Lansing Neurosurgery
A DIVISION OF COMPASS HEALTH

1575 RAMBLEWOOD DRIVE
EAST LANSING, MI 48823
517 827-1800 (P)
517 827-1805 (F)

NEW PATIENT INFORMATION

Patient Name: _____ Age:_____ Date of Birth:_____ Sex: ____

Family Doctor: _____ Doctor Who Referred You: _____

Height: _____ Weight:_____

CHIEF COMPLAINT

Symptoms or problem that led to today's visit: _____

_____

How did your problem start? _____

When did your problem start? _____

Current problem is a result of: (Please check all that apply and list date of injury)

☐ Car Accident ☐ Work Accident ☐ Other: _____ Date of Injury: _____

☐ My problem did not result from an accident.

What studies or tests have you had done? (Please check box and include approximate date)

☐ X-rays _____
☐ Angiogram _____
☐ Myelogram _____
☐ Nerve Block _____
☐ Shunt Study _____
☐ MRI _____
☐ CT Scan _____
☐ EMG _____
☐ Discogram _____
☐ Other (specify) _____

Have you had:

Physical therapy?	☐ Yes	☐ No	Did it help you?	☐ Yes	☐ No
Chiropractic manipulation?	☐ Yes	☐ No	Did it help you?	☐ Yes	☐ No
Treatment at a pain clinic?	☐ Yes	☐ No	Did it help you?	☐ Yes	☐ No

Surgeries & Hospitalizations	Year	Complications

Current Medications	Dose	Frequency

Allergies to Medications:

Any problems with anesthesia? ☐ Yes ☐ No

Have you ever been diagnosed with an antibiotic resistant infection such as MRSA or VRE? ☐ Yes ☐ No

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DEMOGRAPHIC FORM

Please provide the following information for our records.
Please bring your INSURANCE CARD and DRIVERS LICENSE to your appointment. Thank you.

Patient Name: _____ **DOB:**_____

Sex: _____Social Security Number: _____

Marital Status:_____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Hawaiian or Pacific Islander ☐ Other (please list) _____

Ethnic Group: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other (please list) _____

Preferred Language: ☐ English ☐ Spanish ☐ Other (please list) _____

Address: _____

City, State, Zip Code: _____

Telephone -- Home: _____Work: _____ Cell:_____

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Email address:_____

How would you prefer to be contacted: ☐ Phone ☐ Mail ☐ Email

How would you prefer to receive reminders from our office? *(Please choose one reminder method.)*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email

Referred By: _____ Family Physician: _____

Address: _____ Location seen:_____
Telephone: _____ Telephone: _____

Spouse/Partner Name: _____ Spouse/Partner Employer: _____

Name of Parents (if patient is dependent/minor): _____

Address (if different from patient): _____

City, State, Zip Code: _____

Emergency Contact Not Living With You: _____

Relationship to Patient: _____ Telephone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Employer: _____ Occupation: _____

Address: _____

City, State, Zip Code: _____

Is This Visit Related to Any of the Following?

Work Injury	☐ Yes	☐ No
Auto Accident	☐ Yes	☐ No
Other Incident	☐ Yes	☐ No

Please Explain: _____

If you answered yes to any of the above, please list the date of injury: _____

☐ My problem did not result from an accident.

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Physician Consent for Medical Treatment

I hereby authorize and direct Dr. _____to treat:

_____ Date of Birth:___/___/____
(Patient's full name)

I, the undersigned, agree to the following:

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN:

_____(if required)
Parent/Legal Guardian must remain present during entire appointment.

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INSURANCE INFORMATION

INSURANCE COMPANY: _____ Primary Insurance: ☐ Yes ☐ No

Address: _____

City, State, Zip Code: _____

Policy/Claim Numbers: _____

Subscriber: _____ Date of Birth: _____ Relationship to Patient: _____

Employer of Subscriber (if different from above): _____

Address of Employer (if different from above): _____

Claim Adjuster Name (if applicable): _____ Telephone: _____

OTHER INSURANCE: (Insurance Company) _____

Address: _____

City, State, Zip Code: _____

Policy/Claim Numbers: _____

Subscriber: _____ Date of Birth: _____ Relationship to Patient: _____

Employer of Subscriber (if different from above): _____

Address of Employer (if different from above): _____

Claim Adjuster Name (if applicable): _____ Telephone: _____

MEDICARE:

Medicare Number: _____ Are you or your spouse employed? ☐Yes ☐No

What is the basis for the patient's entitlement to Medicare?

☐ Age ☐ Disability ☐ Renal Disease ☐ Other (Explain) _____

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Authorizations

- I authorize the release of any medical information necessary to process my insurance claim.
- I authorize payment of medical benefits to Compass Health for services rendered when they
  request that payment be made directly to them.
- I understand that I am ultimately responsible for payment of services that are rendered to me.
- I understand that Compass Health will bill my insurance company, but that I am responsible for any balance that my insurance does not pay as well as any copayments and/or deductibles.

_____ _____
Signature (Patient, Responsible Party) Date

Consent for Use and Disclosure of Your Health Information

By initialing below, you acknowledge that you have Been Offered Received the Compass Health Notice of Privacy Practices.

I Do____ Do not____ authorize Compass Health to leave detailed messages on my voicemail.

_____ _____
Initial Date

Authorization for release of Protected Health Information

If you choose to have your Protected Health Information released to another person either verbally or in writing, please complete the information below. Signing the below authorization will not affect your treatment at Compass Health.

I , _____approve Compass Health to release my Health records to the individuals listed below at my request.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I understand this authorization is valid for one year from this date and can be revoked or revised at any time with written notice.

_____ _____
Signature Date

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Payment Policy

1. Thank you for choosing our practice. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy.

2. **INSURANCE**. Most insurance plans participate with Compass Healthcare, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
3. **CO-PAYMENTS, CO-INSURANCE, and DEDUCTIBLES**. All co-payments, co-insurance, and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit card payments in the office. You may also pay with your PayPal account from our website. A $10.00 statement fee will be assessed if you do not pay at time of service.
4. **CREDIT CARD ON FILE**: As a convenience to you, a credit card can be kept on file and automatically charged for outstanding balances. This information is kept in a secure and protected file and authorization revoked at any time. _____
5. **PROOF OF INSURANCE**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be held responsible for the balance of a claim.
6. **CLAIM SUBMISSION**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **COVERAGE CHANGES**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Failure to notify us may result in you being responsible to pay for services in full.
8. **NONPAYMENT**. If your account is over 90 days past due, we may refer your account to a collection agency, and you may be discharged from the practice. If this happens you will be notified that our physician will only be able to treat you on an emergency basis for 30 days.
9. **MISSED APPOINTMENTS**. Our policy is to charge $25.00 for missed office appointments or office appointments not canceled within a reasonable amount of time (24 hours). Further, it is our policy to charge $100.00 for missed procedure appointments or procedure appointments not canceled within a reasonable amount of time (48 hours). These charges will be your responsibility and billed directly to you. Habitual no shows and/or cancels may result in being discharged from the practice. Please help us to serve you better by keeping your regularly scheduled appointment.

_____ _____

Signature of patient or responsible party Date