Tulane DOCTORS
Healing People. Defining Medicine.

Neurosurgery Patient Registration Form

Patient Name: _____ Date of Birth: _____

Address: _____

Primary Phone # _____Secondary Phone #_____

Email: _____

How would you like to confirm you appointment by: Text Email Telephone

Marital Status: Married Single Divorced Widow

Social Security #:_____ Gender**:** M or F Ethnicity: _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

_____

Primary Phone #: _____

Secondary Phone #: _____

Pharmacy Information

Name: _____

Address: _____

Phone Number: _____

Referring Physician

Name: _____

Telephone Number: _____

PLEASE HAVE YOUR INSURANCE CARD AND PHOTO ID AVAILABLE TO PRESENT AT EACH VISIT.

4224 Houma Blvd. Suite 540, Metairie, LA 70006 Phone: 504-503-7001 Fax: 504-503-7002

TULANE ADVANCED PRACTICE PROVIDERS

I _____ acknowledge and understand:

The Tulane surgeons are, at times, unable to see clinic patients due to emergent surgeries and other situations. I understand and acknowledge that I will see an Advanced Practice Provider (APP) during those times. Tulane APP's are medical professionals who are well trained and able to perform a wide variety of functions on the healthcare team. They use their clinical knowledge and skills to diagnose illness and create appropriate treatment plans. This includes prescribing medications, performing appropriate procedures and assisting in surgery. Having APP's on our team has many advantages, most importantly in extending direct and timely healthcare to patients.

SIGNATURE: _____

DATE: _____

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Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Tulane University Medical Group Notice of Privacy Practices.

Signature: _____Date:_____

Print Name: _____

If not signed by patient, please indicate relationship: _____

Print name: _____

Witness: _____

No-Show Policy

(Approved 7/26/2016)

Purpose:

To ensure a standardized process is being used for patient no-shows across all clinics. Patients not showing for their scheduled appointments has a significant impact on the quality of patient care. This policy offers guidelines for patient communication and potential termination in a way that is in the best interest of patients, providers, and staff.

Policy:

1. If a patient does not show for their first appointment, a letter is mailed explaining our no-show policy.
2. Subsequent no-show may be billed (where contractually feasible) at $ 50.00 per missed appointment.
3. After the second no-show a letter is mailed that explains a third no-show may result in discharge from the practice.

Process:

1. The first instance of patient no-show: letter No. 1 is mailed. The patient is also sent notification via the patient portal.
2. The third instance of patient no-show: clinic manager and physician are notified. Clinic manager reaches out to the patient via phone to discuss barriers and explain the protocol further. The letter is sent via certified mail regarding the potential for termination.
3. The fourth instance of patient no-show: clinic manager and physician are notified. Termination letter sent upon provider recommendation.

Please sign below to acknowledge your understanding of the above policy.

Signature: _____ **Date:** _____

Tulane University Medical Group
CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

_____	_____	_____
PATIENT NAME	DATE OF BIRTH	PATIENT SIGNATURE
_____	_____	_____
NAME OF AUTHORIZED AGENT, IF ANY	SIGNATURE – IF SIGNED BY AUTHORIZED AGENT	RELATIONSHIP TO PATIENT
_____	_____	_____
WITNESS NAME	WITNESS SIGNATURE	DATE OF SIGNING TIME

RX ELIGIBILITY CONSENT - By signing this consent form you are agreeing that Tulane University Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I hereby provide informed consent to Tulane University Medical Group to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

INITIAL _____

CONSENT FOR TREATMENT DATE _____ TIME _____

I, OR _____ FOR _____ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

REFUSAL OF CONSENT FOR TREATMENT

I, _____ REFUSE TO CONSENT TO _____

_____ UPON _____
_____ I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

PRESCRIPTION MEDICATION POLICY

It is important to report all medications you are taking to every provider you see to avoid potential drug interactions or organ damage. Carrying a medication list with you at all times is a good idea.

In order for us to provide the best care to our patients, we must be able to monitor your progress and response to medication on a regular basis. This allows providers to determine if the dose is appropriate for maximum effectiveness and safety.

- We **ONLY** refill medications prescribed by our physicians or Advanced Practice Providers in this clinic.
- We will **NOT** authorize prescriptions by another physician.
- We will **NOT** refill a prescription if you have not had an appointment within the last three months.

We are aware that each patient and treatment plan are different. The providers and office staff will review each request on a case-by-case basis.

As of 2016, the CDC released new guidelines for improving the way opioids are prescribed. The new guidelines ensure patients have access to safer, more effective chronic pain treatment while reducing the risk of opioid use disorder, overdose and death.

NO NARCOTIC refills will be authorized by our physicians or physician's assistants after the 2 week postoperative period.

> *If you continue to need pain medications after this period, we will send a referral to the pain management physician of your choice. If you do not request a specific provider, we will refer you to a recommended pain management physician.*

As of October 1, 2014, the DEA requires that a hard copy prescription for a narcotic be written. Narcotic prescriptions cannot be faxed or called into the pharmacy.

It is your responsibility as the patient to notify your pharmacy for refills prior to running out. We refill prescriptions during regular office hours.The pharmacy will need to send notification of your request for a refill via fax to office at 504-503-7002.

SIGNATURE: _____ DATE: _____

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PATIENT NAME: _____ **DATE:** _____

DATE OF BIRTH:____/____/_____ **AGE:** _____ **HEIGHT:**_____**WEIGHT:** _____
MO DAY YEAR

REASON FOR THE VISIT: _____

PAST MEDICAL HISTORY: Please circle

Heart Attack	Cancer	Hearing Loss	Alcoholism	High Cholesterol	Anemia	Please List other Medical Problems Below:
Migraines	Glaucoma	Arthritis	Kidney Disease	Liver Disease	Depression	
High Blood Pressure	Bleeding Problems	Thyroid Disease	Blood Clots	Diabetes	Anxiety	
Asthma / COPD	Stroke	Osteoporosis	Kidney Stones	Stroke	HIV	

FAMILY HISTORY:

FAMILY MEMBER	AGE	IF NOT ALIVE, WHAT WAS AGE OF DEATH?	HEALTH PROBLEM OR CAUSE OF DEATH
MOTHER			
FATHER			
SISTER(S)			
BROTHER(S)			
CHILDREN			

VACCINATIONS:
FLU- Y/N DATE OF LAST IMMUNIZATION:____PNEUMONIA -Y/N DATE OF IMMUNIZATION: _____

ALLERGIES: _____

SURGICAL HISTORY and DATES:

1._____2._____

3._____ 4._____

DO YOU SMOKE? YES NO IF YES, HOW MANY CIGARETTES DO YOU SMOKE PER DAY?_____

DO YOU CONSUME ALCOHOL/BEER? YES OR NO IF YES, HOW MANY DRINKS DO YOU HAVE PER DAY? _____

DO YOU HAVE ANY WEAKNESSES: YES or NO IF SO, WHERE?_____

DO YOU HAVE ANY NUMBNESS: YES or NO IF SO, WHERE? _____

MARK THE TREATMENTS YOU HAVE TRIED- PLEASE CIRCLE

PHYSICAL THERAPY	BRACING	IBUPROFEN/ADVIL	OTHER MEDICATIONS	INJECTIONS
CHIROPRACTOR	ACUPUNCTURE	SURGERY	BED REST	PAIN CLINIC
INJECTIONS	RHIZOTOMY	EXERCISE THERAPY		

PAIN LEVEL RIGHT NOW:

HAVE YOU EVER BEEN ON ANY OF THE DRUGS LISTED BELOW? Circle the ones you have been on.

Zyprexa	Olanzapine	Reglan	Metoclopramide	Thorazine	Chlorpromazine
Geodon	Ziprasidone	Compazine	Prochlorperazine	Prolixin	Fluphenazine
Haldol	Haloperidol	Phenergan	Promethazine	Orap	Pimozide
Risderdal	Risperidone	Abilify	Aripiprazole		

List any previous Neurologists: _____

**If possible, please bring old medical records from previous neurology visits, a CD of any old MRIs of the Brain/Spine, or any other records relating to your neurologic condition to the clinic visit.

Primary Care Physician: _____

Any other Physician(s) you would like us to fax the results of this visit to: _____

PLEASE LIST ALL OF THE MEDICATIONS AND YOU ARE CURRENTLY TAKING INCLUDING VITAMINS AND OVER THE COUNTER DRUGS:

_____

_____

_____

_____

REVIEW OF SYSTEMS: Do you currently, or have you had a problem with: Circle Yes or No

CONSTITUTIONAL				ENDOCRINE		
Weight loss	YES	NO		Diabetes	YES	NO
Weight gain	YES	NO		Thyroid disease	YES	NO
Fatigue	YES	NO		Excessive thirst/urination	YES	NO
Fever	YES	NO		GENITOURINARY		
Insomnia	YES	NO		Urinary tract infection	YES	NO
EYES				Painful urination	YES	NO
Wear glasses	YES	NO		Blood in your urine	YES	NO
Infections	YES	NO		Difficult starting/stopping stream	YES	NO
Injuries	YES	NO		Incontinence	YES	NO
Glaucoma	YES	NO		Kidney Stones	YES	NO
Cataracts	YES	NO		Prostate Cancer (male)	YES	NO
EAR, NOSE, THROAT & MOUTH				Uterine of cervical cancer (female)	YES	NO
Wear hearing aid(s)	YES	NO		MUSCULOSKELETAL		
Hearing loss	YES	NO		Broken bones	YES	NO
Ear pain	YES	NO		Arm or leg weakness	YES	NO
Ear infections	YES	NO		Arm or leg pain	YES	NO
Ringing of the ears?	YES	NO		Joint pain or swelling	YES	NO
If yes circle: LEFT RIGHT BOTH	YES	NO		Arthritis	YES	NO
Nose bleeds	YES	NO		INTEGUMENTARY		
Nasal Congestion	YES	NO		Skin disease	YES	NO
Nasal Drainage	YES	NO		Skin cancer	YES	NO
Inability to smell	YES	NO		Breast pain, tenderness (female)	YES	NO
Sinus Problems	YES	NO		Nipple discharge (female)	YES	NO
Balance Disturbance (vertigo, spinning, etc)	YES	NO		NEUROLOGICAL		
CARDIOVASCULAR				Fainting spells or "black outs"	YES	NO
Chest Pains or angina	YES	NO		Seizures	YES	NO
High blood pressure	YES	NO		Problems with memory	YES	NO
Irregular pulse	YES	NO		Disorientation	YES	NO
Heart murmur	YES	NO		Difficulty with speech	YES	NO
High cholesterol	YES	NO		Inability to concentrate	YES	NO
Swelling in the hands or feet	YES	NO		Double or blurred vision	YES	NO
Leg pain while walking	YES	NO		Weakness in arms and/or legs	YES	NO
RESPIRATORY				Loss of sensation	YES	NO
Asthma	YES	NO		Difficulty with balance	YES	NO
Emphysema	YES	NO		PSYCHIATRIC		
Shortness of breath	YES	NO		Anxiety or depression	YES	NO
Pneumonia	YES	NO		Other psychiatric disorder and/or	YES	NO
Lung Cancer	YES	NO		Treatment:	YES	NO
Bloody Sputum	YES	NO		HEMATALOGIC/LYMPHATIC		
GASTROINTESTINAL				Anemia	YES	NO
Nausea	YES	NO		Hemophilia	YES	NO
Vomiting	YES	NO		Bleeding tendencies	YES	NO
Blood in your vomit	YES	NO		Blood transfusion	YES	NO
Liver disease	YES	NO		Persistent swollen glands or lymph nodes	YES	NO
Jaundice	YES	NO		ALLERGIC/IMMUNOLOGIC		
Abdominal pain	YES	NO		Food allergies	YES	NO
Ulcers or gastritis	YES	NO		Inhalant (nasal) allergies	YES	NO
Colon cancer	YES	NO		Autoimmune disease (lupus, rheumatoid	YES	NO
				Arthritis, etc.)	YES	NO