WELCOME TO **NEUROSURGICAL ASSOCIATES OF ABINGTON**

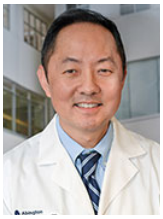
PRACTICE PHYSICIANS


Douglas W. Laske, MD


G. Michael Lemole, Jr., MD


Steven J. Barrer, MD

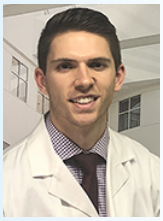

Jonas J. Gopez, MD


Michael S. Yoon, MD

ADVANCED PRACTICE PROFESSIONALS


Bruce T. Sloan, PA-C


Tiffany Buchert, PA-C


Sean T. F arnsworth, PA-C

We look forward to meeting with you to discuss the treatment of your neurosurgical issues.

IMPORTANT MESSAGE FOR ALL NEW PATIENTS

Please arrive 15 minutes before your scheduled appointment and bring the following with you:

- New patient paperwork.
- Discs and reports for MRI scans, CT scans, x-rays, myelograms, EMG studies or other tests. Images taken at Abington or Lansdale Hospitals are available in our office online.
- Photo ID, insurance cards and copay.
- Insurance referral, if your carrier requires one.
- If you have a Worker's Compensation claim or Motor Vehicle Accident claim, you must have a backup referral from your HMO insurer in order to see the doctors.
- There is a $10.00 fee, payable in advance, for all disability, school or work forms completed by the staff to a maximum of $25.00.

If you have any questions, do not hesitate to call us at **215-481-3255**.

Thank you for your kind attention to these matters.

Vickie and Jack Farber Institute for Neuroscience at Abington – Jefferson Health®

Abington Hospital – Jefferson Health
1 Widener
1200 Old York Road
Abington, PA 19001

Abington Jefferson Health
Montgomeryville
1010 Horsham Road, Suite 205
North Wales, PA 19454

Abington Jefferson Health
Blue Bell
721 Arbor Way, Suite 103
Blue Bell, PA 19422

Asplundh Cancer Pavilion
3941 Commerce Ave
Willow Grove, PA 19090

T 215-481-3255 F 215-481-3781

Patient Data

Name: _____ _____ **Gender:** M F TG
(Last) (First) (Middle) (Suffix or Title)

Date of Birth: ____/____/_____ **S.S.N.**: _____-____-_____

Marital Status: S M D W Separated

Street & Apt. #: _____

City: _____ **State:**_____ **Zip:** _____

Emergency Contact Person:
Name: _____
Relationship: _____
Phone: _____
Is this person your Care Giver? Y or N

Phone Numbers: Preferred Contact No.?
Home: ( ) _____-_____ □
Work: ( ) _____-_____ □
Cell: ( ) _____-_____ □

Do you have an Advanced Directive? Y or N

E-Mail:
_____

Race (check applicable): □***Asian*** □***Black or African American*** □***American Indian or Alaska Native*** □***White*** □***Native Hawaiian or other Pacific Islander*** □***Other*** □***Unknown/undetermined***

Ethnicity (check applicable): □***Hispanic/Latino*** □***Non-Hispanic/Non-Latino***

Preferred Language (check applicable): □***English*** □***Spanish*** □***Portuguese*** □***Korean*** □***Other***

The Responsible Party is the person who will be responsible for any unpaid balances after insurance payments.

Responsible Party

Name: _____ _____
(Last) (First) (Middle) (Suffix or Title)

Street : _____

Power of Attorney Information:
Name: _____
Address: _____
Phone: _____

City: _____ **State:**_____ **Zip:** _____
Preferred Phone No.: ( ) _____-_____
Date of Birth: ____/____/____ **S.S.N.**: _____-_____-_____
Relation to Patient: _____

The Insurance Subscriber is the person who is the "holder" of the insurance policy covering the patient.

Name: _____ _____
(Last) (First) (Middle) (Suffix or Title)

Street: _____

City: _____ **State:**_____ **Zip:** _____

Preferred Phone No.: ( ) _____-_____

Date of Birth: ____/____/____ **S.S.N.**: _____-_____-_____

Relation to Patient: □***Self*** □ ***Spouse*** □***Parent*** □ ***Other***

Employer:_____

Other

	Insurance Carrier	Policy No.	Group No.	Subscriber Name/Relationship to Patient
Primary				
Secondary				

Preferred Pharmacy Name & Phone: _____
Prescription Plan Name, Phone ID#: _____
_____
(Please provide a copy of your prescription plan care if applicable)

Other Physicians you see:_____

Please sign below. This is required for your benefits to be paid directly to the practice.

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third party payer, under the terms of the insurance policy or benefit plan be paid directly to Abington Health Physicians (AHP). I understand that:

- I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan.
- If my account is referred to an attorney or agency for collection of any unpaid balances for which I am responsible, that I will also be responsible for reasonable attorney's fees and collection expenses.
- My obligation to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

RELEASE OF INFORMATION

I authorize AHP and/or their agents:

- To give the insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to receive payment or obtain authorization for services, supplies and equipment.
- To request and receive directly, on my behalf, any information related to my insurance policy or benefit plan (including, but not limited to, proof of my healthcare benefits).
- To file, on behalf of themselves or on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against any insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
- To give medical or other information to any healthcare practitioner providing healthcare services to me or receive information from them.

STATEMENT OF ASSISTANCE

I agree:

- To assist AHP in collecting benefits that may be due or payable under my insurance policy or benefit plan for the services, supplies and equipment provided.
- To provide any additional information needed to process the claim for payment.
- That a photocopy or other reproduction of this document shall be considered as valid as the original.

_____ _____ _____

Signature of Patient / Signature of Person Authorized to Consent for Patient ***Relationship to Patient*** ***Date***

_____ _____

Signature of Witness ***Date***

_____

If the patient is unable to sign upon arrival, state the reason and initial

I certify that the information on this form is correct and current:

Date: _____ **Signature:** _____

Date: _____ **Signature:** _____

Date: _____ **Signature:** _____

For office use only:

Authorization No.: _____ **Date:** _____

Review necessary? _____

Form should be completed at patient's first visit, whenever changes are indicated or at least annually per policy.

Abington Jefferson Health

Neurosurgical Associates of Abington

NEW CONSULTATION INFORMATION – Please complete prior to office visit

Patient Name:_____ Date of Birth:_____

Height:_____ Weight:_____ Gender: M F

Reason for Consultation:_____

When did your symptoms begin?_____

Did you have any prior treatment? YES/NO

MEDICAL HISTORY: (Check all that apply)

Cardiac
□Arrhythmias
□Congestive Heart Failure
□Coronary Artery Disease
□High Blood Pressure
□MI (Heart Attack)
□Murmur, Type_____
□PACEMAKER
□Peripheral Vascular Disease

Endocrine
□Diabetes
□Thyroid Disease
□Other Endocrine

GI/GU
□Kidney Disease
□Hepatitis
□Menstrual/Sexual Dysfunction
□Peptic Ulcer Disease
□Urinary Disease

Hematologic
□Anemia, Type _____
□Bleeding Disorder, Type_____

Mental Health
□Alcohol Abuse
□Anxiety
□Depression
□Drug Abuse

Musculoskeletal
□Arthritis
□Cervical Spine Disease
□Lumbar Spine Disease
□Polio

Neurology
□Brain/Spinal Tumor
□Headache
□Head Injury
□Epilepsy/Seizures
□Multiple Sclerosis
□Parkinson's Disease
□Peripheral Nerve
□Spinal Cord Injury
□Stroke

Other
□Cancer, Type_____
□HIV

Pulmonary
□Asthma
□COPD/Emphysema
□Pneumonia
□Tuberculosis

SURGICAL HISTORY: (Type of surgery and date)

_____

_____

_____

_____

Did you experience complications? YES NO
Did you have problems with anesthesia? YES NO

FAMILY MEDICAL HISTORY: (Check box if someone in your immediate family has/had the following:

□Heart Disease
□Diabetes
□Bleeding Disorder
□Osteoporosis
□High Blood Pressure
□Glaucoma
□Kidney Disease
□Stroke
□Epilepsy
□Thyroid Disease
□Cancer
□Convulsions
□Mental Illness

Abington Jefferson Health

NEW CONSULTATION INFORMATION (cont'd)

SOCIAL HISTORY:

OCCUPATION:_____

Circle one: Full time Part time Self-employed Retired On Disability

Do you smoke? YES NO

Yes. How much?_____

No. □Never smoked □Former smoker. How long?_____

Do you drink alcohol? YES NO

Yes. Amount?_____ How often?_____

No. □Never □Former How long?_____

Residential status? □Home □Nursing home

Are you currently pregnant? YES NO

Could you be pregnant? YES NO

REVIEW OF SYSTEMS:

Do you have significant problems with any of the following? If YES, please circle.

Cardiac
□Chest Pain
□Palpitations
□Syncope

General
□Anesthesia Problems
□Fatigue
□Frequent Infections
□Loss of Appetite
□Weight Loss
□Weight Gain
□Sleep Problems

GI/GU
□Abdominal Pain
□Bladder Control
□Blood in Stool
□Blood in Urine
□Constipation
□Diarrhea
□Erectile Dysfunction
□Sexual Dysfunction

HEENT
□Difficulty Swallowing
□Double or Blurred Vision
□Hearing Problems
□Ringing in ears

Integumentary
□Bruises
□Rashes
□Open Areas on Skin

Musculoskeletal
□Swollen Legs or Feet
□Weakness

Neurological
□Blackouts
□Dizziness
□Headache
□Numbness/Tingling
□Seizures
□Speech Problems
□Walking Imbalance

Pulmonary
□Shortness of Breath
□Wheezing

Other
□_____

SIGNATURE: _____ DATE: _____

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Neurosurgical Associates of Abington

MEDICATION UPDATE LIST

PATIENT NAME_____ DATE OF BIRTH_____

LIST ALL OF THE MEDICATIONS YOU CURRENTLY TAKE, INCLUDING ASPIRIN, VITAMINS, HERBALS AND ALL OVER-THE-COUNTER MEDICINES: (***USE BACK IF NEEDED***)

MEDICATION	DOSE	TIMES DAILY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PHARMACY NAME AND ADDRESS	PHONE NUMBER
1.	
	FAX:
2.	PHONE NUMBER:
	FAX:

MEDICATION ALLERGIES:_____

Do you have an allergy to LATEX?	*YES*	*NO*
Do you have an allergy to CONTRAST DYE?	*YES*	*NO*
Do you have FOOD or OTHER allergies? *(If YES, please list)*	*YES*	*NO*

_____

_____

_____

I have completed this document in full, listing all current medications and known allergies.

SIGNATURE:_____ DATED:_____

Abington Jefferson Health

Neurosurgical Associates of Abington

Voice-Mail Authorization

I recognize that timely delivery of results of tests or other communications of health care information is important to the delivery of quality health care. I understand that there may be times when it is more efficient and/or effective to receive information telephonically. In order to allow for the free-flow of such information, the following acknowledgement is executed.

My signature below acknowledges that it is permissible for members of this practice to communicate medical information to me by calling me at the following number: _____. If I do not answer and a voicemail system or answering machine is initiated, the practice is authorized to leave information related to my medical condition on that voicemail system or answering machine. I recognize that this may mean that others who are in the vicinity of the system or machine or who have access to it, may have access to an audio transmission of my private healthcare information. However, the risk of any such incidental disclosure is so small and/or I do not have such privacy concerns in my household, that the benefits of efficient delivery of my healthcare information significantly outweighs any risks involved.

This authorization does not apply to the release of records related to psychotherapy, HIV or drug and alcohol testing, which are subject to more specific protections afforded by state law.

I recognize that I have the right to revoke this authorization at any time by calling the practice. Also, this authorization only allows for such communication that is related to past, present or on-going treatment of me. Any authorizations required by the privacy rule issued as a result of the Health Insurance Portability Act of 1996 ("HIPAA") that are for the release of information to someone other than myself will require a separate authorization form and is not incorporated into this document.

I acknowledge and understand the above:

_____ _____

Signature of Patient/Legal Guardian/Legal Representative Date

_____ _____

Name of Personal Representative Relationship to Patient

Abington Jefferson Health

MEDICARE PATIENTS ONLY

Medicare Secondary Payer Questionnaire

Patient Name:_____
Date of Birth:_____ **Today's Date:**_____
Name of Individual Providing Responses:_____
Relationship to Patient:_____
Account #_____ **Medical Record #**_____

Please complete **ALL** sections:

1. Are you receiving Black Lung benefits **AND** is your treatment today related to your Black Lung?
   _____ **NO** (please continue on to question #2)
   _____ **YES**; Date benefits began (MM/DD/YYYY): ____/____/____ (if yes, please skip to question #5).

2. Are your services to be paid by a government research program?
   _____ **NO** (please continue on to question #3) _____ **YES** (if yes, please skip to question #5)

3. Has the Department of Veteran Affairs authorized and agreed to pay for your care?
   _____ **NO** (please continue to question #4) _____ **YES** (if yes, please skip to question #5)

4. Is your illness/injury due to a work related, automobile or other type of accident?
   _____ **NO** (if yes, please continue to question #5) _____ **YES** – Continue
   - What type of accident? _____ Automobile? _____ Work-related? _____ Other Party?
   - Date of accident (MM/DD/YYYY): ____/____/____
   - If non-work-related, is no-fault insurance available? _____ **YES** _____ **NO**
     If YES, no-fault policy owner:_____
     (No-fault insurance pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident).
   - If non-work-related, is liability insurance available? _____ **YES** _____ **NO**
     If YES, responsible party:_____
     (Liability insurance protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property).
   - Name and address of Automobile insurance carrier, Worker's Compensation carrier or other party insurer:_____
     _____
     _____
     Claim No.:_____
     Adjuster's Name:_____ Adjuster's Phone#:_____

5. Are you entitled to Medicare based on your age? _____ **NO** (Go to question #6) **YES** (Continue)
   - Are either you or your spouse employed?
     ____ **YES:** ____*Both* employed? ____ *Only patient* employed? ____ *Only spouse* employed?
     - Do you have group health plan coverage based on your own or a spouse's current employment? _____ **YES** _____ **NO** (Go to question #6)
     - Does the employer that sponsors your group health plan coverage employ 20 or more employees? _____ **YES** _____ **NO** (Go to question #6)
     - **Complete employment and insurance information section on the next page**.

     ____ **NO**: Please provide employment information and/or retirement dates on the next page.

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Medicare Secondary Payer Questionnaire (page 2)

6. Are you entitled to Medicare based on disability?
   _____ **NO** (Go to question #7) _____ **YES** (Continue)
   - Do you have group health plan coverage based on your own or a family member's current employment? _____ **YES** _____ **NO** (Go to question #7)
   - Does the employer that sponsors your group health plan coverage employ 100 or more employees? _____ **YES** _____ **NO**
   - **Complete insurance information grid at bottom of this page.**

7. Are you entitled to Medicare based on having end stage renal disease?
   _____ **NO** – **You are done filling out this questionnaire. Thank You.**
   _____ **YES** – Continue.
   - Do you have group health plan coverage?
   - _____ **NO** – **You are done filling out this questionnaire. Thank You.**
   - _____ **YES** – Continue. Complete insurance and employment section at bottom of page.
   - Have you received a kidney transplant? _____ **YES** _____ **NO**
     If YES, date of transplant (MM/DD/YYYY) ____/____/____
   - Have you received maintenance dialysis treatments? _____ **YES** _____ **NO**
     If YES, when did dialysis start (MM/DD/YYYY) ____/____/____
   - Did you participate in a self-dialysis training program? _____ **YES** _____ **NO**
     If YES, date training started (MM/DD/YYYY) ____/____/____
   - Are you within the 30-month coordination period?
     _____ **YES** – Coordination period start date (MM/DD/YYYY): ____/____/____
     _____ **NO** – You are done this questionnaire.
   - Are you entitled to Medicare on the basis of either ESRD *and* age OR ESRD *and* disability?
     _____ **YES** _____ **NO**
   - Was your initial entitlement to Medicare based on ESRD?
     _____ **YES** – You are done this questionnaire.
     _____ **NO** – Please make sure you answered questions #5 and #6.

PATIENT Employer Information – If no employed: Retirement date was: _____/_____/_____	
Current Employer Name:	
Employer Address:	
Employer City, State, Zip Code:	
SPOUSE Employer Information – If not employed: Retirement date was: _____/_____/_____	
Current Employer Name:	
Employer Address:	
Employer City, State, Zip Code:	

Group Health Plan / Insurance Company Information	
Group Health Plan Name:	Insurance Company Address:
Subscriber Name/Name of Insured:	Relation to Patient:
Insurance Policy ID#:	Insurance Group#:
Membership #:	