Piedmont Neurosurgical Group, P.A.

Michael N. Bucci, MD, FACS
Aaron C. MacDonald, MD, FACS
Christie B. Mina, MD

109 Montgomery Drive
Anderson, S.C. 29621
(864) 224-5700

3 St. Francis Drive, Suite 330
Greenville, S.C. 29601
(864) 220-4263

PATIENT INFORMATION

PLEASE PRINT USING BLUE OR BLACK INK ONLY

SOCIAL SECURITY # ________________ **DOB** __/__/19___ **MARITAL STATUS** ______ **SEX M F** (Circle One)

PATIENT NAME ____

LAST NAME FIRST NAME MIDDLE NAME

____

STREET ADDRESS APT # CITY STATE ZIP

(_____)________________ (_____)________________ (_____)________________

HOME PHONE WORK PHONE CELL PHONE

EMERGENCY CONTACT (name and #) ____

PATIENT'S EMPLOYER ______________________ **OCCUPATION** ______________________

SPOUSE'S NAME ______________________ **DOB**________________ **SSN**________________

SPOUSE'S EMPLOYER______________________ **PHONE#** ______________________

IS YOUR INJURY RELATED TO A WORK ACCIDENT? ________ **AUTO ACCIDENT?** ________

IF A MINOR:
LEGAL GURARDIAN: ______________________ **PHONE:** ______________________

ADDRESS: ____

PRIMARY INSURANCE

____

INSURANCE COMPANY INSURED'S NAME DOB SSN

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND AUTHORIZE PAYMENT TO PNG, PA.

SIGNATURE: ______________________ **DATE:** ________________

SECONDARY INSURANCE

____

INSURANCE COMPANY INSURED'S NAME DOB SSN

WORKMAN'S COMPENSATION /LIABILITY

____

NAME ADDRESS CITY STATE ZIP

(____)________________ ______________________ ______________________

PHONE NUMBER CLAIM NUMBER ADJUSTOR'S NAME

ACCIDENT DATE___/___/20___ **DATE LAST WORKED**___/___/20___ **DO YOU HAVE LEGALREPRESENTATION**________

ATTY NAME ________________**ADDRESS** ______________________ **PHONE** (____)____________

PHYSICIAN INFORMATION

REFERRING DR. ______________________ **FAMILY DR.** ______________________

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Insurance Authorization and Assignment

Please read carefully then sign the authorizations below. They will remain as part of your medical records for future reference.

Name of Policy Holder ________________________________ HIC/ID Number __________________________

I request that payment of authorized Medicare and/or Other Insurance company benefits be made on my behalf to PIEDMONT NEUROSURGICAL GROUP, P.A. for any consultative or surgical services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize PIEDMONT NEUROSURGICAL GROUP, P.A. to release any medical/other information about me to the Social Security Administration, Health Care Financing Administration and its intermediaries, or other applicable commercial/workman's compensation carriers with the provision that the said release will aid in the payment of my outstanding medical claims at PIEDMONT NEUROSURGICAL GROUP, P.A.
I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payment of my treatment.

____ ______________________

SIGNATURE OF PATIENT **DATE**
(LEGAL GUARDIAN IF PATIENT IS A MINOR)

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Disclosure of Protected Health Information

Date: __________

By Law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I, ___________________________________ am authorizing Piedmont Neurosurgical Group, PA to give medical information as described below to:

____

____

(Name of authorized person(s), example: family member, caregiver, neighbor)

Scheduled Appointment Times?

Patient Only: ☐ Yes ☐ No Parties Listed Above: ☐ Yes ☐ No

Bill and Account Information?

Patient Only: ☐ Yes ☐ No Parties Listed Above: ☐ Yes ☐ No

Can we leave messages on answering machine/voicemail? ☐ Yes ☐ No

Can we call you at home? ☐ Yes ☐ No

If NO, then you MUST provide alternate phone contact information:

____

____

Can we mail appointment reminders or other correspondence relative to your medical care to your home? ☐ Yes ☐ No

If NO, then you MUST provide an alternate mailing address:

____

____

*****This authorization remains in effect until I give written notification to discontinue.**

____
Name of Patient

______________________________________ ________________________________
Signature of Patient Date

Parent/Guardian of minors under age 18 have access to medical records, with the exception of and State Law protecting the privacy of information of minors.

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Prescription Policy

In an effort to provide our patients with the highest quality care, our practice abides by the following prescription policy. We ask that you read this policy and then sign this letter of agreement. By signing this agreement, you are stating that you understand the policy and agree to abide by the policy.

- While a patient of this practice, I shall obtain all controlled substance prescriptions from physicians at PNG PA only.
- I will choose one pharmacy and have all my prescriptions filled there.
  - The pharmacy that I will use is ____
  - The telephone number is ____
- I will not request, nor will I accept any controlled substance medication from any other individual or physician while I am receiving treatment at PNG, PA. The only exception is if I am hospitalized or if I receive prior permission from my treating physician at PNG, PA.
- If I do receive such a prescription from another physician, I am responsible for notifying the nurse at PNG, PA immediately.
- I will take the medication as directed, no more and no less. If I use up my medication sooner than prescribed, I understand that it will not be refilled early.
- I will contact my physician's RN before I make changes in any medication dosage. I will not change the dosage without contacting PNG, PA **first**.
- I am responsible for my controlled substance medication. If the medication is lost, stolen or disappears for any reason, the medication will not be replaced.
- Close monitoring of the medication dosage is required while being treated with controlled substance medications. Therefore, all scheduled appointments must be kept. If an appointment is missed without prior notification or canceled with less than 24 hours notice, this will be a violation of this agreement and no medications will be prescribed until I see my physician at PNG, PA.
- I am responsible for keeping track of the amount of my medication and will call with 48 hours (two days) notification for refills so that I will not run out of medication. Refills will not be made at night, on weekends, or holidays as the physician on call does not have access to my medical history. Calls for refills will be replied to only during regular office hours.
- I understand that any deception used to obtain controlled substance prescriptions is a felony punishable by the law and is grounds for forfeiture of the doctor-patient confidentiality privilege. It is our responsibility to report this type of violation to the appropriate authorities.

Any violation of the above guidelines may result in discontinuation of the prescribed medication permanently. It may also result in discharge form PNG, PA.

_______________________________________   _________________________
Patient   Date

_______________________________________   _________________________
Witness   Date

The physicians of PNG, PA appreciate your cooperation with this policy and apologize for any possible inconvenience that may arise as a result of compliance.