

NAME _____

DATE _____

OCCUPATION _____

AGE: _____

REASON FOR CONSULTING NEUROSURGEON AT THIS TIME:

HEIGHT _____

When did symptoms start? _____

WEIGHT _____

Have you ever had same or similar symptoms? _____

If you were disabled from work due to this illness - Give dates:

PAST MEDICAL HISTORY:

Operations (surgery) - give year

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

FAMILY HISTORY:

AGE:

ILLNESS OR CAUSE OF DEATH

FATHER living _____
 deceased _____

MOTHER living _____
 deceased _____

Living Brothers & Sisters _____

Deceased Brothers & Sisters _____

SERIOUS INJURIES OR ACCIDENTS:

give year

1. _____
2. _____
3. _____

OTHER **ILLNESS** OR **HOSPITALIZATION** NOT LISTED ABOVE WITH YEAR (EXCLUDE THE USUAL CHILDHOOD DISEASES UNLESS COMPLICATED).

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

ALLERGIES TO DRUGS, FOOD, POLLENS, ETC.
(DESCRIBE THE TYPE OF REACTION)

LIST **MEDICATIONS** OR OTHER TREATMENTS THAT YOU ARE NOW TAKING (OR WRITE NONE).

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

IS THERE A HISTORY IN YOUR FAMILY OF:

Diabetes	NO	YES
Heart Attack	NO	YES
Stroke	NO	YES
Cancer or Leukemia	NO	YES
Tuberculosis	NO	YES
Nervous Breakdown	NO	YES
Bleeding Disorder	NO	YES

MISCELLANEOUS HISTORY:

Cigarettes (packs per day)? _____

Coffee, tea, coke (cups per day) _____

Alcoholic beverages (drinks per day) _____

(over please)

DURING THE PAST TWO MONTHS HAVE YOU:

Lost or gained weight? (How much?) _____
Been persistently tired? _____
Had chills or fever? _____
Been depressed, sad, or unhappy? _____
Been nervous or easily upset? _____
Been unable to sleep well? _____

DURING THE PAST YEAR HAVE YOU HAD:

Persistent or severe headaches? NO YES
Dizziness? NO YES
Eye trouble? NO YES
Hearing trouble? NO YES
Nose Bleeds? NO YES
A sore in your mouth or tongue? NO YES

HAVE YOU HAD:

Shortness of breath? NO YES
Chest pains or tightness? NO YES
Asthma or wheezing? NO YES
Persistent cough? NO YES
Blood spitting? NO YES
Abnormal chest x-ray? NO YES

HAVE YOU EVER HAD:

Heart trouble (or coronary attack)? NO YES
High blood pressure? NO YES
A stroke? NO YES
An abnormal electrocardiogram (EKG)? NO YES
Irregular or rapid heart beat? NO YES
Swollen legs or feet? NO YES
Cold feet? NO YES
Phlebitis or varicose veins? NO YES
Tendency to bleed excessively? NO YES

HAVE YOU HAD:

Kidney trouble? NO YES
Burning or pain when you urinate? NO YES
Trouble passing urine? NO YES
Cloudy or bloody urine? NO YES
To get up at night to urinate? NO YES

HAVE YOU HAD:

Back pain? NO YES
Stiff neck? NO YES
Painful or stiff joints? NO YES
Pain in your legs? NO YES
Morning stiffness? NO YES

DO YOU HAVE:

Poor appetite? NO YES
Trouble swallowing? NO YES
Pains in the stomach? NO YES
Belching or gas? NO YES
Indigestion? NO YES
Heartburn? NO YES
Constipation? NO YES
Diarrhea? NO YES
Swollen abdomen? NO YES
Blood in the stool? NO YES
Black bowel movements? NO YES

FOR WOMEN ONLY:

Have you stopped menstruating? NO YES
Are your periods abnormal? NO YES
Do you have a vaginal discharge? NO YES
When did you have your last internal examination? (Pap Test)? _____

Acct No: _____ Reg. By: _____ Entered Date: _____ Office Site: _____

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Name: _____ Last Name First Name MI	Social Security Number: _____
Other Name: _____	Date of Birth: _____
SEX: <input type="checkbox"/> M <input type="checkbox"/> F	Race: (Response is not mandatory. Data is used for statistical reporting.)
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Addr1: _____	Home Phone: (____) _____
Addr2: _____	Daytime Phone: (____) _____
City,St,ZIP: _____	Cell Phone: (____) _____
Employer: _____	Emp Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker
Addr1: _____	<input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Self-Employed
Addr2: _____	Work Phone: (____) _____
City,St,ZIP: _____	

Please complete if guarantor is other than self. (The guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____	Patient's Relationship to Guarantor: _____
Addr1: _____	Social Security Number: _____
Addr2: _____	Date of Birth: _____
City,St,ZIP: _____	Sex: _____
Employer: _____	Home Phone: (____) _____
Addr1: _____	Work Phone: (____) _____
Addr2: _____	
City,St,ZIP: _____	

Emerg Cont: _____	Patient's Relationship to Emerg Cont: _____
Addr1: _____	Home Phone: (____) _____
Addr2: _____	Work Phone: (____) _____
City,St,ZIP: _____	Cell Phone: (____) _____

How did you hear of our practice? Billboard Brochure Health Fair Health Plan Internet JeFF NOW Mass Mailing
 Newspaper/Mag. Ongoing Care Other Patient Phone Bk Phys. Off./ER Relative Radio TV Word of Mouth

Insurance Information

A separate form is required for Worker's Compensation, Automobile Liability, or Legal services.

PRIMARY CARRIER: _____

Address: _____	Telephone #: (____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

SECONDARY CARRIER: _____

Address: _____	Telephone #: (____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

Primary Care Physician/Referring Physician

PCP: _____	Refer. Phys. (if different): _____
Addr: _____	Addr: _____
City,St,ZIP: _____	City,St,ZIP: _____
Telephone #: _____	Telephone #: _____

ASSIGNMENT OF BENEFITS

Medicare I request that payment of authorized Medicare benefits be made either to me or on my behalf to Main Line HealthCare and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has treatment been authorized by the V.A.?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you or your spouse have other insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you covered under the Black Lung Program?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you disabled or have end stage renal disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there Medigap coverage secondary to Medicare?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is illness/injury the result of an auto accident?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there insurance coverage primary to Medicare?	<input type="checkbox"/> Y <input type="checkbox"/> N
Did illness/injury occur at work?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there employer supplemental coverage secondary to Medicare?.....	<input type="checkbox"/> Y <input type="checkbox"/> N

Medigap (Medicare Secondary Insurance) I request that payment of authorized Medigap benefits be made either to me or on my behalf to Main Line HealthCare for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap Coverage) any information needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Commercial **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby authorize payment directly to Main Line HealthCare for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

General **RELEASE OF INFORMATION** – Main Line HealthCare may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Workers Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Main Line HealthCare and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

GUARANTEE OF ACCOUNT – Main Line HealthCare

For and in consideration of services rendered by Main Line HealthCare to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Patient Signature

Date

Patient's Agent Representative and Guarantor Signature

Date

Main Line HealthCare

PATIENT FINANCIAL POLICY

Main Line HealthCare physicians and staff are committed to providing you with the best possible care. We will be happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE unless previous arrangements have been made. In the case of a minor, the patient's accompanying adult, parent, or guardian is responsible for payment at the time of service. This includes all insurance co-pays. **WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.**

WE PARTICIPATE WITH THE FOLLOWING INSURANCE CARRIERS:

Medicare /Railroad Medicare/ PA Blue Shield / Premier Blue/AmeriHealth/Personal Choice/Keystone Health Plan East/Keystone 65 HMO, Personal Choice 65 PPO, National Blue Card PPO, Aetna-(HMO, PPO & POS)/Choice Care Network (aka Humana PPO)/CIGNA (HMO & PPO) /Clear Care/ Community Care Network (CCN)/ Coventry Health Plan of Delaware (HMO & PPO)/ Devon Health Services/ Galaxy Health Network/Great West/Health America Health Assurance/Health Payors Organization/ InterGroup/ Master Care/Mamsi/Multi-Plan / National Provider Network/ One Health/Preferred HealthCare Systems (PHCS)/ Preferred Health Network (PHN)/ Preferred Care/PPO Next/ United Healthcare.

If you are covered by any of these carriers, it is necessary for you to provide our office staff with the required information that enables us to bill your carrier. In some circumstances, even participating insurance plans may leave a balance that you must pay. It is not our responsibility to know what limitations, exclusions, deductibles or copays each group insurance plan might leave to a patient's responsibility. **Your doctor may participate** with other insurance plans not listed above. Please check with the practice office staff to see if your insurance plan will be accepted.

NON-PARTICIPATING INSURANCE PLANS

WE DO NOT ACCEPT DISCOUNT CARDS.

Office Charges: Insurance will *not* be accepted for office charges for non-participating insurance plans; however, a receipt will be provided that includes all of the required information for you to submit to receive reimbursement from your insurance company.

Inpatient, Nursing Facility and Procedure Charges: If an inpatient service or office diagnostic /surgical procedure is performed, we will file an insurance claim as a courtesy to our patients. You must provide our office with specific insurance company information in order for this claim to be filed. If payment has not been received after 30 days, the balance will be transferred to your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, co-insurance, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. As the insurance policy holder, you are responsible for timely payment of your account.

DELINQUENT ACCOUNTS

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency.

MISSED APPOINTMENTS

We would appreciate your help and the courtesy of a call if you are unable to keep your scheduled appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. We reserve the right to charge a missed appointment fee for each appointment that is not canceled in a timely manner.

RETURN CHECK FEE

There will be a transaction fee of \$15 for any check that is returned for insufficient funds.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH, READ, AND UNDERSTAND THE PATIENT FINANCIAL POLICY STATED ABOVE AND AGREE TO BE SUBJECT TO SAME.

Patient/ Guarantor Signature

Date

Main Line HealthCare

Chestmont Neurosurgical

RADIOLOGY STUDIES

At the time of your appointment, you must bring with you all appropriate radiology studies (MRI/MRA, CT Scan, Arteriogram, Myelogram, or regular x-rays). These studies can be on either film or CD/Disc.

Please be advised that failure to bring in these studies could result in your appointment being rescheduled at the discretion of the physician.

Please DO NOT rely on another physician's office or radiology facility to mail or deliver your films.

Thank you!

Chestmont Neurosurgical Staff

**MAIN LINE HEALTHCARE
CHESTMONT NEUROSURGICAL
NOTICE OF PRIVACY PRACTICES**

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

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, pharmacists, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We may contact you, a family member, or a personal representative, directly or by leaving a message on your home, work or cell number or answering machine regarding appointments and information about medical treatment. If you have any restrictions regarding where we call or who we speak to, please advise our staff immediately.

FOR PAYMENT: We may use and disclose your medical information for payment purposes such as submission of a claim form to your health insurer.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President

and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official of correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Organ and Tissue Procurement: We may disclose medical information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Business Associates: A business associate such as a transcription service or a medical record copy service performs certain functions of the practice.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we may charge you for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates share your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

You may contact the Office Manager: Elizabeth O'Connor
3855 West Chester Pike, Ste 245
Newtown Square, PA 19073

Main Line HealthCare

Chestmont Neurosurgical

James A. Kenning, M.D., FACS
Matthew J. Budway, M.D.
Howard A. Richter, M.D.

Bryn Mawr Hospital
Health Center
3855 West Chester Pike
Suite 245
Newtown Square, PA 19073
610-325-3880 Office
610-325-3887 Fax

PATIENT NAME: _____

MRN: _____

(Print Full Name)

DATE OF BIRTH (Required): _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Chestmont Neurosurgical (Main Line HealthCare and Main Line Health System (MLHS))

SIGNATURE: _____

DATE: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT (To be completed only if no signature is obtained)

No acknowledgement of receipt of Privacy Practices was obtained from the patient because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify):

SIGNATURE: _____
(Of MLHC Representative)

DATE: _____

MAIN LINE HEALTHCARE
CHESTMONT NEUROSURGICAL
BRYN MAWR HOSPITAL HEALTH CENTER
3855 WEST CHESTER PIKE, SUITE 245
NEWTOWN SQUARE, PA 19073

WOULD YOU LIKE US TO SEND A REPORT TO YOUR DOCTOR(S)?

If so, please provide us with the following information:
(Please be advised that we cannot and will not send a report with incomplete information.)

PATIENT'S NAME: _____ DATE: _____
.....

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone #: _____

Doctor's Fax #: _____
.....

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone #: _____

Doctors' Fax #: _____
.....

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone #: _____

Doctor's Fax #: _____
