Nkrumah Neurosurgery & Spine™

Patient Demographics

Today's Date: _____

Name: (Last): _____ (First): _____

(Middle Initial): _____ I prefer to be called: _____

Date of Birth: _____/_____/_____ Age: _____ SSN: XXX-XX-_____

☐ Male ☐ Female _____

Race/Ethnicity: _____ Preferred language: _____

Email Address(1): _____ Email Address(2): _____

Home Address: _____ City: _____

State: _____ Zip: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

(if different)

Home Phone: (_____) _____ ☐ OK to leave voice message

Cell Phone: (_____) _____ ☐ OK to leave voice message ☐ OK to text

Preferred contact number: ☐ Home (above) ☐ Cell (above) ☐ Other (_____) _____

_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____

Emergency Contact

Name: _____ Phone: (_____) _____ Relationship: _____

Insurance Information

Is this a Worker's Compensation or No-Fault claim? ☐ No ☐ Yes

(if yes, go to the corresponding section).

Primary Insurance: _____ Phone: (_____) _____

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

Patient ID number _____ Group number _____

Effective from _____ Effective until _____

(MM/DD/YYYY) (MM/DD/YYYY)

Secondary Insurance: _____ Phone: (_____) _____

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

Patient ID number _____ Group number _____

Effective from _____ Effective until _____

(MM/DD/YYYY) (MM/DD/YYYY)

Louis J. Nkrumah, MD, PhD | 4 Ohio Drive Suite 220, Lake Success, NY 11042

Phone: (631) 525-1420 | Fax: (631) 610-4420

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Worker's Compensation

Claim number: _____ Date(s) of Injury: ____/____/_____

Carrier _____ Carrier case/Claim number: _____

Adjuster Name: _____ Phone: (_____) _____

Claims submission address: _____

Employer at the time of injury: _____

Employer's address: _____

_____

No-Fault

Claim number: _____ Date(s) of Injury: _____/_____/_____

Policy number: _____ Adjuster name: _____

Insurance Name /Carrier: _____ Phone: (_____) _____

Claims submission address _____ Fax: (_____) _____

Attorney Name: _____ Phone: (_____) _____

Address: _____ Fax : (_____) _____

Referring Physician

Name: _____ Phone: (____) _____ Fax: (____) _____

Primary Care Physician

Name: _____ Phone: (____) _____ Fax: (____) _____

☐ I certify that the above information is true and correct to the best of my knowledge.

☐ As the responsible party, I agree that any amount not covered by my insurance will be my responsibility unless otherwise stated.

Patient Signature: _____ Date: _____

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Patient History

Name: _____

History of Present Illness

What is the reason for your visit/ what are your symptoms? _____

_____

_____

_____

When did your symptoms begin? _____

Have you seen any doctors regarding your symptoms? ☐ Yes ☐ No

If yes, what is the name of the provider? _____

_____

Physical Therapy/Chiropractor ☐ Yes ☐ No If yes, what are the dates _____

Injections ☐ Yes ☐ No If yes, what are the dates _____

Past Medical History

Please list any medical conditions.

_____

_____

_____

_____

Surgical History

Please list any hospitalizations.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Medication List

Name Dosing

_____

_____

_____

_____

Are you on any blood thinners? ☐ Yes ☐ No If yes, please list _____

Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

Preferred Pharmacy_____ Location_____ Phone (_____)_____

Do you accept blood products? ☐ Yes ☐ No

Social History

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per day? _____

Do you use illicit drugs? ☐ Yes ☐ No If yes, which one(s)? _____

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Authorization
Disclosure of Protected Information

Patient Name: _____ Date of Birth: _____/_____/_____

Name of Insured : _____

Name of Patient : _____

I hereby authorize the above named medical practice to use, disclose or obtain the following protected information:

_____ All Medical Records

_____ Specific Medical Records - specify _____

_____ Medical Imaging - specify _____

_____ Other - specify _____

These records may be obtained from:

_____

_____

_____

Please mail the above requested medical records to:

Nkrumah Neurosurgery & Spine
4 Ohio Drive, Suite 220
Lake Success, NY 11042

Or fax to: **(631) 610-4420**

Name of Patient (print) _____

Signature _____ Date _____

Nkrumah Neurosurgery & Spine™

Assignment of Benefits Form

Name of Insured : _____

Name of Patient : _____

_____ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to the provider listed below for any services provided to me by that provider.

_____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the provider, CMS, my insurance carrier, or other entity if requested. The original authorization will be kept on file by the provider.

_____ I understand that I am financially responsible to the provider for any charges not covered by health care benefits. It is my responsibility to notify the provider of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the provider and/or my health care insurer if the submitted claim/claims or any part of them are denied for payment.

_____ I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

_____ I hereby authorize my provider to release all information acquired during the medical examination and treatment for insurance claim filing. Photocopies of this authorization shall be considered as effective and valid as the original.

Name of Patient _____ **Relationship to Insured** _____

Signature of Patient/Guardian _____ **Date** _____

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Guarantee of Payment Consent Form

Many insurance companies, including managed care organizations, require written authorization for treatment and follow-up visits. As a patient, it is your responsibility to obtain all necessary authorizations from your insurance company prior to receiving medical services.

If you have not received prior approval for the service or authorization has been denied, or if you do not have out-of-network benefits, you are fully responsible for all charges. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

Co-payments are collected at the time of service when they can be anticipated. All returned checks will incur a $50.00 service fee in addition to any fees assessed by our banking institution.

I understand that failure to pay a bill on time (after 3 bills have been sent) may result in a further review by a collection agency and I understand that I will be further responsible for any additional fees or legal fees associated with the collection of any balance of the visit and any related procedures will be collected at the time of the services rendered based upon the best information available to the practice.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

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No Show And Surgery Cancellation Policy

Appointments

When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond your control. In this event, we ask that you **call our office and cancel your appointment no less than 24 hours before the scheduled visit.** This courtesy allows my office staff to schedule another patient who is also in need of medical care.

Surgery

We also understand the financial stress surrounding medical care and we aim to work with every patient no matter what the circumstances may be. Given the sensitive nature of surgical scheduling and the resources that are expended to reserve operating room time and staff, there is a $1,500.00 fee for all canceled surgeries once the date of surgery has been confirmed and a $3,000 fee for cancellation within 2 weeks of the stated date.

Your signature acknowledges that you understand that failure to cancel an appointment or a surgery once a date is selected may result in additional fees that are not covered by health insurance and reflect the cost of such cancellation to Nkrumah Neurosurgery & Spine.

Thank you for your understanding.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

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