INOVA
Join the future of health.

Inova Medical Group Neurosurgery

New Patient Information

Welcome to the Neurosciences Department at Inova. We are committed to making your experience with us as pleasant and stress-free as possible. To enhance our service to you, please fill out this information sheet prior to arriving for your appointment. Please let us know if there is anything we can do to improve your visit with us. We would like you to have an EXCELLENT experience with us and our team.

Today's Date: _____ Patient Name: _____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Your Pharmacy: _____ Phone: _____

Reason for your visit: _____

_____

Occupation: _____

If Retired, Previous Occupation: _____

Are your symptoms related to a work-related injury? □ Yes □ No

Are you currently on or have you applied for disability? □ Yes □ No

Do you have legal action pending regarding this injury? □ Yes □ No

Symptoms:

What are your symptoms? _____

How long have you had your symptoms? _____

What aggravates you symptoms? _____

What reduces your symptoms? _____

Please check if you have any symptoms below:

Symptom	Frequency		Location
Numbness	□ Constant	□ Intermittent	_____
Pins/needles/tingling	□ Constant	□ Intermittent	_____
Sharp Pain	□ Constant	□ Intermittent	_____
Dull/achy Pain	□ Constant	□ Intermittent	_____
Weakness	□ Constant	□ Intermittent	_____
Gait Instability	□ Constant	□ Intermittent	_____
Loss of Bowel Control	□ Constant	□ Intermittent	
Loss of Bladder Control	□ Constant	□ Intermittent	

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Inova Medical Group **Neurosurgery**

New Patient Information

Please check your current or previous therapy:

Type of Therapy	Effect on Your Symptoms			Month/Year of Therapy
Physical Therapy	□ Better	□ Worse	□ No Change	_____
Nerve Blocks	□ Better	□ Worse	□ No Change	_____
Medication Use	□ Better	□ Worse	□ No Change	_____
Chiropractor	□ Better	□ Worse	□ No Change	_____

Review of Symptoms: *(please check Yes or No)*

Constitution:

Activity Change	□ Yes	□ No
Appetite Change	□ Yes	□ No
Chills	□ Yes	□ No
Sweating	□ Yes	□ No
Fatigue	□ Yes	□ No
Fever	□ Yes	□ No
Rapid Weight Change	□ Yes	□ No
Trouble Swallowing	□ Yes	□ No

Ears, Nose Throat:

Facial Swelling	□ Yes	□ No
Neck Pain	□ Yes	□ No
Neck Stiffness	□ Yes	□ No
Ear Discharge	□ Yes	□ No
Hearing Loss	□ Yes	□ No
Ear Pain	□ Yes	□ No
Ear Ringing	□ Yes	□ No
Nosebleeds	□ Yes	□ No
Congestion	□ Yes	□ No
Runny Nose	□ Yes	□ No
Post-Nasal Drip	□ Yes	□ No
Sneezing	□ Yes	□ No
Sinus Pressure	□ Yes	□ No
Dental Problems	□ Yes	□ No
Drooling	□ Yes	□ No
Mouth Sores	□ Yes	□ No
Trouble Swallowing	□ Yes	□ No
Voice Change	□ Yes	□ No

Eyes:

Eye Discharge	□ Yes	□ No
Eyes itching	□ Yes	□ No
Eye Pain	□ Yes	□ No
Eye Redness	□ Yes	□ No
Light Sensitive	□ Yes	□ No
Visual Disturbance	□ Yes	□ No

Respiratory:

Stop Breathing	□ Yes	□ No
Chest Tightness	□ Yes	□ No
Choking	□ Yes	□ No
Cough	□ Yes	□ No
Short of Breath	□ Yes	□ No
Stridor	□ Yes	□ No
Wheezing	□ Yes	□ No

Cardiovascular:

Chest Pain	□ Yes	□ No
Leg Swelling	□ Yes	□ No
Palpitations	□ Yes	□ No

Gastrointestinal:

Stomach Bloating	□ Yes	□ No
Abdominal Pain	□ Yes	□ No
Anal Bleeding	□ Yes	□ No
Blood in Stool	□ Yes	□ No
Constipation	□ Yes	□ No
Diarrhea	□ Yes	□ No
Nausea	□ Yes	□ No
Rectal Pain	□ Yes	□ No
Vomiting	□ Yes	□ No

Genital/Urinary

Difficulty Urinating	□ Yes	□ No
Painful Urinating	□ Yes	□ No
Unable to Urinate	□ Yes	□ No
Side Pain	□ Yes	□ No
Frequent Urination	□ Yes	□ No
Genital Sores	□ Yes	□ No
Blood in Urine	□ Yes	□ No
Penile Discharge	□ Yes	□ No
Penile Swelling	□ Yes	□ No
Scrotal Swelling	□ Yes	□ No
Testicular Pain	□ Yes	□ No
Urgency	□ Yes	□ No
Urine Decrease	□ Yes	□ No

Muskuloskeletal:

Joint Pain/Swelling	□ Yes	□ No
Back Pain	□ Yes	□ No
Walking Problems	□ Yes	□ No
Joint Swelling	□ Yes	□ No
Muscle Pain	□ Yes	□ No

Skin:

Color Change	□ Yes	□ No
Pale Skin	□ Yes	□ No
Rash	□ Yes	□ No
Wound	□ Yes	□ No

Hematologic:

Swollen Nodes	□ Yes	□ No
Bruise/Bleed Easy	□ Yes	□ No

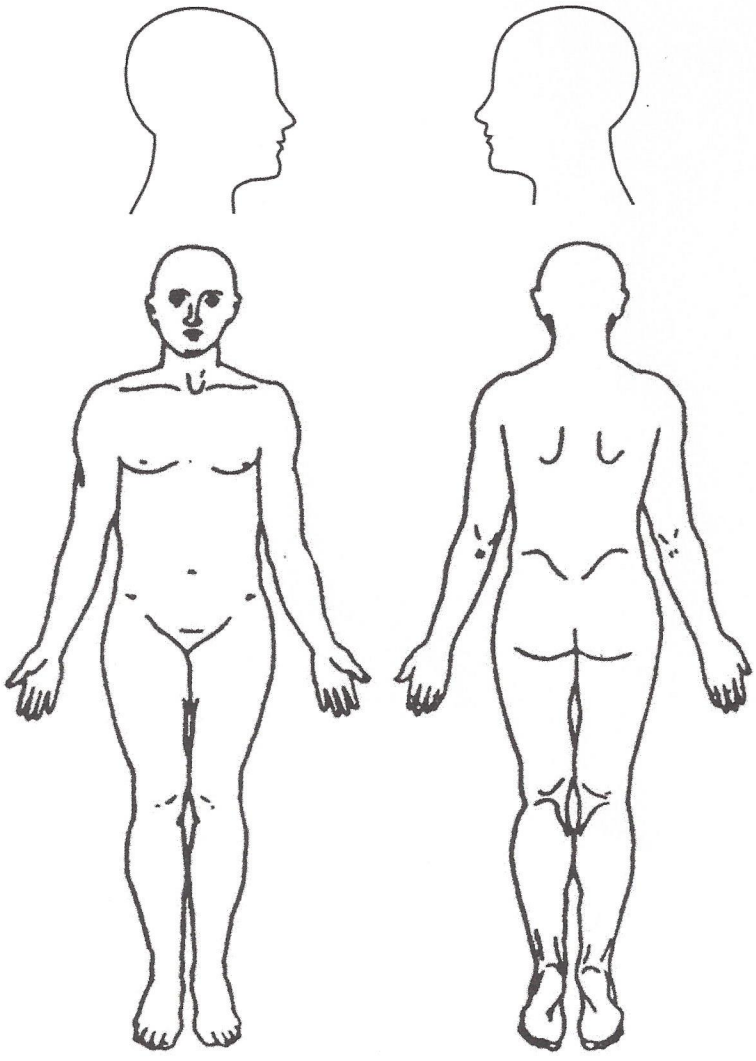
Neurological:

Dizziness	□ Yes	□ No
Facial Asymmetry	□ Yes	□ No
Headaches	□ Yes	□ No
Light-Headedness	□ Yes	□ No
Numbness	□ Yes	□ No
Seizures	□ Yes	□ No
Difficulty Speaking	□ Yes	□ No
Fainting	□ Yes	□ No
Tremors	□ Yes	□ No
Weakness	□ Yes	□ No

Psychiatric:

Agitation	□ Yes	□ No
Behavior Problem	□ Yes	□ No
Confusion	□ Yes	□ No
Decreased Concentration	□ Yes	□ No
Depression	□ Yes	□ No
Hallucinations	□ Yes	□ No
Hyperactive	□ Yes	□ No
Nervous/Anxious	□ Yes	□ No
Self-Injury	□ Yes	□ No
Sleep Disturbance	□ Yes	□ No
Suicidal Ideas	□ Yes	□ No

PLEASE SHADE THE AREAS WHERE YOU HAVE PAIN:



PAIN SCALE

(Circle Your Level of Pain)

Best Days	Worst Days	Overall Average	
1	1	1	*minimal pain*
2	2	2	
3	3	3	
4	4	4	
5	5	5	
6	6	6	
7	7	7	
8	8	8	
9	9	9	*worst pain*
10	10	10	

Please list all medical problems for which you are being treated (high blood pressure, heart disease, etc):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

SURGICAL/HOSPITALIZATION HISTORY:

Please list all Surgical Procedures or major hospitalizations and the year of occurrence:

Reason for Hospitalization: _____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

MEDICATIONS:

Please list all prescription medications, over-the-counter drugs, and other supplements you are taking:

□ None

Medication Name	Dosage	How Often?

ALLERGIES:

Do you have any allergies to medications, food, latex, or eggs? □ No □ Yes

Name	Type of Reaction

SOCIAL HISTORY:

Marital Status: □ Single □ Married □ Partnered □ Widowed □ Divorced

Number of Children: _____

Education: *(highest level completed)* □ Elementary □ High School □ College □ Post Graduate

Alcohol Use: □ None □ Occasional □ Frequent

Tobacco Use: Current Smoker? □ No □ Yes # Packs per Day? _____

Substance Abuse: *Have you ever abused any drug?*
□ Prescription Drug □ Heroin □ Cocaine □ Crack □ LSD □ Marijuana □ Other: _____

FAMILY HISTORY:

Please list pertinent family history (diabetes, heart disease, cancer, etc.):

Relationship	Age	Living?	Deceased?	Major Illnesses/Cause of Death
Father:	_____	□	□	_____
Mother:	_____	□	□	_____
Sibling:	_____	□	□	_____
Sibling:	_____	□	□	_____
Sibling:	_____	□	□	_____
Sibling:	_____	□	□	_____
Sibling:	_____	□	□	_____

_____ _____
Patient Signature Date

If person other than the patient is completing this form:

Relationship to Patient: _____

_____ _____
Signature Date

_____
Printed Name

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Patient Information:

Name (last, first, middle initial): _____ Phone # (home): _____ ❑ cell

Email Address: _____ Alternate Phone #: _____ ❑ work

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: ❑ Male ❑ Female Social Security #: _____

❑ Full Time ❑ Part Time ❑ Unemployed ❑ Retired

Employer: _____ Employment Status: ❑ Student ❑ Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone #: _____

Demographics:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Race: ❑ White/Caucasion ❑ Hispanic ❑ Black/African American ❑ American Indian/Alaskan Native
❑ Asian ❑ More than one race ❑ Declined ❑ Other: _____

Ethnicity: ❑ American ❑ Asian Indian ❑ Carribean Islander ❑ Chinese ❑ Eastern European ❑ Filipino
❑ Vietnamese ❑ Japanese ❑ Middle Eastern ❑ North African ❑ Pakistani ❑ Korean
❑ West African ❑ Declined ❑ Other: _____

Insurance Information:

Primary Insurance: _____ Patient is Subscriber/Policy Holder: ❑ Yes ❑ No

Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ❑ Yes ❑ No

Insured Information (if other than patient): We will request to scan your ID card.

Subscriber/Policy Holder: _____ Relationship to Patient: _____

Address: _____ Social Security #: _____

Date of Birth: _____ Subscriber's Employer: _____

Inova Medical Group reserves the right to charge a fee for any scheduled visits that are:

- Cancelled less than 24 hours prior to scheduled appointment time
- Missed without calling to cancel (No-Show)

Cancellation/No-Show fee: $45.00

Patient/Parent/Guardian Signature: _____ Date: _____ Time: _____

Specialty Care Only: Please indicate your referring doctor as well as other doctors who will need information about your treatment:

Primary Care MD Name: _____ Phone#: _____

Address: _____ Fax #: _____

Specialty Care MD Name: _____ Phone#: _____

Address: _____ Fax #: _____

Specialty Care MD Name: _____ Phone #: _____

Address: _____ Fax #: _____

PATIENT IDENTIFICATION LABEL

Inova Medical Group

Patient Registration Form

INOVA®

1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

Authorization for Claims Payment and Reviews - Ambulatory

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:
I understand that if my insurance carrier or administrator of benefits does not consider any service rendered a covered service or has not authorized these services, they will not pay and I agree to pay for these services. I also understand and acknowledge that in the case of out of plan/network, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing; have had the opportunity to ask questions and have them answered and accept the above conditions and terms; **have read the notice regarding assignment of medical expense benefits for automobile accident patients, if applicable;** and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. I understand and agree this document will remain in effect for my present visit and any future outpatient or physician office visits to Inova, unless specifically rescinded in writing by me.

_____ _____
PATIENT (GUARDIAN, ETC.) DATE / TIME

_____
RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

_____ _____
WITNESS DATE / TIME

Notice: patients are not required to execute this assignment of benefits form. If you do not execute this form, all charges will be billed to you directly instead of to your Insurance Plan.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

INOVA HEALTH SYSTEM

AUTHORIZATION FOR CLAIMS, PAYMENT, AND REVIEWS - AMBULATORY

CAT #20083DT 1PT / R042515 • PKGS OF 25

INOVA

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* All items with an asterisk are MANDATORY fields.

* Patient Name _____ Medical Record Number _____

Social Security# _____ * Patient Date of Birth _____

* Contact Phone Number _____ Contact Email _____

* Patient Address _____
Street Address City State Zip Code

*** I authorize Inova Health System to release or disclose the following information to:**

☐ Physician ☐ Other _____

Phone # (required if records are to be faxed) _____

_____ Fax # (25 pages or less) _____

Name of person or entity to receive information

_____
*Street Address City State Zip Code

*** Information to be Released/Disclosed:**

☐ Complete Medical Record
Facility: _____
Dates of admission/treatment requested: _____
☐ Billing Information
☐ Other _____

Abstracts of Medical Record:
☐ Consultations
☐ Discharge Summary
☐ EKG/EEGs
☐ Emergency Room Records

☐ Laboratory Reports
☐ Operative Reports
☐ Pathology Reports
☐ Radiology Reports
☐ History & Physical

Other Records:
☐ Physician Orders
☐ Plan of Care
☐ Progress Notes
☐ Psychiatric Admit Note
☐ Psychiatric Evaluation
☐ Radiology Images/CD
☐ Other _____

*** Purpose:**
☐ Medical Follow-Up
☐ Attorney
☐ Personal Use
☐ Disability
☐ Insurance
☐ Other _____

*** Record Disposition:**
☐ Release to MyChart
☐ Please mail the records
☐ Fax to the number above
☐ I will pick up the records
☐ I wish to review the records (You will need to make an appointment for the review)

Fees + Postage (if applicable):

Electronic	Release to MyChart	No charge
	CD or Thumbdrive:	$0.13 per page
	Radiology Images on CD:	$10.00 per CD
	Continuing Care	No charge
Paper	Pages 1-50:	$0.50 per page
	Pages 51+:	$0.25 per page
	Microfilm/Microfiche:	$1.00 per page
	Continuing Care	No charge

I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I do not have to sign this form. Treatment will still be provided to me if I do not sign this form.

_____ _____
* Signature of Patient or Authorized Representative * Date/Time (Authorization will expire six months after date signed)

_____ _____
* Print Name of Patient or Authorized Representative * Relationship to Patient

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Health System

Authorization to Release/Disclose Protected Health Information

CAT # 84516/ R042415 • PADS OF 100

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R020609
PKGS OF 100

MR 32-06