Atlantic Neurosurgical Specialists
Brain, Spine, and Neurovascular Surgery

Brian D. Beyerl, MD, FACS
John J. Knightly, MD, FACS
Jonathan J. Baskin, MD, FACS
Ronald P. Benitez, MD
Jay Y. Chun, MD, PhD
David Wells-Roth, MD
Kyle T. Chapple, MD
Scott A. Meyer, MD
Yaron A. Moshel, MD, PhD
Charles B. Stillerman, MD, FACS
Paul S. Saphier, MD
Pinakin Jethwa, MD
Igor Ugorec, MD
Henry Park, MD
Joseph H. Rempson, MD
Joelle S. Rehberg, DO

Dear Patient,

Your consultation is scheduled for ______________________ (date) at _____________________ (time)

With Dr. ________________________________ in our ________________________ office.

You must fill out all of the enclosed forms. We are sending these to you so that you can complete them at your leisure. This will save time when you get to the office. You should have your insurance card in front of you when you are completing the form.

When you come to our office, you will need to bring your radiology films along with any/all reports, insurance card and the completed packet that is enclosed. Also, we would like to remind you that payment is due at the time of service.

If you need to cancel or reschedule your appointment, we would appreciate 24 hours advanced notice. Also, if you have any other questions regarding your packet, feel free to contact us. We look forward to meeting you.

Sincerely,
The physicians and staff of Atlantic Neurosurgical Specialists

310 Madison Avenue Suite 300 PH 973 285 7800
Morristown, NJ 07960 FAX 973 285 7839

11 Overlook Road Suite 180 PH 908 522 2134
Summit, NJ 07901 FAX 908 522 2207

3700 Rt. 33 East 2nd Floor Suite B PH 732 455 8225
Neptune, NJ 07753 FAX 732 455 8227

Glenpointe Centre Atrium PH 201 530 7035
400 Frank W Burr Blvd FAX 201 530 7036
Teaneck, NJ 07666

781 Route 15 South PH 973 729 0266
Jefferson, NJ 07849 FAX 973 726 8215

Welcome to our Practice

Welcome to Atlantic Neurosurgical Specialists. It means a great deal to us that you have chosen us to serve as your professional neurosurgical specialists. We want to assure you that our doctors and staff will constantly strive to earn your continued confidence and satisfaction.

In order to provide you with the best medical care, we will need your comprehensive medical history. You can assists us, and save time during your first visit, by completing the enclosed medical history form in advance. Please bring these completed forms when you come to our office, and be prepared to spend at least one hour with us for your complete and thorough examination. Remember that our doctors sometimes have emergencies to deal with that may affect your appointment time or require that we reschedule.

Payment for your consultation is expected at the time of your visit, unless other arrangements have been made with our staff in advance of your appointment. Please make sure that you have your insurance card with you. If you have an insurance that requires an authorization or referral, you must have it with you at the time of the visit. **Please understand that we do not participate in any HMO plans.** This does not; by any means indicate that you cannot have a consultation with our doctors! It simply means that you will have to have an out of network referral from your Primary Care Physician in order to be reimbursed for your office visit. If surgery is indicated, we will work with you to get approval from the carrier. Regarding other insurances such as PPO plans or POS and traditional plans, we are more than happy to negotiate with them and work towards getting the best possible reimbursement for you. Please do not hesitate to talk to us about your insurance. For surgical cases, we will submit your insurance. We then wait 90 days for your claim to be paid. If they do not pay the claim within that 3 month period, then you will be responsible for any open balance. If you have financial problems that indicate your need to be on a payment plan, our billing department will work with you. We feel an obligation to tell each and every patient our financial policy before the services are provided in an effort to avoid any miscommunication later.

Having said this, please consider our experience and dedication to each and every one of our patients. Nothing is more important to us. We look forward to meeting you and your family.

Please visit our website before your appointment at: www.ansdocs.com

ATLANTIC NEUROSURGICAL SPECIALISTS

REGISTRATION FORM

Patient's Legal Name: Last:	First:	Middle:				
Social Security #:	❑ Mr. ❑ Dr. ❑ Mrs. ❑ Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid				
Preferred Contact # ❑ Home ❑ Cell ❑ Work	Home Phone:	Cell:	Work: ext:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email Address:	Street Address:	City:	State:	Zip Code:		
Employer & Position:	Employer Address:					

Primary Care Physician:		Referring Physician:	
Primary Care (Town/State):		Referring (Town/State):	
Primary Care Phone:		Referring Phone:	
Specialty Doctor:	Specialty:		Town/State:
Specialty Doctor:	Specialty:		Town/State:

We are now required to collect Race, Ethnicity and preferred language. You may choose "Prefer not to answer".

Race:		**Ethnicity:**	**Preferred Language:**	
❑ American Indian or Alaska Native	❑ Prefer not to answer	❑ Not Hispanic or Latino	❑ English	❑ Spanish
❑ Asian	❑ Other	❑ Hispanic or Latino	❑ Prefer not to answer	
❑ Black or African American	❑ White	❑ Prefer not to answer	❑ Other:_____	
❑ Native Hawaiian or Other Pacific Islander				

INSURANCE INFORMATION

❑ Worker's Compensation: Claim #_____		❑ Motor Vehicle Claim
Primary Insurance:		Member ID:
Policy Holder Name & Relationship:	Policy Holder DOB:	Group#:
Policy Holder's Place of Employment:	Policyholder Employment Address:	
Secondary Insurance:		Member ID:
Policyholder Name:	Policy Holder DOB:	Group#:

EMERGENCY & RECORDS CONTACT: EMERGENCY CONTACT: _____

Emergency Contact # :	Contact Relationship:
Authorized Contact's for Information Release: These individuals have been selected by the patient to be contacted for the specified information.	Information **ONLY** to be released to "Authorized Contact" listed to the left. Initial all items that can be released to the "Authorized Contacts".
Authorized Contact 1: Relationship:	_____ Medical Information (Health diagnosis, treatment, etc.) _____ Financial Information (Insurance, payment, balances, etc.) _____ Prescription Pick up
Authorized Contact 2: Relationship:	_____ Documentation Pick Up
May we leave a voicemail containing medical/personal information? ❑ Yes ❑ No	If yes, which number(s)? ❑ Home ❑ Cell ❑ Work
Patient Signature: _____	❑ I Authorize Above Contact(s) to discuss initialed information ❑ I do **NOT** authorize release to anyone else

Assignment of Benefits: I hereby authorize Atlantic Neurosurgical Specialists to apply for Medicare/Medigap, and other health insurance benefits (if applicable No-Fault and Worker's Compensation) on my behalf. I request that payment of all Medicare/Medigap and commercial insurance carriers be made directly to Atlantic Neurosurgical Specialists. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information and records about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, and any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medicare/Medigap and/or Commercial Insurance Carrier benefits be made on my behalf to Atlantic Neurosurgical Specialists. I release any holder of Medicare/Medigap information about me to my insurance carrier(s) necessary to determine benefits payable for related service(s). I hereby authorize this medical provider and its associates to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, claims adjuster, or attorney if applicable.

Signature:_____ **Date:**_____

Financial Policy/Agreement: You will be responsible for payment of any and all services provided to you by the Physicians/ Nurse Practitioners/ Physician Assistants/ Registered Nurse First Assist at Atlantic Neurosurgical Specialists regardless of your insurance coverage. If surgery is necessary, a claim will be submitted to your insurance company with the medical insurance information you have provided to Atlantic Neurosurgical Specialists at the time of service and Atlantic Neurosurgical Specialists will wait 90 days for the insurance carrier to make payment. **At the end of 90 days, you are responsible for the payment of the account in full**. You will be responsible for all co-payments, co-insurance and deductibles not met for the year as well as any non-covered services under your health plan. With the exception of payments which are payable at the time of service, you will be billed for any of the aforementioned fees and payment is due upon receipt of a billing statement. If the correct insurance information is not presented at the time of service, you will be responsible for the full amount of charges incurred. If you do not have medical insurance, financial agreements can be made prior to services rendered; otherwise, full payment is expected at the time of service. Atlantic Neurosurgical does not accept lien letters from attorneys in lieu of payment. We will attempt to resolve all past due balances amicably, but non-payment will be subject to the collection process after 90 days from the date of service. Atlantic Neurosurgical Specialists is an independent private practice and our policies, procedures, and billing process is completely separate from any/all hospitals, surgical centers, facilities or entities. All charges other than Medicare or Medicaid will be submitted to your insurance carrier as an Out of Network provider. You further agree to relinquish all/any checks or correspondence that you receive from your insurance carrier to Atlantic Neurosurgical Specialists within five (5) business days of receipt to properly reflect on your account. **Failure to comply will result in delinquent account and further collection actions. By signing below, you fully understand and agree to the above and take full financial responsibility for your account.**

Signature:_____ **Date:**_____

Privacy Notice/ Acknowledgement (HIPPA): Atlantic Neurosurgical Specialists assures each patient the safety of protecting their healthcare information. The plan is in a binder in the waiting area and is available for reading. This plan describes how Atlantic Neurosurgical assures the safety of my protected health information and explains my rights and their responsibilities to my privacy in regard to the medical care that I am seeking. I understand that I have the right to limit access of my protected health information at any time of service. I also understand that any questions that I have regarding my privacy can and will be answered by the Director of Operations. By signing this acknowledgement form, I agree to the Atlantic Neurosurgical Specialists privacy policy as stated here and in their plan.

Signature:_____ **Date:**_____

Consent to treatment: I consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

Signature:_____ **Date:**_____

History and Review of Systems

Reason for visit: ❑ Brain ❑ Spine ❑ Neurovascular						Date:
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Religious beliefs that may direct treatment? ❑ Yes ❑ No	Children? ❑ Yes ❑ No How many? _____	Education: ❑ H.S./GED ❑ 2-year College Degree ❑ 4-year College Degree ❑ Post-College Degree		Birth date: / /	Age:	Sex: ❑ M ❑ F
Height: _____ Weight:_____	Occupation? ❑ Retired			Litigation Pending ❑ Yes ❑ No		
Tobacco use ❑ Yes ❑ No Type:_____ Packs per day ___ for ___ years [Year quit _____]	Alcohol Use: Drinks _____ per ❑ day ❑ week ❑ month			Illicit Drug Use? ❑ Yes ❑ No		
Caffeine (coffee, tea, soda, chocolate) servings / day: ____ [circle which applies]	❑ Left-Handed ❑ Right-Handed ❑ Ambidextrous					
Physical Activity: ❑ Sedentary ❑ Light ❑ Moderate ❑ Strenuous	Type: _____	Frequency:				

Have you EVER been diagnosed with the following conditions (If yes, check appropriate boxes):

- ☐ None
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Blood Clot
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes ❑ 1 ❑ 2
- ☐ Emphysema
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis ❑ A ❑ B ❑ C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/Aids
- ☐ Kidney Disease
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Neuromuscular disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ PVD
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid/Parathyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Disorder
- ☐ Cancer: _____ _____
- ☐ Other: _____

Do you CURRENTLY have any of these symptoms? (Check appropriate boxes)

- ☐ None
- ☐ Abnormal Bruising
- ☐ Anxiety
- ☐ Arm Pain ❑ L ❑ R
- ☐ Arm Weakness
- ☐ Blurry Vision
- ☐ Chest Pain
- ☐ Depression
- ☐ Difficulty in swallowing
- ☐ Dizziness
- ☐ Double Vision
- ☐ Fainting
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Incontinence
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Leg Pain ❑ L ❑ R
- ☐ Leg Weakness
- ☐ Memory Loss
- ☐ Neck Pain
- ☐ Numbness
- ☐ Palpitations
- ☐ Persistent Infection
- ☐ Rash
- ☐ Ringing in the Ears
- ☐ Seizures
- ☐ Sexual Problems
- ☐ Shortness of Breath
- ☐ Tingling
- ☐ Vision Loss
- ☐ Vomiting/Nausea
- ☐ Weight Gain
- ☐ Weight Loss, Unintentional

Surgical History	Surgery Performed	Year Performed

Has anyone in your Family Ever had? (If yes check box and mark relationship) (M: mother, F: father, S: Sibling)

- ☐ Alcoholism ❑ M ❑ F ❑ S
- ☐ Bleeding Disorder ❑ M ❑ F ❑ S
- ☐ CAD ❑ M ❑ F ❑ S
- ☐ Depression ❑ M ❑ F ❑ S
- ☐ Diabetes ❑ M ❑ F ❑ S
- ☐ High Blood Pressure ❑ M ❑ F ❑ S
- ☐ High Cholesterol ❑ M ❑ F ❑ S
- ☐ Mental Illness ❑ M ❑ F ❑ S
- ☐ Seizures ❑ M ❑ F ❑ S
- ☐ Stroke ❑ M ❑ F ❑ S
- ☐ Cancer & Type ❑ M ❑ F ❑ S

M: _____

F: _____

S: _____

PHARMACY INFORMATION			
Pharmacy Name:			
Street address:	City:	State:	Zip:
Phone:			

Medications:

Name	Dosage	Times a Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies	Reaction
1.	
2.	
3.	
4.	
5.	

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any payments) under my health insurance policy or benefit plan to **Atlantic Neurosurgical Specialists** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service. It is specifically intended by this assignment of benefits to assign to the fullest extent permitted under the law any and all of my rights, including without limitation, the right of one or more of the Providers to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State law rules, regulations and requirements, (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator to timely produce or respond to requests (including appeals) for all information relating to any plan documents describing the rights under any insurance policy or benefit plan as required by any applicable Federal or State law, (iii) to endorse for me any checks made payable to me for benefits and claims collected toward my account, and/or (iv) to bring any appeal, lawsuit or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination of benefits under any insurance policy or benefit plan.

Should this assignment be prohibited under my policy/plan, please disclose to Provider in writing such anti-assignment provision, otherwise this assignment shall be effective notwithstanding any anti-assignment clause in any policy/plan.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including Howard Healthcare Group) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits from any third-party payor under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and private health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPPA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date:_____

Patient Signature: _____

Directions to:
Atlantic Neurosurgical Specialists
Corner of (310) Madison Avenue & Punch Bowl Road
Morristown, NJ 07960
Phone: (973) 285-7800

From the Garden State Parkway: (North & South) Take the Parkway to Route 78 West, which is near the Union toll. Follow Rt. 78 West (stay in local lane). Get onto Route 24 West. Follow Rt. 24 West to exit 2A (Morristown), which will pull you onto Columbia Turnpike. At the traffic light, turn left onto Park Avenue. Go to the second light and turn right onto Punch Bowl Road. We are at the end of Punch Bowl Road on the left side of the street (black glass building, #310). This is the corner of Punch Bowl Road and Madison Avenue.

From Route 287: (North & South) Take Route 287 to Exit 35 (Madison Avenue). Follow the signs "H" to Morristown Memorial Hospital. You will be on Madison Avenue heading towards Madison. Go past the hospital and follow Madison Avenue for about one mile. You will pass Friendly's Restaurant on your left and Jersey Central Power & Light. Turn left onto Punch Bowl Road. We are the first (black glass) building on the corner (#310).

From Route 80: Follow Route 80 East or West to Route 287 and proceed as above.

From Summit, Chatham, and local towns: Take Main Street in Chatham through Main Street in Madison. Main Street turns into Park Avenue. Keep going pas Verizon, past Hamilton Park Conference Center, to the light at Punch Bowl Road. Make a left on to Punch Bowl and we are at the end of Punch Bowl Road on the left side of the street. OR You can follow Main Street to Madison Avenue, and we are about half a mile past the Madison Hotel and Rod's Steakhouse. (#310 on your right, black glass building).

Parking:

You may park in the front of the building. Come in the front doors and walk straight ahead to the elevators which are on your left. Take the elevators to the Third floor. You may also park under the building and enter through the glass doors, taking elevators to the THIRD floor.