

Westchester Spine and Brain Surgery, PLLC

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<http://www.wsbsonline.com>

Bennie W. Chiles III, M.D., F.A.C.S.

Board Certified, American Board of Neurological Surgery

Fellow, American College of Surgeons

Dear Patient,

Your neurosurgical appointment has been made with our office. Please follow the directions below in order to make your visit with us as productive as possible.

1. Complete registration forms and bring with you on the day of your appointment.
2. Bring one form of photo identification.
3. **YOU MUST BRING YOUR MRI OR CAT SCAN FILMS / DISC
ALONG WITH THE WRITTEN REPORT.**

The doctor is unable to make a complete diagnosis or properly recommend the appropriate treatment without viewing the actual films and reports. Please note that films/disc cannot be "faxed" to this office, only "written reports" can be faxed. Hospitals or free standing Facilities DO NOT mail films/discs. It is imperative that you bring a "hard" copy with you to your appointment. If you do not bring the films/disc your appointment will be rescheduled.

INSURANCE :

1. Your insurance identification card will be necessary.
2. If your insurance requires a co-payment you will be responsible for that payment on the date of service.

INSURANCE REFERRALS:

1. Please bring appropriate referrals on the day of your appointment. It is the responsibility of the patient to obtain proper referrals for Specialists from their Primary Care Provider. If referral is not obtained for your appointment, you will be asked to either pay for your visit or reschedule your appointment.

A \$ 25.00 *** NO SHOW FEE WILL APPLY**

If appointments are not cancelled or rescheduled within 24 hours of original appointment date.

*****PLEASE NOTE*****

Due to the nature of our practice it is sometimes necessary to reschedule patient appointments in order to accommodate surgical emergencies. We appreciate your understanding.

***Please be advised that the office requires No Fault/Workers' Compensation claim information prior to your visit for verification.

WORKERS' COMPENSATION: The following information will be needed to properly handle your compensation claim. Please be thorough in completing the paperwork in Part II of this packet. You will need the following information:

1. Insurance Carrier name and address
2. Carrier case/claim number
3. WCB number
4. Date of Injury
5. Name, telephone and fax number of case worker
6. Employer information (Name, address, phone number)
7. Employment status (if you are out of work on “total 100% disability”, please provide our office with the name of the physician who made that determination for our records).
8. Workers’ Compensation attorney or legal representative’s information (name, address, telephone and fax number)

NO-FAULT

(Automobile Accident)

1. Insurance company name and address
2. Name of insured person
3. Claim number
4. Date of the accident
5. Adjusters name, telephone and fax numbers

We also ask that you supply us with your private insurance for our records in addition to your no fault information.

DIRECTIONS

1. Enclosed are directions to our office.
2. You may obtain another version at our web site at www.wsbsonline.com
3. Or by phone, dial 914-332-0396 and hit prompt # 7 for verbal directions.

PART II- INSURANCE INFORMATION

Accident/ injury claims:

Is the reason for this visit due to any type of accident or injury? Y ___ N ___

***If no, please skip this section and go to Health Insurance Information section at bottom of page.**

If yes, please explain cause of accident, date, and location of accident, and provide information requested below:

Auto accident claims:

Date of injury _____ Please indicate part of body injured _____

Have you ever had same or similar condition? _____

Insurance company name _____

Claims address/city/state/zip _____

Insurance company phone #(____) _____

Adjusters Name _____ Tel #(____) _____ ext _____

Claim or file # _____ Is this claim active? _____

Policyholder _____ Relation to patient _____

Attorney name, address and phone # _____

Are you currently working? Y ___ N ___ If no, please indicate last day worked _____

For No-fault (Auto) claims only—Were you the:

Automobile Driver ___ Passenger ___ Pedestrian ___ Bicyclist ___ Motorcyclist ___

Motorcycle passenger ___ Other (specify) _____

HEALTH INSURANCE INFORMATION (please provide ID card(s) and picture ID for copying)

Primary Insurance Check one: HMO ___ PPO ___ Medicare ___ Other _____

Insurance Co. name _____ Referral required? ___ Effective date _____

Insurance company claims address _____

Insurance co. phone number _____ Office Co-pay amount (if applicable) _____

Identification/policy # _____ Group/plan# _____

Subscriber information:

Name _____ Sex _____ Date of Birth _____ Marital Status _____

Social Security # _____ Relation to patient _____

Address (if different than patient) _____

Phone # (if different than patient) _____ Employer _____

Employer address _____

Employer phone# _____

SECONDARY INSURANCE Check one: HMO _____ PPO _____ Medicare _____ Other _____

Insurance Co. name _____ Referral required? _____ Effective date _____

Insurance Co. claims address _____

Insurance Co. phone # _____ Office copay amount (if applicable) _____

Identification/policy # _____ Group/plan # _____

Subscriber information:

Name _____ Sex _____ Date of birth _____ Marital Status _____

Social Security # _____ Relationship to patient _____

Address (if different than patient) _____

Phone # (if different than patient) _____ Employer name _____

Employer address _____

Work phone # _____

Other information you would like to provide: _____

Thank you for your cooperation.

Assignment and Release information

This is to certify that I am being seen today by Bennie Chiles III, M.D. under my regular insurance coverage. This is NOT a Workers' Compensation or No Fault Case.

Signature: _____ **Date** _____
(Patient or parent if minor)

I hereby authorize Westchester Spine and Brain Surgery, PLLC and its agents the release of medical information necessary to process my medical claims and to physicians requesting consultation and third party payers responsible for all or part of the provider's fees.

Signature: _____ Date _____
(Patient or parent if minor)

I hereby authorize Westchester Spine and Brain Surgery, PLLC and its agents to request medical records and/or diagnostic studies necessary in my care and treatment.

Signature: _____ Date _____
(Patient or parent if minor)

I hereby authorize assignment and payments of any medical benefits due me to Westchester Spine and Brain Surgery, PLLC and its agents. I agree to pay all charges that exceed or that are not covered by my insurance.

Signature: _____ Date _____
(Patient or parent if minor)

I request that payment of authorized medical benefits be made to or on my behalf to Westchester Spine and Brain Surgery, PLLC for services furnished by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services by the provider.

Signature: _____ Date _____
(Patient or authorized representative)

ARE THERE ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY: YES NO

PLEASE LIST: _____

SOCIAL HISTORY:

OCCUPATION: _____

MARITAL STATUS: _____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED

AGE: _____ RIGHT OR LEFT HANDED: _____ HEIGHT: _____ WEIGHT: _____

DO YOU SMOKE? YES _____ NO _____ IF YES HOW MUCH: _____

DO YOU DRINK? YES _____ NO _____ IF YES HOW OFTEN: _____

ARE YOU AT RISK FOR AIDS (SEXUAL ORIENTATION, DRUG ABUSE, PREVIOUS BLOOD TRANSFUSION)? YES _____ NO _____ IF YES, PLEASE EXPLAIN: _____

REVIEW OF SYSTEMS:

ARE CURRENTLY OR HAVE YOU HAD ANY PROBLEMS WITH:

FEVER	YES	NO
WEIGHT LOSS		
GLAUCOMA		
CATARACTS		
EAR, NOSE, OR THROAT AND MOUTH		
HEARING LOSS		
RINGING IN EARS RIGHT LEFT BOTH		
BALANCE DISTURBANCES (BALANCE/DIZZINESS)		
SINUS PROBLEMS		
SINUS HEADACHES		
CARDIOVASCULAR		
CHEST PAINS OR ANGINA- DATE OF LAST EKG		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
RESPIRATORY		
ASTHMA		
CHRONIC COUGH		

INDIGESTION OR PAIN WITH EATING	YES	NO
NAUSEA		
VOMITING		
JAUNDICE		
CHANGE IN BOWEL HABITS		
ULCERS OR GASTRITIS		
URINARY TRACT INFECTIONS		
DIFFICULTY STARTING OR STOPPING STREAM		
ARM OR LEG WEAKNESS		
BACK PAIN		
ARM OR LEG PAIN		
ARTHRITIS		
ANXIETY		
DEPRESSION		
DIABETES		
INCREASED APPETITE		
HEMATOLOGIC/LYMPHATIC		
ANEMIA		
HEMOPHILIA		

**LIST ANY PHYSICIANS THAT YOU WOULD LIKE THE DOCTORS OFFICE
NOTE SENT TO:** _____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE

DATE

PROVIDERS SIGNATURE

DATE

Chaperone Policy

Patient Notification

Westchester Spine and Brain Surgery is committed to providing a safe, comfortable environment where patients and staff can be confident that best practice is being followed at all times and the safety of everyone is of paramount importance.

All patients are entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. This chaperone may be a family member or a friend. On occasions you may prefer a formal chaperone to be present. Whenever possible, we would ask you to make this request at the time of booking appointments so arrangements can be made and your appointment is not delayed in any way. Where this is not possible, we will still endeavor to provide a formal chaperone at the time of your request. Rarely, it may be necessary to reschedule your appointment.

Your WSBS physician may also require a chaperone to be present for certain consultations in accordance with our chaperone policy.

If you would like to see a copy of our chaperone policy or have any questions/comments regarding this, please contact our office manager.