

OVERLAKE NEUROSURGERY

A Division of Neurosurgical Consultants of Washington
1515 116th Ave NE, Suite 302, Bellevue, WA 98004
(425) 456-0922, (425) 688-1588 (fax)

When you come for your appointment, you will need to bring the following:

- Your actual X-rays, MRI, or CT scan, printed on film preferably, but CD's are acceptable. Please hand carry these films to your appointment. Many radiology departments offer to mail films to providers. *Please decline*, and bring the films yourself.
- All X-ray, MRI, and CT reports, along with pertinent records from your referring physician.
- Your medical insurance card.
- Any insurance copay that applies. This is required at the time of service. The copay is generally \$15-\$35, but view your insurance card for details. Check with your insurance company to see if a PCP referral is required to see a specialist.

Please note:

- Be prepared to spend at least an hour for your initial appointment, and about 30 minutes for subsequent appointments.
- **Our office charges a fee of \$30.00 per signature for completing short forms, such as the Family Medical Leave Act (FMLA) form. The fee is \$50.00 for Short Term Disability and workplace assessment forms. Please send the payment along with the request, and we will mail the completed forms as quickly as possible.**

If you have any questions, contact our office or visit our website at:
www.JacobYoungMD.com

PATIENT REGISTRATION
PLEASE PRINT & ANSWER ALL QUESTIONS

Patient _____
Last Name First Middle Date Today
Title Preference Dr. Mr. Ms. Mrs. Marital Status: S M P D Separated Widowed
Birthdate _____ Age _____ Gender M F **Medical Reason for Visit** (pain or problem) _____
Home Address _____
Street _____
City State Zip Code _____

Phone (home/cell) _____ SSN: _____

Employer _____ Occupation _____
Business Address _____ Phone _____

Spouse (if married) _____ Phone _____
Parent Name (if a minor) _____
Spouse/Parent/Bill Payer's Birthdate _____ Spouse/Parent SSN _____
Spouse/Parent/Bill Payer's Employer _____ Phone _____

HEALTH INSURANCE INFORMATION - Patient is: Subscriber Spouse Dependent Not Covered

Is your insurance a managed care plan? Yes No
If so, have you obtained pre-authorization and written referral from your physician? Yes No

Primary Insurance Company _____ Subscribers Name _____
Primary Co. ID Number _____
Secondary Insurance Co. _____ Subscribers Name _____
Secondary Co. ID Number _____

Injured? No At Work Auto Accident Date of Injury _____ Claim No: _____

Insurance Carrier _____ Address _____

Referring Physician: Name _____ Phone _____
Address _____ fax _____

Primary Physician: Name _____ Phone _____
Address _____ fax _____

Who should be notified in case of emergency (other than spouse)?
Name _____ Relationship (optional) _____ Phone _____

Assignment of Benefits and Release of Information: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I understand I am responsible for obtaining any required authorization for my visits. I also authorize the doctor or insurance company to release any information required for this claim.

Signed: _____ Date: _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Smythies and Young for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____

Please complete the Medical Questionnaire (a second page).

Past Medical History

- Diabetes
- Hypertension
- Cancer
- Stroke
- Heart trouble
- Arthritis/gout
- Convulsions
- Bleeding tendency
- Acute infections
- Hepatitis
- HIV/AIDS
- Hereditary defects
- Brain or Heart surgery
- Pacemaker
- Fibromyalgia

Other: _____

Date

/ /

/ /

/ /

/ /

/ /

Medications (dose and frequency)

Past Hospitalizations/Operations/Serious injuries

Medication Allergies

Height:

Weight (pounds):

Alcohol

- never moderate
- rarely daily

Tobacco

- never
- previously, quit
- yes, packs/day ____

Dominant hand (writing)

- right
- left
- ambidextrous

Family Medical History

Age

Diseases

If Deceased, Cause Of Death

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause Of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

System Review

<input type="checkbox"/> CONSTITUTIONAL SYMPTOMS	<input type="checkbox"/> asthma or wheezing	<input type="checkbox"/> cold extremities	<input type="checkbox"/> heat or cold intolerance
<input type="checkbox"/> good general health lately	<input type="checkbox"/> GASTROINTESTINAL	<input type="checkbox"/> difficulty in walking	<input type="checkbox"/> change in hat or glove size
<input type="checkbox"/> recent weight change	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> SKIN OR BREAST	<input type="checkbox"/> HEMATOLOGIC/LYMPHATIC
<input type="checkbox"/> fever	<input type="checkbox"/> change in bowel movements	<input type="checkbox"/> rash or itching	<input type="checkbox"/> slow to heal after cuts
<input type="checkbox"/> fatigue	<input type="checkbox"/> nausea or vomiting	<input type="checkbox"/> change in skin color	<input type="checkbox"/> bleeding or bruising tendency
<input type="checkbox"/> headaches	<input type="checkbox"/> frequent constipation	<input type="checkbox"/> change in hair or nails	<input type="checkbox"/> anemia
<input type="checkbox"/> EYES	<input type="checkbox"/> frequent diarrhea	<input type="checkbox"/> varicose veins	<input type="checkbox"/> phlebitis
<input type="checkbox"/> eye disease or injury	<input type="checkbox"/> painful bowel movements	<input type="checkbox"/> breast pain	<input type="checkbox"/> past transfusions
<input type="checkbox"/> wear glasses/contact lenses	<input type="checkbox"/> rectal bleeding or blood in stool	<input type="checkbox"/> breast lump	<input type="checkbox"/> enlarged glands
<input type="checkbox"/> blurred or double vision	<input type="checkbox"/> abdominal pain or heartburn	<input type="checkbox"/> breast discharge	<input type="checkbox"/> ALLERGY or REACTION TO:
<input type="checkbox"/> glaucoma	<input type="checkbox"/> peptic ulcer (stomach or duodenal)	<input type="checkbox"/> NEUROLOGICAL	<input type="checkbox"/> penicillin or other antibiotics
<input type="checkbox"/> EARS/NOSE/MOUTH/THROAT	<input type="checkbox"/> GENITOURINARY	<input type="checkbox"/> frequent or recurring headaches	<input type="checkbox"/> shellfish, melons
<input type="checkbox"/> hearing loss or ringing	<input type="checkbox"/> frequent urination	<input type="checkbox"/> light headed or dizzy	<input type="checkbox"/> morphine, Demerol, or other narcotics
<input type="checkbox"/> earaches or drainage	<input type="checkbox"/> burning or painful urination	<input type="checkbox"/> convulsions or seizures	<input type="checkbox"/> Novacaine or other anesthetics
<input type="checkbox"/> chronic sinus problem or rhinitis	<input type="checkbox"/> blood in urine	<input type="checkbox"/> numbness or tingling sensations	<input type="checkbox"/> aspirin or other pain remedies
<input type="checkbox"/> nose bleeds	<input type="checkbox"/> change in force/strain when urinating	<input type="checkbox"/> tremors	<input type="checkbox"/> tetanus antitoxin or other serums
<input type="checkbox"/> mouth sores	<input type="checkbox"/> incontinence or dribbling	<input type="checkbox"/> paralysis	<input type="checkbox"/> iodine, methiolate or other antiseptics
<input type="checkbox"/> bleeding gums	<input type="checkbox"/> kidney stones	<input type="checkbox"/> stroke	<input type="checkbox"/> other drugs/medications
<input type="checkbox"/> sore throat or voice change	<input type="checkbox"/> sexual difficulty	<input type="checkbox"/> head injury	<input type="checkbox"/> known food allergies
<input type="checkbox"/> swollen glands in the neck	<input type="checkbox"/> male -- testicular pain	<input type="checkbox"/> PSYCHIATRIC	
<input type="checkbox"/> CARDIOVASCULAR	<input type="checkbox"/> female -- pain with periods	<input type="checkbox"/> memory loss or confusion	
<input type="checkbox"/> heart trouble	<input type="checkbox"/> female -- irregular periods	<input type="checkbox"/> nervousness	
<input type="checkbox"/> chest pain or angina	<input type="checkbox"/> female -- vaginal discharge	<input type="checkbox"/> depression	
<input type="checkbox"/> palpitations	<input type="checkbox"/> female -- # pregnancies _____	<input type="checkbox"/> insomnia	
<input type="checkbox"/> swelling of feet, ankles or hands	<input type="checkbox"/> MUSCULOSKELETAL	<input type="checkbox"/> ENDOCRINE	
<input type="checkbox"/> RESPIRATORY	<input type="checkbox"/> joint pain	<input type="checkbox"/> glandular or hormone problem	
<input type="checkbox"/> chronic or frequent coughs	<input type="checkbox"/> joint stiffness / swelling	<input type="checkbox"/> thyroid disease	
<input type="checkbox"/> spitting of blood	<input type="checkbox"/> weakness of muscles / joints	<input type="checkbox"/> diabetes	
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> muscle pain / cramps	<input type="checkbox"/> excessive thirst or urination	
	<input type="checkbox"/> back pain		

Comments: _____

NAME: _____

Driving Directions

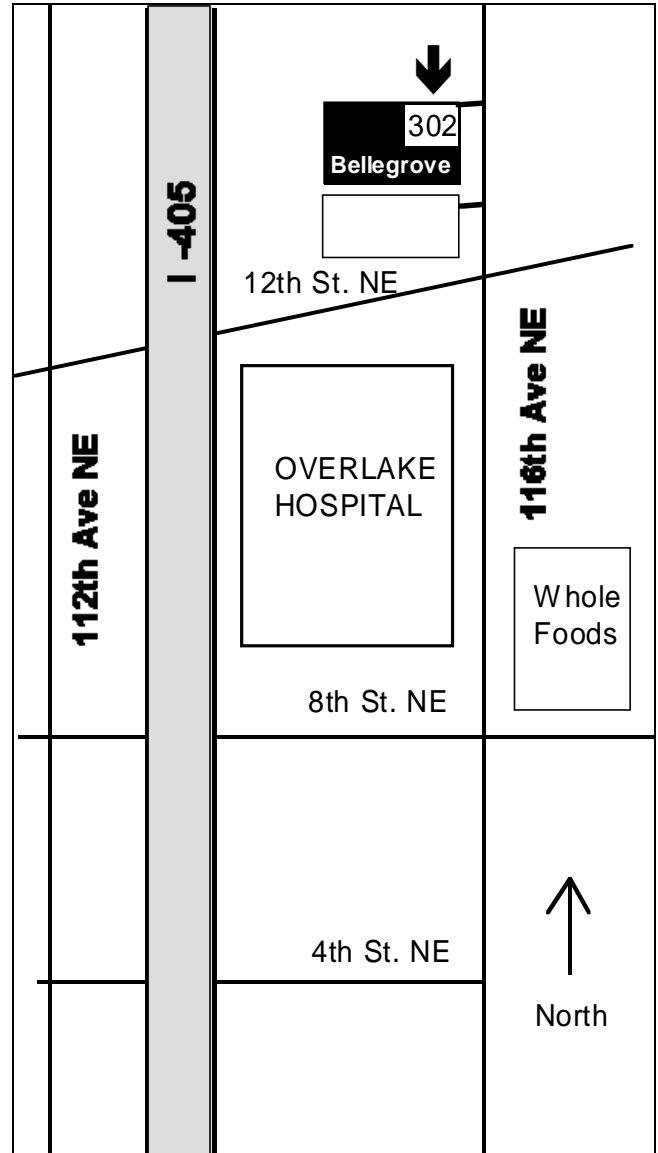
One block North of Overlake Hospital in Bellevue.

FROM NORTH OF BELLEVUE

- Take I-405 S to Bellevue
- Take the N.E. 8th St. East exit 13B - go 0.4 mi
- Bear right onto the N.E. 8th St. East ramp - go 0.1 mi
- Bear right onto NE 8th St, then immediately move to the far left lane - go 0.2 mi
- Turn left at 116th Ave NE - go 0.5 mi
- Travel past Overlake Hospital on the left
- Turn left on the 2nd driveway after 12th Ave, 1515 116th, signed "Bellegrove"
- Park immediately to the left and take the elevators or stairs to Suite 302 in the near building.

FROM SOUTH OF BELLEVUE

- Take I-405 N to Bellevue
- Take the NE 4th St exit 13A - go 0.4 mi
- Bear right onto the NE 4th St ramp
- Turn right at NE 4th St - go 0.1 mi
- Turn left at 116th Ave NE - go 0.8 mi
- Travel past Overlake Hospital on the left
- Turn left on the 2nd driveway after 12th Ave, 1515 116th, signed "Bellegrove"
- Park immediately to the left and take the elevators or stairs to Suite 302 in the near building.



OVERLAKE NEUROSURGERY

A Division of Neurosurgical Consultants of Washington

Jacob N. Young, M.D. and

Christopher Smythies, M.D.

1515 116th Ave NE, Suite 302

Bellevue, WA 98004

(425) 456-0922

(425) 688-1588 (fax)

JacobYoungMD.com

Appointment Date/Time:

NEUROSURGICAL
CONSULTANTS OF WASHINGTON

OVERLAKE NEUROSURGERY

1515 116th Ave NE, Suite 302
Bellevue, WA 98004
425 456-0922, 425-688-1588 (fax)

Dear Patient:

This is a copy of Neurosurgical Consultants of Washington Policies and our Notice of Privacy Practices, which provides information about how health information may be used and disclosed.

Neurosurgical Consultants of Washington will not necessarily fill narcotic medications over the phone. New or refill prescriptions may require an evaluation in the office. Please make an appointment far enough in advance to assure that you do not run out of necessary medications.

All co-pays are due at the time of service.

Special requests for dictated physician letters, disability forms and medical summaries require a separate fee that must be paid prior to receipt of requested information.

By signing below, you authorize insurance benefits to be paid directly to the physician. You also authorize the physician and his delegates to release any information required for the claim.

By signing below, you authorize release of any medical documentation/information to be released to any other providers participating in your care via mail, fax, telephone, etc.

All patient responsibility account balances are due within 30 days. Any balances over 30 days will be charged a rebilling/finance charge of simple interest at 12% annually or \$1.00 per month, whichever is greater. (This does not apply to balances that are shown to be insurance responsibility).

If your insurance requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your medical care. You will be responsible for all charges that are denied for lack of referral. If your primary care physician subsequently authorizes your visit, you will not be responsible for any covered charges. Be aware that your primary care physician is under no obligation to authorize these charges retroactively.

We do not submit billing claims to Motor Vehicle Insurance/PIP plans. You will be required to pay our office directly at the time of service and request reimbursement from your insurance company.

Acknowledgement:

I have read and understand the above clinic policies.

Signature

Date

Print Name

EFFECTIVE DATE: April 14, 2003

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes the practices of all employees, staff and other authorized personnel at Neurosurgical Consultants of Washington (NCW).

NEUROSURGICAL CONSULTANTS OF WASHINGTON, INC. P.S.
Affiliated with Northwest Hospital & Medical Center (NWHMC)

Our Responsibilities

We at NCW respect your privacy: We understand that your personal health information is very sensitive. We will not disclose information to others unless you tell us to do so, or unless the law allows us or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatment, payment; and health care operations.

How We May Use and Disclose Medical Information about You

For Treatment: Information obtained by a nurse, physician or other member of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you. For example, your physician may need to consult with specialists about your care. Information about you would be shared with them to help understand your care needs.

For Payment: We request payment from your health plan or other payers. They need information from us about your medical care such as diagnoses, procedures performed, or recommended care. For example, we may need to give your health plan information about surgery you received so your health plan will pay us or reimburse you for the surgery.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example,

- We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you
- We may disclose information to physicians, nurses, technicians, and other personnel for review and learning purposes.
- We may use and disclose your information to conduct or arrange for services, including:
 - o Medical quality review;
 - o Accounting, legal, risk management and insurance services;
 - o Audit functions, including fraud and abuse detection and compliance programs

Other Uses and Disclosures

Clinic Directory. We may include certain limited information about you in the clinic directory while you are a patient in the clinic. This information may include your name and location in the clinic and may be released to people who ask for you by name. Please let registration staff know if you do not want your name and location given out to people who ask for you by name.

Communication with Family and Friends. We may release medical information about you to a family member or friend who is involved in your care and/or helps pay for your care. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of

interest to you.

Health-Related Benefits and Services. We may tell you about health related benefits, services, or health care education classes that may be of interest to you.

Research. We may disclose information to researchers when an institutional review board has approved the research proposal and established protocols to ensure the privacy of your health information. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are.

As Required By Law. We will disclose medical information about you when required to do so by Federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

Special Situations

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health. As required by law, we may disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Your Health Information Rights

Right to this Notice: You have a right to a paper copy of this notice.. You may ask us to give you a copy at any time.

Right to Inspect and Copy: You have a right to inspect and receive a copy of certain health care information including certain medical and billing records. You must submit your request in writing to our clinic manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical record, you may request that the denial be reviewed. We will comply with the outcome of the review.

Right to Request Amendment: You have a right to ask that your health information be amended by giving a written request to our clinic manager. We have the right to deny this request under certain circumstances. You may write a statement of disagreement if your request is denied. This statement of disagreement will be stored in your medical record, and included with any release of your records.

Right to a List of Disclosures: You have the right to request a list of disclosures. This is a record of certain disclosures we made of medical information about you in accordance with law. You must submit your request in writing to our clinic manager. Your request should identify how you want the information (for example, on paper or electronically). The first time you request a list within a 12 month period will be free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restriction: You have a right to ask us to restrict certain uses and disclosures of your health information. You may be asked to make this request in writing. Ask your caregiver if you have questions about this. We will comply with all reasonable requests.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a specific way or location. For example, you can request that we only contact you at work or by mail.

To request confidential communications, you may be asked to make your request in writing. Ask the person (or department) that gave you this notice for more information about this process. We will comply with all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our clinics.

Complaints

If you believe your privacy rights have been violated, you may contact the NWHMC Privacy Office at 206-368-6538 or submit your complaint in writing to the Privacy Office at: 1550 N. 115th Street MS-D129, Seattle, WA 98133. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you under these circumstances, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we have provided to you.

If you have any questions about this notice please contact the Privacy Office at (206) 368-6538.