Comprehensive Neurosurgical & Spine Care

NEUROSURGEONS OF CAPE COD

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Thank you for placing your trust in our practice. Your care and wellness are our priority.

Please help us provide you with the best possible care by bringing the following items to your appointment:

The completed Information Packet

Insurance cards

Medication List (if not filled out on the packet)

CD (if testing was done at Shields, or any other facility OUTSIDE of Cape Cod Healthcare)

PLEASE ARRIVE 30 MINUTES AHEAD OF YOUR APPOINTMENT TIME FOR CHECK-IN.

We look forward to welcoming you to our practice!

46 NORTH STREET • HYANNIS • MASSACHUSETTS • 02601
(508) 771-0006 • FAX: (508) 790-8337

Name:____ DOB:____________________

<u>Medication Allergies:</u> check if **No Known Drug Allergies** ☐ otherwise list allergies

<u>Current Medications:</u> check if **No Current Medications** ☐ otherwise list medications

Include **Over The Counter** medications

Signature:____ Date:______________

Information Forms

Name:____ Date of Birth_______________

Home Phone:_______________Cell Phone:________________Work Phone:______________

Address:____

City, State & Zip Code:____

Mailing Address if Different:____

Email Address:_______________________________ Social Security #___________________

Please Circle: Sex: **F / M** Marital Status **S M D W** Spouse's Name___________________

Employer:____________________________________Occupation:____________________

Person to notify in Emergency: Name / Relationship and Phone:___________________________

Primary Care Doctor: Name and Phone:____

Referring Physician if different from primary care:______________________________________

Pharmacy Name, Location and Phone:____

Insurance Information

Primary Insurance:____

Subscriber:_________________________________Subscriber Date of Birth_________________

ID#:____

Secondary Insurance:____

Subscriber:_________________________________Subscriber Date of Birth_________________

ID#:____

If your problem is the result of a ***Motor Vehicle Accident*** or an ***Injury at Work,*** please check the appropriate box and ask secretary for the appropriate form to fill out.

☐ MVA

☐ Workers Compensation Date of Injury____________

Authorization to Release Information: I hereby authorize the release of any information acquired in the course of my examination or treatment to my referring physicians and Insurance Company.

Signature:____ **Date:**___________

Name:____DOB:__________________

Personal History: please circle

Do you live alone?	Yes	No	Height:__________Weight:__________		
Do you live with your spouse?	Yes	No	Do you smoke?	Yes	No
Do you have children?	Yes	No	If yes, how much?________How long?___		
Hand preference	Left	Right	Are You A former smoker?	Yes	No
Is it possible that you could be pregnant? **N/A**	Yes	No	Do you use alcohol?	Yes	No
			How much________________________		

Past Medical History: please circle

Anemia	Yes	No	Heart Trouble	Yes	No
Arthritis	Yes	No	High Blood Pressure	Yes	No
Rheumatoid Arthritis	Yes	No	Hypothyroidism Acquired	Yes	No
Cancer	Yes	No	Meningitis	Yes	No
Diabetes	Yes	No	Phlebitis	Yes	No
Epilepsy	Yes	No	Polio	Yes	No
Gonorrhea or Syphilis	Yes	No	Rheumatic Heart Disease	Yes	No
Asthma	Yes	No	**Other**________________		

Past Surgical History (please check the surgery and list the surgeon and approximate date)

Surgery		Surgeon and Date
Abdominal Surgery		
Appendectomy		
Brain Surgery		
Carpal Tunnel Surgery		
Cervical Spine Surgery		
C-Section		
Hernia Repair		
Hip Replacement		
Hysterectomy		
Knee Replacement		
Knee Surgery		
Lumbar Spine Surgery		
Prostate Surgery		
Shoulder Surgery		
Other		

Family History: Do any blood relatives have the following health problems? If so who ie:(Mother, Father, Brother, Sister, Grandmother, Grandfather, Aunts, Uncles)

Aids		Diabetes		Migraine Headaches	
Aneurysm of Brain		Epilepsy		Neurofibromatosis	
Asthma		Heart Attack		Polycystic Kidney	
Bladder Disease		Heart Problem		Psychological Disorder	
Blood Vessel Disease		High Blood Pressure		Stroke	
Cancer		Lung Disease		Spina Bifida	
Type		Type		Other	

Name:____DOB:___________________

Symptoms/Problems: Please list present symptoms, complaints or problems in order of severity:

1. ___________________________________ Date:________________ How:________________
2. ___________________________________ Date:________________ How:________________
3. ___________________________________ Date:________________ How:________________

Review of Symptoms: Have you experienced any of the following in the past year? If so, please check the appropriate response.

Constitutional

☐ Fatigue without apparent reason

☐ Change of appetite

☐ Night sweats

Eyes

☐ Blurred vision

☐ Double vision

☐ Any changes in vision

Head

☐ Ringing in ears

☐ Sinus trouble

☐ Strange persistent odors

☐ Difficulty swallowing

Respiratory

☐ Shortness of breath, chronic or frequent cough

☐ Bloody cough

☐ Number of pillows slept on ______

Neurologic

☐ Frequent or severe headache

☐ Fainting or unconscious spells

☐ Convulsions (seizures)

☐ Dizziness on change of position

Cardiovascular

☐ Chest Pain

☐ Angina Pectoris

☐ Palpitations or fluttering heart

☐ Swelling of hands, feet, ankles

Gastrointestinal

☐ Nausea

☐ Vomiting

☐ Vomiting blood

☐ Abdominal pain

☐ Any blood in bowel movement

☐ Rectal pain with bowel movement

Integument

☐ Skin rash

☐ Dryness of the skin

☐ Change in hair texture

☐ Brittleness of nails

Endocrine

☐ Inability to stand heat, inability to stand cold

Hemolymph

☐ Easy bruising

Musculoskeletal

☐ Joint pain, swelling in joints

Patient Responsibilities

Prescription Policy:

Prescriptions for pain medications will be written for patients who are scheduled for surgery. All other medication requests should be directed to your primary care physician.

Requests for medication refills require a **48-HOUR NOTICE** (2 BUSINESS DAYS). Please do not wait until your medication runs out. We do not handle medication requests on a walk-in basis. You will be called when your prescription is ready for pick up.

No pain medication will be prescribed after hours by the physician on call.

Insurance Referrals:

It is the patient's responsibility to obtain an **INSURANCE REFERRAL** from the primary care physician if it is an HMO insurance plan. If you are unsure, check with your primary care doctor or call the number on the back of your insurance card.

Financial:

Cancellations made less than 24 hours before your appointment may incur a $50.00 charge or if you should **NO SHOW** to an appointment. Co-pays are due at the time of the visit. All other arrangements or financial issues will be addressed by our Billing Department.

I have read and understand the above:

Patient Signature:____ Date:______________

Communication Consent

Other than doctors, I **DO** or **DO NOT** (circle one) give permission to my doctor and office staff to speak with: **ie:(family members, friends, or other BE SPECIFIC)**

____

____

regarding my medical care, information and test results.

Do we have your permission to leave messages regarding your health care and appointment reminders on your Voice Mail? Yes___________ No___________

Name (Please Print): ___________________________________

Patient Signature:____ **Date:**_______________

Neurosurgeons of Cape Cod, P.C.
Confidentiality/Privacy Policy
PATIENT ACKNOWLEDGEMENT

September 23, 2013
This Notice was revised on September 23, 2013.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER at Neurosurgeons of Cape Cod, 46 North Street, Hyannis, MA 02601, 508-771-0006.

About This Notice: We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights-and we have certain legal obligations-regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information? "Protected Health Information" is information that individually identifies you and that we create to get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that is related to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information: We may use and disclose your Protected Health Information in the following circumstances:

For Treatment, Payment, Health Care Operations, Appointment Reminders/Treatment Alternatives/ Health-Related Benefits and Services, Minors, Research, As Required by Law, To Avert a Serious Threat to Health or Safety, Business Associates, Organ and Tissue Donation, Military and Veterans, Worker's Compensation, Public Health Risks, Abuse/Neglect or Domestic Violence, Health Oversight Activites, Data Breach Notification Purposes, Lawsuits and Disputes, Law Enforcement, Military Activity and National Security, Coroners, Medical Examiners and Funeral Directors, and Inmates.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out:

Individuals Involved in Your Care or Payment for Your Care, Disaster Relief.

Your Written Authorization is Required for Other Uses and Disclosures:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes, and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Informaton not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information:
You have the following rights, subject to certain limitations, regarding your Protected Health Information: Right to Inspect and Copy, Right to a Summary or Explanation, Right to an Electronic Copy of Electronic Medical Records, Right to Get Notice of a Breach, Right to Request Amendments, Right to an Accounting of Disclosures, Right to Request Restrictions, Out-of-Pocket Payments, Right to Request Confidential Communications, Right to a Paper Copy of This Notice.

How to Exercise Your Rights: To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes to This Notice: We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future.

Complaints: You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

Patient Signature:____ **Date:**_______________