WASHINGTON NEUROSURGICAL ASSOCIATES, P.C.

5215 LOUGHBORO ROAD, N.W., SUITE 510, WASHINGTON, D.C. 20016

Please Print Clearly.

PATIENT'S NAME: First	Middle	Last	TODAY'S DATE

HOME ADDRESS: Street	APT. NO.

City	State	Zip Code	HOME TELEPHONE	WORK TELEPHONE
			( )	( )

PATIENT'S OCCUPATION	EMPLOYER	REFERRED BY	ALLERGIES TO MEDICATIONS:

PATIENT'S SEX	BIRTH DATE: Mo. Day Year	PATIENT'S SOCIAL SECURITY NO.	MARITAL STATUS (Circle One):
☐ Male ☐ Female	/ /		S M SEP D W

SPOUSE'S NAME	SPOUSE'S TELEPHONE NO.	WORK TELEPHONE NO.	OCCUPATION	EMPLOYER
	( )	( )		

The Responsible Party is the Policyholder and/or the person to receive all bills. If the Responsible Party is someone other than the patient, fill out section immediately below: ☐ Attorney ☐ Spouse ☐ Parent ☐ Workers Comp. Otherwise, skip to the Health Insurance Information Secton.

NAME	ADDRESS
TELEPHONE NUMBER	

DATE OF INJURY	DATE LAST WORKED	TYPE IF INJURY (Circle One)	CASE FILE NUMBER
		Job Auto Other	

HEALTH INSURANCE INFORMATION

INSURANCE INFORMATION

	NAME OF INSURANCE COMPANY		POLICY NUMBER		INSURANCE COMPANY ADDRESS
1.	GROUP NO. OR NAME	POLICY HOLDER'S NAME		EFFECTIVE DATE	
	NAME OF INSURANCE COMPANY		POLICY NUMBER		INSURANCE COMPANY ADDRESS
2.	GROUP NO. OR NAME	POLICY HOLDER'S NAME		EFFECTIVE DATE	

WASHINGTON NEUROSURGICAL ASSOCIATES MAY NOT PARTICIPATE WITH YOUR INSURANCE PLAN. IF WE ARE NOT A PARTICIPATING PROVIDER, YOU ARE ENTITLED TO REQUEST A WRITTEN ESTIMATE OF SURGICIAL FEES AND CPT CODES ASSOCIATED WITH YOUR SURGERY. IF YOU DESIRE SUCH AN ESTIMATE PLEASE CONTACT OUR OFFICE MANAGER AT (202) 966-6300.

THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. IT IS YOUR RESPONSIBILITY TO REVIEW YOUR INSURANCE POLICIES FOR SECOND SURGICAL OPINIONS AND HOSPITAL PREAUTHORIZATION. IT IS CUSTOMARY TO PAY FOR SERVICES RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. IF IT BECOMES NECESSARY TO PLACE THIS ACCOUNT IN COLLECTIONS, THE PATIENT AGREES TO BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES EQUAL TO 25% OF THE UNPAID BALANCE, TOGETHER WITH ADDITIONAL COST AND EXPENSES OF COLLECTION TO THE EXTENT PERMITTED BY LAW.

Patient's Authorization

I, ______________________________ hereby authorize Washington Neurosurgical Associates, P.C. to apply for benefits on my behalf for covered services rendered by Washington Neurosurgical Associates, P.C. and request that payments from Medical Service of D.C./Medicare and/or ______________________________ (other insurance co. name) be made directly to Washington Neurosurgical Associates, P.C. (or in case of Medicare Part B benefits, to myself or to the party who accepts assigment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above billing agent, Medical Service of D.C. (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration)/Medicare and/or ______________________________ (other insurance co. name). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

Acknowledgment of Receipt of Privacy Notice: I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice.

I have read and understand the above Information.

PATIENT ACCOUNT NO.

______________________________ Signature of Subscriber or Beneficiary

__________ Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT **YOU** MAY BE USED AND DISCLOSED, AND HOW **YOU** CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (**HIPPA**) requires all healthcare records and other individually identifiable health information (protected health information) used or disclosed to us in any form (electronically, on paper, or orally) be kept confidential. This federal law gives You, the patient, significant new rights to understand and control how your healthcare information is used. HIPPA provides penalties for entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your healthcare information, and how we may use and disclose that information. Without specific written authorization, we are permitted to use and disclose your healthcare records for the purposes of treatment, payment, and healthcare operations.

Treatment means: providing, coordinating, and managing healthcare and related services by one or more healthcare providers. An example of this would include: consults, follow-up visits, and testing. Payment means: obtaining reimbursements for services, confirming coverage, billing or collection activities, and utilization review. An example of this would include: billing your health plan for health services rendered. Healthcare Operations (the business aspects of running our practice) means: conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would include: a periodic assessment of our documentation protocols, etc.

Your confidential information may be used to remind you of an appointment (by phone or mail), or provide you with information about treatment options or other health related services, including release of information to friends and family members that are directly involved or assists in your care.

We will use and disclose your **protected health information** when we are required to do so by federal, state, or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, or to a health oversight agency for activities authorized by law. This may include, but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party requested. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the general public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of the U.S. or Foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose your protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosures for these purposes would be necessary: (a.) for the institution to provide healthcare services to you, (b.) for the safety and security of the institution, and/or (c.) to protect your health and safety or the health and safety of other individuals or the general public.

We will release your **protected health information** if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or

coroner to identify the deceased individual, or to identify the cause of death. If necessary, we may also release information to funeral directors in order for them to perform their jobs. If you are an organ or tissue donor, we may release your protected health information to organizations that handle organ, eye, or tissue procurement or transplantation. We may release your protected health information to/for workers compensation and similar programs.

Any other uses and disclosures (revoking or permitting) will be made only with your written authorization. However, we are **not** required to honor and abide by that written request. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. We are **not** required to agree to a written request restriction against the HIPPA privacy practices required by federal, state, or local law.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and provide you with notice of your legal duties and privacy practices with respect to your protected health information.

We are required to abide by the terms of the **Notice of Privacy Practices** currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all **protected health information** that we may obtain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal written complaint with us, or with the Department of Health and Human Services, Office of Civil Rights in the event you feel your privacy rights have been violated at the addresses below. We will not retaliate against you for filing a complaint.

You have certain rights in regards to your protected health information, which you can exercise with a written request to our Privacy Officer at the practice address listed below.

For more information about our Privacy practices, please contact:
Washington Neurosurgical Associates
5215 Loughboro Road, NW Suite 510
Washington, DC 20016
202-966-6300

For more information about HIPPA or to file a complaint, please contact:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201
877-696-6775 (toll free)

Patient's Name: ______________________ **Date:** ______________

Washington Neurosurgical Associates, P.C.
Patient Intake Form

Name: ____________________
Age: ______________________
Height: ___________________
Weight: ___________________
Do you smoke: ____________ If yes, how many packs per day: ______________
Do you drink alcohol: ______ If yes, how many drinks per day: _____________

Let us know about your other doctors
Please list your primary care physician, your referring physician, or any other doctors that you would like to be informed of the results of your visit.
____
____
____

Describe your Pain
On a scale of 0 (no pain) to 10 (worst pain imaginable), please list your pain level:
Neck pain: ______________
Right arm pain: ______________
Left arm pain: ______________
Back pain: ______________
Right arm pain: ______________
Left arm pain: ______________

Review of Symptoms (circle all that apply)

Constitutional	**Allergy**	**Neurologic**
Fever	Drug allergy	Paralysis
Weight loss	Food allergy	Seizures
Musculoskeletal	**Hematologic**	**Respiratory/Cardiac**
Stiffness/Swelling	Anemia	Shortness of breath
Fractures	Excessive bleeding	Irregular heartbeat
Gastrointestinal	**Endocrine**	**HEENT**
Constipation	Menopause	Swallowing difficulty
Diarrhea	Obesity	Hoarseness
Skin	**Genitourinary**	**Psychiatric**
Rash	Sexual difficulties	Depression
Eczema	Pain urinating	Anxiety

Please list the names of all your medications (including over the counter medications), vitamins, and supplements.
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____
____
____
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