PATIENT INTAKE

(Please print and write legibly)

875 Oak St. SE
Bldg. C, Suite 5060
Salem, Oregon 97301
Phone: 503-399-1386
Fax: 503-399-1182

CAPITAL NEUROSURGERY SPECIALISTS

Patient Name:_____ Social Security#: _____

List any previous/alternate names on backside

Date of Birth: _____/_____/_____ Age: _____ Birth Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female Race:_____ Ethnicity: _____

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

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

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Emergency Contact:_____ Relationship: _____ Phone Number: _____

Martial Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Life Partner ☐ Widowed Veteran: ☐ Yes ☐ No Preferred Language: _____

Primary Care Physician: _____ Office Phone: _____

Referring Physician:_____ Office Phone: _____

Employer: _____ Office Phone: _____

Would you be interested in using our online patient portal? ☐ Yes ☐ No Email: _____

VOICEMAIL AUTHORIZATION

The purpose of this authorization is to provide our patients an opportunity to permit verbal release of Protected Health Information (PHI). By checking Yes, you authorize Capital Neurosurgery Specialists, their physicians, physician assistants, medical assistants, administration staff and other personnel to leave detailed messages concerning medical advice, test results, billing and appointment details at the number(s) indicate below.

Authorization ☐ Yes ☐ No Authorized Phone Number: _____

PRIVATE INSURANCE INFORMATION

◉ Personal Health Insurance ○ Work Injury ○ Auto Accident ○ Other

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company: _____	Insurance Company: _____
Address: _____	Address: _____
Subscriber Name: _____	Subscriber Name: _____
Identification or Claim Number: _____	Identification or Claim Number: _____
Relationship to Patient: _____	Relationship to Patient: _____
Subscribers DOB: _____	Subscribers DOB: _____
Employer/Date of Injury: _____	Employer/Date of Injury: _____

I hereby authorize Capital Neurosurgery Specialists to release to the insurance company(s) any information acquired in the course of my examination or treatment. I agree to be fully responsible for all expenses incurred to my account in the course of my treatment and hereby assign to Capital Neurosurgery Specialists any and all insurance and settlement benefits due me to the full extent of my financial obligation to Capital Neurosurgery Specialist. I further understand that my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred (If patient is minor, parent or guardian sign). For further detail please reference our company Financial Policy. By signing below I acknowledge receipt of a copy of the notice. I hereby consent to medical treatment per the treatment plan established by my doctor.

Print Name: _____

Patient Signature or Authorized Representative: _____ Date: _____

ACKNOWLEDGMENT & CONSENT OF HEALTH INFORMATION

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CAPITAL NEUROSURGERY SPECIALISTS

NOTICE OF PRIVACY PRACTICES

I understand that Capital Neurosurgery Specialists (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below. I agree that I have reviewed the information above and that I have been offered a copy of the Notice of Privacy Practices.

INFORMATIONAL RELEASE AUTHORIZATION

Permission to release confidential medical information to family members, friends or legal representatives.

☐ I authorize Capital Neurosurgery Specialists to release information to: (Please mark all that apply).

Contact Name 1: _____ Phone Number: _____

☐Discuss information regarding my appointment ☐Discuss my medical condition
☐Leave phone messages ☐Emergency Contact ONLY ☐ALL

Contact Name2: _____ Phone Number: _____

☐Discuss information regarding my appointment ☐Discuss my medical condition
☐Leave phone messages ☐Emergency Contact ONLY ☐ALL

☐ I understand that I may revoke or change this authorization at any time. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Capital Neurosurgery Specialists. Please understand that revocation of this Consent will not affect any action we took in reliance of the Consent before we received your revocation.

☐ **I do not want information shared with anyone other than myself.** Subject to HIPAA regulations, see above.

TELEHEALTH CONSENT

I understand Telehealth allows my provider to diagnose, consult, treat and/or educate using interactive two-way audio, video and/or data communication regarding my treatment. I hereby consent to participating in Telehealth visits with the providers at Capital Neurosurgery Specialists. I understand that my Telehealth visits will become part of my confidential medical records with Capital Neurosurgery Specialists. I fully understand that with Telehealth , there are limitations to what my provider can do, such as take vitals, assess an injury or medical issue that could only be diagnosed and/or treated with a physical exam. I fully understand that with the Telehealth visits, my insurance will be billed for the services rendered. I understand that I will be responsible for any balance remaining, per my insurance benefits, such as copays, deductibles, and/or co-insurance. In addition, I fully understand that if my insurance benefits do not include Telehealth coverage, I will be responsible for the full self-pay balance for services rendered.

☐ Approved ☐ Declined

Print Name: _____ Date of Birth: _____

Patient Signature or Authorized Representative: _____ Date: _____

FINANCIAL POLICY

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CAPITAL NEUROSURGERY SPECIALISTS

We would like to thank you for choosing CNS and allowing us to provide your healthcare needs. Policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the lowest cost. We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding our financial responsibility and payment policy.

Payment Responsibility
It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the time of service. Copays, deductibles, and surgery deposits are due at the time of service. Payment will be accepted in cash, checks, Visa, Discover, MasterCard & Amex. Patients needing to make payment arrangements will be referred to the Patient Account Representative for the necessary arrangements. The clinic will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangements for payments will be made at the clinic's discretion based on the amount. It is your responsibility to understand your benefit plan.

Release of Information
By signing our Acknowledgement of Consent form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third-party payers. Medical and billing records will be on file with CNS for a minimum of ten years. When requesting medical records, please allow up to 30 days for release of information. Charges may apply to certain parties as allowed by Oregon law.

Patient Responsibility
Balances after insurance are due within 30 days of the insurance payment, unless other arrangements have been made with the Patient Account Representative, the financial counselors of the clinic. Statements are sent out on a monthly basis and it is required by the clinic that balances be paid within 30 days of the statement date. Past due accounts which have not contacted our office to set up payment arrangements may be sent to an outside collection agency for account receivable assistance. In cases where suit needs to be filed in order to recover a past-due balance, all court costs and attorney's fees will be borne by the patient/guarantor. All services may not be covered by all insurance companies. It should be understood that by accepting the service(s), the patient/guarantor is responsible for payment regardless of the insurance coverage. Checks returned for Non-Sufficient Funds (NSF) are subject to a reprocessing fee of $35.00.

Uninsured Patients
If you are not covered by insurance, our clinic policy requires a $400.00 deposit for New Patient visits and a $250.00 deposit for Follow-Up visits at the time of scheduling. This deposit will be applied to the total cost of your visit. Please contact the Patient Account Representative to make payment arrangements on any outstanding amounts. Subsequent appointments cannot be scheduled until you have payment arrangements in effect.

Out of Network Patients
If the clinic is not an in-network provider with your insurance company, you may still have out of network benefits that would allow you to be seen. In the event that your insurance carriers pay you directly for services performed at CNS you're required to turn over the check to our office within 7 days of receipt.

Outstanding Bills
The clinic reserves the right to request deposits and payment for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed. The clinic will make every effort to work with the patient on creating the appropriate payment plan if needed. If the account is not paid in full or payment and/or payment arrangements haven't been made within the allowed time frames, the clinic reserves the right to refer the account to an attorney and/or collection agency for collection of the balance.

Patient Scheduling
Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinic's Financial Policy on the initial visit. By signing the bottom of the Financial Policy at the initial appointment the patient/guarantor acknowledges receipt of copy of the clinic's Financial Policy.

Attendance Policy
If you should need to cancel or re-schedule any appointment or surgery, please call the office at least 24 hours in advance. If you miss an appointment and fail to contact our office as described above, you may be charged a fee. If you arrive more than 15 minutes late for your appointment, we reserve the right to cancel your appointment. If you repeatedly miss or reschedule your appointment, you may be referred back to your PCP. The first time there is a cancellation without notice or no-show for clinic appointments there may be a fee of $25.00 to the patient. A 2nd occurrence may result in a $75 fee to the patient. The 3rd occurrence may result in a $75 fee and the patient may be discharged from the practice. For surgery cancellations without notice there may be a fee of $250.00 to the patient.

Acceptance of Insurance
The clinic will submit a bill to the insurance carrier(s) on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient/guarantor of financial responsibility. The patient/guarantor will be responsible for payment in full on all claims not paid within the allowed period of time (see patient responsibility). The clinic will make every effort to verify insurance coverage, deductible, acceptance of payment for services and other limits for the patient as a courtesy.

Pre-Certification
The clinic will make every effort to pre-certify and/or obtain written referral for all services and procedures that are required, provided the clinic is supplied with the necessary and correct information. In addition, the clinic will make every effort to certify ongoing authorization and referrals as needed. It is, however, the responsibility of the patient to verify that all authorization and referrals are on file and have been approved by the insurance company. In the event authorization has not been obtained you have the option to be seen at our private pay rates.

Rejected Claims/Services Not Covered
Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, and we will make every effort in helping get your claims and services covered, we cannot act as a mediator on your behalf. The Administration and Management welcomes the opportunity to discuss any aspect of the Financial Policy. We appreciate your confidence and strive to provide you with the best quality healthcare.

I have read the CNS Financial Policy Statement and agree to the payment policies and understand my patient responsibilities.

_____
Print Name Date of Birth

_____
Signature of Patient or Authorized Representative

_____
Date: SSN:

MEDICAL HISTORY

Name: _____

DOB: _____

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PATIENT HEALTH HISTORY

REVIEW OF SYMPTOMS: Please check if you have experienced any of the following in the last month:

- ☐ Abdominal pain
- ☐ Back pain
- ☐ Chest pain
- ☐ Chills
- ☐ Cough
- ☐ Dizziness
- ☐ Easy bleeding/bruising
- ☐ Feeling off-balance while walking
- ☐ Fever
- ☐ Headache
- ☐ Nausea
- ☐ Night sweats
- ☐ Vomiting
- ☐ Palpitations (Heart skipping beats)
- ☐ Ringing in ears
- ☐ Sexual dysfunction
- ☐ Shortness of breath
- ☐ Swelling in feet/legs
- ☐ Weight gain
- ☐ Weight loss

Do you see a cardiologist? ☐ Yes ☐ No If yes, who? _____

Do you see a pulmonologist? ☐ Yes ☐ No If yes, who? _____

Do you see other specialists? ☐ Yes ☐ No If yes, who? _____

Please check the corresponding box if you have EVER had any of the following conditions:

- ☐ Angina
- ☐ Anxiety Disorder
- ☐ Arthritis
  Type: ☐ Osteo ☐ Rheumatoid
- ☐ Asthma/COPD Emphysema
- ☐ Bleeding Issues (If checked describe below)
- ☐ Cancer (If checked describe below)
- ☐ Depression
- ☐ Diabetes
  TYPE: ☐ One ☐ Two
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Epilepsy/Seizures
- ☐ GERD/Reflux/Ulcers
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease / Hepatitis
- ☐ Multiple Sclerosis
- ☐ Neuropathology
- ☐ Osteoporosis
- ☐ Pacemaker/Defibrillator
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease

Explanations if necessary, and other conditions if not listed above: _____

_____

PAST SURGICAL HISTORY

List any previous surgeries? (Attach additional sheet if necessary)

Type of Surgery	*Year*	*Surgeon*	*Complications? Problems with Anesthesia? Describe*

Explanations if necessary, and other conditions if not listed above: _____

_____

_____

MEDICAL HISTORY

Name: _____

DOB: _____

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CAPITAL NEUROSURGERY SPECIALISTS

MEDICATION INFORMATION

Pharmacy Name: _____ Location: _____

Allergies to Medications and Associated Reactions: _____

Please list all prescription, over-the-counter, vitamins, supplements, and herbal remedies you take. If you have a list please write SEE ATTACHED in first box and include it in this packet.

DRUG	*DOSE*	*FREQUENCY*

DRUG	*DOSE*	*FREQUENCY*

FAMILY HISTORY

ISSUE	*FATHER*	*MOTHER*	*FATHER'S PARENTS*	*MOTHER'S PARENTS*
Anesthesia Problem				
Bleeding Disorder				
Cancer				
Diabetes				
Epilepsy / Convulsions				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Mental Illness				
Stroke				

SOCIAL HISTORY

Do you use tobacco/nicotine? ☐ Yes ☐ No ☐ Former

Quit Date: _____ Age when quit: _____

Which type ? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Vaping

How much per day? _____

How long? (months/years): _____

Do you use alcohol? ☐ Yes ☐ No ☐ Former

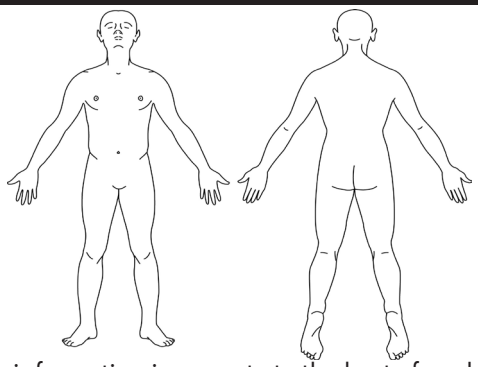
Quit Date: _____

Which type ? ☐ Beer ☐ Wine ☐ Hard Liquor

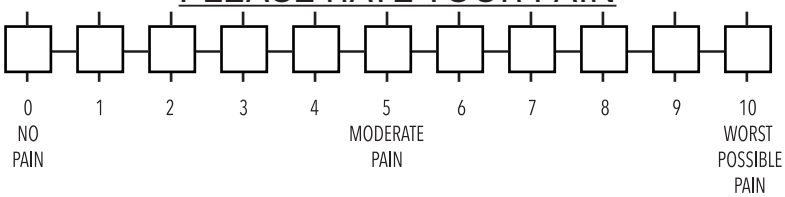
If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Are you: ☐ Right Handed ☐ Left Handed

PAIN DESIGNATIONS AND LEVELS



PLEASE RATE YOUR PAIN



This above information is accurate to the best of my knowledge.

Patient Signature : _____ Date: _____