Appointment Confirmation

MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL ASSOCIATES

23961 CALLE DE LA MAGDALENA SUITE 504
LAGUNA HILLS, CA 92653-3665
949-588-5800

Patient:____

Appointment with: ______________________________________

Date: __________________ Time: ______________

If you are unable to keep this appointment, please give us at least 24 hours notice. Please call us at (949) 588-5800.

It is very important you complete, date, and sign **all** of the enclosed forms and bring them in at the time of your appointment. Please do not wait until your arrival in the office to complete the information mailed to you. Failure to have all forms completed can result in rescheduling of your appointment. Do not mail them prior to your appointment. Please bring your insurance card(s), and any records, test results, and x-rays (with) reports which may be related to the problem for which you will be seen.

Please take note of the following:

Work Related injuries: Pre-authorization is required from the carrier who will be responsible for paying your bills. We will assist you with this procedure, but you must notify us in 48 hours prior to your appointment.

Medicare: This office accepts Medicare assignment and we will submit all of your charges directly to Medicare by electronic transmission. It is imperative that you give us your supplementary insurance information.

Private Insurance/contracted coverage: We will bill your insurance provided we have your ID#, your carrier's name, address, and a phone number for follow up. If coverage is denied for any reason, you will be responsible for all charges.

YOUR INSURANCE CO-PAYMENT WILL BE COLLECTED FROM YOU AT THE SAME TIME WE COLLECT YOUR PAPERWORK, X-RAYS, ETC.

We look forward to serving you. Please feel free to call us for any further explanations of our office policies and procedures.

MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL ASSOCIATES
23961 CALLE DE LA MAGDALENA, SUITE 504
LAGUNA HILLS, CA 92653

Tel: (949) 588-5800
FAX: (949) 380-3344
www.massooudimd.com

PAYMENT POLICY

It is the policy of Massoudi and Jackson Neurosurgical Medical Associates to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D./subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of employer.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Massoudi and Jackson Neurosurgical Medical Associates does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan **before** services are rendered. This also applies to any facility or provider your doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, noncovered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party. It is the policy of this medical group to receive payment in full 90 days from the date of service.

HMOs and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered. **Authorization does not guarantee payment by the insurance company.**

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 90 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, check, money order, and Mastercard, VISA, or Discover as your method of payment.

The fee for a returned check is $15.00.

I have read the above policy and understand I am financially responsible for all medical services rendered.

_______________________________ _______________________
Signature of Patient or Responsible Party Date

____
Print Name

MASSOUDI & JACKSON NEUROSURGICAL MEDICAL ASSOCIATES

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Massoudi & Jackson Neurosurgical Medical Associates may use and disclose protected healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Massoudi & Jackson Neurosurgical Medical Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Massoudi & Jackson reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Massoudi & Jackson Neurosurgical Medical Associates 23961 Calle de la Magdalena, Suite 504, Laguna Hills, CA 92653.

With my consent, Massoudi & Jackson Neurosurgical Medical Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

With my consent, Massoudi & Jackson Neurosurgical Medical Associates may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical treatment, including but not limited to: laboratory or radiological findings.

By signing this form, I am giving consent to Massoudi & Jackson Neurosurgical Medical Associates for the use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon this prior consent. Massoudi & Jackson Neurosurgical Medical Associates may decline treatment to me without this signed consent.

________________________________ ____________________

Signature of Patient Date

____

Patient’s Name

Medications

MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL ASSOCIATES

Please list any medications you are currently taking and bring this form with you to your appointment. Make sure to note any allergies you have to medications or other substances in the space provided below.

IF YOU ARE NOT TAKING ANY MEDICATION AND/OR IF YOU HAVE NO ALLERGIES, PLEASE INDICATE BY WRTING N/A UNDER EACH HEADING.

REMEMBER TO PLACE YOUR NAME ON THE FORM AND THE DATE. THIS IS VERY IMPORTANT.

Name: ______________________________ **Date:** _____________

Medications	Amount	Frequency

Allergy	Type of Reaction

ORANGE COUNTY NEUROSURGICAL ASSOCIATES

Patient Information Form

Please print or write legibly. CIRCLE ONE- Dr. Massoudi Jackson Kim

(LEGAL NAME)
Patient ____ ____________**Male**____**Female**___ **Marital Status S** *M W D*
Last First MI

Address ____
Street City State Zip Apt #

Home Phone (**)** ___________________________ **Cell #: (** **)** _________________________

Date of Birth _____________________ **Age**____ **Social Security #** _______ ______ ________

Employer ____ **Work Phone # (** **)** ______________ **Ext** ________

Employer Address ____
Street City State Zip

FIRST NAME AND LAST NAME OF REFERRING MD.____

Contact (not living with you) ______________________**Relationship** _____________ **Phone # (** **)** _________
Employer ____ **Work Phone # (** **)** ______________________________

Employer Address ____
Street City State Zip
Spouse (or parent if patient is a minor) ____

Address ____ **Home Phone # (** **)** _________________________
Employer ____ **Work Phone # (** **)** ______________________________

Employer Address ____

Primary Insurance _____________________ **Effective Date** __________ **Co-pay Amt $**_________ **Deductible** _______

Name of Insured ______________________**Date of Birth** _____________ **Employer** _________________________

Subscriber #___________________ **Group #** ________________ **Relationship to Patient** ____________________

PPO POS HMO EPO Medicare Medi-Cal W/C INSURANCE CARD MUST HAVE PHONE # AND ADDRESS FOR BILLING PURPOSES.

Insurance Co. Address ____ **Phone # (** **)** ____________________________

Secondary Insurance _______________________ **Effective Date** ___________ **Co-pay Amt** __________ **Deductible** ________

Name of Insured ________________________**Date of Birth** _______________ **Employer** ____________________________

Subscriber #_____________________ **Group #** __________________ **Relationship to Patient** _______________________

PPO POS HMO EPO Medicare Medi-Cal *Insurance Card must have phone # and address for billing purposes.*

Insurance Co. Address ____ **Phone # (** **)** ____________________________

Financially Responsible Party (circle one): Patient Spouse Parent/Guardian Other:_________________________

I hereby assign the insurance benefits to which I am entitled to, directly to Robert J. Jackson, M.D., K. Anthony Kim M. D. , Farzad Massoudi, M.D., Chiedozie Nwagwu, M.D. or Sylvain Palmer, M.D. I understand that I am financially responsible for all charges. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A Photostat of this authorization is accepted with the same authority as the original.

Signature ____ **Date** __________________________________

Print Name ____

Health Questionnaire

Name**___________________________________** ***Age*** **_________** ***Date*** **__________________**
Address **_______________________________________** ***Phone*** **_______________________**

Past Illness History *Have you ever had:*

Childhood

Measles	**No**	**Yes**	Rheumatic fever	**No**	**Yes**
Mumps	**No**	**Yes**	Heart Disease	**No**	**Yes**
Chicken Pox	**No**	**Yes**	Tuberculosis	**No**	**Yes**
Diabetes	**No**	**Yes**	Venereal Disease	**No**	**Yes**
Strokes	**No**	**Yes**	Congenital Abnormalities	**No**	**Yes**
Cancer	**No**	**Yes**	Other serious illnesses ___________________		

____

Adult
Have you had any serious illness? If so, for what? ____
Have you ever been hospitalized ? If so, for what? ____
Have you been under medical care? If so, for what ____

Operations
Have you had any surgeries? **No** **Yes**
List surgeries and dates ____
____
____
____

Injuries

Have you had any broken bones?	**No**	**Yes**
Have you had any head concussions or injuries?	**No**	**Yes**
Have you ever lost consciousness?	**No**	**Yes**

FAMILY HISTORY	If Living: Age	Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High Blood Pressure	No	Yes
Husband/Wife					Stroke	No	Yes
Son/Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding Tendency	No	Yes
					Gout or other Arthritis	No	Yes

Social History:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife?…………………………………………………….. **No** **Yes**
Is your sex life satisfactory?…………………………………………………………..……… **No** **Yes**
Do you have dependents at home?……………………………………………………………. **No** **Yes**

Alcoholic beverages? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Smoking: ☐ Currently smoke _____ packs/day ☐ Smoked, but quit _____ years ago ☐ Never smoked

Employment: ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed, but looking for work
☐ Retired ☐ Homemaker ☐ Student

If working, what is your job? ____

Are you exposed to fumes, dusts or solvents? **No** **Yes**

How much time have you lost from work because of your health during the past… …six months? __________
…one year? ____________
…five years? ____________

Continued on reverse…

SYSTEMIC REVIEW: Do you have any of the following?				
General:			Genitourinary:	
Recent weight change?	No Yes		Loss of urine	No Yes
Good general health most of your life?	No Yes		Frequent urination	No Yes
Head-eye-ear-nose-throat:			Night time urination	No Yes
Eye disease or injury	No Yes		Burning or painful urination	No Yes
Do you wear glasses?	No Yes		Blood in urine	No Yes
Double vision	No Yes		Kidney trouble	No Yes
Headaches	No Yes		Kidney stones	No Yes
Glaucoma	No Yes		Bright's disease	No Yes
Itching eyes or nose	No Yes		Locomotor-Musculoskeletal:	
Sneezing or runny nose	No Yes		Varicose veins	No Yes
Nosebleeds	No Yes		Weakness of muscles or joints	No Yes
Chronic sinus trouble	No Yes		Any difficulty in walking	No Yes
Ear disease	No Yes		Any pain in calves or buttocks when walking	No Yes
Impaired hearing	No Yes		…relieved by rest?	No Yes
Dizziness or transient unconscious episodes	No Yes		Neuro-psychiatric:	
Neck			Have you ever had psychiatric care?	No Yes
Stiffness	No Yes		Have you been advised to see a psychiatrist?	No Yes
Thyroid trouble	No Yes		Do you have, or ever had, fainting spells?	No Yes
Enlarged glands			Convulsions	No Yes
Respiratory:			Paralysis	No Yes
URI (cold) now	No Yes		Hematological:	
Spitting up blood	No Yes		Are you slow to heal after cuts?	No Yes
Chronic or frequent cough	No Yes		Blood disease	No Yes
Asthma or wheezing	No Yes		Anemia	No Yes
Difficulty breathing	No Yes		Phlebitis	No Yes
Any trouble with lungs	No Yes		Excessive bleeding after tooth extraction or surgery?	No Yes
Pleurisy or pneumonia	No Yes		Have you had abnormal bruising or bleeding?	No Yes
Cardiovascular			Allergic:	
Chest pain or angina pectoris	No Yes		Any allergies, including medication?	No Yes
Shortness of breath walking or lying down	No Yes		Endocrine:	
Difficulty walking two blocks	No Yes		Thyroid disease	No Yes
Heart trouble or heart attacks	No Yes		Hormonal therapy	No Yes
High blood pressure	No Yes		Change in hat or glove size	No Yes
Swelling of hands, feet or ankles	No Yes		Change in hair growth	No Yes
Awakening in the night smothering	No Yes		Has your skin been colder or dryer than before?	No Yes
Heart murmur	No Yes		Skin	
Gastrointestinal			Skin disease	No Yes
Peptic ulcer (stomach or duodenal)	No Yes		Jaundice	No Yes
Vomiting blood or food	No Yes		Hives, eczema or rash	No Yes

Gallbladder disease	**No Yes**		Frequent infection or boils	**No Yes**
Liver trouble	**No Yes**		Abnormal pigmentation	**No Yes**
Hepatitis	**No Yes**		Gynecological:	
Painful bowel movements	**No Yes**		Any pain with your periods?	**No Yes**
Bleeding with bowel movements	**No Yes**		Age periods started ___________________________________	
Black stools	**No Yes**		How long do periods last? ______________________________	
Hemorrhoids or piles	**No Yes**		Number of pregnancies ________________________________	
Recent change in bowel habits	**No Yes**		Number of miscarriages _______________________________	
Frequent diarrhea	**No Yes**		Date and results of last cancer smear ___________________	
Heartburn or indigestion	**No Yes**		Frequency of periods; every _______________________ days	
Cramping or pain In the abdomen	**No Yes**		Number of children __________ Ages __________________	
Does food stick in throat?	**No Yes**		Date of first day of last period ________________________	

ALLERGIES AND SENSITIVITIES

	Circle one			What other drugs or food?
Penicillin or other antibiotics	Yes	No	Don't know	____________________
Morphine, codeine, Demerol or other narcotics	Yes	No	Don't know	____________________
Novocain or other anesthetics	Yes	No	Don't know	____________________
Aspirin, Empirin or other pain remedies	Yes	No	Don't know	____________________
Sulfa drugs	Yes	No	Don't know	____________________
Tetanus antitoxin or other serums	Yes	No	Don't know	____________________
Adhesive tape	Yes	No	Don't know	____________________
Iodine or merthiolate	Yes	No	Don't know	____________________
Any other drug or medication	Yes	No	Don't know	____________________
Any foods, such as eggs, milk or chocolate	Yes	No	Don't know	____________________
Drugs Recently Taken During the past six months, has patient taken:				
Cortisone	Yes	No	Don't know	
ACTH	Yes	No	Don't know	
Anticoagulants	Yes	No	Don't know	
Tranquilizers	Yes	No	Don't know	
Hypotensives (high blood pressure medication)	Yes	No	Don't know	
Aspirin	Yes	No	Don't know	
Has the patient ever received treatment for asthma, rheumatism or rheumatic fever?	Yes	No	Don't know	

Source of information, if other than patient:____

Signature of person acquiring this information: ____

______________________ ______________ ______________________

Doctor Date Signature of patient