LIFEBRIDGE HEALTH
The Sandra and Malcolm Berman Brain & Spine Institute

DEPARTMENT OF NEUROSURGERY ~ ***Phone: 410-601-4417; fax: 410-601-7138***

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❒ **Crossroads Medical Center,** 4801 Dorsey Hall Drive, #220, Ellicott City MD 21042
❒ **Fisher Medical Office Building**, 193 Stoner Avenue, #310, Westminster MD 21157
❒ **Mirowski Medical Office Building,** 5051 Greenspring Avenue, #200, Baltimore MD 21209
❒ **Mt. Airy Health & Wellness Pavilion**, 504 East Ridgeville Boulevard, Mt. Airy MD 21771
❒ **Northwest Hospital Professional Center,** 5415 Old Court Road, #S04, Randallstown MD 21133
❒ **Quarry Lake,** 2700 Quarry Lake Drive, #360, Baltimore MD 21209
❒ **Woodbridge Center**, 1401 Pulaski Highway, Suite M, Edgewood MD 21040

Welcome to The Sandra and Malcolm Berman Brain & Spine Institute

You have an appointment with the physician whose name is checked above and at the location that is checked above

on _____, _____, 20 ____ at _____ ❒ am ❒ pm
day of the week *month and day*

You are expected to arrive at your registration time _____ ❒ am ❒ pm

➲ **Please make note of the location of your appointment.**
Directions and map to the location of your visit are enclosed.

➲ **Please arrive at the registration time above to allow for a timely registration.**

➲ You will receive an automated reminder call 48 hours prior to your appointment.

Things You Must Know or Do

1. Read the pages of this packet for **important instructions**
2. Complete and sign the forms on pages 4–10 of this packet **before** your visit and bring them with you when you come (**do not mail them**).
3. If your insurance company requires you to obtain a referral, **it is your responsibility to do so.**
4. If you do not arrive in sufficient time to allow for registration or if you do not bring a required referral, **your appointment may be rescheduled**.
5. To print out more copies of this packet, go to www.lifebridgehealth.org/bsipaperwork.

Things You Must Bring

1. Insurance card **2.** Co-pay, if necessary **3.** Photo ID

4. Referral, if necessary, and/or authorization from requesting physician.
5. Completed and signed pages of this packet—pages 4–10.
6. A list of current medications (see page 10 of this packet) or bring your medication bottles.

If you have any questions, please contact us at
➲ **410-601-4417 or bsiphysicians@lifebridgehealth.org**

We look forward to caring for you.

LIFEBRIDGE HEALTH

The Sandra and Malcolm Berman Brain & Spine Institute

Department of Neurosurgery
Important Information

Please make note of the doctor's name, the location of your appointment, and your expected arrival time on the first page of this packet.

Please help us to be respectful to all of our patients and to our physicians by arriving at the **registration** **time listed on the first page of this packet**.

If you do not arrive at the scheduled registration time, **we may reschedule your appointment.**

Please bring your insurance card and photo ID with you to every visit.

If your insurance requires a referral, please ensure that it is valid and that we have a copy of it prior to your visit. IT IS YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL AND TO FOLLOW THROUGH TO ENSURE THAT WE HAVE IT. If you do not have your referral at the time of your scheduled visit, you may need to reschedule, or you will be responsible for your bill. Please inform us before your appointment of any changes in your insurance coverage.

If for any reason you cannot make your appointment, please call **410-601-4417** to cancel at least 72 hours prior to your appointment.

If you do not arrive for your scheduled appointment and you have not canceled at least 24 hours in advance, you will be charged a $25 no-show fee.

NECESSARY MEDICAL INFORMATION FOR YOUR VISIT

Please have available for the physician the name, office address, and phone number of your referring physician and primary care provider so that we can communicate with him/her.

Please bring a written list of all medications that you currently take, including dose and frequency, or bring the medication bottles—**this is important for new and follow-up patients.**

If you have had any relevant testing (MRIs, EEG, bloodwork, consultations/reports from other providers), please ensure that you bring those reports, films (actual films or CD), or both, with you.

Do not assume that your primary care physician will send this information.

MESSAGES/PHONE CALLS

We attempt to return all phone calls within 24 hours. Sometimes, your call will be returned by another physician or a physician assistant.

PRESCRIPTION REFILLS

For prescriptions refills, your pharmacy must fax a refill authorization request to us at **410-601-7138**. If we have no questions, we will refill your prescription. All refill requests will be completed within 2 business days of receipt, and you should follow-up with your pharmacy to check on the refill.

Please do not wait until the last minute to contact your pharmacy to request a refill.

If your pharmacy advises you of problems with the refill, call 410-601-4417. If your call is answered by the messaging system, please leave a complete message. We will resolve any issues within 2 business days.

IF YOU EXPERIENCE PROBLEMS WITH YOUR MEDICATION AND NEED EMERGENCY CARE, CALL 911.

If you experience problems with your medication but do not need emergency care, call **410-601-4417** and leave a complete message.

DO NOT call this phone line for automatic refill requests.

BILLING QUESTIONS

Before your visit, we check to determine if your insurance is active and to obtain any authorizations that are required. However, it is your responsibility to obtain any referral that may be required by your insurance company and to determine your financial responsibility for your visit, including any amounts that will be charged against your deductible or co-insurance. If you require billing codes to determine your out-of-pocket expenses, we will be happy to provide them. We must receive the request for this information a minimum of 5 business days prior to your appointment.

Following your visit, you may receive two bills, one for physician services and one for hospital services.

For billing questions about your doctor's bills, please call 410-469-4369.
For questions about bills from Sinai Hospital,
call 410-601-1094 (800-788-6995 out of Baltimore area).
For questions about bills from Northwest Hospital,
call 410-521-5959 (877-617-1803 out of Baltimore area).

We know that the payment and the insurance process related to your visit may seem confusing. Please do not hesitate to ask any staff member for clarification. We are here to ensure that your visit is productive, positive, and comforting.

Our staff is committed to providing quality care and customer service to all of our patients. Your safety and privacy are important to us, and we will do our utmost to safeguard them. If during your visit you have any questions or concerns, please do not hesitate to let us know. If at any time you are not satisfied with the handling or resolution of your concern, you may contact Guest Relations at 410-601-8778.

Thank you for your attention to our policies. We look forward to seeing you and will do our best to provide you with excellent care.

LIFEBRIDGE HEALTH

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DEPARTMENT OF NEUROSURGERY
New Patient Registration Sheet

Please complete these documents and bring them with you on the day of your appointment.

Name:_____ Date: _____

Social security #: _____ DOB: _____ Sex:_____

Address: _____

City, state, zip _____

Home phone: _____ Work phone: _____

Cellphone:_____ email address: _____

Marital status:_____ Languages:_____ Religion:_____

ADVANCE DIRECTIVES ~ Do you have a living will or advance directive? ❒ Yes ❒ No

Have you named a person to make medical decisions for you if you are unable to make them for yourself?

❒ Yes ❒ No If so, who is that person? _____

INSURANCE HOLDER INFORMATION

Name of insured if other than patient: _____

SSN:_____ DOB_____ Relationship:_____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

City, state, zip: _____

Primary (main) insurance company: _____

Effective date: _____ Retirement date:_____

Insurance ID number: _____

Secondary (supplemental) insurance company: _____

Effective date: _____ Retirement date:_____

Insurance ID number: _____

~ PLEASE CONTINUE TO THE OTHER SIDE OF THIS SHEET ~

The information furnished above will be used ONLY for billing and accounting purposes.

Please complete these documents and bring them with you on the day of your appointment.

PATIENT NAME _____ DOB _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Work number: _____ Home number: _____

REFERRING PHYSICIAN

Name: _____ Phone: _____

FAX: _____

Address: _____

City, state, zip: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone: _____

FAX: _____

Address: _____

_____

City, state, zip: _____

PHARMACY

Name: _____

Phone: _____ FAX: _____

The information furnished above will be used ONLY for billing and accounting purposes.

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Authorization and Assignment of Insurance Benefits

Patient name _____ DOB _____

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees to the following:

1. I authorize payment of medical benefits to the physician(s) rendering service(s).
2. I agree and acknowledge that my signature on this document authorizes my physician(s) to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on every claim submitted for me and/or my dependent(s). I will be bound by this signature as though the undersigned had personally signed the particular claim.
3. I will pay to the physician(s) any balance due for services rendered. I understand that if payment is not made on my behalf (by my insurer, legal representative, or workers compensation insurance), I will be responsible for any outstanding balance.
4. I understand that the Department of Neurosurgery checked with my insurance company prior to this visit to determine whether my insurance is active and to obtain any required authorizations.
5. If I have received neurodiagnostic testing, I understand that following my visit, I will receive two bills—one for the doctor's services and one for the hospital's services.
6. I understand that it is my responsibility to obtain any referrals required by my insurance company and to determine my financial responsibility for all charges for this visit, including those from the doctor and from the hospital and any amounts that will be charged against my deductible or co-insurance.

❒ The reason for this visit **is not** the result of a Workers Compensation claim and, therefore, payment for this visit **is not** eligible for payment by Workers Compensation insurance.

❒ The reason for this visit **is** the result of a Workers Compensation claim, and the claim for services provided should be submitted to my Workers Compensation carrier:

_____	_____	_____
Workers Compensation carrier	*claim number*	*adjuster's phone number*

I UNDERSTAND THAT IF I HAVE NOT PROVIDED CORRECT AND TRUTHFUL INFORMATION REGARDING THE REASON FOR THIS VISIT AND INSURANCE COVERAGE, I WILL BE RESPONSIBLE FOR ANY UNPAID CLAIMS.

_____	_____
signature of patient, parent/guardian, guarantor	*date*

LIFEBRIDGE HEALTH

The Sandra and Malcolm Berman Brain & Spine Institute

Patient Authorization

Patient name _____ DOB _____

The providers in the Department of Neurosurgery are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this patient authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize the Department of Neurosurgery to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.
2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.
3. Send me notices, clinical notes, and lab results via: ❒ text message ❒ email
4. I would like to receive an email invitation that provides instructions on how to register for the Sinai Hospital Patient Portal. ❒ yes ❒ no

   _____
   please print email address

5. Call my home or work and leave a message to contact the office.

   My preferred method of contact for appointment reminders is

   ❒ home phone ❒ cell phone ❒ text message on cell phone ❒ email

   _____ _____
   home phone number *cell phone number*

6. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.
7. Update my personal demographic information either on the phone or in the office at the time of my appointment.
8. I give permission to discuss my personal health with the designated person(s) below:

   _____ _____
   name *relationship*

   _____ _____
   name *relationship*

I have read and agree to the above policies.

_____ _____
patient signature *date*

MR7350-501-L

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Patient's Date of Birth _____

Patient's Street Address _____ Social Security Number _____

City, State, Zip Code _____ Phone Number _____

I, the undersigned, hereby authorize _____

☐ to **release** copies of medical records to: ☐ to **obtain** copies of medical records from:

☐ **Verbal** release only of medical information to:

Department of Neurosurgery, LifeBridge Health — Name of Person or Agency

410-601-4417 — Phone Number

Address — City, State, Zip Code

410-601-7138 — Fax Number

The purpose or need for such disclosure is _____

Dates of Service: _____

_____ is authorized to release the following: (Please check information to be released) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV / AIDS testing, HIV / AIDS results or HIV / AIDS information.

- ☐ Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
- ☐ Emergency Room Record
- ☐ Outpatient Surgery
- ☐ Discharge Summary
- ☐ Admission History and Physical
- ☐ Consultation Report
- ☐ HIV / AIDS Report
- ☐ Doctor's Office Notes
- ☐ Operative Report / Pathology Report
- ☐ Alcohol / Detox / Drug Abuse
- ☐ X-ray, EKG, EEG, Labs, Cardiopulmonary
- ☐ Physical Therapy / OT / Speech
- ☐ Nuclear Medicine
- ☐ Clinic
- ☐ Mental Health / Psychiatry
- ☐ Other _____

Signature **Date** **Relationship to Patient**

Witness **Date**

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d) ***Photo Id** **may be requested at the time of release.**

MR# Date Completed Completed By # pages

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DEPARTMENT OF NEUROSURGERY
New Patient Information Sheet

Patient name: _____ Age: _____ Birthdate _____
mm/dd/year

REASON FOR VISIT

_____

_____

REVIEW OF SYSTEMS—IN THE PAST 2 WEEKS, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? IF YES, PLEASE EXPLAIN.

YES	NO	➔ Please check "No" or Yes." If you check "Yes," please explain in the space provided.
❒	❒	Fever/chills _____
❒	❒	Weight loss/weight gain _____
❒	❒	Changes in vision _____
❒	❒	Changes in hearing _____
❒	❒	Chest pain _____
❒	❒	Breathing difficulties _____
❒	❒	Nausea, vomiting _____
❒	❒	Bowel changes _____
❒	❒	Changes in urination _____
❒	❒	Skin sores/discoloration _____
❒	❒	Bruising or bleeding _____
❒	❒	Unusual illnesses _____
❒	❒	Other problems _____

PAST MEDICAL HISTORY— HAVE YOU HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

	YES	NO			YES	NO
High blood pressure	❒	❒		Diabetes	❒	❒
Heart attack	❒	❒	When? _____	Heart disease	❒	❒
Cancer	❒	❒	Type? _____	Low thyroid	❒	❒
Stroke	❒	❒	When? _____	Asthma/COPD	❒	❒
Sleep apnea	❒	❒		Blood clots	❒	❒

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS? IF SO, PLEASE EXPLAIN.

_____

_____

HAVE YOU HAD OTHER SURGERIES? Yes ❒ No ❒ **IF SO, PLEASE LIST.**

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient name:_____ DOB _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? Yes ❒ No ❒ **IF SO, PLEASE LIST.**

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

DO YOU HAVE ALLERGIES OR REACTIONS TO ANY DRUGS? Yes ❒ No ❒ **IF SO, PLEASE LIST.**

_____

_____

_____

Family History—Please list any health problems in your family.

Father: age _____ ❒ Deceased Health problems: _____

Mother: age _____ ❒ Deceased Health problems: _____

Brother(s): age _____ ❒ Deceased Health problems: _____

Sister(s): age _____ ❒ Deceased Health problems: _____

Social History

Do you smoke? ❒ Yes ❒ No If yes, how much?_____ How many years? _____

Have you smoked in the past? ❒ Yes ❒ No When did you quit? _____

Do you drink alcohol ❒ Yes ❒ No How much?_____

Do you use recreational drugs? ❒ Yes ❒ No What is your height? _____ Your weight? _____

What is your occupation? _____

Is this injury work related? ❒ Yes ❒ No If yes, please explain. _____

_____

_____

Employer: _____

Workers' Compensation company: _____

Adjustor: _____ Phone number: _____

Address: _____

Claim #: _____ Date of injury: _____

Is this injury related to an automobile accident?

Date of accident: _____ Insurance: _____

Attorney name & address (if applicable): _____

_____