

## PATIENT INFORMATION

Please Print

Today's Date: \_\_\_\_\_

**PLEASE FILL IN ALL INFORMATION COMPLETELY**

New Patient Yes or No

Patient's Name: First	Middle	Last	Sex: M / F	Date of Birth	Age
Patient's SS#					
Patient's Street Address:		City	State	Zip Code	
Patient's Home Phone Number: (With Area Code)	Work Number:	Cell Number:			
Patient's Employer:	Type of Work:	How Long Employed:			
Marital Status: M S D W	Spouse's Name	Nearest Relative Name and Phone Number			

### Responsible Party Information (If Patient Please Leave Blank)

Name: First	Middle	Last	Sex: M / F	Date of Birth	Age
Address:		City	State	Zip	Phone# With Area Code

Who referred you to our office?	<input type="checkbox"/> Physician	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Yellow Pages	
	<input type="checkbox"/> Internet Site (please specify site) _____			
Name of Family Physician:	City/State	Phone Number: With Area Code		

Is this a Claim Workers Compensation? YES / NO	Name of Case Manager and Phone #				
Company to Be Billed:	Adjuster's Name	Phone # With Area Code	Fax # With Area Code		
Claim Number:	Date of Injury:				

### INSURANCE INFORMATION

Primary Insurance Carrier: (Please Circle) Blue Cross / Medicare / UHC / Aetna / Cigna / Other _____		
Policy Number:	Group #	Policy Holder's Date of Birth

Secondary Insurance Carrier: (Please Circle) Blue Cross / Medicare / UHC / Aetna / Cigna / Other _____		
Policy #	Group #	Policy Holder's Date of Birth

PATIENT'S SIGNATURE:

RESPONSIBLE PARTY'S SIGNATURE:

\_\_\_\_\_  
(Signing Indicates All Information On This Page Is Valid and Correct)

\_\_\_\_\_

# ALABAMA NEUROSURGEONS, P.C.

## FINANCIAL POLICY

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Thank you for choosing us as your health care provider. We are committed to giving you our valued patient, superb care and exceptional service. Please understand, however, that part of your treatment is also payment of medical services rendered. To better serve our patients, we are committed to the following Financial Policy:

- Payment is expected at time services are rendered
- We accept cash, check, Visa, Mastercard and many major credit cards
- Please read and sign Financial Policy
- We would be happy to answer any questions or address any concerns

### INSURANCE

We may accept assignment of insurance benefits. However, we do require a co-pay to be paid at the time services are rendered. If the insurance company does not pay the balance, the remaining portion will then be the responsibility of the patient. Once the proper paper work is filled out with the insurance information included, we will be happy to file your insurance claim. However, if your insurance company has not paid the balance due in full within 60 days, the balance may become the patient's responsibility. If you do not have insurance coverage, payment is required in full at the time services are rendered.

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please be aware that some and perhaps all of the services may be non-covered and not considered reasonable and necessary under some insurance programs.

I hereby waive all rights of exemption of property under the Constitution and Laws of Alabama and agree to pay any costs of collecting, attempting to collect or securing this debt, including reasonable attorney's fee.

Thank you for understanding our Financial Policy. This Financial Policy will help keep our fees to a minimum and better serve you. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION**

1. I, \_\_\_\_\_, hereby give my consent to \_\_\_\_\_  
\_\_\_\_\_ for release of my medical records  
to:

Thomas A. Staner, M.D.	OR	Dr Tuan Nguyen MD PC
Alabama Neurosurgeons, PC		7500 Hugh Daniel Drive Suite 200
7500 Hugh Daniel Drive Suite 200		Birmingham, AL 35242
Birmingham, AL 35242		Fax# (205)991-8287
Fax# (205)991-8287		

2. Information from the medical record of:

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Phone: \_\_\_\_\_

3. Information to be released including : \_\_\_\_\_  
pertaining to the care of this patient.

4. Purpose of Disclosure:  
 Medical Care                       Insurance                       Other  
 Personal                               Attorney

5. This authorization shall be in effect for 90 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the facility. A photocopy of this authorization shall constitute a valid authorization.

Signature of Patient or Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE TO RECIPIENT**

If the materials disclosed contain data related to alcohol and/or drug abuse, the information has been disclosed from the records whose confidentiality is protected by federal law. Federal Regulations (42 CFS Part 2) prohibits making further disclosure without the specified consent of the person to whom the information pertains or otherwise permitted by such regulations.

**Consent for Use or Disclosure of Protected Health Information (PHI) for Payment, Treatment and Health Care Operations**

By signing below, you hereby consent for Alabama Neurosurgeons, P.C. (the "Practice") to use or disclose information about you (or another person for whom you have given the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Notice of Privacy Practices for PHI, attached, before signing this consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Practice's Privacy Officer for a copy.

You also have the right to request that the Practice restrict how your PHI is used or disclosed in carrying out treatment, payment, or health care operations. Please be aware, however, that the Practice is not required to agree to these requested restrictions. Should the Practice agree to your requested restrictions, though, the restrictions are binding.

Information about you is protected under federal law, and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the Practice has already taken in reliance on your consent (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Alabama Neurosurgeons, P.C. may communicate confidential information, including payment invoices and appointment reminders, to me at the following address and/or phone numbers. I understand that I need not supply either, provided I do not wish to be contacted by the Practice. In such case, I agree to pay for all charges incurred during my visit at the time of service.

\_\_\_\_\_ The Practice may send correspondence to me at the address listed on my patient information form.

\_\_\_\_\_ The Practice may leave me messages at the following numbers:

\_\_\_\_\_

\_\_\_\_\_ The Practice may release my medical records to the following:  
(i.e.: the patient, people, or doctors' offices)

\_\_\_\_\_

\_\_\_\_\_

I authorize the following persons to communicate on my behalf with the Practice concerning my medical care:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Signature of patient or Legal Guardian: \_\_\_\_\_

Signature of Alabama Neurosurgeons, PC Representative: \_\_\_\_\_

Date: \_\_\_\_\_



FOR PATIENTS WITH PAIN

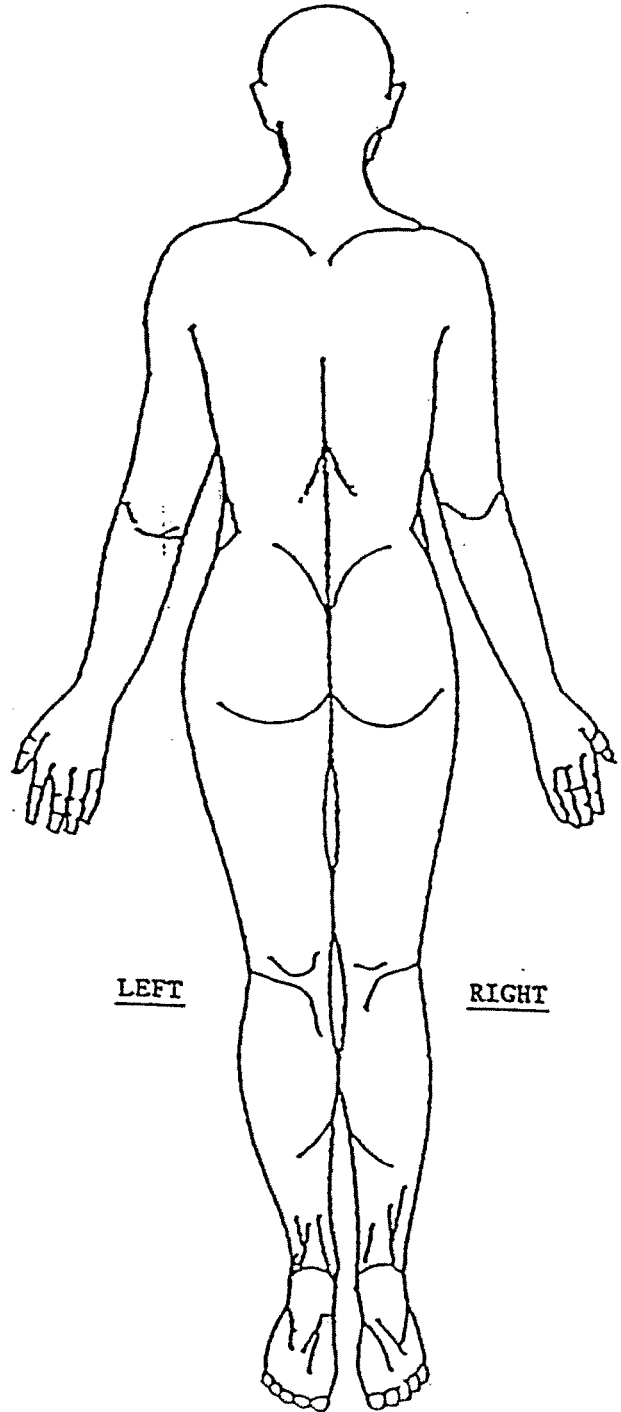
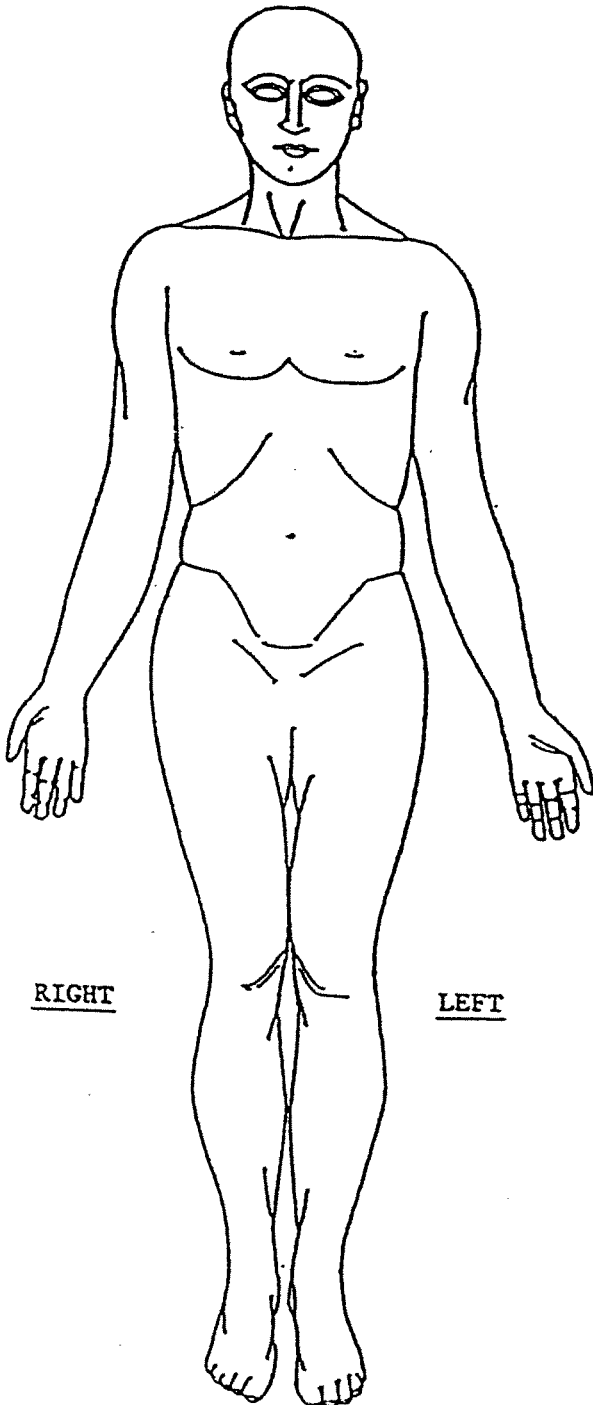
Thomas A. Staner, M.D.

Name: \_\_\_\_\_

ON THE SCALE BELOW CIRCLE THE AMOUNT OF PAIN WITH "0" BEING NO PAIN AT ALL AND "10" BEING THE WORST PAIN IMAGINABLE.

0 1 2 3 4 5 6 7 8 9 10

PLEASE SHADE IN AREA OF PAIN



# PAIN PATIENTS

DATE \_\_\_\_\_ NAME \_\_\_\_\_

Please assist us with **specifics**:

Have you been treated for this condition by another Physician? \_\_\_\_\_

IF so, **which** physician(s), and **list** ALL types of Treatments, including DATES:

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Have you been on anti-inflammatory Medications for this condition? \_\_\_\_\_

If so How long? \_\_\_\_\_ and which ones (Please List below)?

Have you had physical therapy for this condition? \_\_\_\_\_

If so, 1) when, \_\_\_\_\_ and 2) how long? \_\_\_\_\_

Have you had Epidural Blocks for this condition? \_\_\_\_\_

How many? \_\_\_\_\_ and when was Last One? \_\_\_\_\_

PLEASE ANSWER **ALL** QUESTIONS.

Thank you.