ADVANCED NEURO & SPINAL SURGERY
Mike W. Chou, M.D.
1110 Professional Blvd. • Evansville, IN 47714 • 812-401-7577

QUESTIONNAIRE

Patient Name: _____

What is the main complaint that brought you here today? _____

_____

_____

When did your symptoms begin? _____

Was there an accident or injury prior to these symptoms? ❒ Yes ❒ No
If yes, please complete "Accident Form."

Before this episode, had you ever experienced:

❒ Neck pain ❒ Back pain ❒ Leg pain ❒ Arm pain

(Mark all that apply) If yes, when? _____

Have you ever seen a doctor for ❒ Neck pain ❒ Back pain ❒ Leg pain ❒ Arm pain?

If yes, provide date and name of doctor: _____

Do you currently have ❒ Back pain ❒ Neck pain?

If yes, describe: _____

Do you currently have:

❒ Leg pain; If yes, indicate which leg: ❒ Right ❒ Left ❒ Both Legs

❒ Arm pain; If yes, indicate which arm: ❒ Right ❒ Left ❒ Both Legs

If yes, please describe: _____

Which is the worst? ❒ Back pain ❒ Neck pain ❒ Leg pain ❒ Arm pain

What makes the pain worse? _____

_____

What makes your pain better? _____

_____

Are your symptoms ❒ Improving ❒ Getting worse ❒ Staying the same

Are you able to live with the pain? ❒ Yes ❒ No

Do you have problems with your walking? ❒ Yes ❒ No If yes, describe:

_____

_____

How far can you walk (such as 1 block, 50 feet, etc)? _____

On a scale from 1 (no pain) to 10 (worst pain), what is your pain level? _____

Patient Name: _____

Have you noticed any numbness or weakness? ❒ Yes ❒ No If yes, where and describe:

_____

_____

Have you noticed any changes in your bowel or bladder habits? ❒ Yes ❒ No

If yes, explain: _____

_____

Have you had any treatment on your spine for

❒ Neck pain ❒ Back pain ❒ Leg pain ❒ Arm pain (mark all that apply)

If yes, what treatments have you received? Describe response (pain improved, stayed the same, treatment made the pain worse, etc.) and the last date of treatment:

❒ Chiropractic: _____
Response *Date of Treatment*

_____

❒ Oral Steroids: _____
Response *Date of Treatment*

_____

❒ Physical Therapy: _____
Response *Date of Treatment*

_____

❒ Epidural Injections: _____
Response *Date of Treatment*

_____

❒ NSAIDS (Advil, Aleve): _____
Response *Date of Treatment*

_____

❒ Traction: _____
Response *Date of Treatment*

_____

❒ Other: _____
Response *Date of Treatment*

_____

What testing have you had for the problem?

❒ X-rays Date done: _____ Where? _____

_____

❒ MRI Date done: _____ Where? _____

_____

❒ CT Scan Date done: _____ Where? _____

_____

❒ Other, describe (include dates done and where) _____

_____

Are your films (X-rays, MRI images, etc.) and reports here with you today? ❒ Yes ❒ No

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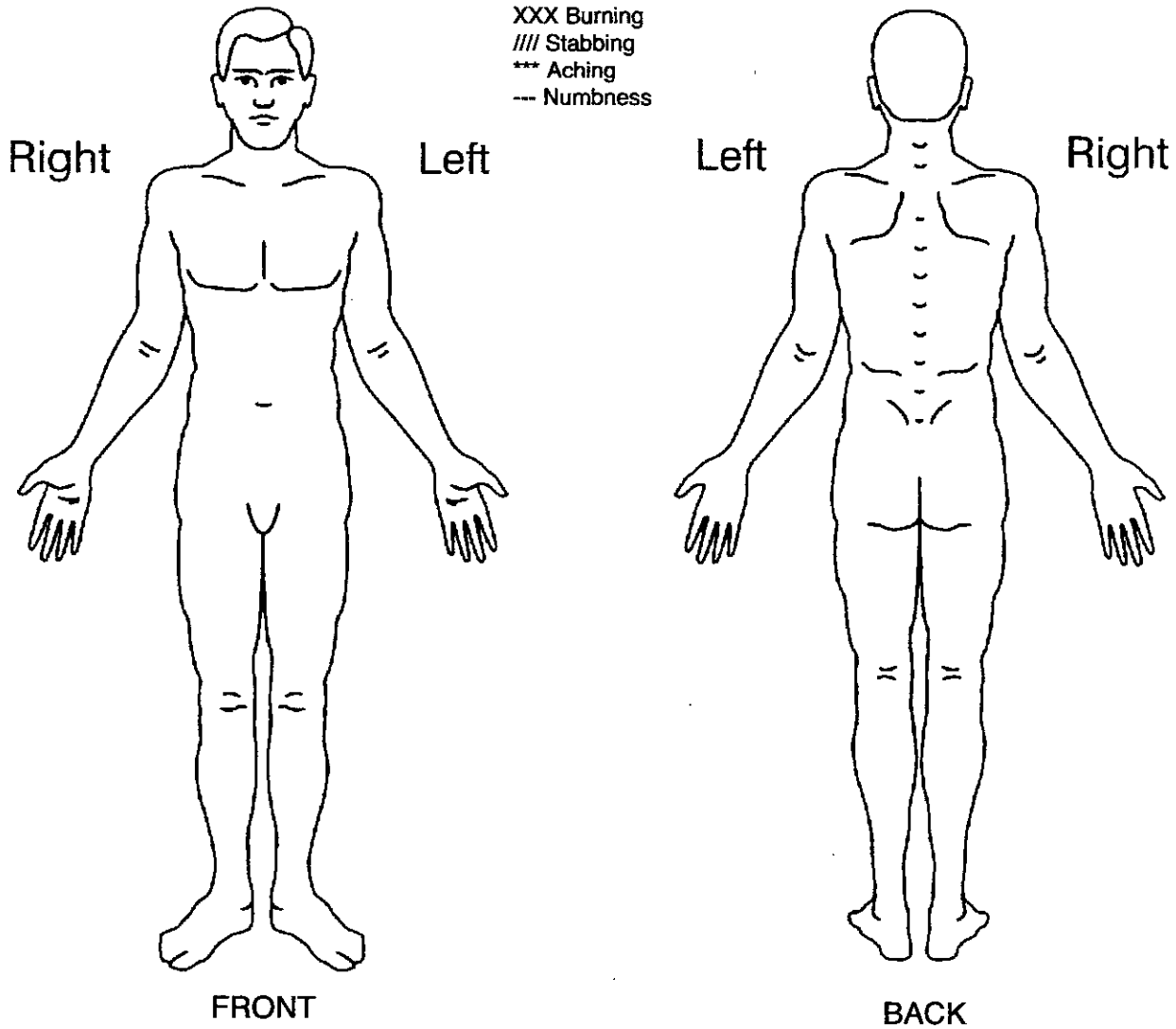
BODY SHEET

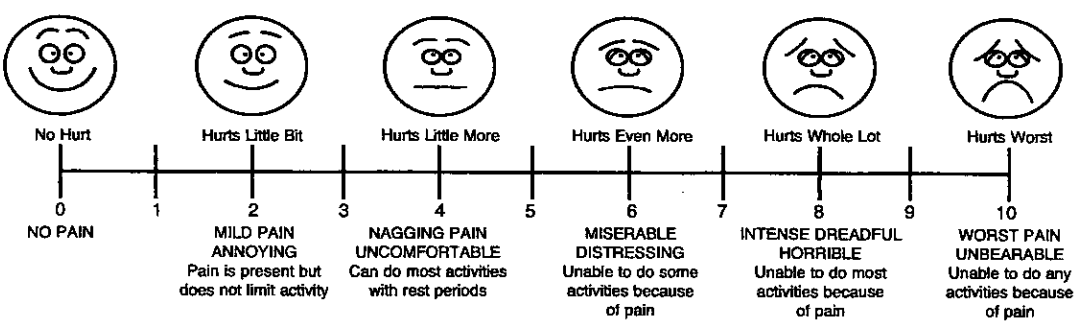
Patient Name: _____ Date: _____

1. Please indicate the location of your pain. Using the symbols below, mark which area(s) of the body are involved.

000 Pins & Needles
XXX Burning
//// Stabbing
*** Aching
--- Numbness



2. On the 0 - 10 pain scale and the Faces scale below, circle the number which best describes your pain.



Name _____ DOB _____ Date _____

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your **back or leg pain** is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which **most clearly describes your problem.**

Section 1: Pain Intensity

- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but can manage most of my personal care
- o I need help every day in most aspects of self-care
- o I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives me extra pain
- o Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
- o Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- o I can only lift very light weights
- o I cannot lift or carry anything

Section 4: Walking

- o Pain does not prevent me walking any distance
- o Pain prevents me from walking more than 1 mile
- o Pain prevents me from walking more than ½ mile
- o Pain prevents me from walking more than 100 yards
- o I can only walk using a stick or crutches
- o I am in bed most of the time

Section 5: Sitting

- o I can sit in any chair as long as I like
- o I can only sit in my favorite chair as long as I like
- o Pain prevents me sitting more than one hour
- o Pain prevents me from sitting more than 30 minutes
- o Pain prevents me from sitting more than 10 minutes
- o Pain prevents me from sitting at all

Section 6: Standing

- o I can stand as long as I want without extra pain
- o I can stand as long as I want but it gives me extra pain
- o Pain prevents me from standing for more than 1 hour
- o Pain prevents me from standing for more than 30 minutes
- o Pain prevents me from standing for more than 10 minutes
- o Pain prevents me from standing at all

Section 7: Sleeping

- o My sleep is never disturbed by pain
- o My sleep is occasionally disturbed by pain
- o Because of pain I have less than 6 hours sleep
- o Because of pain I have less than 4 hours sleep
- o Because of pain I have less than 2 hours sleep
- o Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- o My sex life is normal and causes no extra pain
- o My sex life is normal but causes some extra pain
- o My sex life is nearly normal but is very painful
- o My sex life is severely restricted by pain
- o My sex life is nearly absent because of pain
- o Pain prevents any sex life at all

Section 9: Social Life

- o My social life is normal and gives me no extra pain
- o My social life is normal but increases the degree of pain
- o Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- o Pain has restricted my social life and I do not go out as often
- o Pain has restricted my social life to my home
- o I have no social life because of pain

Section 10: Traveling

- o I can travel anywhere without pain
- o I can travel anywhere but it gives me extra pain
- o Pain is bad but I manage journeys over two hours
- o Pain restricts me to journeys of less than one hour
- o Pain restricts me to short necessary journeys under 30 minutes
- o Pain prevents me from travelling except to receive treatment

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PATIENT MEDICAL HISTORY

Patient Name: _____

Please complete all sections. This is information your doctor needs to treat you.

Name of your family doctor:

_____

Name of the doctor who sent you to us:

_____

PAST MEDICAL HISTORY

Please check all conditions you have now or have had in the past.

❑ **NONE; none of the conditions below apply to me.**

❑ Heart Disease
- ❑ Heart Attack
  Year:_____
- ❑ Stent
  Year:_____
- ❑ Pacemaker

❑ High Blood Pressure
❑ Stroke, when? _____
_____
❑ Seizures/convulsions
❑ Parkinson disease
❑ Cancer (type/treatment)_____
❑ Arthritis (name or type): _____

❑ Diabetes Mellitus
If so, how do you treat it?
- ❑ Insulin dependent
- ❑ Pills
- ❑ Diet controlled

❑ Thyroid dysfunction
❑ Bleeding difficulties
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ HIV
❑ Hepatitis
❑ TB

❑ **Other conditions, including anything else you see a doctor for on a regular basis:** _____
_____

Explain any conditions you checked above: _____

ALLERGIES/TYPE OF REACTION

❑ **NONE; I do not have any known drug allergies**

❑ **Latex** ❑ **Tape** ❑ **Other (please specify):** _____

Allergy	Reaction (what happens?)	Allergy	Reaction (what happens?)
1.		4.	
2.		5.	
3.		6.	

PRESCRIPTION MEDICINES

❑ **NONE; I am not on any prescription medicines**

❑ ***I am on a blood thinner (such as Coumadin, Plavix, aspirin)***

Name of Medicine	Dose/Number per day	Name of Medicine	Dose/Number per day
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Please continue on next page

Patient Name: _____

NON-PRESCRIPTION MEDICINES

❑ NONE; I am not taking any non-prescription medicines

Herbal supplements/preparations

1._____
2._____
3._____
4._____

Over the counter drugs/Vitamins

1._____
2._____
3._____
4._____

PAST SURGICAL HISTORY

❑ NONE; I have not had any previous surgeries

Type of surgery	What year?	Type of surgery	What year?
1._____		5._____	
2._____		6._____	
3._____		7._____	
4._____		8._____	

REVIEW OF SYSTEMS

Please check any of the following that you are currently experiencing.

General
- ❑ Weight Loss
- ❑ Loss of appetite
- ❑ Weight Gain
- ❑ Fever/Chills
- ❑ Fatigue

Cardiovascular
- ❑ Chest Pain ❑ Murmur
- ❑ Palpitations (heart skipping a beat)
- ❑ Fainting
- ❑ Feet swelling

Musculoskeletal
- ❑ Joint Swelling
- ❑ Joint Redness
- ❑ Joint Pain
- ❑ Gait problems (walking)
- ❑ Back or neck pain
- ❑ Muscle pain/weakness
- ❑ Fibromyalgia
- ❑ Osteoporosis

Psychological
- ❑ Anxiety ❑ Depression
- ❑ Severe stress ❑ Panic
- ❑ Insomnia Attacks

Eyes
- ❑ Wear glasses/contacts
- ❑ Pain
- ❑ Cataracts
- ❑ Discharge
- ❑ Light sensitive
- ❑ Blurred vision
- ❑ Double vision
- ❑ Eye disease/injury
- ❑ Glaucoma

Gastrointestinal
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Blood in stool
- ❑ Ulcers
- ❑ Hiatal Hernia
- ❑ Reflux
- ❑ Constipation
- ❑ Change in, or pain with, bowel movements

Skin/Breast
- ❑ Rash ❑ Itching
- ❑ Sores ❑ Abscess
- ❑ Discharge

ENT
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Ringing in ears
- ❑ Nose bleeds
- ❑ Hard of hearing

Genitourinary
- ❑ Urinary Frequency
- ❑ Urinary Hesitation
- ❑ Painful Urination
- ❑ Flank Pain
- ❑ Incontinence
- ❑ Sexual Difficulties

Endocrine
- ❑ Excessive sweating
- ❑ Excessive thirst
- ❑ Overly hot
- ❑ Overly cold
- ❑ Thyroid disease
- ❑ Glandular/hormone problems

Respiratory
- ❑ Wheezing
- ❑ Cough
- ❑ Shortness of breath
- ❑ Sleep Apnea

Neurological
- ❑ Headaches
- ❑ Confusion
- ❑ Numbness/Tingling
- ❑ Slurred speech
- ❑ Seizures
- ❑ Head injury
- ❑ Tremors
- ❑ Dizziness

Hematologic/Lymphatic
- ❑ Bleeding tendencies
- ❑ Excessive bleeding during procedures
- ❑ Easy bruising
- ❑ Lymph node swelling
- ❑ Blood clots

Please continue on next page

Patient Name: _____

SOCIAL HISTORY

Please check all that apply

Tobacco Use
- ❑ Never
- ❑ Chewing tobacco
- ❑ Pipe
- ❑ Cigars
- ❑ Cigarettes
  Packs per day: ____
- ❑ Quit Smoking
  When: _____

Alcohol Use
- ❑ None
- ❑ Socially
- ❑ Daily
  Drinks per day: _____

Have you ever been treated for alcoholism?
- ❑ Yes ❑ No

If yes, when?_____

Other Substance use
- ❑ None
- ❑ Marijuana
- ❑ Cocaine
- ❑ Amphetamines
- ❑ Other: _____

Have you ever been treated for drug addiction?
- ❑ Yes ❑ No

If yes, when? _____

I currently live in:
- ❑ A house
- ❑ An apartment
- ❑ A mobile home/trailer
- ❑ A retirement facility
- ❑ Other: _____

Marital Status
- ❑ Single
- ❑ Married/Partnered
- ❑ Divorced
- ❑ Widowed
- ❑ Children, #?_____

Environmental exposures at home or work: ❑ Fumes ❑ Dust ❑ Solvents ❑ Airborne particles ❑ Noise

Please list: _____

OCCUPATIONAL HISTORY

Employer: _____ **Occupation:** _____

Type of work you do: _____

Have you altered your job as a result of the problem that brought you here today? ❑ Yes ❑ No

If yes, explain: _____

If you are currently off work as a result of this problem, how long have you been off work? _____

If appropriate, please check the level of physical activity your normal job requires:

❑ Sedentary (desk work)	❑ Light	❑ Medium	❑ Medium Heavy	❑ Heavy	❑ Very Heavy
Sitting most of the day; rarely lifting and always less than 10 lbs.	Sitting part of the day; sometimes lifting 10 lbs.	Moving part of the day; often lifting 10 lbs. sometimes up to 20 lbs.	Moving most of the day; often lifting up to 25 lbs. sometimes up to 50 lbs.	Moving most of the day; often lifting 35 lbs. sometimes up to 75 lbs.	Moving all day; often lifting 50 lbs. sometimes up to 100 lbs. all day.

Please continue on next page

Patient Name: _____

FAMILY HISTORY

Has an immediate family member (mother, father, brother or sister) ever experienced any of the following conditions?

❑ Heart disease ❑ Diabetes ❑ Stroke ❑ Cancer ❑ Other: _____

Father: ❑ Living, age: _____ ❑ Deceased, age at death: _____ Cause of death: _____

Mother: ❑ Living, age: _____ ❑ Deceased, age at death: _____ Cause of death: _____

Brothers: Number alive: _____ Number deceased: _____ Ages: _____

Cause of death: _____

Sisters: Number alive: _____ Number deceased: _____ Ages: _____

Cause of death: _____

The information on this form was provided by: _____ _____
Signature of patient or family member *Relationship to patient*

_____
Date

FOR OFFICE USE ONLY

This record of the patient's past medical history, surgical history, current medications, allergies, review of systems, family and social histories has been reviewed by me. This information is a permanent part of my consultation for this patient.

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ACCIDENT INFORMATION

Patient Name: _____ Date: _____

Is this visit the result of an accident? ❑ ***Yes*** ❑ ***No***

If yes, please continue filling out this form.

Nature of accident

❑ Car accident ❑ Fall ❑ Sporting accident ❑ Assault (a fight or beating) ❑ Gunshot

Where were you injured?

❑ **In my own home**

❑ **At work**

Is this a worker's comp injury? ❑ Yes ❑ No

Date of injury: _____

Your employer's worker's comp carrier name: _____

Address of carrier: _____ Phone #: _____

City/State: _____ Zip: _____ Claim #: _____

Case manager name: _____ Phone: _____ Fax: _____

❑ **In a car accident**

Date of accident: _____ Location of accident: _____

Have you contacted the other driver's car insurance company? ❑ Yes ❑ No

❑ **At a business**

Date of accident: _____ Have you filed an insurance claim? ❑ Yes ❑ No

What is the name of the business?_____

What is the owner's name? _____ Phone #: _____

What is the address of the business? _____

❑ **At someone's home**

Date of accident: _____ Have you filed a homeowner's insurance claim? ❑ Yes ❑ No

What is the name of the person who owns the home? _____

What is the address? _____

No matter what type of accident, please complete the questions below

Is there litigation pending (suing in a court of law)? ❑ Yes ❑ No

Are you considering litigation (suing)? ❑ Yes ❑ No

If yes, what is the name and phone number of the attorney: _____

Please continue on next page

Patient Name: _____ Date: _____

Please describe the accident: _____

_____

_____

_____

_____

_____

Had you ever experienced your symptoms before the accident? ❑ Yes ❑ No

If the accident was due to a fall, how far did you fall? _____

If this was a bicycle, motorcycle or ATV accident, were you wearing a helmet? ❑ Yes ❑ No ❑ N/A

If this was a car accident, did you have your seat belt on? ❑ Yes ❑ No ❑ N/A

Did you have a shoulder strap on? ❑ Yes ❑ No How fast was your car driving? _____

Did the air bag deploy or go off? ❑ Yes ❑ No How fast was the car that hit you driving? _____

Where were you sitting in the car? ❑ Driver's seat ❑ Front Passenger seat ❑ Back seat, driver's side

❑ Back seat, passenger side ❑ Other: _____

When did you first seek medical treatment?_____ Where?_____

What tests were done?_____

What was your diagnosis? _____ Who was your doctor?_____

Were you taken to a hospital by ambulance? ❑ Yes ❑ No

If you were in the hospital, for how long? _____ Hospital name: _____

Doctor's name: _____

What kind of work do you do? _____

What was the last day you worked? _____

Please list anything else you would like your doctor to know about the accident and its effects on you:

_____

_____

_____

_____

_____

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REGISTRATION FORM
CONFIDENTIAL

Given the specialty nature of our practice, we need to collect a great deal of information from you. This is to help us bill you correctly and to give your doctor all the information needed to treat you.

Please print all information.

Patient's Name: _____ Birthdate: _____

Home Address: _____

City/State: _____ Zip: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Patient's Employer: _____

Social Security #: _____ Gender: ❑ Male ❑ Female

Race: ❑ Asian ❑ Black/African American ❑ Hispanic ❑ Alaska Native ❑ Native American
❑ Pacific Islander ❑ Bi-racial ❑ White/Caucasian ❑ Unknown ❑ Other: _____

Are you: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other: _____

Name of Spouse: _____ Birthdate: _____

Spouse's Social Security #: _____ Spouse's Cell Phone: _____

Spouse's Employer: _____ Work Phone: _____

If the patient is a child, the person responsible for the child should complete the following section (Responsible Party)

Name of Responsible Party: _____

Is this person the child's ❑ Parent(s) ❑ Foster Parent(s) ❑ Legal Guardian ❑ Other: _____

Responsible Party's Social Security #: _____

Responsible Party's Address: _____

Responsible Party's Home Phone: (_____) _____

Responsible Party's Work Phone: (_____) _____

Responsible Party's Cell Phone: (_____) _____

Name of child's caseworker: _____

Caseworker's phone number: (_____) _____

Please list the patient's nearest relative not living with the patient.

Name: _____

Relationship: ❑ Parent ❑ Sibling ❑ Child ❑ Aunt/Uncle ❑ Grandparent ❑ Cousin ❑ Other: _____

Address: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Physician Information

Name of Family Doctor: _____

Type of Doctor (check one): ❑ MD ❑ DO ❑ OD ❑ DC ❑ Other: _____

Address of Family Doctor: _____

City/State/Zip: _____

Phone Number: (_____) _____

Who is the doctor that referred you (or sent you) to our office (Referring Doctor)?

Name of Referring Doctor: _____

Type of Doctor (check one): ❑ MD ❑ DO ❑ OD ❑ DC ❑ Other: _____

Address of Referring Doctor: _____

City/State/Zip: _____

Phone Number: (_____) _____

The front office staff is REQUIRED to make a copy of your insurance card AND have you fill out this section. We copy your insurance card and picture ID to help prevent insurance fraud. We expect you to complete this form with the most recent insurance information you have. This will help us bill your insurance company correctly and prevent problems in the future.

Primary Insurance

Insurance Company Name: _____ Copay Amount for Specialist Visit: _____

Name of Policy Holder (whose insurance is it?): _____

Relationship to patient: _____ SS #:. _____ Birthdate: _____

Policy Holder's Employer: _____

Group Number: _____ Policy ID Number: _____

Secondary Insurance

Insurance Company Name: _____ Copay Amount for Specialist Visit: _____

Name of Policy Holder (whose insurance is it?): _____

Relationship to patient: _____ SS #:. _____ Birthdate: _____

Policy Holder's Employer: _____

Group Number: _____ Policy ID Number: _____

I hereby authorize the physicians and/or employees of Advanced Neuro and Spinal Surgery to release any current reports or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force until revoked by me in writing.

I authorize and request insurance companies to pay directly to Advanced Neuro and Spinal Surgery the surgical and/or medical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services.

Attorney fees and court costs incurred by Advanced Neuro and Spinal Surgery, the account balance will be my responsibility.

Print Name: _____

Signed: _____ Date: _____

NOTE: This authorization MUST be signed and dated by the patient unless patient is a minor or has a legal guardian. In this case, a parent or legal guardian must sign and date.

ADVANCED NEURO & SPINAL SURGERY
Mike W. Chou, M.D., F.A.A.N.S.

HEALTHCARE PERMISSION FOR VERBAL COMMUNICATIONS AND/OR TO LEAVE MESSAGES

About this form

Dr. Mike Chou and staff recognize confidentiality as a very important part of your relationship with them. To protect your confidentiality, they will not routinely speak to individuals or leave messages regarding your healthcare treatment unless you specifically give permission to do so. This authorization allows health care providers and staff to share health information as you specify.

By completing the reverse side of this form, you can authorize any combination of the following:

1. Permission for verbal communication (both in person and on the telephone) between our health care providers and the person designated on the form.
2. Permission to leave voice mail messages regarding your care at a specific phone number.
3. Permission to leave a message with a specific person who answers a specific phone number.

If you wish to limit the types of health information that health care providers and staff may share, you can indicate so on the reverse side of this form.

Return Instructions

Please complete, sign, and return this form to:

ADVANCED NEURO & SPINAL SURGERY
1110 Professional Blvd
Evansville IN 47714

fax: 812-401-5342

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

In the event Mike W. Chou/Advanced Neuro & Spinal Surgery may need to give your test results or medical information, may we.....(check all that apply)

- ❒ Leave a detailed message on an answering machine.
- ❒ Leave a message with your spouse or family member.
- ❒ Call you on your cellular phone, the number is _____
- ❒ Call you at work, the number is _____
- ❒ Speak to you directly. **ONLY**

I, _____ (DOB)_____, give Dr. Mike Chou/Advanced Neuro & Spinal Surgery and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records department.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or heathcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

Unless, otherwise revoked, this authorization will not expire.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian or Personal Representative Date

_____ _____

Witnessed by Date

ADVANCED NEURO & SPINAL SURGERY
Mike W. Chou, M.D.

IMPORTANT NOTICE TO OUR PATIENTS

Patient Name: _____

As required by the HIPAA Privacy Regulations, all patients who receive health care services in our office on or after April 14, 2003 must have:

- **A copy** of the current "Notice of Privacy Practices" Form made available; and
- **Sign** the "Acknowledgment" Form below and return it to our front desk for our records.

Please note that the Privacy Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions in the past.

Please Sign the Acknowledgment Form below and return it to our front desk for our records.

Thank you very much.

ACKNOWLEDGMENT FORM

I hereby acknowledge that a current copy of the Privacy Notice has been made available to me.

_____

Patient or Personal Representative* Signature *Date*

(*) if signed by Personal Representative, please state your relationship to Patient:

_____

ADVANCED
NEURO
AND SPINAL SURGERY

MIKE W. CHOU, M.D., F.A.A.N.S.
BOARD CERTIFIED NEUROSURGEON

FINANCIAL POLICY

Please read this policy carefully. Payment is expected at the time of service unless other arrangements have been made prior to the appointment. Our Patient Accounts representatives are available Monday through Friday from 8:00 AM to 4:30 PM to discuss financial arrangements. For your convenience, we accept Master Card and Visa. Please call 812-401-7577 or toll free at 877-401-7577.

Advanced Neuro and Spinal Surgery contracts with patients for their medical care; any arrangements made by the patient with attorney, insurance companies, or other third parties will not be considered in the collection of your account.

Charges for Professional Services - Every professional service and associated expense rendered will be charged to the patient according to a fee schedule determined by the practice. Contractual discounts to third parties agreed to by the practice will be honored in good faith. No fee or charge can be reduced or waived without the permission of the administrator, or his or her designee. An estimate of these fees can be requested.

Insurance - Health insurance is primarily a contract between the patient and the insurance company; however, Advanced Neuro and Spinal Surgery also has mutually agreed contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Advanced Neuro and Spinal Surgery will make available substantial resources to facilitate insurance payment and will dedicate resources towards contractual obligations with these entities.

Payment - Payment for services rendered is due on the date of service and is part of the professional relationship unless a prior contractual agreement exists between Advanced Neuro and Spinal Surgery and your insurance company.

All co-payments will be collected at the time of service. All past-due balances or balances in collection must be paid prior to seeing an Advanced Neuro and Spinal Surgery practitioner.

Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient non-compliance with this financial policy. Only the administrator, billing manager, or their designated representative can amend this policy.

Down-Payment for Non-Urgent Surgical Procedures - Patient will be responsible for paying any deductible, coinsurance, and co-pays prior to receiving the non-urgent surgical services from Advanced Neuro and Spinal Surgery physicians. Benefits will be verified prior to scheduling the surgery, and patient will be notified of any pre-surgical financial obligations. Down payment must be received prior to scheduled surgery. Failure to pay required down-payment may result in cancellation of surgery.

Patient Referrals and Out of Network - If patient is enrolled with an insurance carrier with network benefits, patient is entitled to full benefits of said plan when certain guidelines are followed. If patient does not obtain a referral from his/her Primary Care Physician (PCP) for services rendered by Advanced Neuro and Spinal Surgery physician or provider, patient may be responsible for all or a portion of charges incurred. Patient will be responsible for charges incurred when choosing to go out of the designated managed care network.

Collection Agencies - Advanced Neuro and Spinal Surgery will use all reasonable means to collect owed funds. Defaults in payment of agreed amounts will be referred to a collection agency for payment. Patient will be responsible for collection agency fees incurred while account is in collection.

Non-Sufficient Funds (NSF) - Advanced Neuro and Spinal Surgery will charge a $40 fee for all checks returned by the bank for non-sufficient funds.

Medicare Patients - Advanced Neuro and Spinal Surgery physicians are participating providers and accept the Medicare assignment of benefits. Medicare patients will be responsible for deductible, 20 percent coinsurance and/or non-covered charges when applicable. By signing this policy, the Medicare recipient requests payment of authorized Medicare benefits be made on patient's behalf for any services furnished by Advanced Neuro and Spinal Surgery including physician services.

Medigap/Secondary Insurance Authorization - Medicare recipient authorizes Advanced Neuro and Spinal Surgery or its agent to release medical or other information to supplemental insurance in order to process all medical claims. A copy of this authorization may be used in place of the original Medicare recipient requests payment of medical insurance benefits to Advanced Neuro and Spinal Surgery for services provided.

_____ _____

Patient or Responsible Party Date

_____ _____

Witness Patient's Name

545 Willow St.
Vincennes, IN 47591

1110 Professional Blvd.
Evansville, IN 47714

1950 St Charles St.
Jasper, IN 47546

Phone: (812) 401-7577 • Fax: (812) 401-5342