Brain and Spine Center, P.L.C

Hemant K. Pandey, MD

****Please complete entire form in blue/black ink****

Name: ____ Date of Birth: ____________________
Last First MI

SS#:____________________________

Address: ____ Gender: M or F Age: ________
Street

____ Marital Status: S M D W
City State Zip

Telephone: Home ( ) ________________ Cell ( ) ________________ Work ( ) ________________

******Please indicate preferred primary phone number*** ☐ Home ☐ Cell ☐ Work Text Okay? Yes No

Employer: ____ Occupation: ____________________
Name

____
Street City State Zip

May we contact you via email? YES NO Please provide Email: ______________________________

Primary Care Doctor: ____________________ Primary Care Doctor's Phone #: ( ) ______________

Referring Doctor: ______________________ Referring Doctor's Phone #: ( ) ______________

Race (circle one): African American Caucasian Hispanic Asian Native American

Primary Language (circle one): English Spanish Other: ____________________

Do you have a Power of Attorney or a Caregiver? Yes______ NO ______ Name of Individual: ______________

Who referred you to our office? ☐ Family Physician______________ ☐ Other Physician______________

☐ Friend/Patient:______________________ ☐ other :(define)______________________________

Emergency Contact Person:
Name: ____________________ Phone: ____________ Relationship: __________ Hippa Rights? YES NO

Preferred Pharmacy:

Pharmacy Name**:** __________________ **Cross Roads:** __________________ Phone Number**:** ____________

Address: ____
Street City State Zip

Major Crossroads: ____

Medication History Consent:

A medication history is a list of medicines that Brain and Spine Center,Plc and other doctors have recently prescribed for a patient. It is collected from a variety of sources, including, a patient's pharmacy, health plans, other healthcare providers, and the Arizona State Pharmacy Board.

I give my consent for Brain and Spine Center, Plc to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature: ______________________________ **Date:** ____________________

Primary Insurance: **********MUST BE COMPLETED BY PATIENT FOR INSURANCE TO BE BILLED FOR SERVICES**********

Insurance Plan: ______________________________ Policy Holder: ______________________________

ID #: ______________________________ Group #:______________________________

Claims
Address:____
Street City State Zip

SS#: ______________________________ D.O.B:______________________________

Relationship to Policy Holder: ____

Employer of Policy Holder: ______________________________ Phone:______________________________

Address:____
Street City State Zip

Secondary Insurance:

Insurance Plan: ______________________________ Policy Holder: ______________________________

ID #: ______________________________ Group #:______________________________

Claims
Address:____
Street City State Zip

SS#: ______________________________ D.O.B:______________________________

Relationship to Policy Holder: ____

Employer of Policy Holder: ______________________________ Phone:______________________________

Address:____
Street City State Zip

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient Signature: ______________________________ Date: ______________________________

DO WE HAVE YOUR PERMISSION TO DISCUSS YOUR CASE WITH CERTAIN SPECIFIED RELATIVES AND/OR FRIENDS OF YOUR CHOOSING?

Name/Relationship: ______________________________Phone: ______________________________

Name/Relationship: ______________________________Phone:______________________________

Name/Relationship: ______________________________Phone:______________________________

Name/Relationship: ______________________________Phone:______________________________

Do we have you permission to leave messages on your answering machine at home or voicemail at work? YES NO

Brain and Spine Center, P.L.C

Hemant K. Pandey, MD

Financial Policy

Thank you for choosing Brain and Spine Center as your neurologist. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

******PLEASE INITIAL ALL OF THE FOLLOWING:***

1._____ I understand that if I do not have my insurance card, referral, co-payment, deductible, and/or coinsurance that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2._____I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefit payments. I understand I will be responsible for the portion not covered by my insurance.

3._____I understand that if I am unable to make a scheduled appointment I need to contact the office at least 24 hours prior to my scheduled appointment. A $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

4._____I understand that if I have three No-Shows or Same Day Cancelations I may be discharged from the practice.

5._____I understand there is a $35 charge for a Non-Sufficient Funds (NSF) check.

6._____ I understand there is a $50 charge for all forms deemed appropriate, filled out by the Physician (e.g. Disability, FMLA, etc.) and I understand that I need an appointment with the Doctor to fill out these forms.

7._____I understand if my account is not paid in full within 90 days, a $35 collection-processing fee will be added to the outstanding balance and will be turned over to a collections agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

8._____***I have read and I understand the above Financial Policy and I agree to abide by its terms.***

Signature of patient (or parent / guardian): ____

Print Name: ___________________________________ **Date:** ________________________

<u>Brain and Spine Center, P.L.C</u>

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Brain and Spine Center, PLC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

____ _______________________

Signature of the Patient or the Patient's Legal Representative Date

____

Print Name

FOR OFFICIAL USE ONLY

I, _________________________, made a good faith effort to obtain written acknowledgement of _______________________'s receipt of the Notice of Privacy Practices of ________________________. However, I could not obtain written acknowledgement because:

☐ Individual refused to sign this acknowledgement

☐ Communications barrier prohibited obtaining written acknowledgement

☐ An emergency situation prevented obtaining written acknowledgement

☐ Other (please specify): ____

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