NORTHWESTERN NEUROSURGICAL ASSOC., S.C.

A Comprehensive Brain and Spine Practice in Chicago

Initial Clinical History & Physical Form

Date:_____/_____/_____

Patient Name:_____ **D.O. B.:**_____/_____/_____

Chief complaint:_____

Please rate your pain

	NO PAIN									SEVERE PAIN
Regular day:	1	2	3	4	5	6	7	8	9	10
Worst day:	1	2	3	4	5	6	7	8	9	10

Review of Systems

(Please circle any of the following you currently experience)

General	**Eyes**	**ENT**	**Respiratory**
Weight loss	Pain	Sore throat	Wheezing
Weight gain	Discharge	Hoarseness	Cough
Fever	Light sensitivity	Ear ringing	Shortness of breath
Fatigue	Blurred vision	Nose bleeds	

Cardiovascular	**Gastrointestinal**	**Genitourinary**	**Neurological**
Chest pain	Abdominal pain	Frequency	Headache
Fainting	Nausea	Hesitancy	Confusion
Feet swelling	Vomiting	Flank pain	Numbness
Palpitations	Diarrhea	Painful urination	Slurred speech
	Blood in stool	Blood in urine	Seizure

Musculoskeletal	**Skin/Breast**	**Endocrine**	**Hematological/Lymphatic**
Joint swelling	Rash	Excess sweat	Bleeding tendencies
Joint redness	Itching	Excess thirst	Lymph node swelling
Joint pain	Sores	Excess hot	Easy bruising
Gait problems	Abscess	Excess cold	
	Discharge		

Psychologic	**Explanation or other**
Anxiety	
Depression	
Severe stress	
Panic	

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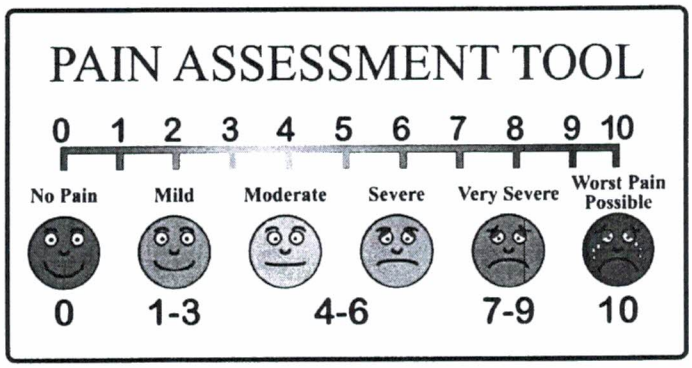
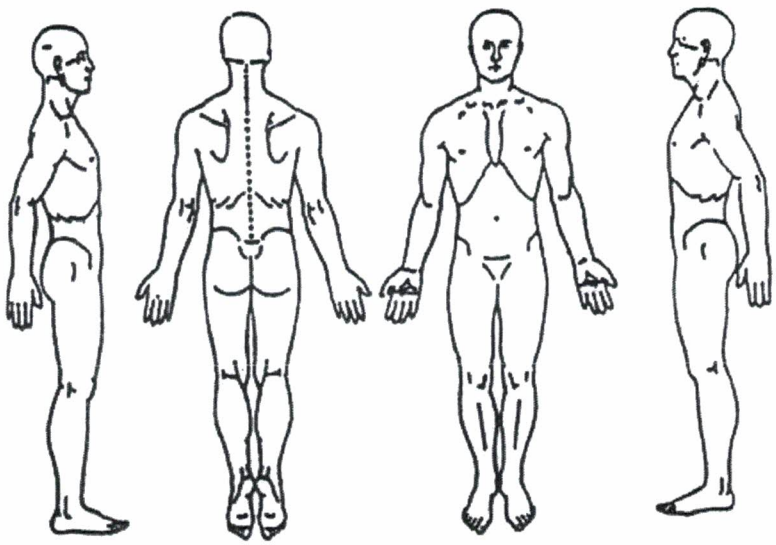
Are you currently experiencing any of the following:

____ Back pain – please rate your pain
____ Leg pain – please rate your pain
____ Leg numbness/tingling
____ Neck pain – please rate your pain
____ Arm pain – please rate your pain
____ Arm numbness/tingling
____ Headaches



Please mark the area where you are currently experiencing pain/numbness.
Use **X** for pain **O** for numbness



How long have you been experiencing these symptoms (approximately)_____
Have you tried any of the following conservative measures:

____ Physical therapy
Facility name:_____
____ Pain medication
Medication name:_____
____ Pain management
Physician name:_____

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Patient Name: _____ Age: _____

Sex: Male – Female Date of Birth: ____/____/_____ S.S.N.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)_____ Cell Phone: (____)_____

Emergency Contact: _____ Phone: (____)_____

Primary Care Physician: _____ Phone: (____)_____

Hospital Affiliation: _____

Cardiologist: _____ Phone: (____)_____

Referring Physician: _____ Phone: (____)_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

1. When did your symptoms begin? _____
2. Was your accident/injury sustained at work or during a motor vehicle accident? _____
3. Do you currently have a claim open for the accident/injury? _____
4. Do you currently have a secondary insurance? _____
5. If you are a Medicare member, have there been any changes to your plan that we should be made aware of? _____

EMPLOYER INFORMATION:

Company Name: _____ Phone Number: (____)_____

Address: _____

City: _____ State: _____ Zip Code: _____

ATTORNEY INFORMATION: (Applies if work related or motor vehicle accident)

Name: _____ Phone Number: (____)_____

Address: _____

City: _____ State: _____ Zip Code: _____

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PRIMARY INSURANCE/WORKER'S COMPENSATION INFORMATION:

Insurance Name: _____ Subscriber Name: _____

DOB: ____/____/____ Relationship to Patient: _____ S. S. N.: _____

ID/Claim File Number: _____ Policy/Group Number: _____

Adjuster Name: _____ Adjuster Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ Subscriber Name: _____

DOB: ____/____/____ Relationship to Patient: _____ S. S. N.: _____

ID/Claim File Number: _____ Policy/Group Number: _____

TERTIARY INSURANCE INFORMATION:

Insurance Name: _____ Subscriber Name: _____

DOB: ____/____/____ Relationship to Patient: _____ S. S. N.: _____

ID/Claim File Number: _____ Policy/Group Number: _____

NOTE TO PATIENTS: Payment is due in full at the time of treatment, unless other arrangements have been made with the account manager. Insurance contracts are made between the patient and the insurance company **NOT** between the doctor and the insurance company. Therefore, you are at all times responsible for payment. We are, however, prepared to file claims for you to help you recover the portion of your medical expenses that are covered by your contract.

RELEASE OF MEDICAL INFORMATION: I authorize the release of medical information necessary to process this claim, including medical history, diagnosis, prescriptions and other medical information related to my treatment at Northwestern Neurosurgical Associates, S.C. This authorization shall be valid for the during of this claim. I agree that a reproduced copy of this authorization will be valid as well as the original.

ASSIGNMENT OF BENEFITS TO PROVIDER OF SERVICE: I ASSIGN PAYMENT OF MEDICAL BENEFITS DIRECTLY TO NORTHWESTERN NEUROSURGICAL ASSOCIATES S.C.:

Signature:_____ Date:_____/_____/_____

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Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practice Form

I, _____, hereby give my consent to:
(Name of Patient or Authorized Agent)

Northwestern Neurosurgical Associates, S.C., to use or disclose for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in my records.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. I understand that written revocation of consent must be sent to the physician's office.

Signature: _____ Date: _____/_____/_____

If you are not the patient, please specify your relationship to the patient: _____

Power of Attorney: _____ (you must provide legal documentation for our files)

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Thank you for choosing us as your Healthcare Providers. We are committed to providing the very best care possible. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship.

We are happy to bill your insurance directly. However, we **MUST HAVE A COPY OF THE INSURANCE CARD**. Please notify us immediately of any changes in your coverage.

SELF-PAY: Payment is expected at the time of service, unless prior arrangements have been made. We accept CASH, CHECK, VISA and MASTERCARD.

MEDICARE: We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved charge and the amount Medicare pays and, of course, your deductible. If you have a supplemental or secondary insurance, we will be happy to bill it directly for you.

HMO/PPO: ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE. We are members of most plans. You are responsible for verifying that our providers are within your network. If you are an HMO member, you are required to provide the necessary referral/authorization for the date of service. If a referral/authorization is not provided at the time of service, your plan requires that we ask you to reschedule your appointment. PPO patients will only be responsible for their co-pay/co-insurance as long as they have verified with their insurance that our physician is within their network.

WORKERS' COMPENSATION: If you are here as a result of a work-related injury, we will require your claim information. A letter of authorization, on company letterhead, must be received from the workers' compensation carrier. The authorization should include the claim number, address, adjuster name, and phone and fax number. If you have an attorney, please provide their contact information. If the mentioned information is not provided, you may pay out-of-pocket or reschedule your appointment.

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MOTOR VEHICLE ACCIDENT: If you are here as a result of a motor vehicle accident, we will require a letter from the auto insurance carrier and a copy of your health insurance. The letter should include the claim number, address, and phone and fax number. If you have an attorney, please provide their contact information. If the mentioned information is not provided, you may pay out-of-pocket or reschedule your appointment.

UCR (USUAL AND CUSTOMARY RATES): We are committed to provide the best treatment possible and we charge for what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

PAST DUE ACCOUNTS: Past due accounts will be referred to the collection agency. A collection fee of up to 30% will be added to the balance to recover costs of collection. In the event that litigation is necessary, you will be liable for our costs and attorney fees.

NO SHOW FEE: We ask that you call us to cancel or reschedule your appointment at least 24 hours prior to your scheduled appointment. Failure to do so will result in a $50 fee.

IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER OR RESPONSIBLE PARTY WITHIN 90 DAYS, WE HAVE THE RIGHT TO BILL YOU DIRECTLY.

I UNDERSTAND THAT IF THE OFFICE AGREES TO BILL INSURANCE AS COURTESY, I MUST SUBMIT INFORMATION AS NEEDED TO ENSURE PAYMENT FOR SERVICES RENDERED TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES AND THAT I WILL RECEIVE A BILL AFTER THE INSURANCE COMPANY HAS PAID OR DENIED THEIR PORTION OF THE SERVICES RENDERED.

Signature: _____ Date: _____/_____/_____

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"Healthcare operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of general knowledge is not the primary purpose of studies resulting from such activities; population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment.
2. Reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of healthcare learn under supervision to practice or improve their skills as healthcare providers, training of non-healthcare professionals, accreditation, certification, licensing or credentialing activities.
3. Underwriting, premium rating and other activities relating to creation, renewal or replacement of a contract of claims for healthcare, including stop-loss insurance and excess of loss insurance.
4. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods or payment or coverage policies.
6. Business management and general administrative activities including but not limited to; (a) management activities relating to HIPPA privacy rule compliance (b) customer services, including the provision of data analyses for policy holders, plan sponsors or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor or customer (c) resolution of internal grievances (d) due diligence in connection with the sale or transfer of assets to potential successor in interest, if the potential successor in interest is covered entity or following completion of the sale or transfer will become a covered entity (e) creating de-identified health information, fundraising for the benefit of the covered entity and marketing for which an individual authorization is not required.

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"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of healthcare. The activities referred to in the definition relate to the individual to whom healthcare is provided and include but are not limited to;

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims.
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related healthcare data processing.
3. Review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.
4. Utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services.
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, social security number, payment history, account number, and name and address of the physician.

"Treatment" means the provision, coordination or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party, consultation between healthcare providers relating to patient, or the referral of a patient for healthcare from healthcare provider to another.

"Use" means the sharing of employment, application, utilization, examination or analysis of patient information within the physician's practice that maintains such information.

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