Harron Neurosurgery, P.C.
150 Spartan Drive | Salem, VA 24153
P: 540.400.8777 | **F:** 540.400.8795
www.harronneurosurgery.com

Dear_____:

Thank you for choosing Harron Neurosurgery, P.C., for your health care needs. You have an upcoming appointment on _____ at _____am/pm.

Our office is located at 150 Spartan Drive, Salem, VA 24153. Directions and a map are enclosed.

We are enclosing several forms for you to complete prior to your appointment. **Please bring these completed forms at the time of your appointment and give them to the receptionist when you sign in.** Also, please bring your MRI or CT films and CD-ROM to your appointment. Please arrive 15 minutes prior to your appointment time so we can review your documents and gather additional information if necessary. Your form packet includes:

- Patient Information
- Medical Information
- Review of Systems
- Current Medications
- Consent and Authorization
- Medication and Disability Policy
- Acknowledgement of Receipt of Privacy Notice/Consent
- Surgery Information

In addition to these completed forms, please bring your current insurance cards and your driver's license or valid picture ID. If your insurance requires a referral from your primary care physician, it is your responsibility to obtain that referral prior to arriving for your appointment. Any copayment required by your insurance company will be collected when you sign in.

Please call our office at 540.400.8777 should you have questions prior to your appointment.

Very truly yours,

Medical Secretary

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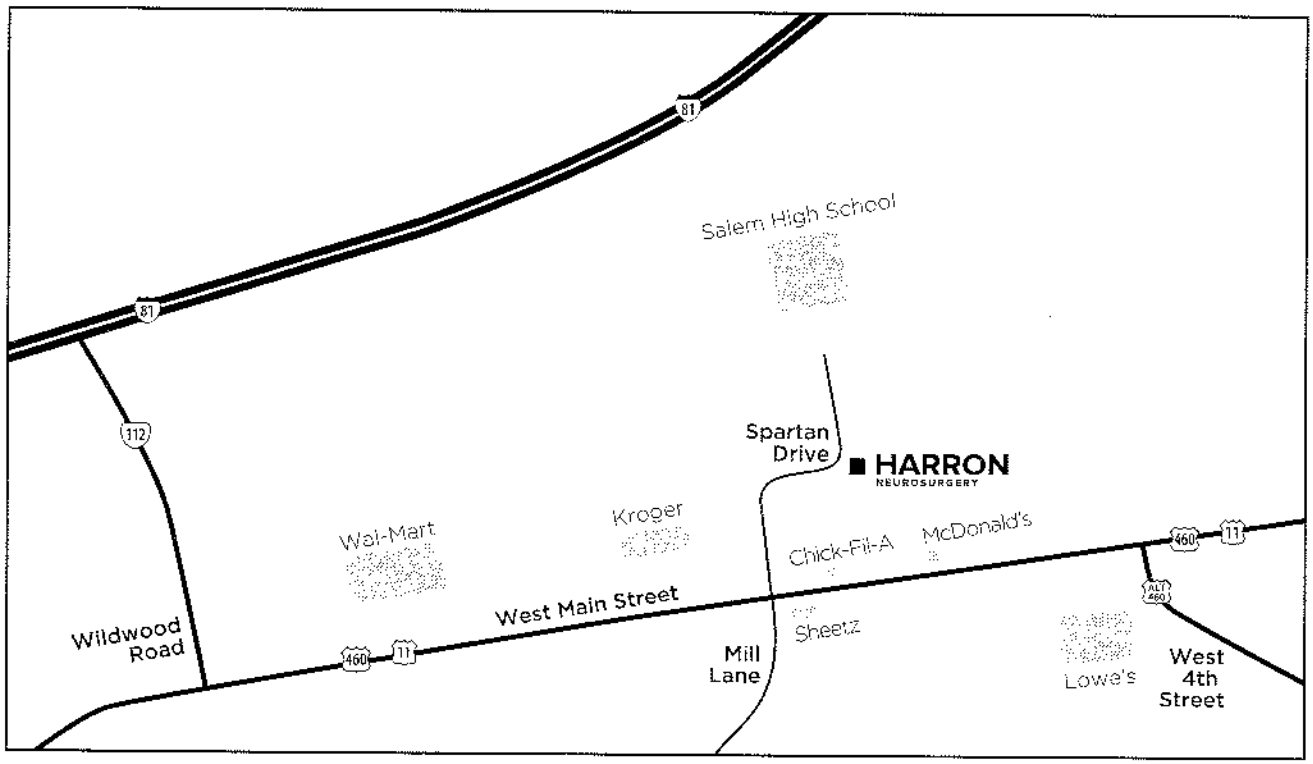

Directions from I-81 SOUTH:

- Take Exit 137 and turn LEFT onto Wildwood Road.
- Take a LEFT turn onto US 11/460E/West Main Street.
- Stay in the LEFT lane.
- Turn LEFT onto SPARTAN DRIVE.
- The office is on the RIGHT: 150 SPARTAN DRIVE.

Directions from I-81 NORTH:

- Take Exit 137 and turn RIGHT onto Wildwood Road
- Take a LEFT turn onto US 11/460E/West Main Street.
- Stay in the LEFT lane.
- Turn LEFT onto SPARTAN DRIVE.
- The office is on the RIGHT: 150 SPARTAN DRIVE.

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PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT NAME: _____
(Last) (First) (Middle) (Maiden)

Address: _____
Street or P.O. City State ZIP

Home Phone: _____ Work Phone: _____ Cellular Phone: _____

SS#: _____ DOB: _____ Age: _____ Sex: M F Marital Status: S M D W

Race: _____ Ethnicity: _____ Preferred Language: _____

Emergency Contact Name: _____ Telephone: _____

E-Mail Address _____

EMPLOYER: _____ RETIRED: Yes ☐ No ☐

Address: _____ Telephone: _____

SPOUSE or PARENT/GUARDIAN (if minor)

NAME: _____ DOB: _____ SS#: _____

Employer: _____

Employer Address: _____ Telephone: _____

PRIMARY INSURANCE COMPANY: _____

Subscriber or Insured Name: _____ DOB: _____

Policy #: _____ Group #: _____ Effective Date: _____

Relationship to Patient: _____ SS#: _____

SECONDARY INSURANCE COMPANY: _____

Subscriber or Insured Name: _____ DOB: _____

Policy #: _____ Group #: _____ Effective Date: _____

Relationship to Patient: _____ SS#: _____

FAMILY PHYSICIAN: _____

CARDIOLOGISTS/OTHER SPECIALTY PHYSICIANS: _____

REFERRED BY: _____

PHARMACY: _____ PHONE: _____

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PLEASE FILL OUT THIS FORM IN AS MUCH DETAIL AS POSSIBLE.

MEDICAL INFORMATION

Name: _____
Chart: _____
Date _____

Height:_____ Weight:_____

Briefly describe your symptoms and how they began:

_____

_____

Past and Current Illnesses:

- ☐ High Blood Pressure
- ☐ Heart Problems (Murmur, Heart Attack, Mitral Valve Prolapse, Angina)
- ☐ Diabetes - diet-controlled
- ☐ Diabetes - diet and pills
- ☐ Diabetes - insulin required
- ☐ Breathing Problems (Asthma, Sleep Apnea)
- ☐ Other: (Please describe) _____

Surgical History: operations you have had, back or neck surgeries

Date	Reason	Physician

List any drug allergies/food and environmental allergies:

_____

_____

Do you take blood-thinning medications? ☐ Yes ☐ No
Do you use: ☐ a TENS unit ☐ Ice ☐ a Heating Pad
Do you take Aspirin? ☐ Yes ☐ No
Do you take Ibuprofen? ☐ Yes ☐ No
Bed Rest makes my pain: ☐ Better ☐ Worse ☐ No Change
Do you use tobacco products? ☐ Yes ☐ No How long?_____ How much?_____

I am currently:
- ☐ Working Full-Time
- ☐ Working Part-Time
- ☐ On Disability
- ☐ Applying for Disability
- ☐ Retired
- ☐ On Worker's Compensation

Have you had:

☐ Physical Therapy (in the past 6 months) Frequency_____ Where? ☐ Neck ☐ Back
How much relief has physical therapy given you? ☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

☐ Chiropractic Therapy (in the past 6 months)
How much relief has chiropractic therapy given you? ☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

☐ Epidural Steroid Injections If so, how many?_____ Where? _____
How much relief did you receive from the injections? ☐ 0%-25% ☐ 26%-50% ☐ 51%-75% ☐ 76%-100%

☐ Change in Gait: If so, explain _____

Pain Assessment:

Do you experience pain as part of your daily life? ☐ Yes ☐ No
If yes, on a scale of 1-10, how would you rate your pain? Please circle:

No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain

How does your pain affect your Activities of Daily Living? Please list: _____

_____

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NEUROSURGERY

Name: _____ Today's Date _____

Date of Birth: _____

REVIEW OF SYSTEMS

Please check Yes or No for the symptoms you currently have.

Yes	No	
		chills
		fatigue
		fever
		sleep loss/problems
		weight gain/obesity
		weight loss
		angina
		chest pain/pressure
		edema (swelling)
		elevated blood pressure
		exercise intolerance
		fainting/blackouts/pass out
		heart murmur
		irregular heartbeat
		asthma
		bronchitis
		difficulty breathing
		difficulty breathing at rest
		difficulty breathing on exertion
		frequent cough
		swelling of ankle and foot
		numbness/tingling
		headache
		motor weakness
		paresis (weakness)
		seizure
		spasms/spasticity

Yes	No	
		speech difficulties
		syncope (fainting)
		vertigo (room spinning)
		stroke
		tremors
		seasonal allergies
		cancer of head and neck
		difficulty swallowing
		epistaxis (bloody nose)
		hoarseness
		back pain
		neck pain
		sciatica
		double vision
		blurred vision
		photophobia (sensitivity to light)
		vision change
		urinary incontinence
		urinary retention/hesitancy
		stomach pain
		bowel incontinence
		nausea/vomiting
		blood clots
		bleeding/bruising
		pulmonary embolus (clots to the lungs)
		venous thrombosis (clots in the veins)

Name: _____ Date of Birth: _____

Allergies to: _____ Type of Reaction: _____

Allergies to: _____ Type of Reaction: _____

CURRENT MEDICATIONS

Drug Name	Date Started	Strength	Dose	Frequency	Prescribing Doctor	Reason for Medication	Nurse Use Only

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CONSENT AND AUTHORIZATION

Name: _____

Chart: _____

Date: _____

1. Consent to Treatment: I, the undersigned, do consent to the physicians of Harron Neurosurgery, P.C., to administer any and all treatments deemed necessary for diagnostic or treatment purposes while in their care. This consent is given for a period of one year, ending one year from the date signed below.

2. Consent to HIV Testing: In case a health care worker of this Clinic, during your care, is punctured by a needle or is directly exposed to fluids that may transmit the HIV virus, in accordance with Section 32.1-45.1 of the Virginia Code, you will be deemed to have consented to the Clinic's right to draw blood for testing for the HIV virus and the release of such test results to the Clinic and the worker who suffered the exposure. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.

3. Consent for Virginia Jurisdiction: The relationship between the undersigned Patient and Harron Neurosurgery, P.C., shall be in accordance with and governed by the laws of the Commonwealth of Virginia in effect as of the date of this Registration. The Patient hereby consents to the personal jurisdiction of any state or federal courts located within the Commonwealth of Virginia.

4. Authorization of Benefits: I authorize the release of any medical information necessary to process my insurance claims for services rendered by Harron Neurosurgery, P.C., and request payment to be made directly to Harron Neurosurgery, P.C. I accept responsibility for all charges incurred at Harron Neurosurgery, P.C.

5. Consent to Medical Photography: I consent for medical photographs to be made of me or my child (or person for whom I am legally responsible). By consenting to these medical photographs, I understand that I will not receive payment from any party for them. I understand the photograph(s) may be used in my medical record and for purposes of medical teaching.

6. Authorization to Release PHI for Participation in Electronic Prescription Database: I authorize the use or disclosure of my individual Protected Health Information (PHI) as described below, with the understanding that this authorization is voluntary and may be revoked at any time by notifying HN, in writing, except to the extent it has already taken action in reliance on this Authorization. This authorization covers individual prescription (present and future) PHI and prescription history disclosed by the physicians and other employees of Harron Neurosurgery, P.C. (HN), as well as to employees and agents of Sure Script and SRSsoft. The purpose of this disclosure of PHI is to permit HN to provide prescription and prescription history information to a national electronic clearinghouse of such information to facilitate accessibility to and exchange of such information among my various health care providers and third-party pharmacy program payors for purposes of my treatment, reimbursement for prescriptions, and for any related purpose. If the organization authorized to receive the PHI is not a health plan, health care clearinghouse or health care provider covered by federal privacy regulations, the released PHI may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s). I understand that I may see and receive a copy of the information described above if I request it in writing, I have the right to a copy of this consent, I have a right to refuse to sign this consent, and acknowledge that this consent will expire on termination of my status as a patient of Harron Neurosurgery, P.C.

I have read and understand the consent information above. I understand any changes to the above consents must be made in person or in writing.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

As the patient's ___Parent ___Legal Guardian or ___Power of Attorney, I am authorized to sign on behalf of the above named patient.

Authorized Signature: _____ Date: _____

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MEDICATION AND DISABILITY POLICY

MEDICATION POLICY

Please be advised that it is the policy of this office to only prescribe narcotic medications to patients requiring surgical intervention. Up until the time of surgery, all narcotic medications will be administered by your referring physician. If, after a consultation in this office, surgery is not recommended, no prescription medications will be provided.

Following surgery, we will prescribe appropriate prescription pain medication. These prescriptions will not be filled outside of our normal office hours (9:00 am-5:00 pm Monday through Friday), nor on weekends. After an appropriate period of time, you will be weaned off narcotic medications and converted to nonnarcotic medications. If further chronic pain management is necessary and no further surgical intervention is warranted, you will be referred for chronic pain management with either your referring physician or a physician at a chronic pain management center.

DISABILITY POLICY

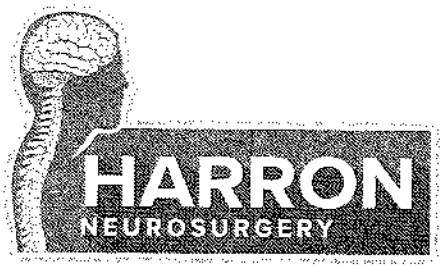
Dr. Harron does not make disability determinations. For patients who have surgery, he will require that they return to their regular jobs after a reasonable post-op period. This may require some rehabilitation.

For patients who have not had surgery, or for whom surgery is not planned, Dr. Harron will not make any work capacity evaluation. Dr. Harron is also under no obligation to answer questionnaires or similar forms submitted for completion by attorneys, insurance companies, or other related entities.

Dr. Harron also will not become involved in litigation processes, such as depositions and/or court appearances, which arise out of desire to establish causality and/or compensability in auto accidents or other personal injury cases.

I have read and understand the above.

Signature: _____ Date: _____



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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE/CONSENT

I have been presented with a copy of this practice's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law.

I hereby authorize Harron Neurosurgery, P.C., to release any and all information pertaining to my health care, test results, procedures, billing and/or accounting, appointment needs or any other information contained in my records to the following person(s) or agencies:

☐ Spouse — Name: _____

☐ Parents — Name: _____

☐ Other — (Please Specify): _____

☐ No One

I further authorize any Harron Neurosurgery, P.C., representative to contact me in one or more of the following ways:

By phone: ☐ at home ☐ at work ☐ on my mobile phone

By leaving a message on an answering machine or voice mail: ☐ at home ☐ at work ☐ on my mobile phone

By sending a postcard through: ☐ postal mail ☐ e-mail

I understand that Harron Neurosurgery, P.C., may release any information to those persons whom I have designated. They may receive this information without a separate consent or prior notification. I also understand that this relates to ALL the above-mentioned information. IF I WISH TO MAKE ANY CHANGES TO THE STATUS OF THIS FORM, I MUST DO SO IN WRITING.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship to the patient (e.g., spouse)

Relationship: _____

Witness: _____

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SURGERY INFORMATION

IF SURGERY IS REQUIRED

If Surgery is required and your provider schedules you for surgery, he/she will have you meet with the surgery coordinator who will schedule you. The coordinator will get authorization from your insurance company and will advise you what to expect on the day of your surgery. The coordinator will then give the procedure codes for your surgery to one of our financial counselors, who will then contact you with an estimate of your responsibility to pay based on your insurance plan. Our financial counselor will then collect a surgery pre-payment (deposit) from you, prior to surgery. This is just an estimate based on the codes your provider gives the counselors. Please understand that there may be an additional amount to your deductible or coinsurance that is your responsibility after the insurance company processes the claim. There will be other additional surgery charges not related to Dr. Harron. This may include hospital, anesthesia, specialty care, radiology, lab, etc.

OUR STATEMENT PROCESS

Once your insurance processes your claim, and their payment is posted into our system, any remaining balance to your responsibility will be billed to you. You should receive at least two current statements, a phone call, a past due letter, and a final notice letter. If no response is received, you will then receive a personal phone call to warn you of your balance going to collections, and will have an opportunity to make payment arrangements. If a payment is still not received, your balance will then go to an outside collection agency for recovery. To ensure you are billed correctly, please make sure that your insurance information, address, and phone numbers are current with our office at the time of your appointment. To make payment arrangements, please contact our billing department at (540) 777-0683.

DURABLE MEDICAL EQUIPMENT (DME)

If you are prescribed a DME product, you will be asked to pay a deposit and sign a waiver acknowledging your financial responsibility. This deposit amount may or may not be your total responsible amount for the product. We will bill your insurance the charges. Patients are responsible for any remaining deductible or co-insurance costs for the product. Products are nonreturnable unless there is a material defect. If you have received DME in the past, your insurance company may not cover the purchase. This depends on your insurance and your coverage.