IGEA BRAIN AND SPINE

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

***Please present ALL Insurance cards and Drivers License to the receptionist**

ALL FIELDS ARE REQUIRED TO BE COMPLETED.

Patient Information: **Please Complete All Fields Using Legal Names of the Parties Involved.**

Name: (First)________________________________ (MI)______ (Last)____

Date of Birth: ____________ Age: _____ Sex: □ Male □ Female Marital Status: Single Married Divorced Widow

Mailing Address: ____

City: __________________________________ State: _____ Zip: ________ Social Security#: ______________________

Home Phone: _____________________ Cell: ________________________ Email address: ________________________

Occupation: __________________________ Employer: ____________________ Work Phone: ___________________

Employer Address: ____

Pharmacy Name: __________________________ Town: __________________Phone#:__________________________

Primary Care Physician: ____________________ Town: __________________ Phone#:__________________________

Referring Physician: ________________________ Town: __________________ Phone#:__________________________

Emergency Contact Name: ___________________ Relationship: _____________Phone#:__________________________

New Patients: How did you hear about IGEA Brain and Spine? Family Friend Physician
Self Referred ER Newspaper/ Magazine Brochure Internet TV Radio Other

Primary Insurance Plan:_____________________________________ID#______________________________________

Address: ____

Primary Insurance Plan Holder's Name:________________________ DOB:_____________ Relationship to patient:______________

Mailing address of Plan Holder if different from patient: ____

Home Phone of Plan Holder: _________________________ Cell phone of Plan holder: _______________________________

Secondary Insurance Plan: ___________________________________ID#______________________________________

Address: ____

Secondary Insurance Plan Holder's Name:________________________ DOB:___________ Relationship to patient:_____________

Patient Release: MUST BE SIGNED BY PATIENT : I hereby authorize IGEA Brain and Spine 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, *or in the case of Workers Compensation Motor Vehicle claims, to my present or past employer(s)*. Be informed that IGEA does not participate in and is out-of-network with all insurance companies with exception to Medicare and specific QualCare plans. I understand that I am financially responsible for all charges if they are covered by insurance. I also understand that I will be balance billed for any amount not covered by insurance. I authorize IGEA 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:** ________________

IGEA BRAIN AND SPINE

Patient Medical History and Chief Complaint

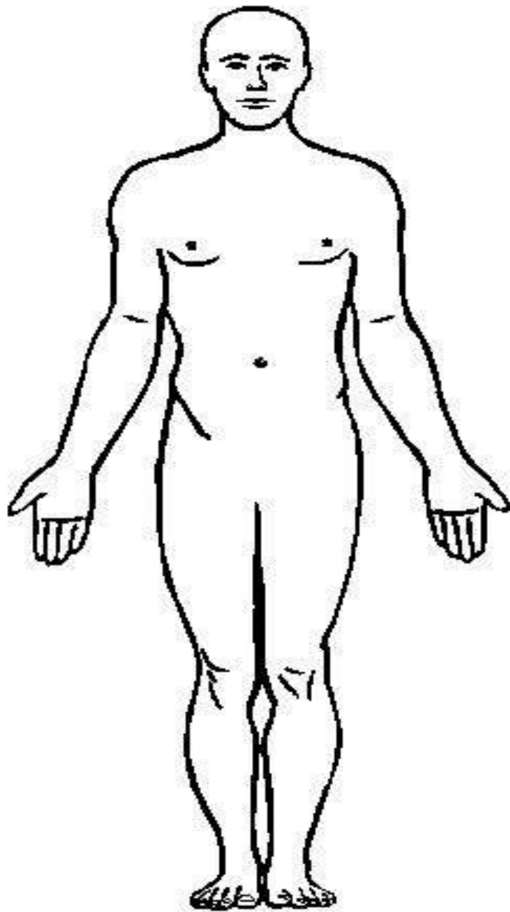
Please describe the reason(s) for your visit today: ____

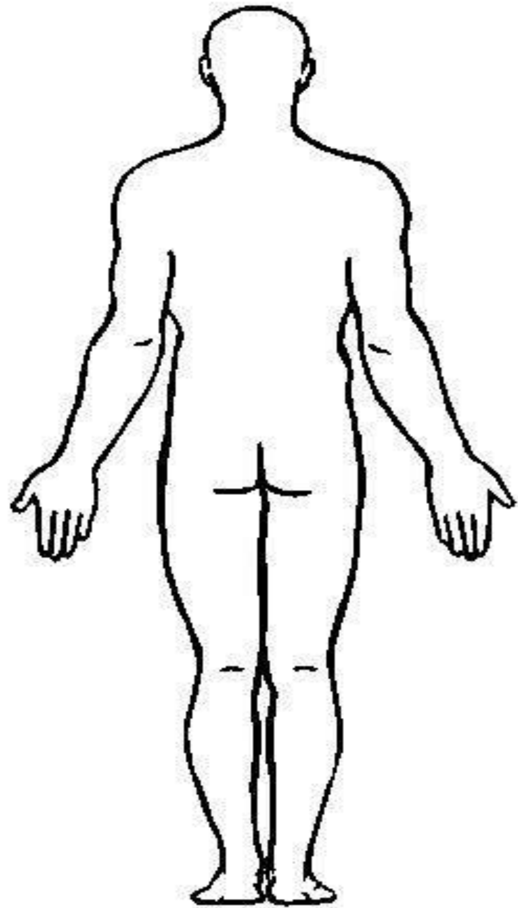
____

____

Pain Diagram

- Please shade in effective areas
- LABEL type of sensation or pain in each area (example: burning, aching, throbbing, stabbing, tingling, numbness etc.)
- If multiple locations please indicate where pain is most severe.





Wong-Baker FACES® Pain Rating Scale

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

IGEA BRAIN AND SPINE

Past Medical History

Surgeries (include dates) ____

____

Allergies to medication or foods (please list) ____

Please mark your past medical history (illnesses/ injuries/ hospitalizations etc.)

○ Anemia ○ Headaches ○ Head Injury/Concussion ○ Osteoporosis ○ Arthritis ○ Thyroid Problems
○ Seizures ○ Blood Clots ○ Asthma/ Lung Disease ○ Cancer ○ Stroke ○ Kidney Disease
○ Hypertension ○ Diabetes ○ Heart Disease
○ Other ____

Please list your history of motor vehicle accidents, back injuries, ect. (date/ did symptoms resolve/ duration of symptoms)

____

____

Review of Systems

Please circle all that apply to your current state of health

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nail changes
Head/Neck	Head injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks/ Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardio-vascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of conscious-ness		
Gastro-Intestinal	Abdominal pain	Nausea/vomiting	Diarrhea/ Constipation	Bright red Blood per rectum	Dark, black Tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet, productive)	Sputum (color and amount) ____________	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness/Tingling	Bowel/ Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip Pain	Knee Pain	Shoulder Pain	Back Pain	Joint Pain	

IGEA BRAIN AND SPINE

Social History:				
	Never*	**Occasionally**	**Frequently**	**Daily**
Alcohol Use				
Tobacco (Specify:__________)				
Cigars				
Illicit Drugs (Specify:__________)				
Vape				

*If you have quit indicate when

Conservative Treatment prior to Office Visit today			
	Was it successful	**Did you only get temporary relief**	**Comments (Last Visit/Intervention)**
Physical Therapy			
Bed Rest			
Cervical Collar			
Analgesics			
Chiropractor Name: ________________________			
Epidural Steroid Injection			
Pain Management Doc: ________________________			

Family History: Check if applicable and relationship:				
	Mother	**Father**	**Sister**	**Brother**
Cancer				
Diabetes				
Epilepsy				
Tuberculosis				
Stroke				
Aneurysm				
Sudden Death/ Brain Bleed				
High Blood Pressure				

Medication List

Medication Name	Dosage (mg)	Frequency	Date Started	Date Discontinued

IGEA BRAIN AND SPINE

Patient Policies

NARCOTICS AND MEDICATIONS: Please allow 48 hours for a response to medication requests. Narcotics are not prescribed as a general pain treatment. As surgeons, we recommend pain management techniques or surgery to treat pain. Medications are not prescribed prior to surgical intervention. We do prescribe postoperative pain management medications in the form of narcotics for a determined period-of- time and not later than 3 months after surgery. It is our policy to prescribe urinary drug testing on any of our patients that are prescribed narcotic medications by our office. Patients receiving narcotic medications in their postoperative period must contact the office with 72-hour lag time for prescription refills. Prescriptions will not be refilled in a 24-hour time slot or on weekends. Prescriptions may be mailed to the patient's address on file or picked up at the office. A signed Pain Management Agreement may be necessary to continue to provide narcotic medications.

FILM AND DISKS: Please allow two weeks for out physician to review your films/ disks and contact you with an interpretation. We cannot mail your films/ disks back to you and therefore, must be picked up in person. If you cannot pick them up within three months, they will be destroyed according to our office policy.

We may contact you via text message, cell phone, or email unless you provide written notification to opt out.

FORMS AND CLAIMS: Please allow 10-days for our Physicians to complete paperwork related to our treatment. When you submit claims/ forms please include instruction for their disbursement**.**

INSURANCE BENEFIT INFORMATION: With exception to Medicare, IGEA Brain and Spine is an Out of Network Practice. This is very commonplace among Neurosurgery practices in our area. Out of Network means we do not participate with most insurance plans. However, many insurance plans provide for Out of Network benefits, which allow us to work with your insurance company. Typically, patients who have Out of Network benefits will have a different responsibility. Each insurance plan is different and we are here to assist you with understanding your plan.

FINANCIAL ARRANGEMENTS: IGEA Brain and Spine recognizes that all healthcare plans have shifted a greater responsibility to our patients to assist in paying for their care. We are committed to working with you needs not just medically, but financially as well.
By law, we are unable to "write off" co-insurances, copayments or deductibles. Our dedicated billing team works with each patient to create payment plans and assist them through the challenge of understanding their healthcare plans.

FINANCIAL POLICY: Our billing team will work diligently to assure your insurance company meets their obligations to you. If our billing team choses to appeal a decision, we ask you work with them to assist in assuring maximum reimbursement is obtained in order to reduce your out of pocket financial obligations.
With your Out of Network Benefits, there are times when the insurance company will send the payment for services directly to the patient, rather than our office. The reason for this is many other practices chose to have the patient pay up front for services and are then reimbursed by the insurance company. We recognize this is a hardship for our patients and do not require payment up-front for our services. **In the event that you receive any payment from an insurance carrier relating to services rendered, you agree to hold such payment in trust for the provider and agree to send any such payment to the provider within one week after receipt of same.** Failure to submit this payment will result in an additional 18% monthly interest rate until the debt is paid in full. Furthermore, it is the responsibility of the patient to reimburse all attorneys' fees expended in connection with obtaining payment of the debt.

Despite our efforts to arrange for payment plans over time after a patient is balanced billed, in the event that your account is turned over to an attorney for collection, you agree to pay a collection fee equal to 33 1/3% of the outstanding balance, plus court costs and attorney's fees.

AUTOMOBILE ACCIDENTS: You must have opened a claim with your insurance in order to be seen, Documentation must be provided from an adjuster on billing information. We do not accept letters of representation / protection from an attorney. Once documentation from your adjuster is received and benefits are available, we will file your claim. All patients seen for automobile accidents are required to provide their health insurance information in order to be treated in the practice.

WORKERS COMPENSATION: You must have opened a claim with our employer to be seen. Documentation must be provided from adjuster employer on billing information. Once received, we will file your Workers Compensation insurance for you.

Patient Signature: ____ **Date:** __________________

IGEA BRAIN AND SPINE

HIPAA Notice and Information

Patient Name: ____ **DOB:** ________________________

Our intent of this notice is to make you aware of IGEA Brain and Spine's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996. The Notice of Privacy Practices outlines 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.

I acknowledge and understand I may request a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

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

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of IGEA Brain and Spine from discussion appointments, medications, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and you parents assist with prescriptions and appointments.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information about you. Should you wish to update the names below, please ask the receptionist for a HIPAA form.

Name of Individual (please print)	Relationship to Patient
____	____
____	____
____	____

Patient Signature: ____ **Date:** _______________

IGEA BRAIN AND SPINE

Permission for IGEA Billing office to file complaint/ grievance/ appeal on patient's behalf for payment

To Whom It May Concern:

I authorize IGEA Brain & Spine to act as my representative in connection with complaint / grievance/

appeal with (insurance company)____.

I authorize this group to make any request to present or elicit evidence; to obtain information and to receive any notice in connection with my complaint/ grievance or appeal. I understand that personal health information related to my claim may be disclosed to my representative in the course of complaint/ grievance or appeal.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand this information and grant my consent for my representative to file a complaint/ grievance or appeal on my behalf.

Thank you.

Date: _________________________________

Patient Name: (print) ____

Patient Signature: ____

Date of Birth: ________________________

IGEA BRAIN AND SPINE

Workers Compensation/ Automobile Liability/ Legal Registration Form

Skip to the next page if you are not seeking treatment due to Workers Compensation or Automobile Liability issues.

Patient Name: ____________________

Please Circle: Workers Comp Automobile Other

Insurance Company Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: __________

Adjustors Name: ____________________ Phone: ____________________

Injury Type: ____________________ Injury Date: ____________________ Claim #: __________

Policy #: ____________________ State where accident/ injury occurred: ____________________

Insured's Name: ____________________ Insured's Phone # ____________________

Insured's Address: ____________________ Insured's DOB: ____________________

Patient Relationship to Insured: (circle) Self Spouse Child Employer Other

If Legal Case, please complete the following:

Legal Firm Name: ____________________ Attorney'sName ____________________

Address: ____________________

____________________ Phone: ____________________

Assignment of Benefits

I, the undersigned, hereafter referred to as "The Patient" do hereby assign all of my rights and interests to IGEA Brain and Spine, hereafter referred to as "the Medical Provider" **to pursue and obtain payment on my behalf.** This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

I assign, to the Medical Provider, all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my medical bills, I hereby authorize and give the medical provider power of attorney to sign any document s on my behalf to pursue a claim for personal injury protections benefits. However, upon consent of both parties, same shall be revocable.

I, the patient do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

I, the patient authorize my bodily injury attorney to pay directly to the medical provider any monies undue on my account, or, have same deducted from any settlement made on my behalf.

I, the patient do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/ or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

Initial __________

I, the patient do hereby acknowledge that I will not file suit and or arbitration for the payment of above providers medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Patient Signature: ____________________ Date: ____________________

IGEA BRAIN AND SPINE

Medicare Signature on File

Please complete this form in order to ensure proper billing of your services;
Skip to the next page if you are not insured by Medicare or a Medicare Replacement plan

I request the payment of authorized Medical Benefits be made on my behalf to IGEA Brain and Spine 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 and 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 other insurer or agency shown.

IGEA Brain and Spine agrees to accept the charge determination of the Medicare Carrier as the full charge**, I am responsible for and deductible and/or co-insurance deemed payable by Medicare.**

Medigap (Medicare Secondary Insurance)

I request that payment of the authorized Medigap benefits be made either to me or on my behalf to IGEA Brain and Spine 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 Name: ____

Patient Signature: ____ **Date:** _____________