Welcome to the Comprehensive Neurosurgery Network LLC and the office of Dr. Ravish Patwardhan. Thank you for choosing us as your healthcare provider. We are committed to providing the best medical brain and spine care possible.

In order to save you time and effort during your clinic visit, we request that you please complete the attached forms fully. Please bring the following items for all appointments:

- Completed attached forms
- Driver's license
- Insurance cards
- All spine/head x-rays, MRI, CT/Myelogram films and copies of the reports (for initial visit, and only new films for subsequent visits)
- All medical records pertaining to your current condition (for initial visit)

Please arrive 10 minutes early to your first appointment. To receive directions to our clinic via email, fax or over the phone, please call us at 318.797.5543. You can also map directions from your location to ours by visiting our website at www.brainspinecare.com/visitor-information.

Payment is due at the time of service. Your portion (including deductible, co-pay, or patient percentage) is determined by your insurance company. Please contact your insurance company if you have any questions regarding your financial responsibility as outlined in your policy.

Thank you,

Dr. Ravish Patwardhan and staff

8001 Youree Drive, Suite 970, Shreveport, LA 71115
318.797.5543; FAX 318.797.7608
www.brainspinecare.com

New Patient Information Record

Name____ Social Security #________________
Last First Middle

Age:_____ Date of Birth: ____________________ ☐ Male ☐ Female

Mailing Address ________________________________ Home Phone (____) ______________________

City____________________ State__________ Zip_________ Cell/Alt. Phone (____)________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Are you employed? ☐ Yes ☐ No ☐ Retired Email Address:__________________________________

Employer's Name ____ Work Phone (___)_____________

Employer's Address______________________________City______________State______Zip________

Emergency Contact: __________________________ Relationship____________ Phone___________

Primary Care Physician _____________________ Primary Care Physician Phone: (___)_____________

Primary Care Physician Address: ____

Referring Physician____________________Referring Physician Phone #________________________

Responsible Party ☐ (Check here if same as above)

☐ Check if W/Comp ☐ Check if Attorney is representing you for injury Date of Injury___________

Person Responsible for Account____
Last First Middle

Mailing Address ____ Home Phone ________________

City ____________________________State_________ Zip__________ Date of Birth _______________

Social Security # _________________ Relationship to Patient __________________________________

Are your Symptoms Related to an Accident?

Are you a Workman's Compensation Case? ☐ Yes ☐ No

Accident: ☐ Yes ☐ No **Type:** ☐ Auto ☐ Home ☐ Work ☐

Other:__________________________________

Date of Injury:______________ Circumstances of

Injury____

Have you hired an attorney? ☐ Yes ☐ No

Are you contemplating legal action related to your symptoms? ☐ Yes ☐ No

Insurance Coverage

Primary Insurance ____

Policy/Contract # ______________________________Group # ____________________

Subscriber's Name ________________________ Relationship to Patient ________________

Subscriber's Date of Birth ________________Subscriber's Social Security # ________________

Subscriber's Employer____________________________ Work Phone ________________

Is the Patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance ____

Policy/Contract # ______________________________Group # ____________________

Subscriber's Name ________________________ Relationship to Patient ________________

Subscriber's Date of Birth________________ Subscriber's Social Security # ________________

Subscriber's Employer ____________________________ Work Phone ______________

Additional Insurance ____

Policy/Contract # ______________________________ Group # ____________________

Subscriber's Name ________________________ Relationship to Patient ________________

Subscriber's Date of Birth ________________ Subscriber's Social Security # ________________

Subscriber's Employer ____________________________ Work Phone (___)___________

Confidential Communication Request

If you would like for Comprehensive Neurosurgery Network to contact you with your health information at an alternate phone number or address, please list this information below:

Mailing Address:____

City:______________________ State: __________ Zip ___________________________

Daytime Telephone #: (__)________________ Evening Telephone #: (__)__________________

PATIENT LIABILITY ACKNOWLEDGMENT

To Prospective Patients:

Comprehensive Neurosurgery Network LLC welcomes the opportunity to provide the highest quality medical assistance and treatment to you. However, because prior patients' involvement in their personal injury claims and/or lawsuits against third parties caused great administrative costs and burdens to Comprehensive Neurosurgery Network LLC, Comprehensive Neurosurgery Network LLC does not evaluate and treat patients who are involved in any actual or potential litigation and/or liability claims, without full disclosure prior to the office visit.

In connection with any medical condition that may be evaluated by Comprehensive Neurosurgery Network LLC medical staff, Comprehensive Neurosurgery Network LLC respectfully requests that you acknowledge the following in the space provided below:

"THERE IS NO PENDING OR PROSPECTIVE LIABILITY CLAIM AND/OR LAWSUIT ASSOCIATED WITH MY MEDICAL CONDITION(S) THAT WILL BE EVALUATED TODAY BY COMPREHENSIVE NEUROSURGERY NETWORK LLC."

Comprehensive Neurosurgery Network LLC reserves the right to cancel the appointment of any person who chooses not to sign the above statement confirming that such person is not involved in any actual or potential litigation and/or liability claim related to their medical condition.

**The term "litigation" means any injury that could potentially be covered by another third party, such as an auto accident, malpractice claim, workers compensation claim, or any other accident that could be the responsibility of another person or company.

Thank you for your anticipated understanding of Comprehensive Neurosurgery Network LLC's position.

ACKNOWLEDGED AND AGREED TO THIS _______________DAY OF____________________, 2010.

____
SIGNATURE

____
PRINT NAME

List of Current Medicines

List all medicines you are currently taking. Include prescriptions (pills, inhalers, creams, shots), over-the-counter medications (i.e. aspirin, antacids, vitamins), and herbals (i.e. ginseng, gingko). Include medications taken as needed (i.e. nitroglycerine, inhalers)

Patient Name:____ Date Completed_________
Allergies:____
____
____

Start Date	**Name of Medication**	**Physician Prescribing**	**Dose (i.e. mg)**	**How often taken**	**Reason for taking**

Comprehensive Neurosurgery Network, LLC, 8001 Youree Drive, Suite 970, Shreveport, LA 71115
Phone: 318.797.5543 · FAX: 318.797.7608 · www.brainspinecare.com

Designation of Personal Representative
(For Use and Disclosure of Health Information Only)

The Health Insurance Portability Act of 1996 (HIPPA) grants you the right to designate the listed individual(s) to be your personal representative for your health information. Your designation can be revoked at any time.

DESIGNATION

I, the undersigned, hereby designate the following person to act as my personal representative with respect to decisions regarding the use and/or disclosure of my health information.

____ ________________________________

Representative's Name (Please Print) Relationship to you

This person shall be given all of the privileges that would belong to me regarding my health information.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____ I do not authorize anyone to receive information regarding my medical care.

_____I authorize my physician and staff of this clinic to speak with:

1. Person____Relationship:____________________
   Phone number(s):____

2. Person____Relationship:____________________
   Phone number(s):____

3. Person____Relationship:____________________
   Phone number(s):____

I understand that I may revoke this designation at any time by signing a revocation and delivering it to Comprehensive NeuroSurgery Network. I further understand that any revocation will not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on my previous designation.

_______________________________________ _______________________________________

Patient's Name (Please Print) Date

____

Patient's Signature

Dr. Ravish Patwardhan
8001 Youree Dr. Ste. 970
Shreveport, LA 71115
318-797-5543 ~ Fax: 318-797-7608

AUTHORIZATION TO OBTAIN OR FOR RELEASE OF PRIVATE HEALTH INFORMATION FROM MEDICAL PROVIDERS

I hereby authorize Comprehensive Neurosurgery Network to obtain or release any and all private health information concerning my care from any physician, hospital, or other health care provider providing medical care to me at any time for the purpose of treatment, payment, enrollment or eligibility on whether I sign this authorization. I understand that I or my legal representative may revoke this authorization at any time by written request. I also understand that any information disclosed may be subject to re-disclosure by the recipient and no longer under the control of The Comprehensive Neurosurgery Network. I understand that the information released/obtained may contain information regarding psychiatric treatment, HIV/AIDS treatment, or alcohol/substance abuse treatment.

PATIENT NAME:____

SOCIAL SECURITY #_______________________________D.O.B___________________________

IF MINOR, RELATION TO PATIENT____

____ _________________________________

Signature of Patient/Guardian Date

(office use only)

FACILITY/DOCTOR ___________________________________

____

____

Specific Request: ___Medical Records ___Radiology___Lab ___X-Ray

Other____

For Dates____

Medicare/Medigap Card

SIGNATURE ON FILE

Name of Patient____

HIC Number____

Name of Medicap Insurer (If applicable)_____________________________

Medigap Policy # (If applicable)___________________________________

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to the Comprehensive Neurosurgery Network LLC for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Patient's Signature____

Date Signed_____________________________

1. **Consent for Treatment**
   I/We consent to inpatient or outpatient services, treatment and diagnostic procedures by the Comprehensive Neurosurgery Network LLC as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. I will have the opportunity to discuss with my doctor and consent or refuse before having surgery or major procedures done or laboratory work to be provided by a outside lab. My consent will be obtained except in emergencies or unusual circumstances.
2. **Financials Agreement (Assignment of Benefits)**
   I assign to the Comprehensive Neurosurgery Network LLC all benefits covering medical expenses. I further agree that should the amount of paid be insufficient to cover the entire medical expense, I will be responsible for payment of any differences. I authorize release of any information about me to any insurance company or other payor source when this information is required for payment to the Comprehensive Neurosurgery Network LLC. I understand that my physican will send me a separate bill for their services, and this authorization and assignment also applies to them.
3. **Medicare (Title XVII) and Medicaid (Title XIX)**
   I certify that the information I give in applying for payment under Medicare or Medicaid is correct.
4. **Champus/Medicare Notice (If Applicable)**
   I understand that CHAMPUS/Medicare will not pay for private rooms, personal convenience items, tests, or hospital care unless they are medically necessary. I understand that I will be responsible for payment of any difference.
5. **Valuables**
   I understand that the Comprehensive Neurosurgery Network LLC assumes no responsibility for personal possessions including cash, jewelry, dentures, eyeglasses or any other personal possessions which I choose to keep in my room. I have been advised that valuables should be placed in the care of my family.
6. **Authorization for Release of Information**
   I give the Comprehensive Neurosurgery Network LLC permission to release my medical information to another health care provider, who may be involved in my follow-up care. I also give permission for my medical records to be reviewed for research purposes.
7. **Designated Medical Decision Maker (For inpatient admissions only)**
   If I am unable to make medical decisions for myself for any reason, I have authorized ____ to make decisions on my behalf.

I ☐ have / ☐ have not given written authorization to anyone to make medical decisions for myself.

______________________________ ____________ ☐Patient ☐Parent ☐ Other
Authorized Signature Date

______________________________ ______________________________
Guarantor Signature (if different from above) Witness

RECEIPT OF NOTICE OF FINANCIAL POLICY & PRIVACY PRACTICES

FINANCIAL POLICY

Regarding Insurance – Comprehensive Neurosurgery Network accepts most insurance plans. As a courtesy, we will bill your insurance company for the services provided to you. It is your responsibility, however, to know the benefits and conditions of your insurance plan. Some procedures require pre-certification or an authorization before the service is performed. We expect you to be aware of these situations and while we will typically ensure that pre-certification is obtained prior to performance of services, you will be responsible for only the payment as per contract with your insurance company. If for some reason your insurance company fails to pay, we will expect you to pay the balance in full. If we are contracted with your insurance company, we will charge you only the amount allowed by your insurance. We cannot submit claims to your insurance company without a copy of your insurance card and are not responsible for insurance denials for services rendered if you do not provide the current insurance information. Your insurance policy is a contract between you and your insurance company. If we do not have a contract with your insurance company and they have not paid the claim within 60 days, the balance of your account will be billed to you. If payment is not received within 60 days after the account has been billed to you, your account will be considered due in full and placed for collection. Please be aware that some services provided may be "non-covered" services and/or not considered reasonable and necessary under your plan.

Customary Payment – we are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty, based upon numerous factors. Our fees are not negotiable, unless prior written agreement has been reached.

Returned Checks – a fee of $25 will be charged for all checks returned as unpaid by our bank. In addition, no future payments by check will be accepted from you.

Refunds – patient refunds for any amount over $15.00 will be processed quarterly. Any amounts under $15.00 will be refunded when a request is received by the payer.

Unless I have received approval to be treated under workers compensation claim, I will be responsible for payment of the total bill incurred as the result of treatment received (Medicare patients will be responsible for their portion of the Medicare allowable). I understand that the filing of insurance forms does not constitute payment of any portion of the bill and I understand that I am responsible for all charges billed me for treatment of the patient listed below unless this visit has been approved as a Workers Compensation claim. Comprehensive Neurosurgery Network LLC is a Louisiana Limited Liability Company of which Ravish Patwardhan MD has an ownership interest. I hereby acknowledge this disclosure. Furthermore, I have read and understand the financial policy of the Comprehensive Neurosurgery Network LLC and agree to the terms set forth in this policy.

PRIVACY PRACTICES

By signing this form, you also acknowledge that you have received a copy of the privacy practices attached. Our Notice of Privacy Practices provide information about how we may use and disclose your protected health information. We encourage you to read it in full.

I, ____, hereby acknowledge that I have received a copy of the privacy practices.

____ _____________________________________

Signature of Patient or Patient Representative Date

____ _____________________________________

Relationship to Patient Witness Signature

(For Staff Use Only)

Inability to Obtain Acknowledgement

It is not possible to obtain the individual's acknowledgement. Describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

____

____

____

____

____

Date:______________________ Signature of Office Staff:_____________________________________

8001 Youree Drive, Suite 970, Shreveport, LA 71115
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COMPREHENSIVE NEUROSURGERY NETWORK
8001 Youree Drive, Suite 970
Shreveport, Louisiana 71115
(318) 797-5543

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MIGHT BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information: Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for your future care or treatment. It may also contain correspondence and other administrative documents. All of this information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- A tool for educating health professionals;
- A source of data for medical research;
- A source of information for public health officials charged with improving the health of the nation;
- A source of data for planning and marketing; and
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

"Protected Health Information" refers to information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

Your Health Information Rights: Although your health record is the physical property of the health practitioner or facility that compiled it, the information belongs to you. You have the right to:

1. **Inspect and copy your health record.** In order to inspect or obtain a copy of your health record, you must submit a written request to Amy Shafer at the address shown above. The form for your request to inspect or copy your health record is available at our office. Additionally, you can contact our office at the telephone number listed above and request that a copy of the form be mailed to you. If you request a copy of the information, we may charge a fee as permitted by Louisiana law for the costs of copying, mailing or other supplies associated with your request.

   Your request to inspect and copy your health record can be denied by Comprehensive NeuroSurgery Network in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

2. **Amendment to your health record.** If you feel that medical information maintained by Comprehensive NeuroSurgery Network is incorrect or incomplete, you may ask Comprehensive NeuroSurgery Network to amend the information. You have the right to request an amendment to your health record only during the time the information is kept by, or on behalf of, Comprehensive NeuroSurgery Network.

   To request an amendment, your request must be made in writing and submitted to Amy Shafer at the address shown above. In addition, you must provide a reason that supports your request. The form for your request for an amendment to your health record is available at our office. Additionally, you can contact our office at the telephone number listed above and request that a copy of the form be mailed to you.

   We may deny your request for an amendment to your health record if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend information that:

   - Was not created by Comprehensive NeuroSurgery Network;
   - Was created by a person or entity who is no longer available to make the amendment;
   - Is not part of the medical information kept by or for this office;
   - Is not part of the information which you would be permitted to inspect and copy; or

- Is accurate and complete medical information.

If your request for an amendment is denied, you have the right to file a statement of disagreement. Comprehensive NeuroSurgery Network also has the right to prepare a rebuttal to your statement of disagreement and will provide you with a copy of any rebuttal.

3. **Request restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could request that we not use or disclose information about any services provided by us to you.

   We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Comprehensive NeuroSurgery Network at the address listed above. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit the use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your child. The form for your request for a restriction/limitation on medical information disclosed is available at our office. Additionally, you can contact our office at the telephone number listed above and request that a copy of the form be mailed to you.

4. **A paper copy of this notice**. You have the right to obtain a copy of this notice. You may ask us to give you a copy of the notice at any time.

   You may obtain a paper copy of this notice by contacting Amy Shafer at the address listed above.

5. **Obtaining an accounting of disclosures of your health information.** You have the right to obtain an accounting of disclosures of your health information other than for treatment, payment or healthcare operations. To exercise this right you must submit your request in writing to Comprehensive NeuroSurgery Network at the address listed above. The form for your request for an accounting of disclosures is available at our office. Additionally, you can contact our office at the telephone number listed above and request that a copy of the form be mailed to you. Your request must state a time period that may not be longer than six years and may not include dates prior to April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. **Request confidential communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask we only contact you at work or by mail. We will accommodate all reasonable requests to the best of our ability.

   To request confidential communications, you must make your request in writing to Comprehensive NeuroSurgery Network at the address shown above. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted.

Our Responsibilities: Our medical practice is required by law to:

- maintain the privacy of your health information;
- provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We will not use or disclose your information without your consent or authorization except as provided by law or described in this notice.

Examples of Disclosures for Treatment, Payment and Healthcare Operations: The following are examples of when your health information can be disclosed pursuant to law:

We Will Use Your Health Information For Treatment. Your protected health information will be used and disclosed to coordinate your healthcare and any related services. For example, information obtained will be recorded in your record and used to determine the course of treatment.

We Will Use Your Health Information For Payment. Your protected health information must be used and disclosed in order to obtain payment for the medical services you receive. For example, a bill may be sent to you or a third-party payer for the medical services provided to you. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. In the event that payment is not made, we may also provide limited information to certain collection agencies, attorneys, credit reporting agencies and other organizations as necessary to collect for services rendered.

We Will Use Your Health Information For Healthcare Operations. Your protected health information will be used to facilitate our operations and business activities. For example, a representative with our office may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates. There are some services provided to our practice through contracts with business associates. Examples of business associates include a copying service used when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates to enable them to perform their contracted services and to bill you or your third-party payer for services rendered. We require the business associates to appropriately safeguard your protected health information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication With Family. Unless you object, health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identity, health information relevant to that person's involvement in your care or payment related to your care.

Health Oversight Activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings. Health Oversight Agencies that seek this information include governmental agencies that oversee the healthcare system, government benefit and regulatory programs and civil rights laws.

Judicial And Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

National Security. We may disclose your health information for military, intelligence, counterintelligence, and other national security activities authorized by law.

Change Of Ownership. In the event that this practice is sold or merged with another organization, your health information will become the property of the new owner.

Other Disclosures. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinic standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem: If you have a question about our privacy policies or believe your privacy rights have been violated, you may contact Amy Shafer at 8001 Youree Drive, Suite 970, Shreveport, Louisiana 71115. Additionally, you may file a complaint with the Secretary of Safety of Health and Human Services. There will be no retaliation against an individual for filing a complaint.

The Federal Standards for Privacy of Health Information will go into effect on or after April 14, 2003. Therefore, we reserve our right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will make the new version available to you upon request.