METROPOLITAN NEUROSURGERY

Patient Registration Form

Patient Name:_____ Age:_____ Sex: ( ) Male ( ) Female

Address:_____ City: _____ State:_____Zip:_____

Cell Phone #:_____Home #:_____Work #:_____

Email:_____ Social Security Number:_____

D.O.B:_____ Marital Status: ( ) S ( )M ( )D ( )W ( )Other

Pharmacy Name and Address:_____

Pharmacy Phone #:_____

Occupation:_____ Employer:_____

Spouse's Name:_____Spouse's D.O.B:_____Spouse's SSN:_____

Emergency Contact's Name and Phone #:_____

Referring Physician's Name:_____ Phone #:_____

Referring Physician's Address:_____

Primary Care Physician's Name:_____ Phone #:_____

Primary Care Physician's Address:_____

How did you hear about us?_____

Please circle if your visit today is related to either: MVA or Worker's Compensation Accident

Date of Accident:_____Claim #:_____

Insurance Carrier:_____

Address:_____ City:_____State:_____Zip:_____

Name of Claim Representative:_____Phone #:_____

**If WC claim, please include Employer's Name, Address and Telephone Number below:

_____

MEDICAL INSURANCE

Primary Plan:_____ Policy ID:_____ Group #:_____

Medical Claims Address:_____ City/State/Zip:_____

Phone #:_____Primary Policy Holder Name_____ DOB:_____

Secondary Plan:_____ Policy ID:_____ Group #:_____

Medical Claims Address:_____ City/State/Zip:_____

Phone #:_____Primary Policy Holder Name_____ DOB:_____

METROPOLITAN NEUROSURGERY ASSOCIATES, PC

Name: _____ **Date of Birth:**_____**Age:**_____

(Current problem (briefly state why you are here to see the doctor)_____

_____

Medical History:

Current Height:_____ **Weight:**_____**Right or Left Handed?**_____

Please review the following list and circle Yes or No if you have the following conditions:

Conditions/Disease

Pneumonia----------	Yes No	Liver Disease----------	Yes No
Diabetes----------	Yes No	High Blood Pressure-----	Yes No
Kidney Disease-----	Yes No	Heart Attack----------	Yes No
Heart Disease-------	Yes No	Stroke----------	Yes No
Heart Murmur------	Yes No	Congenital Heart Defect-	Yes No
Asthma ----------	Yes No	Lung Disease----------	Yes No
Anemia ----------	Yes No	Rheumatic Fever-------	Yes No
Hepatitis----------	Yes No	HIV/AIDS----------	Yes No
Cancer----------	Yes No	Atrial Fibrillation-------	Yes No
Arthritis----------	Yes No	Hemophilia----------	Yes No
Osteoporosis------	Yes No	Tuberculosis----------	Yes No
Seizures / Epilepsy--	Yes No	Bleeding Disorders-----	Yes No
Endocrine Problems-	Yes No	Cirrhosis----------	Yes No
Headaches----------	Yes No	Hormone Therapy-------	Yes No
Metal / Latex allergy-	Yes No	Pacemaker----------	Yes No

Other Significant Illnesses for which you have taken medicine and/or have seen a physician

_____

_____

_____

_____(Please list all surgeries with the approximate dates):

Type of Surgery: **Date:** **Hospital:**

_____

_____

_____

Allergies: List all medications and health products you have had a bad reaction to and type of reaction)

_____

_____

_____

Medications: (List all medication names including non-prescription medications, vitamins, herbs, or supplements.) Please include the dosage, and how many you take daily (example; Lasix Mg 1 tablet daily)

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____
9._____ 10._____

Current Activity Status:

_____ Fully Active; Normal
_____ Have difficulty with strenuous activity; Can do light activities (housework, office work)
_____ Unable to work; Can care for self; Out of bed or chair more than 50%
_____ Can only do limited self-care; Stay in bed or chair more than 50% of waking hours
_____ Can not do self-care; Confined to bed or chair

1. If you currently have pain, where is it?_____
1. If you currently have pain, please rate your pain: 0-1-2-3-4-5-6-7-8-9-10
   (0=NO pain 10= worst possible pain)
2. What are you currently doing to relieve your pain?_____
3. Have you recently had any physical therapy?_____
4. Have you had epidural injections?_____

Social History:

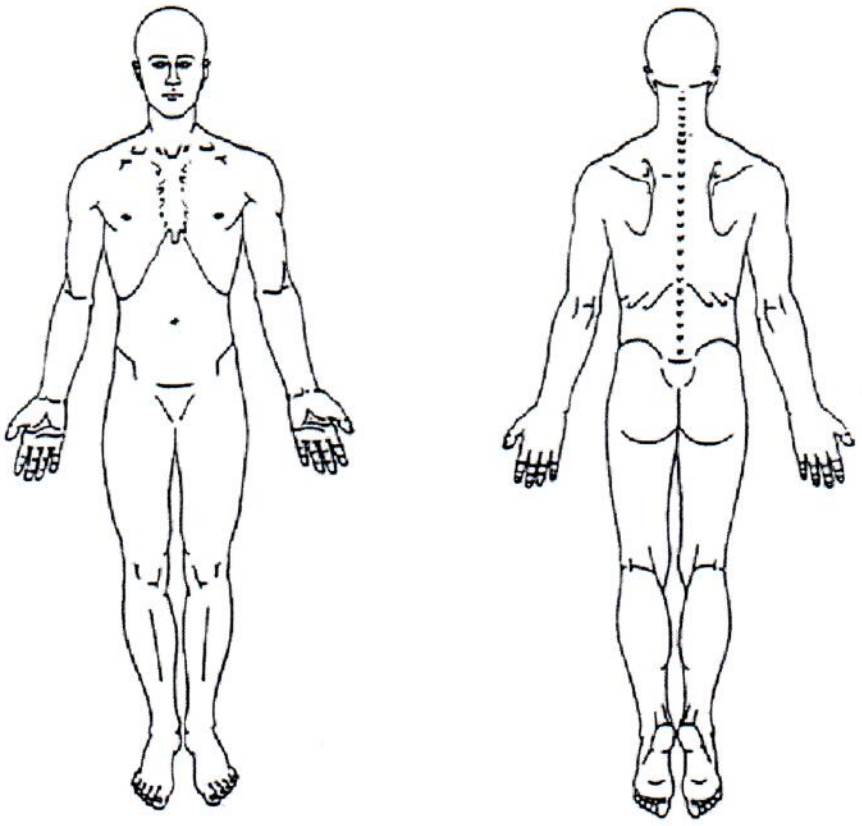
1. Marital status **(circle one):** Married / Single / Separated / Divorced / Widowed.
   Do you live alone? **(Circle one):** Yes No
2. What is your occupation?_____.
   Are you retired? **(Circle one):** Yes No
3. Do you use tobacco products? **(Circle one):** Yes No How many years?_____
   Have you stopped? (circle one) Yes No When?_____
   What did you use?(circle) Cigarettes (# packs/day), Cigars, Pipe Chewing Tobacco
4. Do you drink alcohol? **(Circle one):** Yes No How often?_____
5. Do you use recreational (street) drugs? Yes or No Type_____ Frequency_____

Family history:

Do you have anyone in your immediate family who has been diagnosed with Heart Disease, Diabetes, Cancer, Arthritis, Kidney Disease, Blood disorders, Blood Clots, ect?
(Circle one): Yes No
Please list the family member affected and what their condition was:

_____
_____
_____

_____ _____
Patient's Signature **Date**



Please circle the area of pain, put XXX for tingling, OOO for burning and ### for no feeling at all.

What is the level of pain you have had for the last two weeks?

No pain 1 2 3 4 5 6 7 8 9 10 worst pain

METROPOLITAN NEUROSURGERY
*Diplomate American Board of Neurological Surgery

*KEVIN C. YAO, M.D., F.A.C.S.
*YAKOV GOLOGORSKY, M.D., F.A.C.S.
*FRANK M. MOORE, M.D., F.A.C.S.
*OMAR N. SYED, M.D., F.A.C.S.
*ALFRED A. STEINBERGER, M.D., F.A.C.S.
JACOB L. GOLDBERG, M.D.

Informed Consent for Telehealth/ Telemedicine Services

I understand that Telehealth/telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to and individual when he/she is located at a different site than the provider; and herby consent to Metropolitan Neurosurgery Associates providing health care services to me via telemedicine.

I understand telehealth/medicine can have limitations as to the physical examination/ testing that can be performed.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. The physician will keep a record of the consultation in my medical record.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Metropolitan Neurosurgery Associates. As long as this consent is in force (has not been revoked) Metropolitan Neurosurgery may provide heath care services to me via telemedicine without the need for me to sign another consent form.

Name of Patient:_____

Signature of Patient:_____

Date:_____

309 Engle Street, Englewood, NJ 07631
Telephone (201) 569-7737
Fax (201) 373-2041

METROPOLITAN NEUROSURGERY
*Diplomate American Board of Neurological Surgery

*KEVIN C. YAO, M.D., F.A.A.N.S.
*YAKOV GOLOGORSKY, M.D., F.A.A.N.S.
*FRANK M. MOORE, M.D., F.A.A.N.S.
*OMAR N. SYED, M.D., F.A.A.N.S.
* A.A. STEINBERGER, M.D., F.A.A.N.S.
Jacob L. Goldberg, M.D.

Patient Name:_____

In accordance with the newly enacted legislature passed in NJ, we are required to obtain the following information and enter it into your Medical Record. If you prefer not to share, please just check the prefer not to state box. Thank you for your cooperation.

If you prefer not to answer this form in its entirety, please just check this box ☐

Assigned Sex at Birth

- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Prefer Not to State
- ☐ Other_____

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Non-Binary
- ☐ Genderqueer
- ☐ Prefer Not to State
- ☐ Other_____

Preferred Pronouns

- ☐ She/Her
- ☐ He/Him
- ☐ They/Them
- ☐ Other_____

Sexual Orientation

- ☐ Heterosexual (Straight)
- ☐ Homosexual
- ☐ Bisexual
- ☐ Other_____

METROPOLITAN NEUROSURGERY
*Diplomate American Board of Neurological Surgery

*KEVIN C. YAO, M.D., F.A.C.S.
*YAKOV GOLOGORSKY, M.D., F.A.C.S.
*FRANK M. MOORE, M.D., F.A.C.S.
*OMAR N. SYED, M.D., F.A.C.S.
*ALFRED A. STEINBERGER, M.D., F.A.C.S.
JACOB L. GOLDBERG, M.D.

Horizon Blue Cross Blue Shield Omnia Information

<u>*If you do not have Horizon Blue Cross Blue Shield Insurance you do not need to complete.</u>

Please be advised Metropolitan Neurosurgery Associates, and its providers, are considered Tier 2 under all **<u>Horizon Omnia</u>** plans. If you have a traditional Horizon Blue Cross Blue Shield plan there are no Tier 1/Tier 2 distinctions, therefore this <u>does not apply to you.</u>

By signing this form, you acknowledge that you have been advised we are Tier 2 and subject to whatever your Tier 2 deductible/out of pocket max may be.

If you have any questions, please ask a member of our staff, or contact your insurance company directly.

Name of Patient:_____

Signature of Patient:_____

Date:_____

309 Engle Street, Englewood, NJ 07631
Telephone (201) 569-7737
Fax (201) 373-2041

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/ RELEASE OF PHI/RECORD OF DISCLOSURE

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any payments) under my health insurance policy or benefit plan to Metropolitan Neurosurgery Associates, (MNA), (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service. It is specifically intended by this assignment of benefits to assign to the fullest extent permitted under the law any and all of my rights, including without limitation, the right of one or more of the Providers to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State law rules, regulations and requirements, (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator to timely produce or respond to requests (including appeals) for all information relating to any plan documents describing the rights under any insurance policy or benefit plan as required by any applicable Federal or State law, (iii) to endorse for me any checks made payable to me for benefits and claims collected toward my account, and/or (iv) to bring any appeal, lawsuit or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination of benefits under any insurance policy or benefit plan.

If the Insurance carrier responsible for making medical payments to MNA for medical services rendered to me does not accept my assignment of benefit rights , or if my assignment is challenged or deemed invalid, I execute this limited special power of attorney and appoint and authorize MNA and their attorney or other representative as my agent and attorney in fact to assert any and all of my benefit and non-benefit rights for and on my behalf , including, without limitation , to bring any appeal, pre-litigation demand, demand for payment , arbitration, lawsuit, independent dispute resolution or administrative proceeding for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers) or any other person or business that provides healthcare activity services as a "business associate' (including Howard Healthcare Group) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits from any third-party payor under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and private health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPPA.

3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of

benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

5. The right of my Authorized Representative to pursue any rights, claim or cause of action through litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me. I authorize MNA to use and/or disclose my health information which specifically identifies me, or which can reasonable used to identify me to carry out treatment, payment and health care operation. I have been informed MNA, has prepared a notice (HIPAA Notice of Privacy Practices) which is displayed in the waiting area and more fully describes the uses and disclosures that can be made of my health information for treatment, payment, and health care operations.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Record of Disclosure

For any PHI communication I wish to be contacted in the following manner (check all that apply):

By phone : ____ Cell ____ home ____ work

_____OK to leave message with detailed info _____Leave message with call back # only

By written communication: ____ OK to mail to my home address

By email: _____ using the following email address :_____

Patient Name: _____ DOB:_____

Patient Signature: _____ Date:_____

Our physicians are Medicare Participating providers. We will bill Medicare directly and accept assignment. Medicare will pay 80% of the Medicare allowed charges and you, the patient, are responsible for 20%. You are also responsible for your annual deductible and any non-covered service.
We will submit all claims to all insurance carriers as long as you provide our office with your current/ correct insurance information. We do not participate with insurance plans aside from Medicare and the current list posted in our office. You the insured are responsible for deductible and co-ins. portions not covered by your plan. **We can treat any patient whose plan has out of network benefits.**

Lifetime Insurance Signature Form

I request payment of insurance benefits, (Ii.e. Medicare, commercial, PIP, worker's comp., or any type of policy I am covered under), be made directly to the provider of services Metropolitan Neurosurgery Associates, PA, (herein referred as MNA) and affiliated physicians on my behalf. I authorize the release of any medical information necessary to process an insurance claim or determine benefits. Patients sent here specifically for IME's are not responsible for any payment.

I hereby authorize MNA to release any information acquired in the course of my treatment and examination. I hereby assign to MNA all money to which I am entitled, for medical or surgical expenses and services provided by any of their affiliated doctors (Drs. Yao/Gologorsky/Moore/Syed/Steinberger/Goldberg). I agree to forward any payment made to me by insurance for services rendered by MNA directly to their office upon receipt of such payment made to me by insurance for services rendered by MNA directly to their office upon receipt of such payment with the EOB attached. I understand that any insurance money paid to me for services rendered by MNS and not forwarded to same to satisfy payment for services rendered will be pursued according to law.

I understand that I am responsible to follow up with my insurance for payment for services provided to assure timely payment. Any charges over 90 days are subject to collections by an outside agency or attorney. I agree to pay all costs involved with collection procedures. Further, I understand that I am entering into a contractual relationship with MNA for professional care. I further understand that meritless and frivolous claims for medical malpractice and an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider.

As an additional consideration for professional care provided to me by MNA, I the undersigned patient and /or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Metropolitan Neurosurgery Associates, PA.

Furthermore, should a meritorious medical malpractice case or case of action be initiated or pursued. I, the patient and /or my representative agree to use the ABNS (American Board of Neurological Surgery) board-certified expert medical witness(es) in the same or similar specialty as our physicians. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/ or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such case. In further consideration for this, we the physicians in MNS, agree to the same stipulations.

I certify that I have read this document, agree to its content and that all information stated is true and correct to the best extent of my knowledge. This contract is effective from the date of first service.

_____ Date: _____

Signature of patient or authorized representative

WHAT IS THE PURPOSE OF THIS FORM?

A lifetime insurance signature form is a document that allows someone to authorize another person to submit claims to their insurance provider for a lifetime. This form can also allow the release of medical information.

How is it used?

- A beneficiary can sign a lifetime signature authorization form to allow a physician or supplier to submit claims on their behalf.
- A patient can sign a lifetime signature authorization form to allow a dermatologist to submit claims to their insurance carrier.

What does it include?

- The beneficiary's name and health insurance number
- A request to pay authorized benefits to a specific provider
- Authorization to release medical information to the insurance provider

Why is it important?

- A lifetime signature authorization form allows the insurance provider to submit claims on the beneficiary's behalf without needing to obtain the beneficiary's signature each time.

METROPOLITAN NEUROSURGERY
*Diplomate American Board of Neurological Surgery

*KEVIN C. YAO, M.D., F.A.C.S.
*YAKOV GOLOGORSKY, M.D., F.A.C.S.
*FRANK M. MOORE, M.D., F.A.C.S.
*OMAR N. SYED, M.D., F.A.C.S.
*ALFRED A. STEINBERGER, M.D., F.A.C.S.
JACOB L. GOLDBERG, M.D.

NOTICE

BLUE CROSS BLUE SHIELD, AMERIHEALTH & AETNA INSURED PATIENTS

This notice is to inform you that Blue Cross Blue Shield (including Braven Medicare Advantage), AmeriHealth and Aetna will not cover x-rays performed in our office. The codes that will not be covered are 72040, 72050, 72082, 72083, 72100, 72114, 72050, 72010, 71010, 70250, and 74000.

You have the option to have these services performed at a facility outside of our office where they are covered by your plan.

If you prefer to have the services performed here in our office, your signature below is giving our office, Metropolitan Neurosurgery Associates, the authorization to render the service for a fee of $25 for each set of x-rays performed. This fee is payable by you at the time of the service, and not billable to, or covered by your insurance.

This authorization will remain in effect from the date below unless revoked in writing and placed on file with our office.

Please do not hesitate to ask if you have any questions regarding this policy.

Thank you.

Metropolitan Neurosurgery Associates

PLEASE ONLY COMPLETE IF YOU HAVE A BLUE CROSS BLUE SHIELD, AMERIHEALTH OR AETNA INSURANCE PLAN.

Name of Patient: _____

Signature of Patient: _____

Date: _____

309 Engle Street, Englewood, NJ 07631
Telephone (201) 569-7737
Fax (201) 373-2041