separation issues. For any patients under the age of eighteen (18), the parent or guardian who accompanies the minor on the date of their first visit will be held financially responsible for any and all charges incurred.

NESC accepts Cash, Credit Cards, Checks, Money Orders and Traveler's Checks as payment for services rendered. There is a \$25 charge for returned checks. Refunds will be issued on a monthly basis in the form of a check.

NESC reserves the right to turn any patient over to an attorney and/or a collection agency if it is deemed that the account has been in default of the payment obligations or compliance of these policies and will result in doctor/patient relation termination. A \$30 processing fee will be added to your account if this action is taken. NESC will also terminate doctor/patient relations and any further medical care.

I _____ have read and understand the above financial policy of NESC. I agree to the terms outlined in the policy and understand that if I do not adhere to NESC's financial policies, I may be turned over to an attorney and/or a collection agency for payment of debt.

Signature: _____

Date: _____



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Due to the many changes in healthcare and our ability to comply with these changes, we have put in place the following policies and procedures. This handout is designed to provide you with concise information about our conditions, expectations and procedures.

Appointments: We make a sincere effort to adhere to our appointment schedule however, at times, an appointment may take longer than planned or an emergency may arise. We appreciate your understanding and patience when this happens. Patients arriving more than 15 minutes late for an appointment will be asked to reschedule. Please be advised that if you cancel your appointment less than 24 hours in advance repeatedly or do not show up for an appointment twice we will ask you to find medical care with another physician. You will be charged the amount of an office visit fee for all no-shows and appointments canceled with less than 24 hours notice.

Letters: If you request a letter or any insurance documents to be generated, on your behalf, there will be a \$25 charge. The fee is due at the time of the request. This is not a covered insurance benefit and the patient is responsible for the charge.

Lost Information: Should you misplace any items produced by this office there will be a \$10 fee for replacing them. This is not a covered insurance benefit and the patient is responsible for the charge.

Prescription Refill Requests: Please contact your pharmacy and ask them to fax a prescription refill request to our office. Your doctor will approve or deny the request at that time.

Signature: _____

Date: _____



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PLEASE READ CAREFULLY, INITIAL BLANKS AND SIGN BELOW

____ Insurance co-pays are due **AT THE TIME OF SERVICE** and **before** you see the doctor. **If you do not have your co-pay, insurance card (s), and films your appointment will need to be rescheduled.** Please keep in mind that Dr. Kim, Dr. Miley & Dr. Patel are considered “specialty” physicians and higher co-pays may apply.

____ It is the patient’s responsibility to obtain HMO referrals from their primary care physician. **If you do not have your HMO referral, your appointment will need to be rescheduled.**

____ It is the patient’s responsibility to know if a doctor participates in your plan or not. As well as where your insurance company requires you to obtain your labs, x-rays and other ancillary services.

____ NESC follows governmental guidelines for billing our services. Many insurance companies will process charges for ancillary services (labs, x-rays, procedures, etc.) and make the patient responsible for balances above the office co-pay. This could be in the form of deductibles, co-insurance or additional co-pays. We participate with many insurance companies to enable our patients’ affordable medical care. Because of this, we are obligated to follow the guidelines that the insurance companies give us on patient balances. If you have specific questions about how your insurance company processed your claim, please call them directly.

____ If we do **NOT** participate with your insurance company, you are considered an Out-of-Network patient and will be responsible for your co-insurance and deductibles. Please contact your insurance company to verify your coverage.

For billing questions, please call 617-2810 and ask for Linda Salinas.

Patient Signature

Date



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Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



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Disclosures to Family & Loved Ones

Purpose:

This office honors the important role that families, friends, and other loved ones play in supporting our patients' health care and treatment. At the same time, we are committed to protecting our patients' privacy as well as complying with both state and federal law. Accordingly, disclosure to other people, even family, must remain a decision that rests with the patient. To the extent that is possible, we will follow the alternative addressed in this policy.

Policy:

- This practice will comply with any patient's request for us to share their personal health information with family member(s) and other designated person(s). We will comply with their request as long as: 1.) the oral request is noted in the patient's record (e.g. "at patient's request will share information with John Doe"), 2.) the patient is competent to make this decision, and 3.) the patient has not revoked that request. Note that revocations or limitations must also be documented in the patient's record.
- Patients who arrive at this office with others will be asked privately if they would like those persons present while they are being seen and/or treated.
- Patients who are undergoing procedures requiring anesthesia will be asked if they would like information shared with anyone prior to their awakening.
- If the individual cannot express his/her request for sharing information, because of incapacity or an emergency circumstance, our physician(s) will exercise their professional judgement and determine whether the disclosure is in the best interest of the individual. If so, we will disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care.
- Patient family members, neighbors, etc. that come to this office to pick up prescriptions, equipment, direction, or other items associated with a patient's care will be permitted to do so if it is reasonable to infer they are involved with our patient's care.
- Notification of appropriate third parties also may occur without a patient's request or approval, to the extent this office is involved with disaster relief services, or acting in the role of notifying a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death.

Patient Signature: _____ Date: _____

Person or persons we can release information to and how they are related:
