BRAIN AND SPINE SURGERY, PC

Please print all information clearly. Thank You. Date: ____________

Patient Name: ___________________________________ Social Security # : ____________________________

Home Address: ___________________________________ Date of Birth: ________________________________

___________________________________ Martial Status: ____ Married ____Single ____Divorced

Home Telephone: _________________________________ ____Widowed ____Minor

Work Telephone: _________________________________ In Case of Emergency:

Alternate #: _____________________________________ Notify: _____________________________________

Employer: _______________________________________ Relationship: ________________________________

Primary Care Physician: ___________________________ PCP's Telephone #: ___________________________

Referring Physician: ______________________________ Referring MD's Telephone #: ___________________

Private Health Insurance Information

Primary Insurance: ____

Name of Policy Holder (if not patient): ____________________________________ D/O/B: _______________

Insurance ID#: __________________________________ Group#: _____________________________________

Secondary Insurance: ____

Name of Policy Holder (if not patient): ____________________________________ D/O/B: _______________

Insurance ID#: __________________________________ Group#: _____________________________________

Type of Case: ____Regular Insurance ____Workers' Compensation ____No Fault Date of Injury: __________

Do you need a referral to see a specialist? ____Yes __No Do you have a copayment/deductible? ____Yes ___No

Deductible Amount: $_________________ Copayment Amount: $___________________________

Assignment of Benefits/Authorization for Release of Information

I request that payment of authorized Medicare or private insurance benefits be made for any covered services furnished to me by Magdy S. Shady, MD and/or J. Frederick Harrington, MD. I authorize any holder of medical information about me to release the Health Care Financing Administration and it's agents, Champus and it's agents, or to any private insurance company, any health information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for charges in a timely manner, or I fail to provide within thirty (30) days the information necessary to submit the claim for payment.

____ _____________________

Signature of Patient (Parent/Guardian if patient is a minor) Date

____ _____________________

Signature of Representative (if patient is unable to sign) Date

BRAIN AND SPINE SURGERY, PC

Please print all information clearly. Thank You. Date: ____________

Patient Name: ____ Date of Birth: __________________

Height: ________________________________ Weight: _____________________________________

PCP:__________________________________ Referring MD: ________________________________

Health Information / Please Check All that Apply

Drug Allergies (if none please indicate): ____

Medications (if none please indicate): ____

Hospitalizations: ____

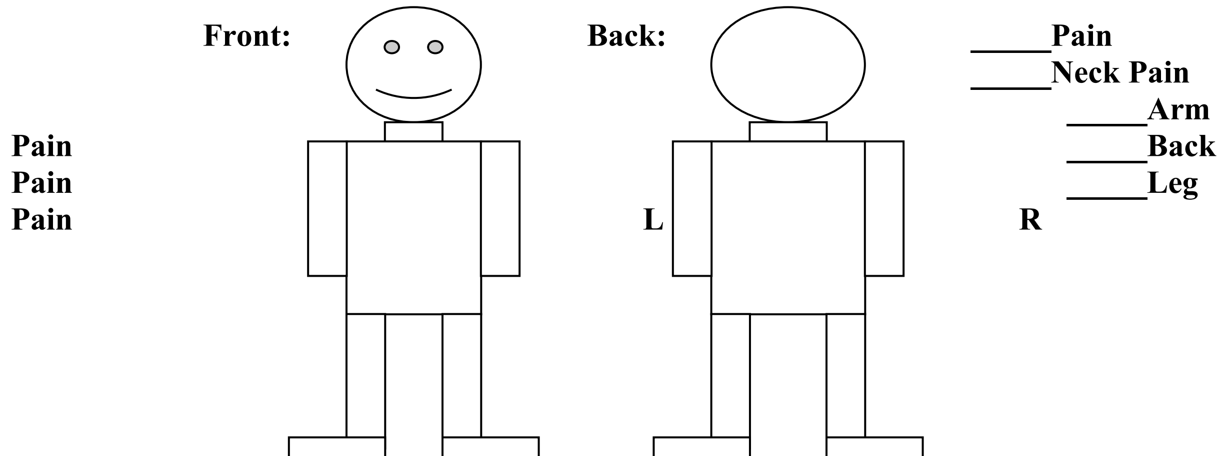
Operations: ____

Please Check: ____ Right Handed ____Left Handed

____ Alcohol Use ____Drug Use ____Smoking ____Weight Loss

____ High Blood Pressure	____ **Blood Disorders**	____ **Infectious Disease**
____ Diabetes Mellitus	____ Clotting Problems	____ Tuberculosis
____ Stomach Ulcers	____ Anemia	____ Lyme's Disease
____ **Heart Disease**	____ Immune Deficiency	____ **Neurological Disease**
____ Angina/Chest Pain	____ **Liver Disease**	____ Stroke
____ Heart Attack	____ Hepatitis	____ Epilepsy/Seizures
____ Heart Surgery	____ Yellow Jaundice	____ Parkinson's Disease
____ Irregular Heart Beat	____ **Kidney Disease**	____ Multiple Sclerosis
____ Heart Failure	____ Dialysis/Failure	____ Neurofibromatosis
____ Pace Maker	____ Infection	____ Headache/Migraine
____ Valve Disease	____ **Endocrine Disease**	____ Urinary Problems
____ **Respiratory Disease**	____ Thyroid Disease	____ Walking Difficulties
____ Emphysema	____ Adrenal Disease	____ Visual Problems
____ Asthma	____ Pituitary Disease	____ **Cancer**
____ Tuberculosis	____ **Arhtritis**	____ **Malignant Hyperthermia**
____ Bronchitis	____ Rheumatoid Arthritis	____ Other: _________________
____ Sinusitis	____ Lupus	_____________________

Please use the diagram below to indicate location of pain:



BRAIN AND SPINE SURGERY, PC

2500 Nesconset Highway, Building 18C, Stony Brook, New York 11790
Telephone 631.751.2700 ~ Facsimile 631.751.5853

HIPPA PRIVACY AUTHORIZATION FORM

Authorization

I, ____, hereby authorize Brain and Spine Surgery, PC and its affiliates and employees to use and disclose the protected health information described below to:

Name(s) Contact Number(s) Relationship(s)

____

____

____

Effective Period

This authorization for release of information covers the period of health care from (choose one):

_____ The period from _______________ to _______________

_____ All past, present and future periods

Extent of Authorization

This authorization for release of information covers the following (choose one):

_____ I authorize the release of my complete health record

_____ I authorize the release of my complete health record with the exception of the following information: ____
____

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force and effect until ____________ (date or event), at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditional on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law.

Signature: ____ Date: ___________________

Your Name (Printed): ____

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Magdy S. Shady, MD
Diplomate American Board of Neurological Surgery
Fellow of the American Association of Neurological Surgeons
Clinical Assistant Professor of Neurosurgery and Radiation Oncology

James F. Harrington, MD
Diplomate American Board of Neurological Surgery
Fellow of the American Association of Neurological Surgeons

I have been notified by the staff that Dr. Shady and/or Dr. Harrington are not participants with my insurance plan. I am aware that I will be responsible for costs associated with consultations and any treatments by Dr. Shady and/or Dr. Harrington. Additionally, I understand that my insurance carrier may send a reimbursement check directly to me, and I agree to forward any such reimbursement for services rendered by Dr. Shady and/or Dr. Harrington directly to their billing office, including the explanation of benefits (EOB). Failure to do so may result in finance charges.

Print Name: ____

Signature: ____

Patient Name (if different than above): ___________________________

Date: ____

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Diplomate American Board of Neurological Surgery
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Clinical Assistant Professor of Neurosurgery and Radiation Oncology

J. Frederick Harrington, MD
Diplomate American Board of Neurological Surgery
Fellow of the American Association of Neurological Surgeons

RECORDS RELEASE AUTHORIZATION AND CONSENT

I request and authorize you to release the complete medical history concerning my illness and/or treatment during the period from ____________________ to ____________________ to:

Brain and Spine Surgery, PC
2500 Nesconset Highway
Building 18C
Stony Brook, NY 11790
Fax # 631-751-5853

Patient Name: __________________________________ Date of Birth: ____________________

Address: ____

Phone Number: ______________________________ Cell #: ___________________________

Name at time of service, if different: ____

Patient Signature: ____ Date: ____________

Signature of Representative (if patient is unable to sign): _______________________________