

\_\_\_\_\_, M.D.  
Neurosurgical Associates, P.C.  
710 West 168<sup>th</sup> Street  
New York, NY 10032

UNIT # \_\_\_\_\_

**PATIENT INFORMATION**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name:

\_\_\_\_\_  
(Last Name)

\_\_\_\_\_  
(First Name) (Middle Initial)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Father's First Name: \_\_\_\_\_

Mother's First Name: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Spouse Name: \_\_\_\_\_

(Last Name)

\_\_\_\_\_  
(First Name)  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

**If different than patient:**

Guarantor's Name: \_\_\_\_\_

(Last Name)

\_\_\_\_\_  
(First Name)  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Cell #: (\_\_\_\_) \_\_\_\_\_

**INSURANCE**

Primary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Check if apply and answer the following questions:**

Workers Compensation

Auto Accident/NoFault

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Carrier Name: \_\_\_\_\_

Representative Name: \_\_\_\_\_

State of Accident: \_\_\_\_\_

Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**REFERRING PHYSICIAN**

Referring Physician Name:

\_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician Name:

\_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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### PATIENT FINANCIAL OBLIGATION AGREEMENT

I understand that all applicable copayments and deductibles are due at the time of services. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Neurosurgical Associates, P.C. for services rendered. I authorize representatives of Neurosurgical Associates/Columbia University Medical Center to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. If my current policy prohibits direct payment to the doctor, I will forward the check and explanation of benefits to Neurological Associates.

**Patient Signature:** \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Guarantor Signature:** \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I am aware that \_\_\_\_\_, M.D. does not participate with my Commercial Insurance and is an Out-of-Network Provider.

**Patient Signature:** \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

**Patient Name:** (Print) \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**If completed by a patient's representative, please print and sign below:**

**Representative:** (Print) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### MYCOLUMBIADOCTORS PATIENT PORTAL SIGN UP

Access your personal records securely, 24/7, on a computer, smartphone, or iPad.

- YES, Send me an invitation to join myColumbiaDoctors. Email: \_\_\_\_\_
- NO, do not** send me an invitation to join myColumbiaDoctors.

Look for an email invite from **noreply@followmyhealth.org** and click the registration link.

Patient's Preferred Language \_\_\_\_\_  I decline to respond.

**Patient Signature:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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### MARKETING PATIENT SURVEY

Please take the time to fill out the following information, so we may better serve you and future patients. All information will be kept anonymous.

Patient Name: \_\_\_\_\_ (not required)      Your Doctor: \_\_\_\_\_

1. Who was your source of referral or how did you find out about us? Please select all that apply and indicate below.

- Family/Friend: \_\_\_\_\_
- Physician: \_\_\_\_\_
- Print Media: \_\_\_\_\_
- Website/Search engine: \_\_\_\_\_
- Social Media: \_\_\_\_\_
- Other: \_\_\_\_\_

2. Did you visit our website ([www.columbianeurosurgery.org](http://www.columbianeurosurgery.org))? If so, which page(s) or video(s) were helpful?

- Doctor's Bio Page
- Medical Conditions and Treatments Page
- Specialties Page
- Doctor's Video
- Patient Testimonial Video
- Blog
- Other: \_\_\_\_\_

3. Did you visit a patient review site (i.e. Healthgrades.com) about our doctor before you came in?

- Yes
  - If yes, which patient review website(s) did you visit?
    - Healthgrades.com     Vitals.com     RateMds.com     Other : \_\_\_\_\_

No

4. Would it be ok for a representative from the marketing department to contact you for your opinion or feedback?

- Yes     Texts: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_     Emails: \_\_\_\_\_
- No