Dear Valued Patient:

Your appointment is scheduled for _____/_____/______ at__________
with Dr. __________________________.

The following are required for your upcoming appointment. Failure to complete these documents may result in your appointment being rescheduled.

1. Fill out completely and bring with you to your appointment. Please make sure all items are filled out on the patient forms.

2. You must have your MRI or CT films (the actual film or CD, not just the reports), and please bring all relevant medical records including past chemotherapy, surgeries, pathology, radiation, etc. reports. (exception: we have access to Hoag films)

3. Please bring your insurance cards with you. If you have an HMO, be sure to obtain authorization from your insurance provider prior to your appointment.

Finally, in order to provide the highest level of care, it is the policy of Brain and Spine Surgeons of Orange County to review scans and test results in our office. We cannot discuss results over the telephone. Please schedule an appointed time to speak with your doctor in person.

Patient signature: ____________________________________________

Please print name: ____________________________________________

Thank you, and we look forward to seeing you!

www.brainandspinesurgeons.com
MAP AND DIRECTIONS

3900 West Coast Hwy, Suite 300, Newport Beach, CA 92663-3509
Hoag Conference Center/Neuroscience Institute (signage to be added soon)

Directions:
55 Freeway which ends and becomes Newport Blvd.
Continue to PCH North (North on PCH.)
Right on Hoag Hospital
Right on Hoag Drive
Right into Parking Lot

South on PCH.
Left at First Light after Superior is Hoag Hospital
Right on Hoag Drive.
Right into Parking Lot
# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

## PERSONAL DATA

**Name** (Last, First, M.I.): [ ] M [ ] F [ ] DOB:  

**Marital status:** [ ] Single [ ] Partnered [ ] Married [ ] Separated [ ] Divorced [ ] Widowed  

**Primary Language:**

**ETHNICITY:**

**PARENT'S CURRENT ADDRESS**

**Height:** [ ]  

**Weight:** [ ]  

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Social Security #</th>
<th>Occupation</th>
<th>Work Phone</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Best number to call:**  

[ ] Home  

[ ] Cell  

[ ] Work  

**Best time to call:**

**Email address:**

## EMERGENCY CONTACT

**Name:**  

**Relationship:**  

**Phone:**

## SPOUSE / If Minor, PARENT

**Name of Spouse:**

**Social Security #:**

**Spouse's Employer:**

**Cell Phone:**

**Spouse's Employer Address:**

**Work Phone:**

**City:**

**Occupation:**

**State:**

**Zip Code:**

## INSURANCE DATA

**Does the patient have insurance:**  

[ ] Yes  

[ ] No  

**Is this a work related injury:**  

[ ] Yes  

[ ] No  

**PRIMARY Insurance Company:**  

[ ] PPO  

[ ] HMO  

[ ] POS  

**Address:**

**Insured Name:**

**City, State:**

**Insured DOB:**

**Subscriber & Group #:**

**Insurance Phone #:**

**SECONDARY Insurance Company:**  

[ ] PPO  

[ ] HMO  

[ ] POS  

**Address:**

**Insured Name:**

**City, State:**

**Insured DOB:**

**Subscriber & Group #:**

**Insurance Phone #:**

## What is the reason for your consultation today?

**Diagnosis (if known):**

**When did the symptoms begin:**

**REFERRING PHYSICIAN:**

**Address:**

**Specialty:**

**City:**

**Phone:**

**State**

**Zip Code:**

**Fax:**
### PERSONAL HEALTH HISTORY

#### Current Medical Conditions:

#### Surgeries

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason</th>
<th>Hospital</th>
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#### Other hospitalizations

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<tr>
<th>Year</th>
<th>Reason</th>
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#### List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

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<thead>
<tr>
<th>Name the Drug</th>
<th>Strength</th>
<th>Frequency Taken</th>
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#### DEEP BRAIN STIMULATOR PATIENTS:

#### Programming Physician:

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<tr>
<th>Programming Physician</th>
<th>Phone</th>
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### DOB: [ ] Patient Name: [ ]

### Primary Care Physician:

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<th>Address</th>
<th>Specialty</th>
<th>Date of last physical exam:</th>
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### Radiation Oncologist:

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### Neurologist:

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<th>Specialty</th>
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### Cardiologist:

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### Other Physicians:

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### DEEP BRAIN STIMULATOR PATIENTS:

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| DOB: [ ] Patient Name: [ ] |
Are you currently taking any **blood thinners**; such as aspirin, Motrin or Coumadin?  
☐ Yes  ☐ No

**ALLERGIES to medications**

Name the Drug  
Reaction You Had

Do you have an allergy to LATEX  
☐ Yes  ☐ No

**FAMILY HEALTH HISTORY**

Is there any family history of the following: Neurological disorders, Heart Disease, Cancer

<table>
<thead>
<tr>
<th>AGE</th>
<th>SIGNIFICANT HEALTH PROBLEMS</th>
<th>AGE</th>
<th>SIGNIFICANT HEALTH PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td>Children</td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Sibling</td>
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<tr>
<td>☐ M ☐ F</td>
<td>☐ M ☐ F</td>
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</tbody>
</table>

Have you ever taken steroids (such as Decadron, dexamethasone, Medrol, hydrocortisone) for your CURRENT condition:  
☐ Yes  ☐ No

What medication  
Dose  
How long?

What medication  
Dose  
How long?

**HEALTH HABITS AND PERSONAL SAFETY**

**PLEASE CHECK APPROPRIATE BOX IN EACH SECTION BELOW:**

**GENERAL HEALTH QUESTIONS**

Do you drink alcohol?  
☐ Yes  ☐ No  
What kind?  How many drinks per week?

Have you had cancer?  
☐ Yes  ☐ No  
If so, what type of cancer?

Do you use tobacco?  
☐ Yes  ☐ No  
Did you ever smoke?:  Years:  Or year quit:

Cigarettes-pks/day  Chew-#/day  Pipe-#/day  Cigars-#/day

Do you currently use recreational or street drugs?  
☐ Yes  ☐ No

Have you ever had radiation therapy?  
☐ Yes  ☐ No  
To what part of the body?  When?

**CARDIOVASCULAR**

Hypertension  
☐ Yes  ☐ No  
Angina/Chest Pain  
☐ Yes  ☐ No

Heart Attack - Date  
☐ Yes  ☐ No  
Congestive Heart Failure  
☐ Yes  ☐ No

Coronary Artery Disease  
☐ Yes  ☐ No  
High Cholesterol  
☐ Yes  ☐ No

Cardiomyopathy  
☐ Yes  ☐ No  
Poor Circulation in lower extremities  
☐ Yes  ☐ No

Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs  
☐ Yes  ☐ No  
Family history of heart disease

Age of onset  Father  ☐ Yes  ☐ No  
Mother  ☐ Yes  ☐ No  
Siblings  ☐ Yes  ☐ No

Arrhythmias i.e. A-Fib  
☐ Yes  ☐ No  
Carotid Artery Disease  
☐ Yes  ☐ No

Rheumatic Fever  
☐ Yes  ☐ No  
Heart Valve problems  
☐ Yes  ☐ No

Heart murmur  
☐ Yes  ☐ No  
Pacemaker, what brand  
☐ Yes  ☐ No

**PULMONARY**

Asthma  
☐ Yes  ☐ No  
Sleep Apnea  
☐ Yes  ☐ No

COPD/Bronchitis/Emphysema (circle)  
☐ Yes  ☐ No  
Do you use a C-Pac Machine  
☐ Yes  ☐ No

Pneumonia - Date  
☐ Yes  ☐ No  
Chronic Cough  
☐ Yes  ☐ No
<table>
<thead>
<tr>
<th><strong>DOB:</strong></th>
<th><strong>Patient Name:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Blood clots in lungs or legs</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>GASTROINTESTINAL</strong></td>
<td><strong>GENITOURINARY</strong></td>
</tr>
<tr>
<td>Hiatal Hernia</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Ulcers/GERD/Gastric Reflux (circle)</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Gallstones</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Hepatitis A, B, or C</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>HEMATOLOGIC</strong></td>
<td><strong>ENDOCRINE</strong></td>
</tr>
<tr>
<td>Anemia</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Easy Bruising</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>NEUROLOGIC</strong></td>
<td></td>
</tr>
<tr>
<td>Stroke/TIA's Date:</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Myasthenia Gravis</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Paralysis</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Seizures</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>PAIN</strong></td>
<td></td>
</tr>
<tr>
<td>Chronic Pain Treatment</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Back/Neck Pain</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>GENERAL HEALTHCARE</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer Location:</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Immune Deficiency</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (circle)</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>WOMEN ONLY</strong></td>
<td></td>
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<tr>
<td>Any possibility of being pregnant</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>History of Malignant Hyperthermia (MH)</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Any history of bleeding problems</td>
<td>☐ Yes ☐ No</td>
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</tbody>
</table>

**Patient signature:** ____________________________  Date: ____________________________

*(If patient is a minor, Parent or Guardian signature)*
RECORDS RELEASE AUTHORIZATION

Patient’s Name:__________________________________________

Medical Record #______________________________________

Birth Date: ___________________________  Male  Female

Telephone Number:_________________________

I, the undersigned, hereby authorize Christopher Duma, M.D. P.C., and Richard Kim, M.D., M.S., to obtain the following information:

Medical Information   _______________________________  (initials)
Pathology              _______________________________  (initials)
Radiology              _______________________________  (initials)

From the following physicians:

(Name)  (Address)  (Phone)

(Name)  (Address)  (Phone)

Please send records to: Christopher M. Duma, M.D., P.C.  
Richard B. Kim, M.D., M.S.  
3900 W. Coast Hwy., Suite 300  
Newport Beach, CA 92663  
(949) 642-6787

Or Fax records to:  (949) 642-4833

(Patient Signature)  (Date)

(If patient representative, sign and state relationship)  (Date)
PATIENT PHARMACY INFORMATION

Patient Name: ____________________________

Patient DOB: ____________________________

Allergies: _________________________________

Patient Tel #: ____________________________

Pharmacy Name: ____________________________

Address: _________________________________

Telephone #: ______________________________
Authorization to Release Information to Family Members

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are no longer allowed to release patient information to anyone other than the patient, unless the patient gives specific written authorization. In the space below, list any family members that you give your permission for the Doctor or nurse to discuss your medical information. This permission can be rescinded at any time per the patient's verbal or written request.

1. ___________________ Relationship: _______________ Phone: ___________________

2. ___________________ Relationship: _______________ Phone: ___________________

3. ___________________ Relationship: _______________ Phone: ___________________

Authorization to Identify Self with Messages
(Authorization to leave messages on recorder)

My signature below authorizes Dr. Duma or Dr. Kim and/or his staff to identify themselves from the doctor’s office when calling to leave a message regarding my appointments, results, referrals or other medical information on any answering device or with another person answering the phone.

Patient/Guarantor (signature) ________________________________

No – I do not authorize this (signature) _______________________

Notification of Insurance Information Changes

We are committed to providing you with the best possible care. If you have insurance, we are happy to submit your claims for processing. However, please be advised that you are responsible for payment of services should you fail to notify us before services are rendered, of any changes in your insurance information. This would include changes in your medical group or IPA, health plan, primary physician, referring physician, benefits, and eligibility. Please submit to our office your updated insurance card to inform us of any changes in your insurance. Remember, your notification of any changes in your insurance must be submitted to us before services are rendered.

IN SIGNING BELOW, YOU ARE STATING THAT YOU HAVE 1) READ AND UNDERSTAND THE INFORMATION CONTAINED HEREIN 2) WILL PRESENT CURRENT INSURANCE CARD AT TIME OF APPOINTMENT

Patient/Guarantor Signature ________________________________

Patient/Guarantor printed Name ______________________________

Date: ________________
NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Brain and Spine Surgeons of Orange County Notice of Privacy Practices

Signature of Patient or Representative  ____________________________  Date ____________________________

Relationship to Patient

Printed Name

Signature of Witness  ____________________________  Date ____________________________

If the patient does not sign this acknowledgement, please identify what effort was made to obtain an acknowledgement:

☐ Patient given a copy of the Notice but refused to sign form.

☐ Patient unable to sign acknowledgement related to:
  ___ Emergency treatment situation
  ___ Mentally Incompetent
  ___ Language Barrier
  ___ Other

☐ Other explanation:

Signature of Provider Employee  ____________________________  Date ____________________________

www.brainandspinesurgeons.com
MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

MESSAGE TO OUR PATIENTS REGARDING INSURANCE BILLING

We are happy to bill your insurance carrier for services rendered by Brain and Spine Surgeons of Orange County. In order to do this, we must have your current insurance card. We will make a photocopy and submit a claim to your insurance company. At the time of service we will ask for your co-payment.

If you are covered by insurance and do not have a card yet, we require a statement from your insurance company, agent or employer verifying coverage. The information needed is: 1) Name of Insurance Company, claims address and phone number. 2) Subscriber Name and ID number. 3) Group Name. 4) Effective date of coverage. 5) Amount of deductible and amount met to date.

If this information is not available, we will be happy to see you on a CASH basis and provide you with the necessary information to bill your insurance yourself.

It is also the patient’s responsibility to confirm with their insurance carrier that Dr. Duma and Dr. Kim are covered under the patient’s insurance company’s plan. Your insurance company may require prior authorization for you to see Dr. Duma and Dr. Kim. Please contact your insurance carrier if you have any doubts about the coverage for your visit today.