Advanced Neurosurgery

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Email address:		(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F	
Street address:		Social Security no.:	Home phone no.: ( )			
Cell phone no.: ( )	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Chose clinic because/Referred to clinic by (please check one box):	☐Dr.	☐Hospital/ER	☐Insurance			
☐ Family/Friend:	☐ Close to home/work	☐ Internet	☐ Other			
In case of emergency:	Name:	Home phone no.:	Work phone no.:	Relation to patient:		

INSURANCE INFORMATION

Please give your insurance card to the receptionist. If **LIEN or WORKCOMP** skip this section and fill out alternate insurance page

Person responsible for bill:	Date: / /	Address (if different than above):	Home phone no.: ( )
Relation to Patient:	Social Security no.:		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ☐ Yes ☐ No			
Primary insurance company:			
Contract no.:	Group no.:	Subscriber no.:	
Name of secondary insurance (if applicable):	Subscriber's name:	Relation to patient:	Birthday: / /
Address (if different from patient's):			
Subscriber employed by:	Business phone no.: ( )	Social Security no.:	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Song all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

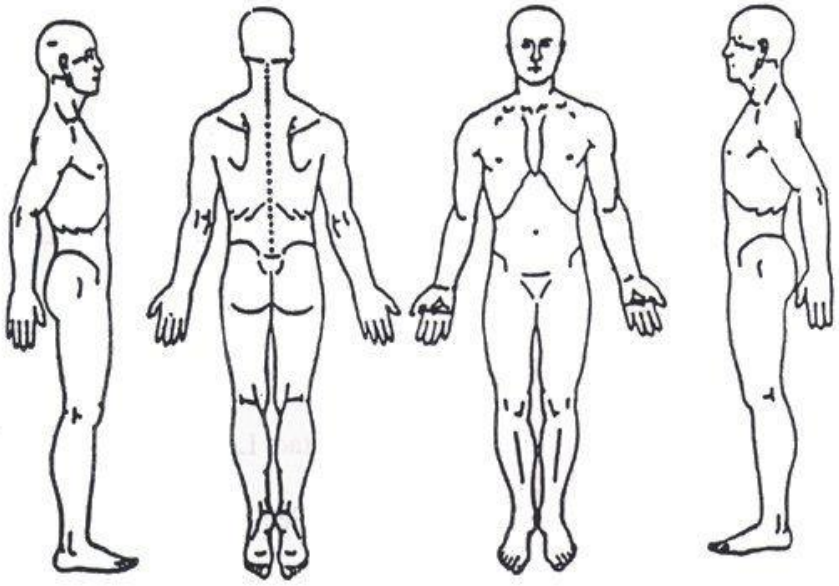
Patient/Guardian signature *Date*

Please print name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*

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Name:	DOB:	Occupation:

1. Are you [Right-Handed] or [Left-Handed]? (circle one)
2. What brings you in today? __Neck pain __Upper back pain __Mid back pain __Low back pain __Shoulder pain __Arm pain (Right or Left) __Elbow Pain __Forearm pain __Leg pain (Right or Left) __Thigh pain __Calf pain __Knee pain __Foot pain ___ Hip Pain ___ Shoulder pain
   Other:_____
3. When did it start? _____
4. Has the pain stayed the [same] , [gotten worse], or [improved]? (circle one)
5. Is the pain: __ Severe __Moderate __Mild __Slight
6. Is the pain: __Constant __Occasional
7. Does the pain radiate? _____ If yes, where?: _____
8. Is the pain: ___ Burning ___Sharp ___Aching ___Dull ___ Stabbing __ Other: _____
9. Are you having any: _____Numbness _____ Tingling _____Weakness
10. Rate your pain level on a scale of 1-10: _____



11. What makes it better? _____
12. What makes it worse?_____
13. Have you tried: [Physical Therapy] [Epidurals/Injections] [Massage] [Chiropractor]
    When: _____ Where: _____
    Did this provide relief? _____ Other: _____
14. What medications are you taking specifically for this problem?
    _____
15. What tests have you had done for this problem: ___ MRI ___CT ___ X-rays ___EMG

SYMPTOMS			
Check (√) conditions you currently have or have had in the past year			
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	CARDIOVASCULAR
☐ Chills	☐ Appetite poor	☐ Bleeding gums	☐ Chest pain
☐ Depression	☐ Bowel changes	☐ Blurred vision	☐ Shortness of breath
☐ Dizziness	☐ Constipation	☐ Vision changes	☐ Fainting
☐ Fever	☐ Diarrhea	☐ Difficulty swallowing	☐ Irregular heart beat
☐ Forgetfulness	☐ Excessive hunger	☐ Earache	☐ Low blood pressure
☐ Headache	☐ Excessive thirst	☐ Ear discharge	☐ Poor circulation
☐ Loss of sleep	☐ Indigestion	☐ Hay fever	☐ Rapid heart beat
☐ Loss of weight	☐ Nausea	☐ Hoarseness of voice	☐ Swelling of ankles
☐ Nervousness	☐ Rectal bleeding	☐ Loss of hearing	☐ Varicose veins
☐ Sweats	☐ Stomach pain	☐ Nosebleeds	GENITO-URINARY
SKIN	☐ Vomiting	☐ Persistent cough	☐ Blood in urine
☐ Bruise easily		☐ Ringing in ears	☐ Frequent urination
☐ Rash			☐ Lack of bladder control
☐ Poor wound healing			
OTHER:			

CONDITIONS			
Check (√) conditions you currently have or have had in the past year			
☐ AIDS	☐ Chemical dependency	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gout	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Heart Disease	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ High Blood Pressure	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease
OTHER:			

HEALTH HISTORY

MEDICATIONS – List medications you are currently taking. Dose & How Often.		**ALLERGIES**

HOSPITALIZATIONS/SURGICAL PROCEDURES		
Hospital	Year	Reason for Hospitalization/Surgical Procedure

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Have you ever had a blood transfusion? □ Yes □ No If yes, please give approximate dates _____/____/_____		
Serious Illness/Injuries	Date	Outcome

FAMILY HISTORY							
Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HEALTH HABITS		PREGNANCY HISTORY		OCCUPATIONAL			
If yes, indicate amount and frequency:		Year of birth	Complications	Check (√) if your work exposes you to:			
Caffeine					Stress		Hazardous Substances
Tobacco					Heavy Lifting		Other
Street Drugs				Occupation:			
Alcohol							

PRIMARY HEALTH MAINTENANCE AND ADVANCED DIRECTIVES			
	DATE OF LAST	Do you have any of the following:	
Pneumococcal Vaccine		Living Will	
Influenza Vaccine		DNR	
Mammogram		Durable Power of Attorney	
Colonoscopy		POLST	

CMS: Centers for Medicare & Medicaid Services OBJ-304C Meaningful Use Required Questionnaire		
Ethnicity – please specify your ethnicity:	Race – please specify your race:	Language – please specify:
Hispanic or Latino	White	English
Not Hispanic or Latino	Asian	Spanish
Prefer not to say	American Indian or Alaska Native	Russian
	Black or African American	Other
	Prefer not to say	Prefer not to say

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Relationship to Patient

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PATIENT ACKNOWLEDGMENT AND SIGNATURE PAGE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USES AND DISCLOSURES:

Disclosures of your health information or its use for any purpose other than those listed in the "Notice Of Privacy Practices" require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision. You have the right to request restriction on use and disclosure of your health information.

USE AND DISCLOSURE OF INFORMATION

___ I Authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Advanced Neurosurgery.
___ I do not authorize the following information to be disclosed to any other parties except to me as the patient (fill below):
___ I would like the following restrictions regarding the use and my disclosure of my health information (fill below):
_____

PERSONS AUTHORIZED TO RECEIVE INFORMATION:

Health information which Advanced Neurosurgery collects or receives about you may be disclosed to the following person(s):
_____
This authorization is effective indefinitely unless revoked or terminated by the patient. You may revoke or terminate this authorization by submitting a written revocation to Advanced Neurosurgery.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & FINANCIAL/OFFICE POLICIES

Federal Law requires that we seek your acknowledgement of receipt of the Notice of Privacy Practices and Financial/Office Polices. I acknowledge that I have received this Notice of Privacy and Financial/office policies from Advanced Neurosurgery and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.
I acknowledge that there is a $100.00 no-show cancellation fee for appointments not cancelled with greater than 24-hour notice. Patients with habitual late cancellations and/or no-show appointments will be terminated from the Practice.

CONTROLLED SUBSTANCE MEDICATION AGREEMENT & INFORMED CONSENT ACKNOWLEDGEMENT

Ashlee Rego, PA-C Michael H. Song, M.D.

I agree to only take medications prescribed and will not share my medication with any other person. I agree to inform my prescriber of any the following: other controlled substances, both prescribed or otherwise, whether or not I consume alcohol or cannabinoid compounds while using prescribed controlled substances, any other state that I previously resided or have had a prescription for a controlled substance filled in the past. I agree to random pill count of the prescribed medication in my possession. I agreed to testing and monitoring of drug use when deemed medically necessary by my provider. I understand my provider may change or discontinue this controlled substance treatment for the following reasons: Any evidence of aberrant behavior, evidence of significant or dangerous side effects, lack of appropriate analgesia, inappropriate affect and/or if the medication is not helping to improve my pain and function.

The providers at Advanced Neurosurgery are legally obligated to obtain and review your medical history/records and conduct a physical examination in order to assess your mental health, risk of abuse, dependence, and addiction. Advanced Neurosurgery reserves the right to contact other treating physicians, pharmacies, and hospital as well as review your prescription monitoring program report. I understand the refill policy regarding controlled substances. If the controlled substance is an opioid, I am aware of the availability of an opioid overdose antidote naloxone, which I may obtain from a pharmacist without a prescription. I have informed my provider if I have a history of mental illness, alcohol or drug use in the past.

I have read the Controlled Substances Informed Consent and have reviewed any questions with a medical practitioner of Advanced Neurosurgery. I am aware of the risks, benefits, and possible alternative treatment options, including medication management with non-controlled substances. I agree to abide by proper use, storage and disposal of controlled substances. My signature below indicates that I agree to abide by the policies outlined above and I acknowledge the Controlled Substances Informed Consent in its entirety and agree to abide by the policies accordingly.

_____ _____
Patient Name (Printed) Date

_____
Patient Signature

_____
Patient Guardian Name/Signature (If patient is under 18 years of age)

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PRESCRIPTION REFILL POLICY

Date: ____/____/_____

Name: _____

ADVANCED NEUROSURGERY PRESCRIPTION REFILL POLICY

Patients may be prescribed pain medication in preparation of a surgical procedure or during the normal post-operative period. Prescriptions are written for an appropriate period of time based on your medical condition and type of surgery. Our practice does not provide long-term pain management services. If long-term pain management is required, the patient will be referred to a pain management physician or his or her primary care physician. Post-surgical patients will receive refills for no longer than a period of 6 weeks. For your safety, no refills can be given if you have not been seen by the Doctor within the last year. All patients must agree to the Advanced Neurosurgery prescription policy in order to receive prescriptions from this practice. Routine prescription refill requests will be reviewed during normal business hours, 8:30am-5pm, Monday-Thursday, when our full records are available. Please allow 2 business days for your request to be processed. For the safety of our patients, routine refill requests will not be authorized after normal business hours, on Fridays, during the weekend or on Holidays. Renewals requested during these times will be referred to the Emergency Room. Please have your pharmacy fax your refill request to 775-323 6118 during normal business hours.

I understand and agree to abide by the Advanced Neurosurgery Prescription Refill Policy:

Signature:_____ Date: ____/_____/_____

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Acknowledgment of Financial Interest

I understand that Dr. Song provides consulting services for manufacturers of implantable medical devices, including work aimed at improving the delivery and performance of those devices. Dr. Song is compensated for that work either in the form of royalties on sales of company products (excluding products sold for use in facilities where Dr. Song practices medicine) or by professional consultation fees. Those companies include Globus Medical, Inc, Spineology and 4WEB, Inc.

Dr. Song also has an ownership interest in 4WEB, Inc., Spineology, Alphatec, and Nuvasive which are manufacturers of implantable spinal devices, and owns a membership interest in Song Professional Services, PLLC, which contracts for surgical neuromonitoring services performed by third-party providers in some of Dr. Song's surgical procedures.

_____ _____

Date Patient Signature

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SOCIAL MEDIA RELEASE FORM

I, being of legal age, hereby agree for my medical procedure to be photographed, recorded, and videotaped by Advanced Neurosurgery ("Company"). I further give Company, its licensees, successors, legal representatives, and assigns the absolute and irrevocable right and permission to use my name and to use, reproduce, edit, exhibit, project, display, and/or publish photography images and/or moving pictures and/or videotaped images of me with or without my voice, or in which I may be included in whole or in part, photographed, taped, videotaped, and/or recorded and thereafter, and to circulate the same in all forms and media on Company's social media platforms for advertising/marketing purposes and/or any other lawful purpose whatsoever. I also consent to the use of any printed matter in conjunction therewith. I agree that all images taken by the Company and any materials created by or on behalf of Company that incorporate my image will be owned by Company.

I hereby waive any right that I may have to inspect and/or approve the finished product or products or the editorial, advertising, or printed copy or soundtrack that may be used in connection therewith and any right that I may have to control the use to which said product, products, copy and/or soundtrack may be applied. I understand that Company has no obligation to use my image.

I hereby release, discharge and agree to save Company, its licensees, successors, legal representatives and assigns from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form whether intentional or otherwise that may occur or be produced in the making, processing, duplication, projecting or displaying of said picture or images, and from liability for violation of any personal or proprietary right that I may have in conjunction with said pictures or images and with the use thereof. I further release, discharge, and exonerate Company, its licensees, successors, legal representatives, and assigns from any liability whatsoever related to, in any way, Company's use of the recorded video or still images or any publication of such on its social media platforms. The right to film, record, use, publish, reproduce and incorporate, alone or together with other presentations and materials, for all purposes my name, my voice and my image in print, film or electronic form or in any audio or video recordings in any and all social media. This permission extends to all languages, social media, formats and markets now known or hereafter devised.

I hereby waive the right to receive any payment for signing this release and waive the right to receive any payment for Company's use of any of the material described above incorporating my name, image or voice for any of the purposes authorized by this release. I have read this document and sign it willingly, voluntarily, and with full knowledge.

IN WITNESS WHEREOF, I have executed this release on this ____ day of _____, 20___.

Print Name: _____ Telephone Number: _____
Address: _____ Signature: _____
City: _____ State: _____ Zip: _____

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Recording Consent Form – Clinical Documentation

Healthcare providers today spend a significant amount of time on computers documenting care, which takes away from their ability to spend time focused on patients. To support our mission of providing high quality care, we are using a new technology which uses artificial intelligence and associated workflows to generate documentation based on recorded audio of patient visits. This technology significantly reduces the amount of time your provider spends on documentation and allows more time for providing care to you and other patients. We use a third-party service provider to process the recorded audio and generate our clinical documentation and we have appropriate agreements in place to ensure the confidentiality of your information. All documentation is reviewed, edited if necessary, and approved by your provider, prior to finalization, to ensure the accuracy and completeness of your medical record.
We ask for you to sign this form to indicate your consent to have your visit recorded and processed, in this manner, for the purpose of documenting your care.
This consent is voluntary, and your care will not be conditioned on providing consent.

Please read the statement below carefully and sign to indicate your consent.

_____ Initial: I hereby consent to the recording of my visit today as well as any future visits. I understand that I may revoke my consent to the recording of future visits at any time.

_____ _____
Signature of Patient or Personal Representative Date

_____
If signed by other than patient: PRINT representative name

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FMLA / Medical Leave Certification Forms

Please be advised that a **$30 fee will be charged for the completion of FMLA (Family and Medical Leave Act) certification forms** or other medical leave certification forms required by an employer.

This fee is permitted pursuant to **Nevada Revised Statutes (NRS) 629.0625**, which authorizes a health care provider to charge a fee for completing a certification required by an employer under the Family and Medical Leave Act.

The $30 fee is due at the time the form is submitted for completion. Payment of this fee is not billable to or reimbursable by the patient's insurance unless otherwise specified by the patient's insurance plan.

By requesting completion of an FMLA or medical leave certification form, the patient acknowledges and agrees to the applicable form completion fee.