APPOINTMENT CONFIRMATION

ORANGE COUNTY NEUROSURGICAL ASSOCIATES
23961 Calle de la Magdalena Suite 405
Laguna Hills, Ca 92653-3665
(949)588-5800

Patient: ____

Appointment with: ____

Date: ______________________ Time: ___________________

If you are unable to keep this appointment, please give us at least 24 hours' notice. Please call us at (949) 588-5800.

It is very important you complete, date and sign **all** the enclosed forms and bring them in at the time of your appointment. Please do not wait until your arrival in the office to complete the information mailed/provided to you. Failure to have all forms completed can result in the rescheduling of your appointment. Do not mail them prior to your appointment. Please bring your insurance card(s), and any records, test results, and MRI/CT/X-Rays (with) reports which may be related to the problem for which you will be seen.

Work Related injuries: Pre-authorization is required from the carrier who will be responsible for paying your bills. We will assist you with this procedure, but you must notify us 48 hours prior to your appointment.

Medicare: This office accepts Medicare assignment and we will submit all if your charges directly to Medicare by electronic transmission. It is imperative that you give us your supplementary insurance information.

Private Insurance/Contracted coverage: We will bill your insurance, provided we have your ID#, your carrier's name, address, and a phone number for follow up. If coverage is denied for any reason, you will be responsible for all charges.

YOUR INSURANCE CO-PAYMENT WILL BE COLLECTED FROM YOU AT THE SAME TIME WE COLLECT YOUR PAPERWORK, MRI'S, ETC.

We look forward to serving you. Please feel free to call us for any further explanations of our office policies and procedures

Name:____ Date of Birth: ________________ Date:______________

Medication List

***Please Exclude Vitamins

Medication	Dose	Frequency

- **For more medications, please add the list on a blank sheet of paper**

Allergies

Allergy	Type of Reaction (ex: rash, difficulty breathing)

Preferred Pharmacy

Name:	
Address:	
Phone Number:	**Fax Number:**

Please list full name of other physicians involved in your care

	Doctor's Name	
Primary Care		**Phone:**
Pain Management		**Phone:**
Neurologist		**Phone:**
Oncologist		**Phone:**
Who referred you?		**Phone:**
Cardiologist		**Phone:**
Other		**Phone:**

Please List All Medical Conditions

***Please List Neurosurgical conditions first

Medical Condition	What year were you diagnosed?

Previous Surgical History

***Please List Spinal Surgeries First

Surgery	Date of Surgery	Surgeon

Social History

Have you smoked in the past or currently? ____ Yes ____No if yes, how many years? _______________

- **Did you quit smoking? ______ Yes _______No If so, when? _______________________________**

Do you drink alcohol? ____ Yes ____No if yes, how many drinks/week? _______________

Recreational drug use? _____ Yes ______ No If yes, what type?_____________________________

Are you currently working? ____ Yes ____No if yes, please list profession__________________

If not, are you: Retired________ Homemaker_________ Unemployed________ Disabled__________

Select one:

Married_____ Single_____ Seperated_____ Divorced______ Widowed_______

Domestic Partner________ Other____

Who do you live with at home?

Self______ Spouse/Partner_______ Child/ren________ Other_______________________

1. What is the reason for your visit (circle all that apply):
   a. Neck pain
   b. Back Pain
   c. Balance problems
   d. Weakness
   e. Numbness/Tingling
   f. Tumor
   g. Headaches
   h. Other:______________________

2. If you are having pain, on a scale from 0-10 (10 being the worst), how would you rate your pain on average?__________________________

3. Describe your pain (circle all that apply):
   a. Sharp
   b. Dull ache
   c. Burning
   d. Burning
   e. Pins and Needles
   f. Other:_________________________

4. When did your pain start?: ___________________

5. Aggravating factors (ex: sitting, standing): ____

6. Alleviating factors (ex: ice/heat, medication):____

7. Does your pain travel down your arms or legs?
   a. Yes, if yes where?____
   b. No

8. Do you have weakness in your arms or legs?
   a. If yes, where?____
   b. No

9. Do you have trouble with balance?
   a. Yes
   b. No

10. Where you involved in an accident?
    a. If yes, explain?____
    b. No

11. Have you had any epidural injections?
    a. If yes, how many?_________Who administered the injection(s)?________________________
    b. No

12. Have you completed physical therapy for this condition?
    a. If yes, how many weeks did you complete?____
    b. No

Brian Hwang, MD
NEUROSURGERY

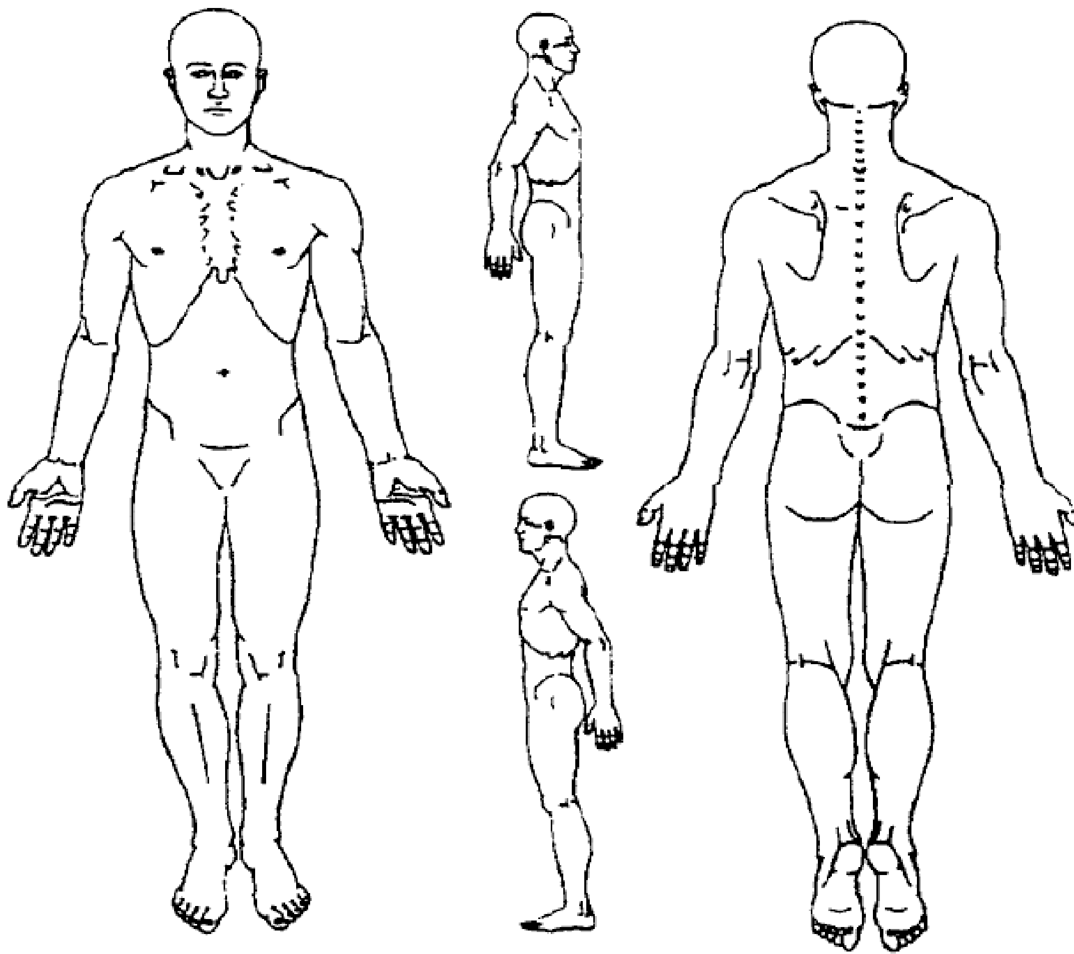
Pain Diagram

Draw the location of your pain on the figures below using the following symbols:

Ache	Numbness	Pins and Needles	Burning	Stabbing	Other
^^^^^	OOOOO	. . . .	= = = = =	/ / / / / /	XXXX

Pain Severity Scale: Rate the severity of your pain by checking one box on the following scale

0	1	2	3	4	5	6	7	8	9	10



Patient Name:__________________________________Date:______________

ORANGE COUNTY NEUROSURGICAL ASSOCIATES

23961 Calle de la Magdalena Ste 405, Laguna Hills, CA 92653

PATIENT INFORMATION FORM

PEASE PRINT OR WRITE LEGIBLY (black or blue pen only)

I AM SEEING (check one) ___ DR. HWANG ___DR. JACKSON ___DR. LIAUW ___DR. MASSOUDI

I WAS REFERRED BY ______________________________________ PH ( ) ___________-___________________

Patient _______________________________ ______________________________ ___________ **SEX** (circle) M F
(LEGAL NAME) LAST FIRST MI

Address ____ ____________
STREET APT #

____________________________________ __________ _________________ ____________________________________
CITY STATE ZIP CODE EMAIL

Phone _________________________________ ________________________________ _________________________
HOME CELL WORK

Date of Birth ___________________________ **Age** _____________ **Social Security #**_________-________-___________

Employer ____ Occupation________________________________

____
EMPLOYER ADDRESS CITY STATE ZIP

Race (check one) ________**White** __________**Black/African American** ______**America Indian/Alaska Native** _______**Asian**

_______ **Native Hawaiian /Pacific Islander** ___________**Middle Eastern/Persian** _____________**DECLINE**

Ethnicity (check one) _______**Hispanic or Latino** _______**Not Hispanic or Latino** ___________**DECLINE**

Emergency Contact ____ **Relationship** __________________________

Phone ______________________________________ ____
HOME CELL

Spouse (or Parent, if minor)________________________________**Ph (** **)**___________**-**_______________

INSURANCE (circle one) Medicare PPO HMO POS EPO WC PI Medi/Medi Medi-Cal Cash

Primary Insurance ____Ph ( )_______________________________

Name of Insured ___________________________________SELF SPOUSE PARENT other **DOB** ____________

Subscriber ID # ____ Group # _______________________________

Secondary Insurance ____Ph ( )_______________________________

Name of Insured ___________________________________ SELF SPOUSE PARENT other **DOB** ____________

Subscriber ID# ____ Group # _________________________________

Financially responsible Party: _____________________________________Relationship _____________________

I hereby assign the insurance benefits to which I am entitled to, directly to Robert J. Jackson, M.D., Farzad Massoudi, M.D., or Jason A. Liauw, M.D. I understand that I am financially responsible for all charges. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A Photostat of this authorization is accepted with the same authority as the original.

Signature ____ Date____________________________

Print Name ____

ORANGE COUNTY NEUROSURGICAL ASSOCIATES
23961 Calle de la Magdalena Suite 405, Laguna Hills, CA 92653
Tel: (949)588-5800 Fax: (949)317-3585
www.ocneurosurgery.com

PAYMENT POLICY

It is the policy of Orange County Neurosurgical Associates to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish for our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D./subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of employer.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, out-of-pocket, co-payments and patient responsibility amounts are due at the time of services.

Orange County Neurosurgical Associates and Dr. Brian Hwang do not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan **BEFORE** services are rendered. This also applies to any facility or provider your Doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, noncovered services, services deemed by the insurance company not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or the responsible party. It is the policy of this medical group to receive payment in full 90 days from the date of service.

HMOs and other insurance plans that require an authorization for treatment from Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self-referrals and services provided by out of network providers are usually not covered. **Authorization does not guarantee payment by the insurance company.**

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 90 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, check, money order and debit/credit card (VISA, MasterCard or Discover) as your payment. **If paying with check, the check should be made out to the doctor rendering the services.** If you do not have insurance and are paying cash for you visit, we **DO NOT** accept checks; you must pay with cash or credit/debit card.

The fee for a returned check is $45.00.
Fee for medical records copy is $30.00 plus .25cents per page. Fee for EDD forms/or any forms that need to be filled out by the doctor is determined by the doctor due to length of form(s). Patient will be notified of fees and payment is due before forms are rendered to patient.

I have read the above policy and understand I am financially responsible for all medical services rendered.

_______________________________	_______________________________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE
_______________________________	_______________________________
PRINT PATIENT NAME	PRINT RESPONSIBLE PARTY (if other than patient)

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Orange County Neurosurgical Associates and Dr. Brian Hwang may use and disclose protected healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Orange County Neurosurgical Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Orange County Neurosurgical Associates and Dr. Brian Hwang reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Orange County Neurosurgical Associates, 23961 Calle de la Magdalena Ste 405, Laguna Hills CA 92653.

With my Consent, Orange County Neurosurgical Associates and Dr. Brian Hwang may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

With my consent, Orange County Neurosurgical Associates and Dr. Brian Hwang may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical treatment, including but not limited to: laboratory or radiological findings.

By signing this form, I am giving consent to Orange County Neurosurgical Associates for the use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon this prior consent. Orange County Neurosurgical Associates and Dr. Brian Hwang may decline treatment to me without this signed consent.

I authorize Orange County Neurosurgical Associates and Dr. Brian Hwang to give the following person/ people information about my medical records, billing information, and or prescription pick up (please print name and write the relationship to the patient):

____

____

____

________________________________	________________________
Signature of Patient	Date
________________________________	________________________
Patient’s Name (Print)	Responsible Party, if applicable (Print)

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean the mother and the mother’s expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

____
Patient’s or Patient Representative’s Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _______________________________________ ___________
Patient’s or Patient Representative’s Signature (Date)

By: ____ __________
Physician’s or Authorized Representative’s Signature (Date)

By: ____
Print Patient’s Name

____
Print or Stamp Name of Physician, Medical Group or Association Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient’s medical records.