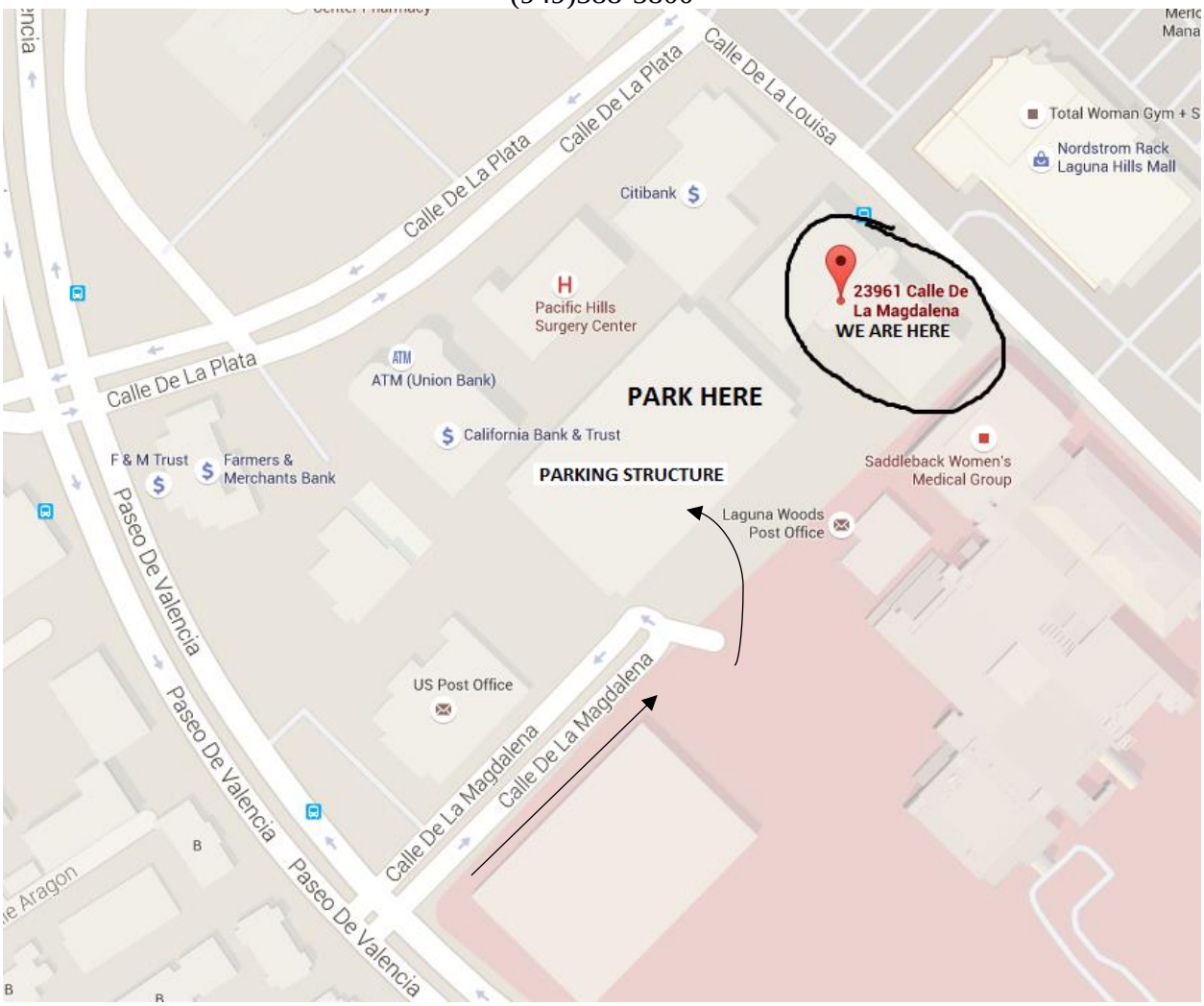
ORANGE COUNTY NEUROSURGICAL ASSOCIATES

DR. FARZAD MASSOUDI * DR. ROBERT J. JACKSON * DR. JASON A. LIAUW
23961 CALLE DE LA MAGDALENA STE 405
LAGUNA HILLS, CA 92653
(949)588-5800



- **WE ARE NOW ON THE 4TH FLOOR**

GOING ON 5 FWY NORTH:
Take 5 N Fwy and exit EL TORO RD. make a LEFT
On PASEO DE VALENCIA make a LEFT
On CALLE MAGDALENA make a LEFT
GOING ON 5 FWY SOUTH:
Take 5 S and exit EL TORO RD, keep straight and continue on PASEO DE VALENCIA
On CALLE MAGDALENA make a left
NOTE: We DO NOT validate parking.

APPOINTMENT CONFIRMATION

ORANGE COUNTY NEUROSURGICAL ASSOCIATES
23961 Calle de la Magdalena Suite 405
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** 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/provided to you. Failure to have all forms completed can result in the rescheduling of your appointment. Do not mail them prior to your appointment. Please bring your insurance card(s), and any records, test results, and **MRI/CT/X-Rays CD (with) reports** which may be related to the problem for which you will be seen.

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 48 hours prior to your appointment.

Medicare: This office accepts Medicare assignment and we will submit all if 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, MRI'S, ETC.

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

Orange County Neurosurgical Associates

Patient Questionnaire

Name:_____DOB:__/__/____AGE:____DATE:_____

Describe your Current problem or Concern?_____

_____

_____

_____

_____

Additional Details:

Date of onset: _____

If you have pain, is it (Circle) constant/intermittent/ dull/ sharp/Ache/ Burning/Pins and Needles

Made worse by-Standing/walking/sitting/lying down

Rate your average pain level on a scale of 0 to 10 0 no pain ----------10 worst : _____

Aggravating factors_____

Alleviating factors_____

(CHECK OR CIRCLE ANY THAT APPLY):

Do you have pain in	Right Arm	☐	Left Arm	☐	Right Leg	☐	Left Leg ☐
Do you have weakness in	Right Arm	☐	Left Arm	☐	Right Leg	☐	Left Leg ☐
Do you have numbness in	Right Arm	☐	Left Arm	☐	Right Leg	☐	Left Leg ☐

Do you have problems with coordination/Balance? _____

_____

Have you had Epidural steroid Injections? If so, how many and date of injections? _____

_____

Have you had Physical Therapy? Yes☐ No☐ If yes, approximately how long/how many sessions? _____

_____

Have you had spinal surgery? _____If yes, what type? _____

When? _____

Have you had other treatments? _____

_____

Is your problem related to an accident? _____

Are you involved in any active litigation?_____

Orange County Neurosurgical Associates

Patient Questionnaire

PREVIOUS MEDICAL HISTORY: (CHECK OR CIRCLE ALL THAT APPLY)

Hypertension	☐	Asthma/COPD	☐	Diabetes	☐
Coronary Heart Disease	☐	Elevated Cholesterol	☐	Neuropathy	☐
Deep Vein Thrombosis	☐	Pulmonary Embolus	☐	Dementia	☐
Other:	☐				

CURRENT HEIGHT: _____ FT/IN WEIGHT: _____ LBS

PREVIOUS SURGICAL HISTORY(DATE):

Spine Surgery: _____
_____

Cardiac Surgery: _____
_____

Other: _____
_____
_____

Medication List

***Please Exclude Vitamins

Medication	Dose	Frequency

- **For more medications, please add the list on a blank sheet of paper**

Allergies

Allergy	Type of Reaction (ex: rash, difficulty breathing)

Orange County Neurosurgical Associates

Patient Questionnaire

FAMILY MEDICAL HISTORY:

List who in your direct family has had the following:

Cancer : _____

Stroke/CVA: _____

Aneurysm: _____

Spine Problems: _____

Other: _____

SOCIAL HISTORY:

SINGLE ☐ MARRIED ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED ☐

LIVES WITH(Check/Circle): SELF ☐ Spouse/Partner ☐ Children ☐ Other ☐

ALCOHOLIC BEVERAGES: NEVER ☐ RARELY ☐ MODERATLEY ☐ DAILY ☐

SMOKING : CURRENTLY SMOKES ____packs/day

SMOKED BUT QUIT____YEARS AGO ☐ NEVER SMOKED ☐

RECREATIONAL DRUG USE: NO ☐ YES ☐ TYPE _____

EMPLOYMENT: FULL TIME ☐ PART TIME ☐ SELF EMPLOYMENT ☐

RETIRED ☐ HOMEMAKER ☐ STUDENT ☐

UNEMPLOYED BUT LOOKING FOR WORK ☐

IF WORKING WHAT IS YOUR CURRENT JOB:_____

SEX LIFE- SATISFACTORY: YES ☐ NO ☐ _____

Preferred Pharmacy

Name:	
Address:	
Phone Number:	**Fax Number:**

Please list full name of other physicians involved in your care

	Doctor's Name	
Primary Care		**Phone:**
Pain Management		**Phone:**
Neurologist		**Phone:**
Oncologist		**Phone:**
Who referred you?		**Phone:**
Cardiologist		**Phone:**
Other		**Phone:**

Patient _____ Date_____

Orange County Neurosurgical Associates

Patient Questionnaire

SYSTEMIC REVIEW: Do you have any of the following? (Check box that applies)

GENERAL	YES	NO	GENITOURINARY	YES	NO
Recent weight change			Loss of urine		
Good general health			Frequent urination		
			Burning or painful urination		
HEAD-EYE-EAR-NOSE-THROAT			Kidney trouble		
Wear glasses					
Double vision			**LOCOMOTOR- MUSCULOSKELETAL**		
Headaches			Weakness of muscles or joints		
Glaucoma			Difficulty in walking		
Ear diesease			Pain in calves/buttocks when walking		
Impaired hearing					
			NECK		
RESPIRATORY			Stiffness		
Chronic or frequent cough			Pain radiates down shoulders		
Asthma or wheezing					
Difficulty breathing			**NEURO-PSYCHIATRIC**		
URI (cold) now			Have you ever had psychiatric care?		
			Been advised to see a psychiatrist?		
CARDIOVASCULAR			Fainting spells		
Chest pain/ angina pectoris					
Shortness of breath walking or lying down			**HEMATOLOGICAL**		
Difficulty walking two blocks			Blood disease		
Heart trouble or heart attacks			Anemia		
High Blood Pressure			Excessive bleeding after tooth extraction		
Awakening in the night smothering			Abnormal bruising or bleeding		
Heart murmur					
			ENDOCRINE		
GASTROINTESTINAL			Thyroid disease		
Peptic ulcer			Hormonal therapy		
Liver trouble			Diabetes		
Painful bowel movements					
Recent change in bowel habits			**SKIN**		
Frequent diarrhea			Hives, eczema or rash		
Heartburn or indigestion			Frequent infection or boils		
Does food stick in throat?			Jaundice		

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PATIENT INFORMATION FORM

PEASE PRINT OR WRITE LEGIBLY (black or blue pen only)

I AM SEEING (check one) ☐ DR. MASSOUDI ☐ DR. JACKSON ☐ DR. LIAUW

I WAS REFERRED BY _____ PH ( ) _____-_____

Patient _____ _____ _____ **SEX** (Check/Circle)M ☐ F ☐
(LEGAL NAME) LAST **FIRST** **MI**

Address _____ _____
STREET **APT #**

_____ _____ _____ _____
CITY **STATE** **ZIP CODE** **EMAIL**

Phone _____ _____ _____
HOME **CELL** **WORK**

Date of Birth _____ **Age** _____ **Social Security #**_____-_____-_____

Employer _____ Occupation_____

_____
EMPLOYER ADDRESS **CITY** **STATE** **ZIP**

Race (check one) ☐ **White** ☐ **Black/African American** ☐ **America Indian/Alaska Native** ☐ **Asian**
☐ **Native Hawaiian /Pacific Islander** ☐ **Middle Eastern/Persian** ☐ **DECLINE**

Ethnicity (check one) ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **DECLINE**

Emergency Contact _____ **Relationship** _____

Phone _____ _____
HOME **CELL**

Spouse (or Parent, if minor)_____**Ph ( )**_____-_____

INSURANCE (Check/Circle One) Medicare ☐ PPO ☐ HMO ☐ POS ☐ EPO ☐ WC ☐ PI ☐ Medi/Medi ☐ Medi-Cal ☐ Cash ☐
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Separated ☐
Other ☐

Primary Insurance _____**Ph** ( )_____

Name of Insured _____**SELF SPOUSE PARENT other DOB** _____

Subscriber ID # _____ **Group #** _____

Secondary Insurance _____**Ph ( )**_____

Name of Insured _____ **SELF SPOUSE PARENT other DOB** _____

Subscriber ID# _____ **Group #** _____

Financially Responsible Party: _____**Relationship** _____

I hereby assign the insurance benefits to which I am entitled to, directly to Robert J. Jackson, M.D., Farzad Massoudi, M.D., or Jason A. Liauw, 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 _____

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23961 Calle de la Magdalena Suite 405, Laguna Hills, CA 92653
Tel: (949)588-5800 Fax: (949)380-3345

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, OCNA doctors and staff may use and disclose protected healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to OCNA 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. OCNA., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to OCNA at 23961 Calle de la Magdalena Ste 405, Laguna Hills CA 92653.

With my Consent OCNA 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, OCNA doctors 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 OCNA doctors and staff 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. OCNA doctors may decline treatment to me without this signed consent.

I authorize OCNA doctors and staff to give the following person/people information about my medical records, billing information, and or prescription pick up (please print name and write the relationship to the patient):

_____
_____
_____

_____ _____
Signature of Patient Date

_____ _____
Patient's Name (Print) Responsible Party, if applicable (Print)

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Tel: (949)588-5800 Fax: (949)380-3344
www.ocneurosurgery.com

PAYMENT POLICY

It is the policy of OCNA to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish for 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, out-of-pocket, co-payments and patient responsibility amounts are due at the time of services.

OCNA 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 not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or the 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 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 debit/credit card (VISA, MasterCard or Discover) as your payment. **If paying with check, the check should be made out to the doctor rendering the services.** If you do not have insurance and are paying cash for you visit, we **DO NOT** accept checks; you must pay with cash or credit/debit card.
The fee for a returned check is $45.00.
Fee for medical records copy is $25.00 plus .25cents per page. Fee for EDD forms/or any forms that need to be filled out by the doctor is determined by the doctor due to length of form(s). Patient will be notified of fees and payment is due before forms are rendered to patient.

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 PATIENT NAME PRINT RESPONSIBLE PARTY (if other than patient)