_____, M.D.
Neurosurgical Associates, P.C.
710 West 168th Street
New York, NY 10032

THE SPINE HOSPITAL
AT THE NEUROLOGICAL INSTITUTE OF NEW YORK

UNIT # _____

PATIENT INFORMATION

Date: _____/____/_____
Patient Name:
_____
(**Last** Name)

_____ _____
(**First** Name) (Middle Initial)

Date of Birth: _____/____/_____ Sex: □ M □ F
Social Security #: _____-_____-_____
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: _____/____/_____
Social Security #: _____-_____-_____
Cell #: (_____) _____-_____
Email: _____

<u>If different than patient:</u>
Guarantor's Name: _____
(**Last** Name)
_____
(**First** Name)
Date of Birth: _____/____/_____ Sex: □ M □ F
Social Security #: _____-_____-_____
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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UNIT # _____

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 RECIEPT

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)? 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