Welcome !!!

Here is your new patient paperwork, please fill out before your upcoming appointment and arrive 15 min early to finalize your registration.

We will need a copy of your ID and Insurance cards when you come in. We will also be collecting any co-pays, so please be prepared to pay.

If you have CDs or reports for any current studies, please make sure you bring them with you.

We have underground parking and there is also street parking.
Our parking structure only accepts cash.

If for any reason you need to cancel or re-schedule your appointment, make sure you do it 24 hours in advance to avoid a $25.00 late cancellation/no show fee.

Thank You

Welcome!

NAME: _____

Home Address: _____

Telephone: _____ Mobile: _____

Date of Birth: _____ SSN: _____

Email Address: _____

Occupation: _____ Employer_____

Work Phone: _____

Female☐ Male ☐ ☐ Married ☐ Single ☐ Widow(er)

☐ Divorced ☐ Domestic Partnership

Name of Spouse (if applicable): _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

EMERGENCY CONTACT (not living at the same address)

Name: _____

Relationship: _____

Home Phone: _____ Alternate Phone: _____

WORKER'S COMPENSATION *(if applicable)*

Did your injury happen on the job? Yes / No Date of Injury: _____

Did you report the accident to your employer? Yes / No

Worker's Compensation Carrier: _____

Adjuster's Name & Number: _____

Insurance Information

[Primary Insurance]

Name of Insurance Company: _____

Policy / ID Number: _____ Group No: _____

Insured's Name : _____ Insured's Date of Birth: _____

Relationship to Patient: _____ SS#: _____

[Secondary Insurance]

Name of Insurance Company: _____

Policy / ID Number: _____ Group No: _____

Insured's Name : _____ Insured's Date of Birth: _____

Relationship to Patient: _____ SS#: _____

I certify the above information is correct. I understand that the doctors are not required to bill secondary insurance for services rendered. As a courtesy, this office will forward secondary insurance claims and request payment. I must inform this office of any insurance changes. I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered by the above named physicians.

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Igor Fineman, MD (Southern Counties Neurosurgical Medical Group, Inc) for any medical services provided to me by this doctor/organization.

HIPAA NOTICE OF PRIVACY PRACTICE – Acknowledgement of Receipt

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I also hereby authorize the and direct Igor Fineman MD to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Patient's Name: _____

Patient's Signature: _____

Date: _____

Raymond
Neurosurgery and Spine

630 S. Raymond Ave., Suite 301
Pasadena, California 91105
phone 626) 535-9552 • *fax* 626) 535-9505
www.raymondneurosurgery.com

Igor Fineman, M.D., FACS
Diplomate, American Board of Neurological Surgery

Jennifer Birch, R.N., A.C.N.P.
Neurological Surgery

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

INSURANCE:

We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the *patient* and the *insurance company* and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for *partial* or *full* payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the services rendered.** It is the responsibility of the patient to provide *accurate* and *timely* insurance information. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered.

PAYMENT is expected at the time of your visit. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. **Co-payments** are due at the time of service. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of you visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!) We will accept cash, check, or credit card. **Returned Checks** will incur a $30.00 service charge. Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.

If special circumstances make immediate payment impossible, payment arrangements must be approved* in advance *by our business office staff.

MEDICAL RECORDS AND FORMS

Completing disability forms, copying medical records, etc., requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $15-$25 per occurrence.

Medical Records

1) If you transfer to another physician, we will provide a copy of your record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2) If you are requesting copies of your records, the copying fee is $25.00. We require 3-day turnaround time and will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

APPOINTMENTS

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $25.00 for appointments that are not canceled at least 24 hours in advance. Additionally, we reserve the right to charge $300.00 for surgery procedures that are cancelled within 1 week of the surgery date, unless the cancelation was medically necessary.

If you are late for your appointment (>20 minutes), we will do our best to accommodate you.

However, on certain days it may be necessary to reschedule your appointment.

We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Patient's Name: _____

Patient's Signature: _____

Date: _____

Medical Records

NAME:

_____

Date of Birth: _____

I hereby authorize you to release my medical records, including:

☐ MRI / CT films and reports

☐ Hospital Records (operative reports)

☐ Other _____

Please release/send my records to:

Igor Fineman, MD
Raymond Neurosurgery & Spine
630 S. Raymond Avenue, Suite 301, Pasadena, CA 91105
Phone: (626) 535-9552
Fax: (626) 535-9505

Patient's Name: _____

Patient's Signature: _____

Date: _____

Medications

Our practice can send your prescription electronically to your pharmacy. Please complete your pharmacy information below.

NAME: _____

Date of Birth: _____ Date: _____

Pharmacy Name: _____ Phone: _____

Address: _____

ALLERGIES: _____

_____

Medication Name	Dosage / Frequency	Purpose	Prescribed by

NAME: _____

Date of Birth : _____

Medication Name	Dosage / Frequency	Purpose	Prescribed by

Patient Medical History

Date: _____

Name: _____ DOB: _____ Gender: (F) (M)

Referring Physician: _____ Primary Care Physician: _____

Other treating physicians in the past five years:

Name:	Phone:
1. _____	_____
2. _____	_____
3. _____	_____

What is the current problem for which you are here? (Chief Complaint)

When did it start? If this is an injury, please list the date the injury occurred.

Are you getting worse?

Is this a work related injury? ☐ *Yes* ☐ *No*

Employer: _____

Did you report this to your employer? ☐ *Yes* ☐ *No*

Name: _____ Date: _____

REVIEW OF SYSTEMS

Do you currently have any of these symptoms?

Constitutional Symptoms

☐ Fever
☐ Night sweats

Cardiovascular Symptoms

☐ Shortness of Breath
☐ Chest pain
☐ Irregular heart beat

Respiratory Symptoms

☐ Chronic Cough
☐ Coughing Blood
☐ Emphysema
☐ Bronchitis
☐ Asthma

Gastro-Intestinal Symptoms

☐ Weight Loss
☐ Blood in Stool
☐ Dark Colored Stool
☐ Abdominal Pain
☐ Hernia
☐ Difficulty Swallowing
☐ Nausea

Genito-Urinary Symptoms

☐ Any burning or urination
☐ Dark or discolored urine
☐ Difficulty starting/ending urine stream
☐ Poor control of bladder
☐ Any type of sexual dysfunction
☐ Inability to obtain/maintain erection
☐ Loss of Sensation

Endocrine Symptoms

☐ Poor appetite
☐ Cold intolerance
☐ Dry skin
☐ Excessive thirst
☐ Loss of body hair
☐ Weight gain

Hematologic/Lymphatic Symptoms

☐ Easy bruising
☐ Nose bleeds

Allergic/Immunologic Symptoms

☐ Body Rash

Skin and Breast Symptoms

☐ Dry Skin
☐ Discharge from nipples

Psychiatric Symptoms

☐ Depression
☐ Disorientation
☐ Hallucination
☐ Euphoria
☐ Anxiety

Musculoskeletal Symptoms

☐ Swelling
☐ Masses
☐ Neck pain
☐ Neck spasm
☐ Cramps
☐ Abnormal arm or leg feelings
☐ Arm or leg weakness
☐ Back Pain
☐ Weakness

Neurological Symptoms

☐ Double vision
☐ Blurry vision
☐ Loss of Hearing (one or both)
☐ Ringing in ears
☐ Numbness in face
☐ Decreased ability to smell
☐ Decreased ability to taste
☐ Droopy eye or face
☐ Hoarseness
☐ Difficulty speaking
☐ Difficulty swallowing
☐ Slurred speech
☐ Headache
☐ Dizziness
☐ Seizure

Other: _____

Name: _____ Date: _____

PAST MEDICAL HISTORY

Please list ant prior major illnesses or injuries:	Date:

List any recent hospitalization or surgeries:	Date:

Please answer Yes or No to the following questions.

Cancer: _____	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Ulcers	☐Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Recent Infection	☐ Yes	☐ No
Recent Immunization	☐Yes	☐ No
Recent Foreign Travel	☐ Yes	☐ No
Allergies / Sensitivities	☐ Yes	☐ No

Allergy/Sensitivity Type (include foods, environmental, or other)
If yes, please allergies & reaction:

_____

_____

_____

Please complete the Medication form – for the listing of your current medications.

Name: _____ Date: _____

FAMILY HISTORY

	Mother	Father	Siblings	Grandparents	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					

SOCIAL HISTORY & LIFESTYLE

Ethnicity / Race: _____ Preferred language: _____

Marital Status: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Domestic Partnership

Highest level of Education: _____

Occupation: _____

Alcohol ☐ Yes ☐ No	Drinks per week	Number of Years
Smoking ☐ Yes ☐ No	Packs per week	Number of Years
Recreational Drugs ☐ Yes ☐ No	Types of Recreational Drug	Number of Years
Exercise ☐ Yes ☐ No	Types of Exercise	Days per Week

My signature signifies that I have completed the above medical history to the best of my knowledge.

Signature: _____ Date: _____

Raymond Neurosurgery and Spine
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www.raymondneurosurgery.com

Dear Patient,

Controlled substance medications (opioid medications, tranquilizers, sedatives, etc.) have a high potential for misuse. There has been a significant increase in the scrutiny over prescribing of such medications by federal and state authorities over the past several months as a result of multiple recent overdose deaths attributed to these medications. The goal of the measures implemented by the authorities is to curtail the use of these medications.

Opiate pain medications are designated for temporary relief of pain to help improve physical and vocational functioning. They are not designed to be used long-term. Long term use renders these medications largely ineffective due to development of tolerance, and exposes patients to dangerous side-effects.

Our healthcare providers, Dr. Fineman and Jennifer Birch, NP take the use of these medications very seriously and therefore are instituting the following policies and patient responsibilities.

I, _____ as a patient of Dr. Fineman have the
(Print Patient Name)

responsibilities listed below:

1. I will take my medication as prescribed
2. I will not change or increase how I take my medication without the prior approval of Dr. Fineman/ Jennifer Birch, NP.
3. I will not obtain pain medications or any other controlled substances from any other physician.
4. I will inform other healthcare providers of all medications I am taking.

5. I will arrange for refills only during office hours and give a 72-hour prior notice. I understand same day refills cannot be done and provider has 72 hours for refills. I will only use one pharmacy and any lost prescriptions may result in tapering or discontinuation of my pain medications.

6. Any forged, sold or abused prescriptions will result in discontinuation of the medications and possible dismissal from the practice. I will consent to random drug screening to assure I am only taking the prescribed drugs. I understand that drug screening is a laboratory test of my urine or blood to determine what drugs I am taking. Failure to submit to testing at the time of the request may result in a discontinuation of my medications.

7. I will not use illegal, street or another person's drugs and understand if I test positive for the above, my medication will be discontinued.

8. I will not share my medications with others.

9. I will not drive while on controlled substances, as controlled substances will impair my judgment.

10. If I am found to be fraudulently refilling, using or abusing any prescribed medications or in possession of any illegally obtained prescriptions, I understand that I will be dismissed from the practice and the appropriate authorities contacted.

11. I understand I will only be prescribed pain medications for up to 90 days after surgery. If I require medication for longer than 90 days, I may be referred to a pain specialist for further care and pain management. Furthermore, I understand it is our office policy to not give pain medication unless surgery is performed.

I have read and fully understand the above policies and my responsibilities as a patient.

Patient Signature: _____ Date: _____

Witness: _____ Date:_____

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION FOR FAMILY MEMBERS

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider Raymond Neurosurgery and Spine to use or disclose my health information to the recipient(s) that I have identified below.

Recipient: I _____authorize my health care information to be released to the following recipient(s):

Name:_____ Relationship _____

Name:_____ Relationship _____

Name:_____ Relationship _____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his / her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- ❑ Only the following records or types of health information:

  *_____.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/ Representative Legal Relationship Date Witness

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Raymond Neurosurgery and Spine. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.