Neurosurgery Associates, LLC
Joseph A. Shehadi, MD, FRCSC, FACS
Tiffany Epps, CNP

Neurosurgery Associates

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SS# _____

SEX RACE

HOME PHONE _____

☐ M ☐ White/Caucasian ☐ African American ☐ Hispanic
☐ F ☐ Other Race ☐ Non-Hispanic

CELL PHONE _____

EMAIL _____ PRIMARY CARE DOCTOR _____

MARTIAL STATUS _____ ADDRESS _____

CITY _____ ZIPCODE _____

ADDRESS _____

CITY _____ ZIPCODE _____ HOW DID YOU HEAR ABOUT US?

EMPLOYER _____ ☐ Our Website ☐ Social Media ☐ Internet

WORK PHONE _____ EXT _____ ☐ Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE

1) INSURANCE CO _____

ADDRESS _____

CITY _____ ZIPCODE _____

MEDICARE/ID# _____

GROUP # _____

SECONDARY INSURANCE

2) INSURANCE CO _____

ADDRESS _____

CITY _____ ZIPCODE _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

EMPLOYER _____

Patient Signature _____ Date _____

Responsible Party Signature _____ Date _____

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INITIAL MEDICAL HISTORY FORM
(Please Print)

Name: _____ Age_____ Today's Date_____

□ Right Handed □ Left Handed Stated Height_____ Weight_____

Referring Physician_____
Address_____Phone_____

Family Physician_____

Address_____Phone_____

PAIN MANAGEMENT or other physicians you have seen for this problem _____

Address_____Phone_____

REASONS FOR THIS OFFICE VISIT

- **Pain:** Where is your pain? _____

Please rate severity of your pain on average *(0 = no pain, 10 = worst possible pain):*

0 1 2 3 4 5 6 7 8 9 10

At best 0-10 _____ at worst 0- 10 _____

How long have you had this pain? _____

Is this a work-related injury? □ Y □ N Is this from a Motor Vehicle Accident? □ Y □ N Lawyer? □ Y □ N

Date of injury (if applicable): _____ what happened? _____

_____

What makes the pain better? (Check all that apply)

□ Pain pills □ Rest □ leaning forward □ other _____

What makes the pain worse? (Check all that apply):

□ Physical activity □ Prolonged sitting □ prolonged standing

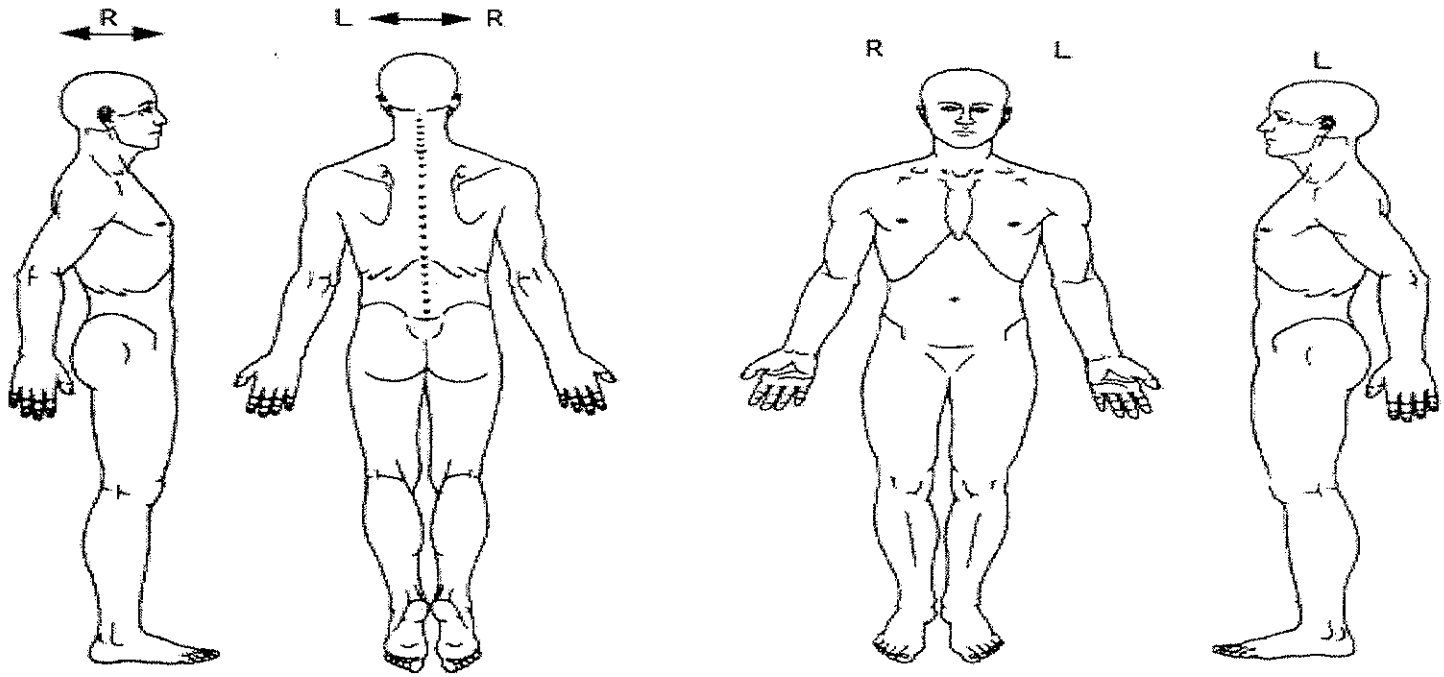
□ Coughing □ bending forward □ other _____

- **Any Numbness:** □ Y □ N Where?

_____

- **Any Weakness:** □ Y □ N Where? _____
- **Any Burning:** □ Y □ N Where? _____
- **Any urine incontinence?** □ Y □ N any **bowel incontinence?** □ Y □ N **any sexual dysfunction?** □ Y □ N

Please **SHADE** in area(s) where your **PAIN and X where the NUMBNESS** is located:



- Is your **pain** constant? □ **Y** □ **N** □ **INTERMITENT**
- **IMAGING STUDIES you have had so far?** **Body part:**
  - □ X-rays _____
  - □ MRI _____
  - □ CT scan _____
  - □ EMG (nerve study) _____
  - □ Other_____
- **CONSERVATIVE TREATMENTS** you had for this problem? (check all that apply):

  □ Pain Medications □ Steroid Injections □ Physical Therapy □ Chiropractic Care □ TENS Unit

  Type _____ Date _____ Date _____

  □ Anti-inflammatories □ Other: _____

  Type _____

Did these treatments help? _____

- **SURGICAL TREATMENTS** you have had for this problem?

  List procedure(s) _____

REVIEW OF SYMPTOMS (past 30 days)

Have you **recently** had problems with any of the following, if so please check all that apply:

Constitutional
- ❑ Fever
- ❑ Unintentional weight loss
- ❑ Excessive fatigue
- ❑ Night sweats
- ❑ Loss of appetite
- ❑ Insomnia

Neurological
- ❑ Fainting
- ❑ Dizziness/lightheadedness
- ❑ Seizures
- ❑ Tension headaches
- ❑ Migraine headaches
- ❑ Problems with your memory
- ❑ Disorientation
- ❑ Difficulty with speech
- ❑ Inability to concentrate
- ❑ Double or blurred vision
- ❑ Face weakness
- ❑ Lack of coordination in arms/legs

Musculoskeletal
- ❑ Arm or leg weakness
- ❑ Arm or leg pain
- ❑ Neck pain
- ❑ Back pain
- ❑ Joint swelling
- ❑ Joint stiffness
- ❑ Joint pain
- ❑ Muscle cramps/spasms

Eyes, Ear, Nose, Throat, Mouth
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Eye infections
- ❑ Eye injuries
- ❑ Ear pain
- ❑ Ear infections
- ❑ Balance disturbance (vertigo/spinning)
- ❑ Lightheadedness
- ❑ Inability to smell
- ❑ Sinus headaches
- ❑ Trouble swallowing

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations
- ❑ Irregular pulse
- ❑ Heart murmur
- ❑ Swelling in the ankles

Respiratory
- ❑ Wheezing
- ❑ Frequent cough
- ❑ Shortness of breath
- ❑ Coughing up blood

Gastro-Intestinal
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Jaundice
- ❑ Abdominal pain
- ❑ Ulcers or gastritis
- ❑ Bowel incontinence

Genitourinary
- ❑ Urinary tract infection
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Difficulty starting/stopping stream
- ❑ Urine incontinence

Integumentary
- ❑ Skin rash
- ❑ Change in skin color
- ❑ Change in hair or nails

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Trouble sleeping

Endocrine
- ❑ High blood sugar
- ❑ Cold intolerance
- ❑ Change in appetite
- ❑ Excessive thirst or urination

Hematologic/Lymphatic
- ❑ Anemia
- ❑ Bleeding easily
- ❑ Bruising easily
- ❑ Persistent swollen glands/lymph nodes

Allergic/Immunologic
- ❑ Food allergies

If yes, list

_____

- ❑ Seasonal allergies

PAST MEDICAL HISTORY (like diabetes, high blood pressure, etc):

- _____
- _____

CURRENT MEDICATIONS/SUPPLEMENTS	Dose	Frequency

Preferred Pharmacy_____

Address_____Phone_____

- Do you currently take **aspirin** or products containing **aspirin**? ☐ Yes ☐ No
- **ALLERGIES**: _____ OR ☐ **NKDA**
- **OTHER ALLERGIES:** (like Latex or contrast dye) _____

_____

PAST SURGERIES/HOSPITALIZATION	Year	Doctor	Complications

FAMILY MEDICAL HISTORY

- Are there any diseases that run in your family? (like Diabetes or Cancer, etc):_____

_____

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Father				

Mother				

SOCIAL HISTORY

- **Marital Status** _____
- **Occupation** _____

  Are you currently working? □ Y □ N □ Full-time □ Part-time

  If not working, when was the last day you worked? _____

  Are you on disability? □ Y □ N If so, for what reason? _____

- **Tobacco**:
  - ❑ Yes, I smoke _____ packs of cigarettes (chew tobacco) per day and have for the past _____ years.
  - ❑ No, I have never smoked cigarettes.
  - ❑ No, used to smoke, but I quit _____ years ago.

- **Alcohol**: How many alcoholic beverages do you consume per week? _____

  What type _____

- **Recreational Drug Use?** □ Yes □ No

  What type _____

- Are you at risk for AIDS or Hepatitis C? (e.g. past blood transfusion) □ Y □ N Explain:_____

- Any metal in your body? □ Yes □ No ****Pacemaker** □ Yes □ No Hearing Aid □ Yes □ No

- Are you claustrophobic? □ Yes □ No

- Is there any SPECIAL information we should know about you that has not already been asked? (Examples: **Bleeding or clotting disorder**, Jehovah's Witness, etc.):_____

All the information provided above is accurate and complete to the best of my knowledge as the patient.

PATIENT SIGNATURE _____ Date _____

Joseph A. Shehadi, M.D., Neurosurgery Associates Financial Policy

Your clear understanding of our **financial policy** is important to our professional relationship. Please understand that payment of your bills is considered part of your overall treatment in our office. In order to keep your cost of healthcare to a minimum, the following financial policies have been adopted for use here at ***Neurosurgery Associates, LLC.***

Acknowledging with your signature below, you understand and accept the following:

Required at Check-In

Each time you check in for your appointment you will be required to:

1) Verify Personal Demographic and Contact Information
2) Present Current Copy of **Insurance Card**
3) Pay any Outstanding Account Balance
4) Pay your **Insurance Co-Pay** for Current Visit

Fees for Administrative Services and Penalties

- **Missed Appointment:** Missed appointments cancelled with less than 24 hour notice or "no show": **$25.00** ***per occurrence.***
- **Form Completion Charge: $10.00** for each ***form.*** These forms include: FMLA, Short-term Disability and Long-term Disability.
- **Returned Check Fee: $30.00** ***per check*** will be assessed on your account.
- **All outstanding balances must be paid in full within 30 days of receiving your bill.** Outstanding balances must be resolved prior to your next visit to ***Neurosurgery Associates, LLC,*** unless other arrangements have been made with the Billing Manager. Outstanding balances are subject to a **$10.00** ***late fee*** for each 30-day cycle past due.
- **Collection Charges:** Accounts that are not paid in a reasonable amount of time may be sent to an external collection agency and reported to the credit bureau, and are subject to ***additional charges*** imposed by the agency.

I understand and agree to abide by the above policies and procedures as outlined in ***Joseph A. Shehadi, M.D., Neurosurgery Associates, LLC, Financial Policy.***

Print Name:_____ **Date:**_____

Patient Signature:_____

10/2013 jls

Joseph A. Shehadi, MD
Neurosurgery Associates

NOTICE OF PRIVACY PRACTICES
ACKNOWLEGEMENT AND CONSENT

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how we may use and share your health records.
Please read it.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will not use your personal health information for services that you pay for privately.
- We will use and share your health records to operate this medical practice.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact and communicate with you regarding your care and treatment.

NOTE: All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Neurosurgery Associates Notice of Privacy Practices

Signature: _____ Date: _____
(of patient or legal representative)

Capacity of Legal Representative (if applicable)*: _____

*May be requested to provide verification of representative status.

CONSENT:

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Please be advised that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information.**

Signature: _____ Date: _____
(of patient or legal representative)

Capacity of Legal Representative (if applicable)*: _____

*May be requested to provide verification of representative status.

The HIPAA privacy rule give individuals the right to request a restriction on uses and disclosures of their personal information (PHI). The individual is also provided the right to request communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's place of employment instead of the individual's home.

Neurosurgery Associates, LLC, Joseph A. Shehadi, M.D.
393 East Town Street, Suite 110
Columbus, OH 43215
Ph: 614-220-5648
Fax: 614-220-5649

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check *all* that apply.)

Telephone Contact

☐ Home Telephone:_____ ☐ Cell Phone:_____

☐ Text Message: _____

☐ It is OK to leave a message with detailed information.

☐ It is OK to leave a message with call-back number only.

☐ Work Telephone:_____ ☐ Other Phone #(s):_____

☐ It is OK to leave a message with detailed information. _____

☐ It is OK to leave a message with call-back number only _____

Written Communication

☐ It is OK to mail information to my home address on file.

☐ It is OK to mail to my work/office address._____

☐ It is OK to fax information to this number: _____

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth:_____

NOTE: if the above area is left blank, it will be assumed that you wish this practice to leave a message with call-back number at your home telephone only.

Please complete the information below in order for our providers to electronically or telephone prescribe medications for you. Please list your primary pharmacy; we will not send medications to multiple pharmacies.

PATIENT NAME:_____ DOB_____

PHARMACY NAME:_____

PHARMACY TELEPHONE NUMBER:_____

SIGNATURE:_____ DATE:_____