TEMECULA VALLEY
NEUROSURGERY
COMPLEX SPINE & BRAIN SPECIALISTS

25150 Hancock Ave, Suite 210
Murrieta CA, 92562
Tel: 951-587-3739 Fax: 951-698-5213

**Bret Abshire, MD**
**Daniel Friedlich, MD**
**Gerald Oh, MD**

**Tracey Anderson, CNP**
**Michelle Lancaster, PA-C**
**Arianna Arroyo, PA-C**

## *PERSONAL INFORMATION*

Date _____ Primary Care Physician _____ PCP Phone # _____

Patient Name _____ Preferred Name _____

Date of Birth_____ SSN# _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address_____

City _____ State _____ Zip_____

Occupation _____ Employer _____

Referred by _____ Pharmacy_____ Pharmacy phone number_____

Advanced Care Plan Available? ☐ Yes ☐ No If yes, Name of Surrogate decision maker_____ Phone number_____

**Contact Information- Please indicate which of the following numbers and/or email address we should use to communicate with you. ONLY list the phone numbers you want us to call. Please specify if a message can be left.**

**Home Phone**_____ Message: ☐ Yes ☐ No **E-Mail** _____ Message: ☐ Yes ☐ No

**Work Phone** _____Ext.# _____ Message: ☐ Yes ☐ No

**Cell Phone**_____ Text Message: ☐ Yes ☐ No Voice Message: ☐ Yes ☐ No

Preferred method of communication? ☐ Home ☐ Work ☐ Cell Phone ☐ Text message ☐ Email

My PHI (personal health information) may be communicated to: Do Not communicate my PHI to:

_____ _____

_____ _____

_____ _____

## *INSURANCE INFORMATION*

| **Primary Insurance** | **Additional Insurance** |
|---|---|
| Name of Insured _____ | Name of Insured _____ |
| Relationship to patient _____ | Relationship to patient _____ |
| Insured's Birthdate _____ | Insured's Birthdate _____ |
| SS #/SIN _____ | SS #/ SIN _____ |
| Employer _____ | Employer _____ |
| Date Employed _____ | Date Employed _____ |
| Occupation _____ | Occupation _____ |
| Insurance Company _____ | Insurance Company _____ |
| Group # _____ | Group # _____ |
| Insurance Co. Address _____ | Insurance Co. Address _____ |
| Deductible _____ | Deductible _____ |
| Max. Annual benefit _____ | Max. Annual benefit _ _____ |

***It is the patient's responsibility to notify Temecula Valley Neurosurgery of any changes in information***

# Temecula Valley Neurosurgery, Inc.
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## POLICIES AND PROCEDURES

**Office hours:**
Our office is open Monday-Thursday from 8:00 am to 4:00 pm, we are closed for lunch from 12:00pm to 2:00pm but frequently see patients during this time and closed Fridays from 8:00am-12:00PM. We are closed in observance of major holidays.

**PLEASE BE AWARE THAT OUR PHYSICIANS DO TAKE TRAUMA CALL AND CAN BE CALLED OUT TO AN EMERGENCY AT ANY GIVEN TIME.**

*Wait times:*
**We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule which can lead to wait times that may exceed up to 1 hour or more. We appreciate your patience and understanding.**

**APPOINTMENTS:**
First-time patients are asked to arrive 20 minutes before their scheduled appointment to allow adequate time for check-in and processing of the initial paperwork. We ask that you hand-carry Insurance cards, Driver's License and ANY CDs with reports related to the appointment reason. Please be advised that all imaging studies must be no more than 1 year old. If a patient arrives to their appointment without the above, they will be rescheduled.

In order to streamline the registration process patients have the option of completing their paperwork online prior to their appointment via our online patient portal. Patients must provide their email address to our office staff so we may send an invitation and portal link. If you would prefer a paper version these can be retrieved from our website, **WWW.TVNEUROSURGERY.COM** under the patient resources tab.

**Late policy:**
If a patient arrives greater than 15 minutes late for their scheduled appointment, they will need to be rescheduled to the next available date. If a patient no-shows to three or more appointments, we will assume another physician is treating them and they will be discharged from our care.

**Cancellation Fee:**
**There will be a fee of $50 if a patient No-Shows to a scheduled appointment.**
If there is a need to reschedule please let our office know at least 24 hours in advance. Same day cancellations will be considered a No-Show. A No-Show occurs when a patient fails to keep a scheduled appointment. When a patient is considered a No-show a fee of $50 will be generated onto the patients' account, this fee will need to be paid before rescheduling an appointment. Three no shows will require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

**Zero Tolerance Policy:**
Temecula Valley Neurosurgery adheres to a zero-tolerance policy and has the right to terminate a relationship with any patient who's abusive (including yelling or threatening physicians, staff, or others), who fails to follow directions or who does not pay for /make arrangements to pay for services. Angry or foul language directed to our staff regardless of the issues involved will not be tolerated and will be grounds for immediate dismissal from our practice.

**Referrals:** If your insurance requires a referral or prior authorization, please be sure one has been obtained prior to scheduling your appointment. We will be unable to schedule an appointment without authorization. Please hand-carry a copy of your authorization to your appointment or make arrangements to have your referring physician fax a copy to our office with any medical records pertaining to the reason for your visit.

**Once a patient is seen by our physicians and further testing is recommended, please allow our referral coordinator 10 business days to process any referrals that require insurance preauthorization.**

**Handicapped access:** There is elevator access in the building for our patients as our office is located on the second floor**.**

**Hospitals:** Our physicians perform surgery at Inland Valley Medical Center, Loma Linda Medical Center- Murrieta and Temecula Valley Hospital

**Medical Records:** Medical records will be stored for 7 years. Copies of medical records can be faxed to another physician upon receipt of a signed medical records release from the patient. If the patient would like a copy of their medical records, we can share documents within the patient portal at no charge. Please contact our office staff to obtain login information. If the patient prefers paper copies of their records, a record release form will need to be completed and signed. Please note there is a $ 0.25 processing fee for each page requested. We will require a 3-day notice for processing medical records requests or for the pickup of films or CD's that have been left in our office.

**Fees and payments:**
Payment in full is due at the time services are rendered unless we are submitting charges to your insurance company. ***Copays and deductibles are due at the time of service or your appointment may be rescheduled.*** We accept most major credit cards. We also accept personal checks, money orders, cashier checks & cash. Those patients without proof of coverage may be required to pay in full or be asked to reschedule their appointment. If we are not contracted with your particular insurance plan, YOU must pay in full at the time of service. You will be given a copy of our charge slip to submit to your insurance company for reimbursement purposes.

Even though we will bill the patient's insurance, we must emphasize that as medical providers our relationship is with the patient, not the insurance company. Billing the insurance does not necessarily ensure payment by the insurance company nor does it release the responsible party from its financial obligation to our office for any unpaid balance. In case of an insurance partial payment, the remaining balance will be due from the patient as noted on the billing statement. Balances over 120 DAYS due may be sent to a collection agency unless other arrangements have been made. A $40 fee or 10% of the balance, whichever is greater will be assessed on accounts placed in collections. A $25 service fee will be charged for returned checks due to insufficient funds. We may also elect to discharge you from our practice should you fail to comply with our policy. Should you require a payment plan, our billing department will be glad to discuss your options with you.

**Medications:** It is our office policy to **ONLY** prescribe narcotic pain medication temporarily to patients who have undergone recent surgery and have a signed pain contract on file with our practice. Non-surgical patients will need to contact their primary care physician for ALL prescriptions. If you are a patient who underwent recent surgery and requires a refill of your medication, please contact our office **DURING BUSINESS HOURS at least 3 business days prior to the refill date.**

***NOTE: REFILLS WILL ONLY BE GRANTED TO PATIENTS WHO HAVE UNDERGONE RECENT SURGERY, HAVE A SIGNED PAIN CONTRACT ON FILE AND HAVE BEEN SEEN IN THE OFFICE FOR REGULAR POST OP CARE.***

***I HAVE READ THE ABOVE POLICIES & PROCEDURES AND I UNDERSTAND THAT IF FOR ANY REASON I DISAGREE WITH THE ABOVE, I DO HAVE THE RIGHT TO CANCEL MY APPOINTMENT AND SEEK TREATMENT ELSEWHERE***

I hereby assign the insurance benefits to which I am entitled, directly to TEMECULA VALLEY NEUROSURGERY, INC., a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility, I authorize the release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by TEMECULA VALLEY NEUROSURGERY, INC. A copy of this authorization is accepted with the same authority as the original.

x_____ _____
SIGNATURE OF PATIENT / GUARDIAN DATE

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required.

Revised 04/2023

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## Acknowledgment of Receipt of Notice of Privacy Practices
## Health Insurance Portability & Accountability Act (HIPAA)

I hereby acknowledge that I have read a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and on their website www.tvneurosurgery.com. I also acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date:_____

Print Name:_____ Telephone: _____

If not signed by the patient, please indicate the relationship:

☐ Parent or guardian of a minor patient.
☐ Guardian or conservator of an incompetent patient.

Name of patient: _____

**Office Use Only**

To be completed only if no signature is obtained. If it is not possible to obtain patient acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why it was not obtained.

Handed to patient: Yes/No
Patient refused to sign: Yes/No
Other:_____

Employee Initials_____

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# Past Medical History

**Patient Name:** _____ **Date of Birth:** _____**Date**:_____

**Reason for Visit**: _____ **PCP:** _____

☐ **No Medical Diagnosis**

**Check the condition(s) that apply to your past medical history -**

- ☐ Anemia
- ☐ Anesthesia problem
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Problems
- ☐ Bladder Infections
- ☐ Bleeding Disorder
- ☐ Blood Clots / CVT
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Congestive Heart Failure
- ☐ COPD / Emphysema
- ☐ Crohns / Ulcerative Colitis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Epilepsy / Seizures
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Heart Disease / CAD
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/ AIDS
- ☐ Hyperthyroid / Hypothyroid
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/ Cirrhosis
- ☐ Lung Disorder
- ☐ Lupus
- ☐ Malaria
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mumps
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Parkinson's
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonally Allergies
- ☐ Sexually Transmitted Diseases
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Smallpox
- ☐ Stroke / TIA
- ☐ Tuberculosis
- ☐ Urinary Incontinence
- ☐ Vertigo
- ☐ Whooping Cough

**Smoking Status:**

- ☐ Current smoker — If yes, Packs/day:____ Number of Years:____
- ☐ Former smoker — Quit Date: _____
- ☐ Never smoker

**Alcohol Use Status:**

- ☐ Does not drink
- ☐ Currently drinks — If yes, Alcohol Type:_____ Drinks/Week:_____
- ☐ Former drinker — Quit Date: _____
- ☐ Quit

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**Illicit/Illegal drugs Status:**

- ☐ Does not take drugs
- ☐ Currently takes drugs If yes, Drug Type:_____
- ☐ Former drug user
- ☐ Quit Quit Date: _____

**Injury Information/ Type of Injury: Related to current symptoms**

- ☐ Work If yes, Injury Date: _____ Injury Details:_____
- ☐ Auto
- ☐ Sports
- ☐ Other

## Family Medical History

**Check the condition(s) that apply and indicate which family member:**

| Condition: | Relationship to patient: eg. Mother, Father, Sister, son |
|---|---|
| ☐ Anemia | _____ |
| ☐ Arthritis | _____ |
| ☐ Asthma | _____ |
| ☐ Blood Clots/DVT | _____ |
| ☐ Cancer | _____ |
| ☐ COPD/Lung Disease | _____ |
| ☐ Depression | _____ |
| ☐ Diabetes | _____ |
| ☐ Heart Disease/CAD | _____ |
| ☐ Hepatitis | _____ |
| ☐ High Blood Pressure | _____ |
| ☐ HIV/AIDS | _____ |
| ☐ High Cholesterol | _____ |
| ☐ Irregular Heartbeat | _____ |
| ☐ Liver Disease | _____ |
| ☐ Osteoporosis | _____ |
| ☐ Prostate | _____ |
| ☐ Stomach Ulcer/Reflux | _____ |
| ☐ Stroke/Seizures | _____ |
| ☐ Vascular Disease | _____ |
| ☐ Thyroid Disease | _____ |
| **Other:**_____ | _____ |

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**Patient Name**:_____ **DOB**:_____

## Past Surgeries

| Surgery/Procedure | Hospital | Date | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Current Prescriptions and Over-the-counter Medications

| Drug name | Dosage | Drug name | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you take aspirin or anti-inflammatory medications?** ☐ **No** ☐ **Yes- Please list below**

What is your preferred pharmacy?_____

**Do you take any of the following medications?** ☐ **Plavix** ☐ **Coumadin** ☐ **Warfarin** ☐ **Pradaxa** ☐ **Xarelto**

## Patient Drug Allergies

☐ **No known drug Allergies.**

| Allergy | Severity (Mild, Moderate, Severe) | Date | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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# Telemedicine Consent

*Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine.*

Please initial each line to show that you have read and understand each statement.

_____ I understand the concept of telemedicine, as well as the particular electronic medium to be used.

_____ I understand the potential risks and limitations of this mode of evaluation/treatment (including but not limited to the absence of in-person examination)and agree to be treated in a remote fashion.

_____ I understand that although there has been great progress made in technology, this telemedicine encounter may still be in the experimental stage.

_____ I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the health care providers.

_____ The nature and potential risks of this telemedicine encounter have been explained to me.

_____ I understand that instead of this telemedicine encounter, I have the option to reschedule for a future appointment within the office setting for a face to face visit

_____ I understand that specific procedures may require additional informed- consent process.

_____ I am aware that there are no guarantees with telemedicine.

_____ I understand that it is my responsibility to verify that Telehealth service is a covered benefit under my insurance plan. I will be responsible for any copays or out of pockets costs as per my plan benefits.

**I certify that I have read and understand this treatment agreement along with the potential risks as stated above. By signing this consent, I agree to be seen via Telehealth and any questions regarding telemedicine have been answered.**

Print Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____