Virginia Neurosurgeons

NIKHIL R. NAYAK, MD

Dear Patient,

Thank you for choosing Virginia Neurosurgeons for your brain, spine, or peripheral nerve condition. We are committed to providing you with exceptional neurosurgical care in a compassionate environment.

Please carefully review the following document packet, which includes: directions to the office; new patient intake questionnaire; financial and insurance forms; office, insurance, and privacy policies; relevant release forms; a copy of our privacy statement. We kindly request you complete this packet in its entirety prior to your visit to ensure you are seen in a timely manner.

For your first appointment, please arrive approximately 15 minutes early to allow for adequate registration time and review of your paperwork. It is very important to bring all relevant diagnostic imaging (MRIs, CTs, x-rays, etc.) in CD format with their corresponding radiologist reports, as well as any other study results involved in the workup of your condition. Having this data is crucial for a thorough evaluation and development of a surgical/non-surgical plan of treatment.

Should you have any questions regarding your care or your upcoming appointment, do not hesitate to contact us at 703-248-0111, Monday – Friday from 9 AM – 5 PM.

I look forward to meeting you.

Sincerely,

Dr. Nikhil R. Nayak, MD

Virginia Neurosurgeons

NIKHIL R. NAYAK, MD

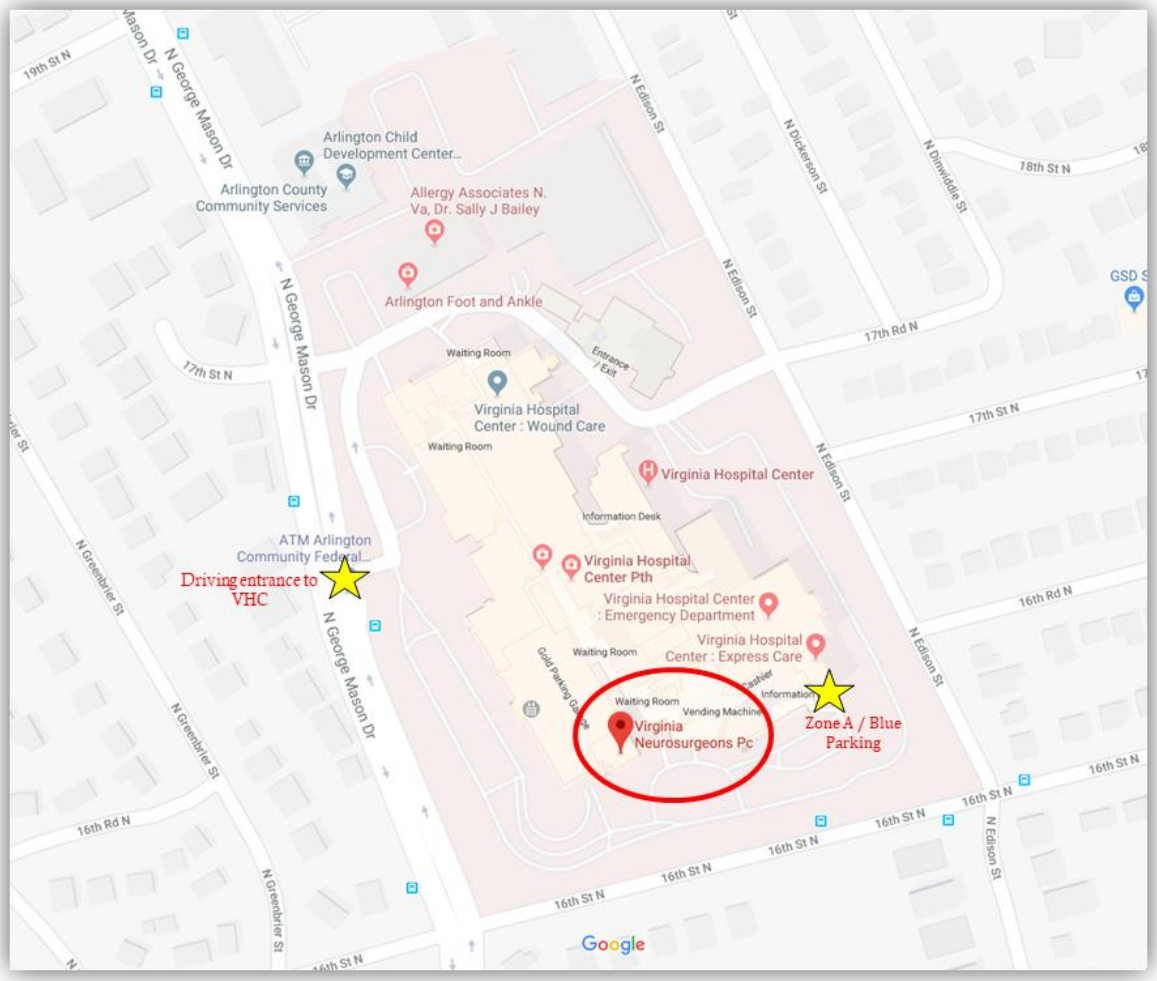
Directions

Our practice is located inside the main hospital of Virginia Hospital Center at 1625 North George Mason Drive, Arlington, VA 22205. We are located on the 4th floor of Zone A, Suite 445.

The main hospital entrance is on George Mason Drive. Make an immediate right turn. You will drive past the Virginia Hospital Center façade to your left, and continue to the visitor parking area. You should plan to park in the Zone A / Blue parking garage.

Once in the hospital, proceed to the Zone A visitor elevators, right off the main lobby near the coffee stand. Our office is on the 4th floor. The entrance to our office is immediately adjacent to the visitor elevators, with a plaque labeled "Virginia Neurosurgeons."

There are on-duty directory assistants in the main lobby of the hospital, or you may call our office at 703-248-0111, should you have any difficulty finding us.



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Patient Intake Form

Date: _____

Patient Information:

Name: _____ Social security #: _____
Last First MI
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Sex: M F Age: _____ DOB: _____
Email address: _____
Pharmacy: _____ Telephone: _____

Authorization to leave medical and/or administrative information via patient's voicemail, secure email, and/or online patient portal:

(Please Initial): Yes _____ No _____

Emergency contact:

Name: _____
Relationship: _____ Telephone: _____

Authorized for medical release of information **(Please Initial):** Yes_____ No_____

Credit Card Authorization

You will receive an Explanation of Benefits (EOB) from your insurance carrier providing the exact amount of your financial responsibility. We receive the same letter within 20-30 days of your appointment. We review each EOB carefully and send you a notification via email letting you know the amount that your credit card has been charged, based on what your insurance plan determines to be your responsibility. We will not charge your card until your insurance carriers have reconciled the amount that you may owe.

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

Primary Insurance Information:

Insurance Company: _____
Obtained on an insurance exchange? Yes _____ No _____
ID#_____ Group#_____
Subscriber: _____ Subscriber DOB: _____
Relationship to patient: □ Self □ Spouse □ Parent □ Other

Healthcare Insurance Benefits:
□ HMO/PPO □ Out-of-Network □ Self-Pay □ Workers' Compensation

Secondary Insurance / Workers' Compensation:

Insurance Company: _____
Obtained on an insurance exchange? Yes _____ No _____
ID#_____ Group#_____
Subscriber: _____ Subscriber DOB: _____
Relationship to patient: □ Self □ Spouse □ Parent □ Other

Healthcare Insurance Benefits:
□ HMO/PPO □ Out-of-Network □ Self-Pay □ Workers' Compensation

Assignment and Release

I, the undersigned, certify that the information provided with regards to my insurance coverage is true and accurate. I further authorize the release of any medical information necessary to process this claim. I hereby assign to NeuroVirginia, PLC those insurance benefit payments for services provided to me. I understand that regardless of this assignment, I remain financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Patient Acknowledgment and Consent

I have been given a copy of the NeuroVirginia, PLC Notice of Privacy Practices and consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative: _____ Date: _____

Printed Name: _____

Relationship if other than patient: _____

Please describe the representative's authority to act on behalf of patient:
_____

Office and Financial Policy

We participate with the following insurance companies:

- Aetna HMO / PP
- CareFirst BCBS HMO/PPO
- Cigna PPO/ Cigna Connect
- Kaiser Permanente / Exchange / Medicaid
- Medicare
- Medicare Advantage PPO
- United Healthcare
- Virginia Medicaid DMAS / Intotal Health / Anthem Healthkeepers

*For insurance carriers requiring a referral or visit pre-authorization, it is the patient's responsibility to obtain appropriate insurance approval/authorization before the clinic visit. Failure to do so will require out-of-pocket payment by the patient for services rendered.

*Please initial each of the following:

_____ There is a $10 fee in addition to my copay amount if not collected at the time of the visit. There is a $40 fee for returned checks. Co-pay and balances are due upon registration and check-in.
_____ **All balances** must be paid in full before appointments can be scheduled.
_____ 48-hour notice is required for any refills requested on medications. No refills will be authorized for patients who have not been seen in over one year. Most controlled substances requiring DEA licensure cannot be called to the pharmacy.
_____ There is a $50 no show fee if an appointment is not canceled at least 24 hours in advance. A $150 fee will be charged for surgery or procedure cancellation. Virginia Neurosurgeons reserves the right to discharge me from the practice after three cancelled appointments without prior notice.
_____ There is a $15 administrative fee and $.50 per page for up to 50 pages/ $0.25 per page thereafter for medical records requests and letters.

I have reviewed the NeuroVirginia PLC Office and Financial Policy. By providing my signature below, I acknowledge that I have read, understand, and approve all of the above.

Signature: _____ **Date:** _____
Printed Name: _____

Photo and Diagnostic Imaging Authorization and Consent

De-identified medical photographs (e.g. intra-operative photographs) and diagnostic imaging (e.g. CT, MRI scans) taken of me, as well as details regarding medical services that I have received at Virginia Neurosurgeons, P.C. / NeuroVirginia PLC, may be used in my medical record, for purposes of medical teaching, in published medical journals/textbooks, and on the internet (including social media) in order to inform the public about neurosurgery methods. By consenting to this use of diagnostic images and de-identified medical photographs, I understand that I will not receive payment from any party. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name, face, or other personally-identifiable features at any time during any use or publication of these materials by any party. I may withdraw my consent in the future at any time with a written request.

By providing my signature below, I acknowledge that I have read, understand, and approve all of the above.

Signature: _____ **Date:** _____
Printed Name: _____

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New Patient Medical History Form

Name: _____ Date: _____

Referring physician: _____ Primary Physician: _____

(Please include first and last name of all physicians)

Are there any other physicians you would like us to contact regarding your care?

1. _____
   Name Address Phone #

2. _____
   Name Address Phone #

CURRENT CHIEF COMPLAINT:

List symptoms related to today's visit:

_____

Date problem started: _____

Please check any of the following you have had done related to your problem:

□ X-rays □ CT scan □ MRI □ EMG □ Physical Therapy □ Spinal Injections

CONSTITUTIONAL

Age: _____ Height: _____ Weight: _____

CURRENT MEDICAL PROBLEMS:

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

Are you *currently* taking any medications? If so, please provide a list or write (include dosage, pain medications, supplements, and over-the-counter drugs): _____

_____

1625 N. George Mason Drive, Suite 445 | Arlington, VA 22205 | Tel: 703.248.0111 | Fax: 703.248.0046

Are you taking any blood thinners (e.g. Aspirin, Warfarin, Lovenox, Xarelto, Eliquis, etc.)?
□ Yes □ No; if yes, specify: _____

Please list any drug allergies and reactions (itching, cough, hives, etc.):

Drug: _____ Reaction: _____
Drug: _____ Reaction: _____
Allergy to Iodine or IV contrast: □ Yes □ No Reaction: _____

SURGICAL HISTORY AND PRIOR HOSPITALIZATIONS:

Reason: _____ Physician: _____ Date: _____
Reason: _____ Physician: _____ Date: _____
Reason: _____ Physician: _____ Date: _____

REVIEW OF SYSTEMS: Please list any symptoms related to the following organ systems?:
(If no relevant symptoms, please leave line blank)

1) Constitutional (e.g. fever, night sweats):_____
2) ENT (e.g. difficulty hearing, trouble swallowing):_____
3) Cardiovascular (e.g. irregular heartbeat, chest pain):_____
4) Respiratory (e.g. shortness of breath, wheezing): _____
5) Gastrointestinal (e.g. abdominal pain, heart burn):_____
6) Genitourinary (e.g. frequent urination):_____
7) Musculoskeletal (e.g. joint pain, aching muscles):_____
8) Skin (e.g. redness, swelling):_____
9) Neurologic (e.g. double vision, tingling):_____
10) Psychiatric (e.g. depression, hallucinations):_____
11) Endocrinologic (e.g. hot/cold intolerance):_____
12) Hematologic (e.g. abnormal bleeding, easy bruising):_____
13) Allergic/Immunologic (e.g. anaphylaxis):_____

IMMEDIATE FAMILY HISTORY:
Do any blood relatives (parents, grandparents, or siblings) have major health problems relevant to you?

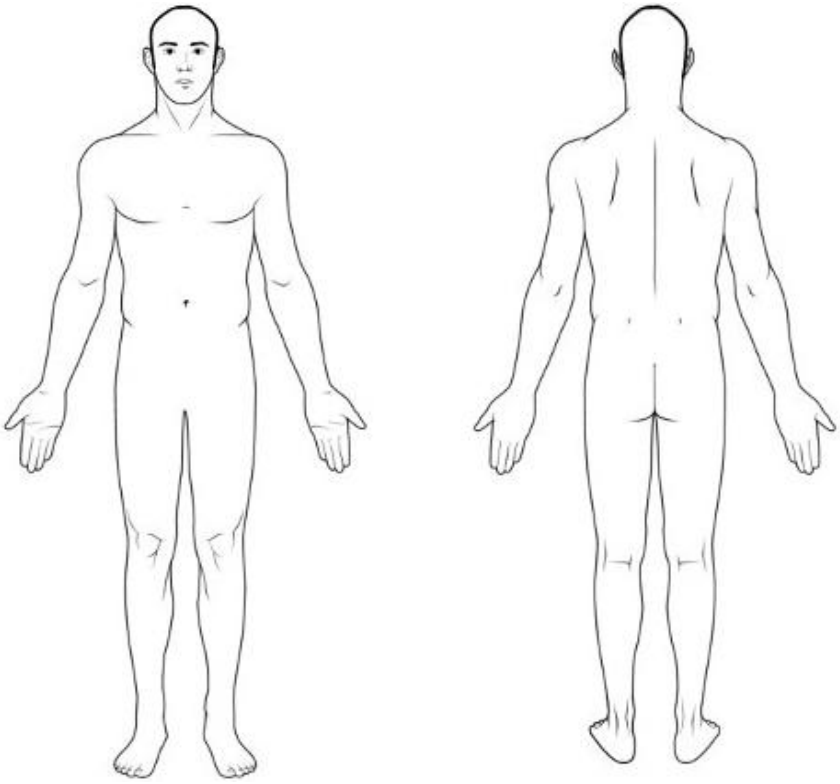
1) Father:_____
2) Mother:_____
3) Siblings:_____

Are there any hereditary diseases in your family that are relevant to your health?
□ Yes □ No. If yes, please list: _____

SOCIAL HISTORY:

Tobacco use (past/present): □ Yes □ No If yes, _____ packs per day for _____ years
Alcohol use: □ None □ Occasional/Social □ Daily (# per day: _____)
Drug use: □ Yes □ No. If yes, please list type and frequency: _____
Are you currently working? □ Yes □ No If disabled, date of disability? _____

Please draw area of pain:



Pain Intensity
Rate on a scale of "0-10", 0 being no pain and 10 being the worst pain (please circle each number) One your best day: 0 1 2 3 4 5 6 7 8 9 10 On your worst day: 0 1 2 3 4 5 6 7 8 9 10 Average: 0 1 2 3 4 5 6 7 8 9 10
If back and leg pain are present, rate the percentage of each below (should = 100%): _____% back pain + _____ % leg pain = 100%
If neck and arm pain are present, rate the percentage of each below (should = 100%): _____% neck pain + _____% arm pain = 100%