GLOBAL NEUROSCIENCES INSTITUTE
CLINICAL EXCELLENCE | RESEARCH | INNOVATION

NEW PATIENT REGISTRATION FORM

PATIENT'S LEGAL NAME:

Last:_____ First:_____ Middle:_____

Mailing Address:_____ Email:_____

Preferred Contact # ☐ Home Phone #:_____ ☐ Cell Phone #:_____

Birth Date: Age:_____ Gender:_____

Social Security #:_____

Patient's Employer:_____ Employer Phone #:_____

We are now required to collect Race, Ethnicity and preferred language. You may choose "Prefer not to answer".

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Prefer not to answer
- ☐ Other
- ☐ White

Ethnicity:

- ☐ Not Hispanic or
- ☐ Latino Hispanic or
- ☐ Latino Prefer not to answer

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Prefer not to answer
- ☐ Other _____

INSURED'S EMPLOYER:

Company Name: _____ Occupation: _____

Company Address:_____

Years Employed:_____ Employer Phone #:_____

Spouse/Parent ***(person to be billed if patient is under age 18)***

Name:_____ Birth Date: / / SSN:_____

Employer Name:_____ Address:_____

Phone:_____ Occupation:_____

PRIMARY INSURANCE Name:_____ Phone #:_____

Subscriber Name:_____ Member ID#:_____ Group #:_____

Effective Date: / / Relationship to Insured:_____ Subscriber DOB: / /

Is this health insurance a benefit of employment? ☐ Y / N ☐

SECONDARY INSURANCE Name:_____ Phone #:_____

Subscriber Name:_____ Member ID#:_____ Group #:_____

Relationship to Insured:_____ Subscriber DOB: / /

REFERRING PHYSICIAN:

Physician Name:_____ Phone #:_____

Address: _____

PRIMARY PHYSICIAN / PCP PHYSICIAN:

Physician Name:_____ Phone #:_____

Address: _____

PHARMACY:

Pharmacy Name:_____ Phone #:_____

Address: _____

EMERGENCY & RECORDS CONTACT:

Emergency Contact:_____ Phone #: _____

Relationship:_____

Authorized Contacts for Release of Information

Authorized Contact 1:_____ Relationship: _____

Authorized Contact 2:_____ Relationship: _____

Information Only to be released to "Authorized Contact" listed above.

☐ Medical Information (Health diagnosis, treatment, etc.)

☐ Financial Information (Balance, payment, insurance)

☐ Prescription Pick up ☐ Documentation Pick Up

May we leave a voicemail containing medical / personal information? Yes ◎ No ◎

Home Phone Number ◎ Yes ◎ No

Cell Phone Number ◎ Yes ◎ No

PATIENT SIGNATURE:

Print Name: _____

Sign: _____ Date: _____

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844-464-6387 | gnineuro.org

Broomall, PA Cherry Hill, NJ Drexel Hill, PA Glen Mills, PA Lawrenceville, NJ Meadowbrook, PA Philadelphia, PA

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PATIENT HEALTH HISTORY FORM

Please provide the following confidential information regarding your medical history. Thank you.

Name: _____ DOB: _____

Reason for Appointment: _____

MEDICAL HISTORY

		Name Dosage Strength Route
Do you take any medications?	YES ○ ○ NO	
Are you allergic to any medications?	YES ○ ○ NO ***(If yes, please explain)***	List:
Do you smoke or chew tobacco	YES ○ ○ NO	How much per day? For how many years?
Do you drink alcohol	YES ○ ○ NO	How much? How often?
Do you take aspirin?	YES ○ ○ NO	How much? How often?
Do you use non-prescription drugs?	YES ○ ○ NO	How much? How often?
Do you bleed or bruise easily?	YES ○ ○ NO	
Have you ever been hospitalized?	YES ○ ○ NO	List:
Have you had any previous surgery?	YES ○ ○ NO	List with dates:
Are you pregnant?	YES ○ ○ NO	
Are there any illnesses that run in the family?	YES ○ ○ NO	List:

Name: _____ DOB: _____

Do you have any of the following medical problems? If yes, please explain.

Heart Disease	YES ○	○ NO	
High Blood Pressure	YES ○	○ NO	
Diabetes	YES ○	○ NO	
Thyroid problems	YES ○	○ NO	
High cholesterol	YES ○	○ NO	
Rheumatic fever	YES ○	○ NO	
Heart murmurs	YES ○	○ NO	
Stomach problems	YES ○	○ NO	
Liver problems or hepatitis	YES ○	○ NO	
Respiratory problems	YES ○	○ NO	
Arthritis	YES ○	○ NO	
Seizures or epilepsy	YES ○	○ NO	
Blood Disorders	YES ○	○ NO	
Cancer	YES ○	○ NO	
Other	YES ○	○ NO	

Do you have any of the following symptoms now?

	YES	NO		YES	NO
Fever	☐	☐	Shortness of Breath	☐	☐
Weight loss	☐	☐	Chest pain	☐	☐
Fatigue	☐	☐	Abdominal pain	☐	☐
Visual Disturbance	☐	☐	Pain upon urination	☐	☐
Hearing Loss	☐	☐	Muscle or joint pain	☐	☐
Nasal Congestion	☐	☐	Rash	☐	☐
Sore throat	☐	☐	Weakness	☐	☐
Hoarseness	☐	☐	Numbness	☐	☐
Cough	☐	☐	Seasonal allergies	☐	☐

What is your present occupation? _____

I certify that the above information is complete and accurate.

Patient's signature: _____ Date: _____

I certify that I have reviewed the above information with the patient.

Physicians Signature: _____ Date: _____

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HIPAA CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date: _____

DOB: _____

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., please indicate where we can leave a message:

PLEASE INDICATE: YES OR NO

HOME NUMBER ◉YES ○NO _____

CELL NUMBER ○YES ○NO _____

II. MY PRIMARY CARE PHYSICIAN INFORMATION

Name: _____

Address: _____

_____

Phone: _____

III. I AUTHORIZE THE FOLLOWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I, _____, agree to the above.
(Patient Name)

Signing this form verifies all information is correct and/or has been updated.

Signature _____ Date _____

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Phone# 844-464-6387
Fax# 215-239-3037
3100 Princeton Pike, Bldg 3 Suite D
Lawrenceville, NJ 08648

Authorization for Patient Access/Release of Health Information

Patient Name:	DOB:
Social Security #:	Phone #:
Home Address:	

Type of Request:
□ Access to review my medical records □ Release of my health information as requested below:
□ Request my medical records from another facility _____

Description of Information to be released: _____
_____

Disclose/ Send Information to:
□ Myself (at the address indicated above) □ To an Organization/Individual:

Organization:	Individual Name:
Address:	
Phone:	Fax:

_____ _____
Signature of Patient or Patient's representative Date

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FINANCIAL POLICY

Welcome to Global Neurosciences Institute, LLC. We are committed to providing you with the highest quality medical care. This financial policy has been established to avoid any misunderstandings concerning payment for our services. We ask you to provide a copy of your current insurance card and legal identification at the time of your visit. Please read the policy and sign prior to any treatment.

Regarding Insurance:

Global Neurosciences Institute, LLC is a professional entity whose providers are participating with Medicare, Medicaid and select commercial insurance companies. If you have a plan that requires an authorization or a referral, it is the patient's responsibility to obtain this information prior to their appointment.

For certain insurance carriers with whom we do not participate, your care will not be limited to the restrictions put in place by your insurance company. At Global Neurosciences Institute, we become your devoted healthcare advocate. To help you understand your plan's non-participating benefits, we will assist you prior to your scheduled surgery or visit and explain what, if any, financial obligations you may incur. These obligations would be related to deductibles, co-pay and co-insurance amounts. Most insurance plans, except for HMO's, allow patients to seek treatment outside of their insurance network. We are committed to helping you, our patient, navigate your out of network benefits and ensure appropriate reimbursement has been received by the insurance company under the terms of your contract.

We will verify your insurance coverage and obtain precertification, if applicable, for physician services. Please understand that a precertification is not a guarantee of insurance payment. All charges will be submitted to your insurance carrier on your behalf. You are responsible for your deductible, copay, and co-insurance amounts required under the terms of your insurance policy. If there is a remaining balance after your insurance company processes your claim, we may request your assistance as we contact the insurance company to resolve these balances. You will be required to sign an Assignment of Benefits form which allows your insurance company to pay Global Neurosciences Institute, LLC directly. In the event your insurance company forwards payment to you, the subscriber, you are required to remit the checks along with the explanation of benefits (EOB) within five business days.

If you were involved in a worker's compensation claim or motor vehicle accident, it is your responsibility to provide the office with the carrier's name, address, open claim number, adjuster's name and phone number in addition to your health insurance information. If your claim is denied, you will be responsible for all charges incurred for these specific types of claims.

Surgical and Inpatient Fees:

As you may be aware, neurosurgeons bill their services separately from hospitals when you have surgery or are an inpatient in a hospital. The fees for the neurosurgeon can include inpatient consults, surgery, routine, uncomplicated postoperative care in the hospital and subsequent visits to our office for defined post-operative periods of time. This postoperative period is defined by independent parties and is dependent on the type of surgery involved. Services not included in the neurosurgeon's fees may include the anesthesiologist, neuromonitoring, assistant surgeon, and the hospital's fees which are billed by those facilities or hospitals separately. Global Neurosciences Institute has no involvement with those charges.

Surgical Assistants:

Depending on the complexity of the procedure, an assistant to the surgeon may be necessary.

Your Responsibility:

If an appeal is required, we ask that you work with our patient advocates to ensure appropriate benefits are paid. If you have any questions regarding our financial policy, please do not hesitate to contact our billing department at 844-464-6387.

I have read Global Neurosciences Institute, LLC's financial policy. I agree that I am financially responsible for all charges related to my medical care regardless of any insurance payment. I further agree to submit all checks received from my insurance carrier to Global Neurosciences.

_____ _____ _____

Signature of Patient or Responsibility Party | Patient Name (print) | Date

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ASSIGNMENT OF BENEFITS / DESIGNATED AUTHORIZED REPRESENTATIVE / LIMITED SPECIAL POWER OF ATTORNEY

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 authorize **Global Neurosciences Institute** to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I request that payment of all Medicare/Medigap and commercial insurance carriers be made payable directly to **Global Neurosciences Institute, LLC** on my behalf. I certify that the information I have given regarding my insurance carrier(s) is valid. 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 penalties or equitable relief) under my health insurance policy or benefit plan to **Global Neurosciences Institute, LLC** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) 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 laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for, and exclusively on behalf of, Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to **Global Neurosciences Institute, LLC** for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its 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. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

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" 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 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 protected health information ("PHI") as further defined under HIPAA.
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 pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, 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 inhibit the exercise of rights under my insurance policy by requiring any further authorization signed by me.

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 3rd 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 3rd 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.

The Assignment of Benefits/Designated Authorized Representative authorization/Limited Special Power of Attorney 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 laws 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.

Patient Name:_____ **Date:** _____

Patient Signature:_____