TEMECULA VALLEY
NEUROSURGERY
COMPLEX SPINE & BRAIN SPECIALISTS

25150 Hancock Ave, Suite 210
Murrieta CA, 92562
Tel: 951-587-3739 Fax: 951-698-5213

Bret Abshire, MD
Daniel Friedlich, MD
Gerald Oh, MD
Tracey Anderson, NP

PERSONAL INFORMATION

Date _____ Primary Care Physician _____ PCP Phone # _____

Patient Name _____ Preferred Name _____

Date of Birth_____ SSN# _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address_____

City _____ State _____ Zip_____

Occupation _____ Employer _____

Referred by _____ Pharmacy_____ Pharmacy phone number_____

Advanced Care Plan Available? ☐ Yes ☐ No If yes, Name of Surrogate decision maker_____ Phone number_____

Contact Information- Please indicate which of the following numbers and/or email address we should use to communicate with you. ONLY list the phone numbers you want us to call. Please specify if a message can be left.

Home Phone_____ Message: ☐ Yes ☐ No **E-Mail** _____ Message: ☐ Yes ☐ No

Work Phone _____Ext.# _____ Message: ☐ Yes ☐ No

Cell Phone_____ Text Message: ☐ Yes ☐ No Voice Message: ☐ Yes ☐ No

Preferred method of communication? ☐ Home ☐ Work ☐ Cell Phone ☐ Text message ☐ Email

My PHI (personal health information) may be communicated to: Do Not communicate my PHI to:

_____ _____

_____ _____

_____ _____

INSURANCE INFORMATION

Primary Insurance	**Additional Insurance**
Name of Insured _____	Name of Insured _____
Relationship to patient _____	Relationship to patient _____
Insured's Birthdate _____	Insured's Birthdate _____
SS #/SIN _____	SS #/ SIN _____
Employer _____	Employer _____
Date Employed _____	Date Employed _____
Occupation _____	Occupation _____
Insurance Company _____	Insurance Company _____
Group # _____	Group # _____
Insurance Co. Address _____	Insurance Co. Address _____
Deductible _____	Deductible _____
Max. Annual benefit _____	Max. Annual benefit _ _____

It is the patient's responsibility to notify Temecula Valley Neurosurgery of any changes in information

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POLICIES AND PROCEDURES

Office hours:
Our office is open Monday-Thursday from 8:00 am to 4:00 pm, we are closed for lunch from 12:00pm to 2:00pm. We do frequently see patients during this time. Fridays from 8:00am-12:00PM. We are closed in observance of major holidays.

PLEASE BE AWARE THAT OUR PHYSICIANS DO TAKE TRAUMA CALL AND CAN BE CALLED OUT TO AN EMERGENCY AT ANY GIVEN TIME.

Wait times:
We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule which can lead to wait times that may exceed up to 1 hour or more. We appreciate your patience and understanding.

APPOINTMENTS:
First-time patients are asked to arrive 20 minutes **before their scheduled appointment** to allow adequate time for check-in and processing of the initial paperwork. We ask that you hand-carry Insurance cards, Driver's License and ANY CDs with reports related to the appointment reason. Please be advised that all imaging studies must be no more than 1 year old. If a patient arrives to their appointment without the above, they will be rescheduled.

In order to streamline the registration process patients have the option of completing their paperwork online prior to their appointment via our online patient portal. Patients must provide their email address to our office staff so we may send an invitation and portal link. If you would prefer a paper version these can be retrieved from our website, **WWW.TVNEUROSURGERY.COM** under the patient resources tab.

Late policy:
If a patient arrives greater than 15 minutes late for their scheduled appointment, they will need to be rescheduled to the next available date. If a patient no-shows to three or more appointments, we will assume another physician is treating them and they will be discharged from our care.

Cancellation Fee:
There will be a fee of $50 if a patient No-Shows to a scheduled appointment.
If there is a need to reschedule please let our office know at least 24 hours in advance. Same day cancellations will be considered a No-Show. A No-Show occurs when a patient fails to keep a scheduled appointment. When a patient is considered a No-show a fee of $50 will be generated onto the patients' account, this fee will need to be paid before rescheduling an appointment. Three no shows will require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

Zero Tolerance Policy:
Temecula Valley Neurosurgery adheres to a zero-tolerance policy and has the right to terminate a relationship with any patient who's abusive (including yelling or threatening physicians, staff, or others), who fails to follow directions or who does not pay for /make arrangements to pay for services. Angry or foul language directed to our staff regardless of the issues involved will not be tolerated and will be grounds for immediate dismissal from our practice.

Referrals: If your insurance requires a referral or prior authorization, please be sure one has been obtained prior to scheduling your appointment. We will be unable to schedule an appointment without authorization. Please hand-carry a copy of your authorization to your appointment or make arrangements to have your referring physician fax a copy to our office with any medical records pertaining to the reason for your visit.

Once a patient is seen by our physicians and further testing is recommended, please allow our referral coordinator 5 business days to process any referrals that require insurance preauthorization.

Handicapped access: There is elevator access in the building for our patients as our office is located on the second floor**.**

Hospitals: Our physicians perform surgery at Inland Valley Medical Center, Loma Linda Medical Center- Murrieta and Temecula Valley Hospital

Medical Records: Medical records will be stored for 7 years. Copies of medical records can be faxed to another physician upon receipt of a signed medical records release from the patient. If the patient would like a copy of their medical records, we can share documents within the patient portal at no charge. Please contact our office staff to obtain login information. If the patient prefers paper copies of their records, a record release form will need to be completed and signed. Please note there is a $ 0.25 processing fee for each page requested. We will require a 3-day notice for processing medical records requests or for the pickup of films or CD's that have been left in our office.

Fees and payments:
Payment in full is due at the time services are rendered unless we are submitting charges to your insurance company. ***Copays and deductibles are due at the time of service or your appointment may be rescheduled.*** We accept most major credit cards. We also accept personal checks, money orders, cashier checks & cash. Those patients without proof of coverage may be required to pay in full or be asked to reschedule their appointment. If we are not contracted with your particular insurance plan, YOU must pay in full at the time of service. You will be given a copy of our charge slip to submit to your insurance company for reimbursement purposes.

Even though we will bill the patient's insurance, we must emphasize that as medical providers our relationship is with the patient, not the insurance company. Billing the insurance does not necessarily ensure payment by the insurance company nor does it release the responsible party from its financial obligation to our office for any unpaid balance. In case of an insurance partial payment, the remaining balance will be due from the patient as noted on the billing statement. Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. A $30 fee will be assessed on accounts placed in collections. A $25 service fee will be charged for returned checks due to insufficient funds. We may also elect to discharge you from our practice should you fail to comply with our policy. Should you require a payment plan, our billing department will be glad to discuss your options with you.

Medications: It is our office policy to **ONLY** prescribe narcotic pain medication temporarily to patients who have undergone recent surgery and have a signed pain contract on file with our practice. Non-surgical patients will need to contact their primary care physician for ALL prescriptions. If you are a patient who underwent recent surgery and requires a refill of your medication, please contact our office **DURING BUSINESS HOURS at least 3 business days prior to the refill date.**

NOTE: REFILLS WILL ONLY BE GRANTED TO PATIENTS WHO HAVE UNDERGONE RECENT SURGERY, HAVE A SIGNED PAIN CONTRACT ON FILE AND HAVE BEEN SEEN IN THE OFFICE FOR REGULAR POST OP CARE.

I HAVE READ THE ABOVE POLICIES & PROCEDURES AND I UNDERSTAND THAT IF FOR ANY REASON I DISAGREE WITH THE ABOVE, I DO HAVE THE RIGHT TO CANCEL MY APPOINTMENT AND SEEK TREATMENT ELSEWHERE

I hereby assign the insurance benefits to which I am entitled, directly to TEMECULA VALLEY NEUROSURGERY, INC., a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility, I authorize the release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by TEMECULA VALLEY NEUROSURGERY, INC. A copy of this authorization is accepted with the same authority as the original.

x_____ _____
SIGNATURE OF PATIENT / GUARDIAN DATE

This agreement will remain valid from this day forward to include all future services relating to the above Patient, or until changes in the above information are required.

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Acknowledgment of Receipt of Notice of Privacy Practices
Health Insurance Portability & Accountability Act (HIPAA)

I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and on their website www.tvneurosurgery.com. I also acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date:_____

Print Name:_____ Telephone: _____

If not signed by the patient, please indicate the relationship:

□ Parent or guardian of a minor patient.
□ Guardian or conservator of an incompetent patient.

Name of patient: _____

Office Use Only

To be completed only if no signature is obtained. If it is not possible to obtain patient acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why it was not obtained.

Handed to patient: Yes/No
Patient refused to sign: Yes/No
Other:_____

Employee Initials_____

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Past Medical History

Patient Name: _____ **Date of Birth:** _____**Date**:_____

Reason for Visit: _____ **PCP:** _____

☐ **No Medical Diagnosis**

Check the condition(s) that apply to your past medical history -

- ☐ Anemia
- ☐ Anesthesia problem
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Problems
- ☐ Bladder Infections
- ☐ Bleeding Disorder
- ☐ Blood Clots / CVT
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Congestive Heart Failure
- ☐ COPD / Emphysema
- ☐ Crohns / Ulcerative Colitis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Heart Disease / CAD
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/ AIDS
- ☐ Hyperthyroid / Hypothyroid
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/ Cirrhosis
- ☐ Lung Disorder
- ☐ Lupus
- ☐ Malaria
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mumps
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Parkinson's
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonally Allergies
- ☐ Sexually Transmitted Diseases
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Smallpox
- ☐ Stroke / TIA
- ☐ Tuberculosis
- ☐ Urinary Incontinence
- ☐ Vertigo
- ☐ Whooping Cough

Smoking Status:

- ☐ Current smoker — If yes, Packs/day:____ Number of Years:____
- ☐ Former smoker — Quit Date: _____
- ☐ Never smoker

Alcohol Use Status:

- ☐ Does not drink
- ☐ Currently drinks — If yes, Alcohol Type:_____ Drinks/Week:_____
- ☐ Former drinker — Quit Date: _____
- ☐ Quit

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Illicit/Illegal drugs Status:

- ☐ Does not take drugs
- ☐ Currently takes drugs If yes, Drug Type:_____
- ☐ Former drug user
- ☐ Quit Quit Date: _____

Injury Information/ Type of Injury: Related to current symptoms

- ☐ Work If yes, Injury Date: _____ Injury Details:_____
- ☐ Auto
- ☐ Sports
- ☐ Other

Family Medical History

Check the condition(s) that apply and indicate which family member:

Condition:	Relationship to patient: eg. Mother, Father, Sister, son
☐ Anemia	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Blood Clots/DVT	_____
☐ Cancer	_____
☐ COPD/Lung Disease	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Heart Disease/CAD	_____
☐ Hepatitis	_____
☐ High Blood Pressure	_____
☐ HIV/AIDS	_____
☐ High Cholesterol	_____
☐ Irregular Heartbeat	_____
☐ Liver Disease	_____
☐ Osteoporosis	_____
☐ Prostate	_____
☐ Stomach Ulcer/Reflux	_____
☐ Stroke/Seizures	_____
☐ Vascular Disease	_____
☐ Thyroid Disease	_____
Other:_____	_____

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Patient Name:_____ **DOB**:_____

Past Surgeries

Surgery/Procedure	Hospital	Date	Comments

Current Prescriptions and Over-the-counter Medications

Drug name	Dosage	Drug name	Dosage

Do you take aspirin or anti-inflammatory medications? ☐ **No** ☐ **Yes- Please list below**

What is your preferred pharmacy?_____

Do you take any of the following medications? ☐ **Plavix** ☐ **Coumadin** ☐ **Warfarin** ☐ **Pradaxa** ☐ **Xarelto**

Patient Drug Allergies

☐ **No known drug Allergies.**

Allergy	Severity (Mild, Moderate, Severe)	Date	Comments