NSG

NEUROSURGERY & SPINE GROUP

AMIR VOKSHOOR MD, FAANS

Diplomate, American Board of Neurological Surgery
Microscopic, Cranial & Spine Surgery, Motion Preservation Surgery
Director of NSG, Co-director of Spine

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Diplomate, American Board of Neurological Surgery
Complex & Minimally Invasive Cranial & Spine Surgery, Motion Preservation Surgery
Co-Director of Spine; Director of Outcomes Research

2811 Wilshire Blvd, Suite 850
Santa Monica, CA
7320 Woodlake Ave. Suite 215
West Hills, CA 91307
Phone: 800-899-0101
Fax: 310-870-8677
Email: office@NSG-LA.com

Thank you for choosing Neurosurgery & Spine Group as your treating Neurosurgeons. We offer Integrative Neurosurgery to our patients and strive to provide the highest level of neurosurgical care. It is our pleasure to welcome you as a patient. We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

New Patient Packet

To allow a thorough review of your information, please be sure to include all documents requested and have the new patient packet filled out completely. Upon completion, please fax back to 310-870-8677 or bring to your visit.

- A copy of your ID and insurance card (front and back).
- MRI reports and any other diagnostic reports (i.e. EMG, CT, X-Rays, etc.)
- Epidural reports and/or operative reports and procedure reports.
- Any medical records relevant to your spine concerns.
- Please **BRING ALL FILM/CDs** with you on the day of your appointment.
- If **discussing surgery, please leave all your information with the surgery scheduler**. If you decide to take your MRI, CT scan, or X-ray, you are responsible for hand-delivering them back to our office prior to your surgical date.

PRELIMINARY PATIENT APPOINTMENT/HISTORY/REGISTRATION SHEET

PATIENT NAME:_____
LAST FIRST

HOME ADDRESS:_____
STREET CITY STATE ZIP CODE

HOME PHONE: (___) _____-_____ FAX: (____) _____- _____ WORK PHONE: (____) _____-_____

CELL NO/PAGER: (___) _____-_____ EMAIL: _____

DATE OF BIRTH: ____/____ /_____ COUNTRY & STATE OF BIRTH: _____

SEX: MALE __ FEMALE __ SS#: _____-_____-_____

HEIGHT _____ WEIGHT _____ MARITAL STATUS: MARRIED __ SINGLE __ WIDOWED __ DIVORCED __

EMPLOYMENT STATUS: FULLTIME____ PART TIME____ NOT EMPLOYED___ RETIRED___ DISABILITY___ PARTIAL DISABILITY___

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP CODE

EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____

CONTACT PHONE AND RELATION TO YOU: _____

PRIMARY INSURANCE _____ HMO ___ PPO ___ POS ___

PRIMARY INURANCE ID#: _____ GROUP#: _____

SUBCRIBER'S NAME _____
LAST FIRST
SUBSCRIBER'S DATE OF BIRTH _____/_____/_____

INSURANCE PHONE: (____) _____-_____

SECONDARY INSURANCE _____ HMO ___ PPO ___ POS ___

SECONDARY INURANCE ID#: _____ GROUP#: _____

SUBCRIBER'S NAME _____
LAST FIRST
SUBSCRIBER'S DATE OF BIRTH _____/_____/_____

SECONDARY INSURANCE PHONE: (____) _____-_____

PREFERRED PHARMACY _____ PHONE: _____

PHARMACY ADDRESS: _____
STREET CITY STATE ZIP CODE

PERSONAL INJURY _____ WORKER'S COMP _____ AUTO INJURY _____

PRIMARY/REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN DETAILS:

PHYSICIAN NAME: _____
LAST FIRST

SPECIALTY: _____ EMAIL: _____

PHONE NO: (___) _____-_____ FAX: (____) _____- _____

INTERNIST/PRIMARY CARE PHYSICIAN DETAILS:

PHYSICIAN NAME: _____
LAST FIRST

SPECIALTY: _____ EMAIL: _____

PHONE NO: (___) _____-_____ FAX: (____) _____- _____

ANY ADDITIONAL PHYSICIAN INFORMATION:

_____

_____

_____

_____

NEUROSURGERY & SPINE GROUP

PAIN DESCRIPTION

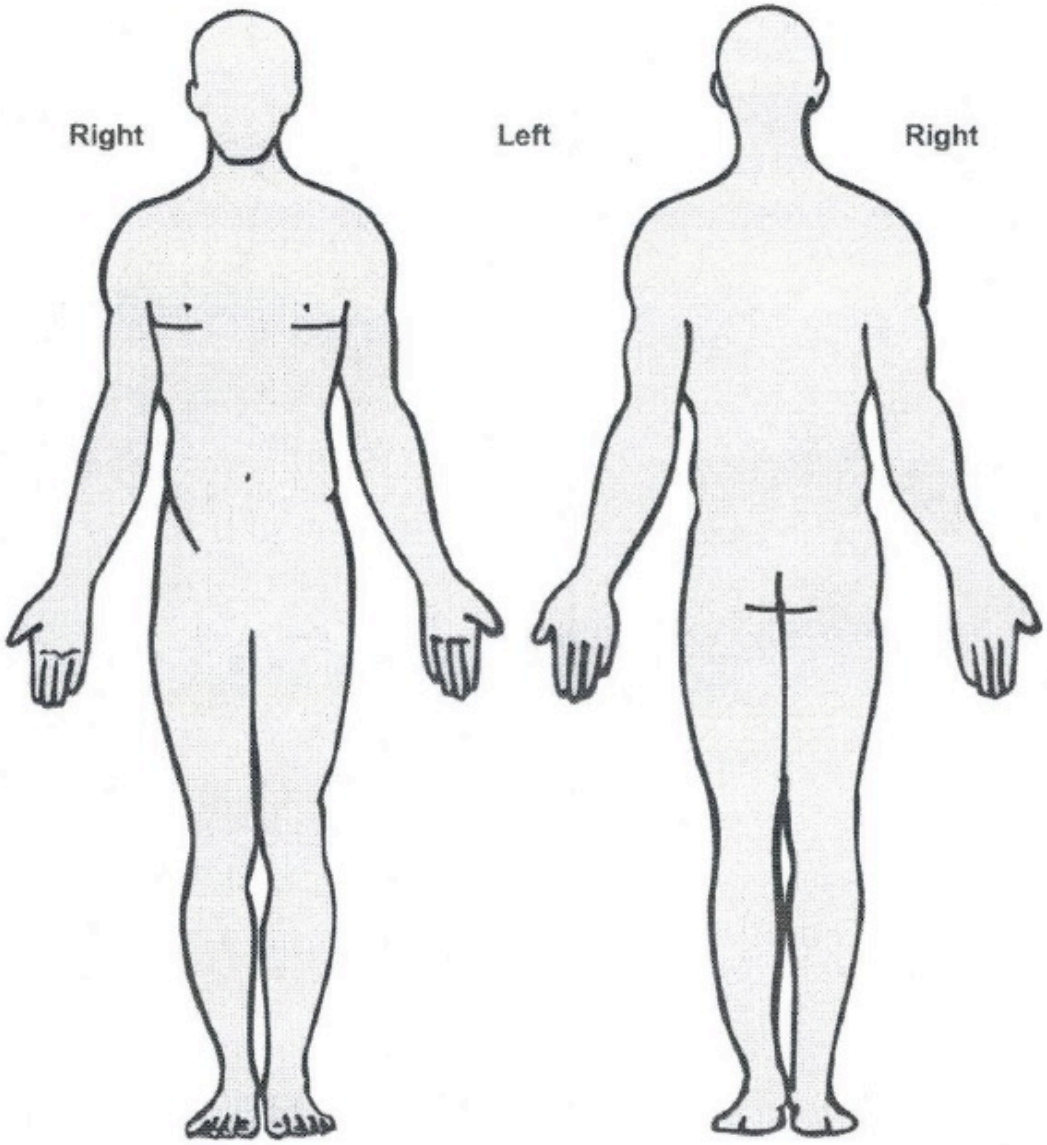
INSTRUCTIONS: Mark the areas on the diagram where you are in pain. (If the right side your neck hurts, mark the drawing on the right side of the neck, etc.) Please indicate which sensations you feel by referring to the key below.

KEY	
∧∧∧	Ache
000	Numbness
■■■	Pins & Needles
XXX	Burning
///////	Radiating Pain

I can tolerate my pain at a pain score of:

Please check the box the best indicates the duration of your pain:

- ☐ Continuous
- ☐ Positional
- ☐ Intermittent (on/off)
- ☐ Unable to Rate



Visual Analog Scale

On a scale of 0 to 10, 0 being "No Pain" and 10 being "Worst Pain Imaginable", please rate your level of neck / back pain, TODAY with a line.

0 No pain — NECK — 10 Worst Pain Imaginable

0 No pain — BACK — 10 Worst Pain Imaginable

Patient Signature _____ *Visit Date* _____

PATIENT HISTORY

PATIENT NAME: _____ AGE: _____ DATE: _____
LAST FIRST

REFERRED BY: _____

1. When did symptoms start? _____ Symptoms are getting: WORSE __ BETTER __ STABLE ___

2. Please describe all present discomforts:

A. Please list all body parts affected : _____

_____

B. Type of pain or weakness , or numbness (please specify):
_____

_____

C. Pain Radiation (Describe:) _____

_____

3. Pain or other symptoms rating: Please mark the degree of pain you are experiencing on the line below:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain)
_____

4. Please describe other symptoms (such as abnormal sensation or function): _____

_____

_____

5. Do you have any pain, numbness, tingling or weakness in your arms or legs? Please describe:
_____

_____

6. What position and/or medication relieves your pain? What exacerbates your pain? _____

_____

_____

7. Previous treatments (including X-Rays, Tests, Physical Therapy, Chiropractic, alternative methods) or seen any health provider for this problem. Please describe the treatment and test results: _____

_____

_____

8. Please list any previous diagnosis and treatments recommended: _____

_____

9. Please list any test you have had in the past related to your problem (MRI, XRAY, ETC.):

TEST/STUDY	DATE	RESULT IF KNOWN

10. Past medical history: (Please circle any of the following which you have had and specify):

Urinary Problems: _____ Heart disease:_____

Cancer: _____ Respiratory system problems: (i.e. Pneumonia)_____

Circulatory/CVA : _____ Problems with asthma, hay fever: _____

Arthritis, Gout: (other) _____ Problems with ears, eyes, nose, throat: _____

Liver problems: _____ Hypertension, High Cholesterol:_____

Kidney problems: _____ Diabetes, Hypoglycemia: _____

Concussion: _____ Gastrointestinal problems, Ulcers: _____

Spinal Problems/Osteoporosis: _____ Drug abuse/Alcohol problems: _____

Fibromyalgia: _____ Headache disorders (Migraines etc.) _____

Hyperthyroidism, hypothyroidism_____ Brain tumors_____

Depression, Anxiety or other Psychological problems: _____

11. Please explain any of the above: _____

12. Have you had any prior surgeries? (Please describe, including any implants): _____

_____

13. Have you had any prior spine surgeries? Yes ____ No ____ if yes, what year _____

Surgery Description/Implants (metal, titanium, PEEK, etc.)? _____

_____

14. Current medical status:

Are you currently receiving treatment for any other medical condition? _____

_____

15. Family Medical History:

a. Is there a history of spinal problems in your family? Yes ____ No ____

b. If yes , please describe _____

c. Is here a family history of other medical problems? (Describe): _____

_____

_____

16. Social History:

a. Number of children_____

b. Do you smoke? If yes, how much? _____

If no, have you ever smoked and for how long? _____

c. Alcohol Intake? If so how much? _____

d. Describe usual physical activity/exercise:

Type (frequency): _____

_____

17. Have you recently had any of the following? (Please check all that apply):

Pain	Anxiety	Fever	Loss of Coordination (in arms or legs)
Fatigue	Heartburn	Numbness	Chest Pain
Fainting	Difficulty voiding	Tingling	Ulcers
Memory Loss	Shortness of Breath	Nervousness	Bowel Problems
Depression	Sleep Difficulty	Loss of Appetite	Early Awakening
Stress	Weakness	Urinary Incontinence	Facial Pain
Loss of Concentration	Headaches	Itching	Nausea
Hearing Difficulty	Vomiting	Joint Pain	Unsteadiness

Other (Please describe):_____

18. Are you right or left handed? Right ___ Left ___

19. Are you Pregnant? Yes ____ No ____ N/A ____

20. Medications: Please list all medications you are currently taking and the daily dosage: (please write on the back of the page if more space needed)

MEDICATION	DOSAGE	DATE

21. Are you taking any herbal or vitamin supplements? Please list all.

_____

_____

22. Are you allergic to any medications/foods/other? Do you have latex allergy? Please list:

_____

_____

_____

INSURANCE ACKNOWLEDGEMENT & FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions, please speak with one of our Billing Representatives.

Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card so that we may copy the front and back of the card for accurate insurance information.
2. Your driver's license so that we may copy the card for accurate demographic and patient specific data.
3. Your referral or authorization for services when applicable.

Self-pay Accounts

If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

Insurance Plans

Neurosurgery & Spine Group is a participating provider for Medicare. Medicare does not cover all services provided. **Neurosurgery & Spine Group is out of network with most PPO Insurance.** We are willing to accommodate you and verify your insurance and, as a courtesy, will submit a claim to your insurance company on your behalf. However, payment may be required at the time of your visit. It is ultimately your responsibility to become familiar with the details of your insurance plan coverage. We recommend you contact your insurance company prior to any service so you may understand your allowable benefits. We will collect the required payment, if applicable, at the time of the visit. In the event that your health plan determines a service to be "non-covered," we will bill you, and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you and is due upon receipt.

Worker's Compensation, Personal Injury, Auto Claims

If you are involved in an "on-the job" work injury, prior to seeing the physician, the following information must be obtained and verified prior to your visit.

- Date of Injury
- Case or claim number
- WCAB#, if applicable
- Workers' Compensation carrier information
- Adjuster's name
- Adjuster's telephone number
- Employer

If you were involved in a motor vehicle accident and have either an attorney representing you or an active auto claim, it is your responsibility to provide the office with necessary info. If your claim comes back denied, you are responsible for the full fee.

Insurance Updates

Due to frequent changes in insurance plans and applicable the benefits offered under those plans, our staff is required to review and update your insurance information on a regular basis.

Other Fees:

- Copy of Records
- Copy of X-rays
- Form Completion Fees
- Mailing of CDs/medical records

X-ray/CTs/MRIs

Please note that your referring provider's contract affiliation will have no bearing on the processing of the claims for imaging.

No Show Fees: Please be advised that out of respect to our doctor and other patients, 'no show' appointments incur a $150 fee for each missed appointment. A credit card is required on file to make an appointment.

Initials _____

The full fee for your initial consultation is $1500. To avoid being sent a bill for any remaining balance, an upfront discounted payment of $750 is offered (your insurance will still be charged for the consultation). You may opt to have your insurance billed upfront for the entire amount, but will be responsible for the remaining balance.

Initials _____

I understand that Neurosurgery & Spine Group agrees to bill my insurance as courtesy, and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for payment for all services.

_____	_____	_____
Name of Patient (please print)	Signature of Patient or Responsible Party	Date
_____	_____	_____
Interpreter/Representative Name	Interpreter/Representative Signature	Date

_____
Initial

*I hereby authorize my card to be charged for any 'no show' appointments or balances on my account unless I opt for an alternative form of payment prior to due date(s).

□ Visa □ Master Card □ American Express □ Other_____

Name as it appears on the card: _____

Card #: _____ EXP: _____ / _____ CVV: _____

Billing Address: _____

It is understood that if payments are missed or credit card payments fail, without prior notification and agreement, the practice reserves the right to transfer collections to a collection agency. Fees and interest may apply.

NEUROSURGERY & SPINE GROUP

Phone: 800-899-0101
Fax: 310-870-8677
Email: office@NSG-LA.com

Medical Records Release

Date _____

Person/Organization providing the information:

Name: _____ Name:_____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

To Whom It May Concern:

I, _____, (DOB ____ / ____ / _____) hereby authorize the use or disclosure of my health information from the organization (s) listed above. I agree to be solely responsible for releasing these medical records and the information contained within.

_____ _____
Patient's Name Patient's Signature

Comments : _____

_____

ALTERNATE CONTACT INFORMATION & RELEASE OF INFORMATION CONSENT FORM

Patient Name: _____ Home Phone: _____

Patient Date of Birth: _____ Work Phone: _____

Cell No./Pager: _____

I. Alternate Contact Information Consent

Neurosurgery & Spine Group has my consent to

a) Leave medical information on my home phone answering machine. Yes ___ No ___

b) Leave medical information on my personal cell phone. Yes ___ No ___

c) Contact me at my place of employment. Yes ___ No ___

d) Leave medical information on voice mail at my place of employment. Yes ___ No ___

e) Leave medical information on Family ____ , Friends ____, Co Workers ___ voice mail. Yes ___ No ___

f) Leave/discuss medical information on Family ___ , Friends ___, Co- Workers ___ e-mail. Yes ___ No ___

NOTE: **Messages will not be left on answering machines or voice mail if the recorded greeting does not include confirmation of your name or phone number**

II. Family/Friends/Co Workers Release of information Consent

I authorize Neurosurgery & Spine Group to discuss any information regarding my care with below mentioned family members(s), friend(s) or co-workers(s).

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

_____ _____

PATIENT OR GUARDIAN'S SIGNATURE DATE

This Authorization is valid until revoked by the patient orally or in writing at any time.
The exception is when communications has already occurred as instructed in his consent

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient's or Patient Representative's Initials _____

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician,
Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical records.