Neurosurgical & Spine Institute

THANK YOU FOR CHOOSING THE INSTITUTE

At the Neurosurgical & Spine Institute of Savannah our doctors specialize in conditions and injuries related to the brain and spine. Thank you for choosing us and trusting our team with YOUR care. We promise to provide quality care and cutting-edge treatment options from top doctors and experts in the field, delivered with the compassion you deserve.

This new patient packet is designed to help you prepare for your upcoming appointment. Please take some time to review and complete the following pages prior to your arrival. This will allow us to collect the information and permissions needed to take care of you on the day of your appointment including:

- Patient Information
- Current Medications List
- Medical Release Authorization
- Treatment & Medication Agreement
- PHI & Disclosure Agreement
- Financial Policy & Payment Agreement
- Appointment Policy
- Pain Management Policy

This packet can be fill in and printed to bring with you on the day of your appointment. Patients are also welcome to print as a PDF and email a completed packet to referrals@neurosav.com in advance of their appointment.

WHAT TO BRING

- ☐ A copy of your current **insurance card(s)**
- ☐ **Photo identification,** such as a driver's license.
- ☐ **A written list of your current medications** (including vitamins and supplements) including the dosages you are currently taking
- ☐ Any radiology films and CDs **(X-rays, CT scans, and MRIs)** you have that pertain to your current problem.

Neurosurgical & Spine Institute

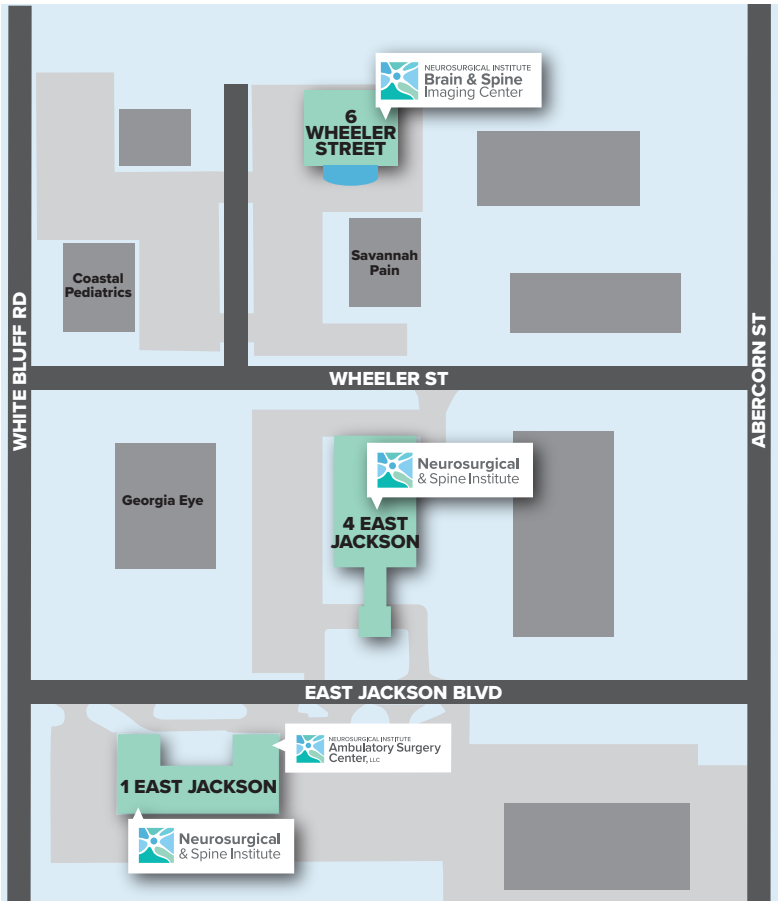
OUR LOCATIONS

SAVANNAH

1 EAST JACKSON BLVD
Kevin Ammar, MD | Louis Horn IV, MD
Jay Howington, MD | James Lindley, Jr., MD
Daniel Y. Suh, PhD, MD
Ambulatory Surgery Center

4 EAST JACKSON BLVD
Roy Baker, MD | Ryan Lingo. MD
Davis Reames IV, MD | Willard Thompson, Jr., MD

6 WHEELER STREET
X-Ray, MRI, CT, Ultrasound, Lab, Angiograms, Myelograms & Kyphoplasty



FROM I-16

- Stay on I-16 to 516 toward Savannah heading East.
- Take Exit 164A; this street will turn into Derenne Ave.
- Turn right onto Abercorn St.; Jackson Blvd. will be the 4th traffic light.
- Turn right onto Jackson Blvd.

FROM I-95

- Turn onto GA Highway 204.
- Take Exit 94 (Abercorn Expwy. to Abercorn St.).
- Continue on Abercorn St. for approximately 12 miles.
- Turn left onto Jackson Blvd.

BLUFFTON

12B Arley Way (Ste 103)
Bluffton, SC 29910

JESUP

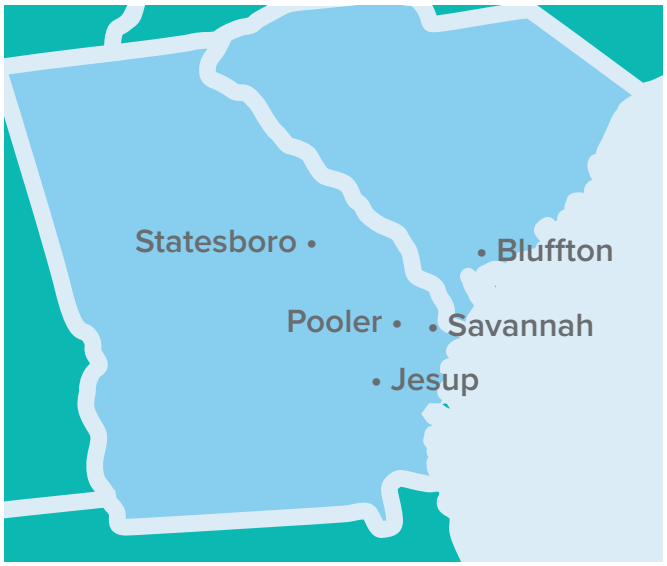
370 Peachtree Street
Jesup, GA 31545

POOLER

101 St. Joseph's Candler Drive, Suite 320
Pooler, GA 31322

STATESBORO

2A Ed Moore Court
Statesboro, GA 30458



Name:_____ DOB: _____
Provider:_____ Date: _____

Neurosurgical & Spine Institute

WHAT TO EXPECT: UPON ARRIVAL

Please plan to arrive 15-30 minutes early for your first visit to make sure all new patient paperwork is completed prior to your appointment time.

When you arrive for your appointment, our Patient Services team will be available to guide you through the check in process. In addition to confirming your name and appointment, they will collect any new patient paperwork and scan a copy of your insurance card(s) and photo identification.

They will then provide you with a form that captures your complete health history. This is something you can complete in our guest lounge while waiting for your team's Patient Care Coordinator to call you back for your appointment.

Once your Patient Care Coordinator gets you settled into your exam room, they will take your vitals, review and input your list of current medications, make copies of any films you have brought with you and collect any additional information your provider has requested. Next, they will notify your provider that you have arrived and are ready to be seen.

NOTE: Your first appointment may actually be with your surgeon's designated nurse practitioner or physician's assistant. These individuals are highly qualified and trained by our surgeons to assess each patient's individual condition. They are able to order additional tests and prescribe any medications or conservative treatments needed to advance your plan of care.

Appointment Policies & Reminders

Our clinic team aims to set aside enough time to provide each patient with the highest quality care. We will make every effort to schedule your appointments as efficiently as possible. In return, it is your responsibility to keep your scheduled appointments and to arrive at your specified time. Below are some of our practices policies and procedures related to patient appointments. Please review these carefully

Suggested Arrival Time: Patients are asked to arrive before their scheduled appointment time as this allows enough time for the patient to check in and update their records before the actual appointment time. We strongly suggest that new patients arrive 30 minutes before their scheduled appointment time. Established patients should plan to arrive 5-10 minutes before their scheduled appointment time.

Late Arrivals: A grace period of 10 minutes will be permitted for any unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their scheduled appointment, and cannot be seen by the provider on the same day, they will be rescheduled for the next available opening.

No Show/Late Cancellation Policy

We do realize that unanticipated events can occur and may prevent you from keeping your appointment. We request that you notify our office immediately when you realize you will not be able to keep your appointment as this gives us the ability to accommodate other patients who may be waiting for a neurosurgery consult. A patient who does not show up for a scheduled appointment or does not provide twenty-four (24) hours notice prior to cancelling an appointment will be charged a $40.00 No Show/Late Cancellation Fee. We require these fees be paid prior to any future appointments.
Non-Compliance Policy: Patients who do not arrive for their scheduled appointments on three occasions may be discharged from the practice for non-compliance.

Multiple Providers: We have multiple providers caring for our patients within the same treatment area; therefore, some patients may be called before others who have been waiting longer because they are seeing a different provider. All patients will be seen in the order they have been scheduled. Patients who arrive before their scheduled appointment time will not be seen early unless there has been a cancellation.

Wait Times: While we strive to keep all scheduled appointment times, our goal is to provide the necessary time and treatment to ensure every patient understands their diagnosis and treatment options. Some patients may require more time than others depending on the variety of complex neurosurgical conditions your surgeon is seeing on the day you are scheduled. For this reason, we suggest each patient plan to be here for up to two hours following their scheduled appointment time.

Name:_____ DOB: _____

Provider:_____ Date: _____

Neurosurgical & Spine Institute

WHAT TO EXPECT: AFTER YOUR VISIT

Your Patient Care Coordinator will help you arrange for any additional tests or referrals ordered by your provider. While some of these may be able to be conveniently completed within our on-site Brain & Spine Imaging Center, we have a list of area imaging centers patients can choose from depending on their preferences.

Regardless of where you choose to go, most insurances require pre-authorization for more advanced imaging like MRI or CT scans. It can take up to 14 days to secure approval depending on your insurance plan. Our team will likely schedule your CT or MRI with this in mind and will often schedule a follow up appointment to occur the same or next day.

Disability and FMLA Forms

If you have disability insurance or are eligible for leave under the Family Medical Leave Act (FMLA), you may drop these forms off at your physician's receptionist.

Completing this paperwork requires additional time and attention to ensure complete and accurate information is provided. This paperwork cannot be billed to your insurance company. Therefore, it is our office policy to charge $35 for the completion of each form.

If the form to be completed is sent to us by an outside organization, we will notify you of the exact amount that is due. We may also request completion of the Authorization to Disclose My Health Information.

Please allow us 7 to 10 business days after receipt of payment to complete these forms. We suggest that you call our office before making a trip to pick-up the completed forms. Alternatively, you may provide a fax number and the forms can be sent for you.

Please note: You may be able to avoid being charged by requesting a copy of your office visit note if your insurance company or employer will accept the note in lieu of a completed form.

Name:_____DOB: _____

Provider:_____Date: _____

Neurosurgical & Spine Institute

PATIENT INFORMATION FORM

PATIENT INFORMATION

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

NAME _____ ☐ MALE ☐ FEMALE
LAST FIRST MI

ADDRESS _____
CITY STATE ZIP

HOME PH (_____) _____ CELL PH (_____) _____ DATE OF BIRTH ____ /____ / _____

SOCIAL SECURITY # _____ /____ / _____

RACE: ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Hispanic/Latino ☐ Hawaiian/Pacific

EMAIL _____ EMPLOYER _____

PHONE (____) _____

GENERAL INFORMATION

Who referred you to our office? (Doctor/Friend/Internet) _____ PHONE (____)_____

Nearest relative (not living with you) _____ PHONE (____)_____

In case of emergency notify: _____

RELATIONSHIP _____ PHONE (____)_____

SPOUSE/PARENT INFORMATION

NAME _____ ☐ MALE ☐ FEMALE
LAST FIRST MI

PHONE (_____) _____ DATE OF BIRTH ____ /____ / _____ SOCIAL SECURITY # _____ /____ / ____

ADDRESS _____
CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN_____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ PHONE (____) _____

SECONDARY INSURANCE PLAN_____ POLICY HOLDER'S NAME _____

ID# _____ GROUP# _____ PHONE (____) _____

VISIT DUE TO: ☐ Auto Accident ☐ Worker's Comp. DATE OF ACCIDENT ____ /____ /_____

CLAIM# _____ BILLING ADDRESS_____

HIPAA INFORMATION Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at ☐ Home ☐ Work ☐ Cell

The office may leave a message at ☐ Home ☐ Work ☐ Cell

I authorized the office to leave detailed messages about appointments/phone calls ☐ Yes ☐ No

Patient (or Parent/Guardian) Signature _____ DATE ____ /____ /_____

Neurosurgical & Spine Institute

CURRENT MEDICATIONS

NAME _____ DATE OF BIRTH ____ /____ / _____
LAST FIRST MI

HEIGHT _____ WEIGHT _____

PREFERRED PHARMACY _____ PHONE (_____) _____

PHARMACY ADDRESS _____
CITY STATE ZIP

CURRENT MEDICATION(S)	DOSE	FREQUENCY

ALLERGIES TO MEDICATIONS/OTHER

Are you taking Coumadin? ☐ Yes ☐ No

Are you taking Glucophage? ☐ Yes ☐ No

Have you ever had problems with anesthesia? ☐ Yes ☐ No

Are you allergic to IVP, X-Ray or Contrast Dye? ☐ Yes ☐ No

Neurosurgical & Spine Institute

TREATMENT & MEDICATION AGREEMENT

The purpose of this agreement is to promote understanding about certain medicines you may be prescribed or may already be taking. This is to help you and your physician comply with the law regarding prescription drugs. This agreement is essential to the trust and confidence necessary in the physician/patient relationship.

The use of narcotic medications has inherent risks with adverse effects including chemical dependency, addiction, CNS depression, hypotension, seizures, constipation, nausea, vomiting, dizziness, headache, confusion, respiratory arrest, somnolence, coma and death. Narcotic medication alone, or in combination with muscle relaxants, sleeping pills, anxiety medications, antihistamines, decongestants, or alcohol can cause cognitive impairment and delayed reaction time.

These guidelines are in place for your safety and well-being. Our hope is that you consider that pain medicine is provided as adjunctive therapy and not as long term management of symptoms while under neurosurgical care.

Please read carefully before signing

1. **I will receive medications from one prescribing physician only.** This means, if you are obtaining medications (pain meds/muscle relaxants) from your following physician, or from ER physicians, you are to continue receiving medications from their office. If our physician assumes your care, and at any time you obtain the above listed medications from any other physician, our physician reserves the right to discontinue further prescriptions for you.
2. **I will not share, sell, or trade my medications with anyone.**
3. **Lost or stolen medicines will not be replaced.** Once the prescription is in your trust, it may not be refilled until time allowed.
4. **Medicine will be refilled Monday through Friday from 9:00am to 4:00pm. No refills will be available during weekends, evenings, or holidays.**
5. **I will use my medicine at no greater rate than prescribed.** A greater rate will result in my being without medicine for a period of time.
6. **I understand that if I am pregnant or become pregnant while taking opioid medications,** my child could become physically dependent on opioid medications, and withdrawals can be life threatening for a baby.
7. Our surgeons and advanced practitioners are only in clinic 2-3 days a week depending on their surgical and emergency call schedule, we require at least 1 business day to respond to all medication requests.
8. If at any time I break the law with regards to my pain medicine, I am aware that the appropriate **law enforcement department may be notified and my records could be released to them.** It is illegal to sell, trade, or share prescription medication. It is illegal to obtain controlled substances from more than one doctor without telling the other doctor. It is illegal to obtain alter or fabricate prescriptions.
9. If I break this agreement, my doctor may stop prescribing these pain control medicines and, if recommended, submit to an evaluation by an addictionologist, or discharge if necessary.

The acceptance of this document authorizes the physician and your pharmacy to cooperate fully with any city, state, or federal law enforcement agents, including this state's Board of Pharmacy in regards to the actions listed above. I authorize the physician to provide a copy of this agreement to my pharmacy.

This agreement has been reviewed and signed on the _____ day of _____ in the year of _____.

PATIENT NAME _____ PATIENT SIGNATURE _____

PHARMACY _____

Neurosurgical & Spine Institute

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby authorize The Neurosurgical & Spine Institute together with its employees, agents and contractors, to use or disclose my protected health information (covered under Privacy and Security Regulations to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) as specified in this authorization. I understand that protected health information includes my medical and billing information and other records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health diagnosis, treatment or related communications, or information relating to diagnosis, testing or treatment for AIDS, HIV, or other communicable diseases (collectively referred to herein as "PHI")).

Recipient(s) of Use or Disclosure
This information may be used by or disclosed to names listed below and its subsidaries, employees, agents and contractors.

Information to be Used or Disclosed
I understand the information to be enclosed shall include all information in my medical record unless specific items have been submitted in writing.

Expiration
This authorization will remain in effect until a written notice is provided to The Neurosurgical & Spine Institute.

Revoking Authorization
I understand that I may revoke this authorization by submitting a written request for revocation to The Neurosurgical & Spine Institute, provided that such revocation shall not be effective with respect to any use or disclosure made in reliance on this authorization prior to the date of The Neurosurgical & Spine Institute receipt of my revocation.

Authorization as a Condition to Treatment
I understand that The Neurosurgical & Spine Institute cannot require me to sign this authorization in order to receive medical treatment from them.

Potential Re-Disclosure
I understand that the PHI used or disclosed by The Neurosurgical & Spine Institute pursuant to this authorization may be subject to re-disclosure by the recipient who may or may not be subject to the HIPAA Privacy Rule and may not be subject to other state or federal privacy laws.

Compensation
I understand that I will not receive compensation from the recipient for the use/disclosure of my PHI. I understand that The Neurosurgical & Spine Institute will not receive compensation for the disclosure of my PHI.

NAME _____
LAST FIRST MI

AUTHORIZED NAME LIST

NAME _____ RELATION _____

NAME _____ RELATION _____

NAME _____ RELATION _____

NAME _____ RELATION _____

(If additional space is needed please attach additional pages.)

I also give The Neurosurgical & Spine Institute staff permission to leave a message at: PHONE (_____) _____
INITIAL _____

I have read and understood this authorization and my questions have been answered. I certify that I am the patient listed above or a person authorized to permit release of records on the patient's behalf. I hereby release The Neurosurgical & Spine Institute and recipient and its officers, trustees, employees, agents and contractors from any liability arising in connection with the use or disclosure of my protected health information pursuant to this authorization. I understand that if this authorization is being requested by The Neurosurgical & Spine Institute they must provide me with a copy of the signed authorization.

PATIENT SIGNATURE _____ DATE ____ /____ / _____

Signature of Patient's Authorized Representative _____

Print Patient's Authorized Representative Name _____

Basis of Authority to Sign for Patient _____

Neurosurgical & Spine Institute

FINANCIAL POLICY

The Neurosurgical and Spine Institute is committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, however, we need your assistance and your understanding of our financial payment policy.

1. Financial Policy

a. Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangement must be made before you see the physician. We accept the following forms of payment: cash, check, American Express, MasterCard, Visa and Discover.

b. **As a courtesy to you, we will file your insurance claim form for reimbursement.** However, in order to do this, we must have current insurance information. Charges not paid by your insurance company within 90 days will become due and payable by you. Patients who do not provide current insurance information will be treated as self-pay (see above).

c. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization number before you see our physicians. If you are unable to obtain the authorization, you can sign a medical waiver and pay us directly for the services we provide you, and we will refund you when we receive the proper authorization for those services.

d. Surgical procedures **will require** a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts are required at the time of scheduling you for your procedure.

e. Parents, a designated family member, or legal guardian are responsible for payment for services rendered to children.

f. We will bill for Workers' Compensation services that have been authorized by your employer or Workers' Compensation insurance carrier.

g. We charge additional fees as outlined below:
• Insurance or Disability forms • CD Copy • Medical record review • Medical deposition

h. Please be aware that any balance on your account over 90 days is subject to collection procedures and may result in denial of future care until overdue balances are paid in full.

i. We provide advanced imaging services (i.e. MRI & CT) as part of our practice for the convenience of our patients. However, please be advised that you have the right to obtain the above services at a provider of your choice. A list of alternative providers of advanced imaging services is as follows:

Bluffton
MRI at Belfair: 843-815-9700

Brunswick
American Health Imaging
in Brunswick: 912-267-6736

Pooler
Pooler Imaging: 912-330-5170
St. Joseph's/Candler Imaging Services: 912-748-0068

Rincon
Effingham Hospital (CT only): 912-826-1400
Effingham Hospital (MRI only): 912-826-6015
Rincon Imaging: 826-1400

Savannah
Coastal Imaging Center: 912-355-6255
Open MRI/Savannah (MRI only): 912-355-6736
Trident Medical Imaging (CT only): 912-355-7523

Statesboro
OPI of Statesboro: 800-4674
Statesboro Imaging: 912-764-5656

Vidalia
Meadows Regional: 912-535-5555

Name:_____DOB: _____
Provider:_____Date: _____

Neurosurgical & Spine Institute

PAYMENT AGREEMENT

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree to pay within 90 days of receipt of notice all balances due such as non-covered services, coinsurance, deductibles and co-payments not paid by my insurance company.

I,_____, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPT THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

SIGNATURE _____ DATE _____ /_____ / _____

Responsible/Authorized Representative (Guarantor) _____

Relationship to Patient _____

Submit