M. Lawrence Drerup, M.D.
Troy M. Vaughn, M.D.
Gregory C. Dowd, M.D.
Stephen D. Downs, M.D.

Alexandria Neurosurgical Clinic
A Professional Medical Corporation

3704 North Blvd., Suite C
Alexandria, LA. 71301-3606
(318) 443-4576

PATIENT REGISTRATION FORM

Date _____

Name _____ Email _____

Address _____ City _____ State ____ Zip _____

S.S. # _____ Home Phone _____ Cell Phone _____

Sex _____ Age _____ Date of Birth _____ Marital Status _____ Spouse _____

Employer _____ Work Phone _____

Address _____ City _____ State ____ Zip _____

Referred By _____ Primary Care Doctor _____

Drug Allergies _____ Pharmacy/Location _____

****Billing: Please complete this section if person responsible for the bill is other than the above patient****

Name _____ Relationship to Patient _____

Address _____ City _____ State ____ Zip _____

S.S. # _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Address _____ City _____ State ____ Zip _____

Insurance Information

Type of Insurance: ( ) Medicare ( ) Medicaid ( ) Champus ( ) Blue Cross ( ) Workers Comp ( ) Other

Please give us all of your pertinent insurance information. If you have more than one policy we need the information on both carriers.

If your coverage requires a second opinion or pre-admission approval it is your responsibility to inform us.

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

Insured Name _____ Insured Name _____

Policy # _____ DOB: _____ Policy # _____ DOB: _____

Contract # _____ Group # _____ Contract # _____ Group # _____

Workers Comp Carrier _____ Do you have an attorney? _____

Address _____ Name _____

Phone _____ Accident Date _____ Address _____ Phone _____

I have received a paper copy or reviewed on the website the clinic's Notice of Privacy Practices and Credit Policy.

_____
Signature

Credit Policy

To avoid misunderstanding, our Credit Counselor invites early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc. General requirements for maintaining your account in good standing are as follows:

1. All charges are due and payable within 30 days of the first billing.
2. Under certain circumstances a payment in advance may be required.
3. Other circumstances may warrant an extended payment plan. Our Credit Counselor will assist you in these special instances at your request.

Office Visit Co-Payments:
Office visit co-payments are collected at the time the services are provided. Please refer to your insurance ID card or contact your health plan to verify your co-payment responsibility.

Surgical Procedure Co-Pays:
If you are scheduled for a surgical procedure, you will be required to pay a deposit prior to the procedure. Our Credit Counselor will provide you with a statement of your estimated financial responsibility and answer any questions you may have. It payment is not received prior to your surgery date, your procedure may have to be re-scheduled.

Insurance:
We cannot accept the responsibility of negotiating claims with insurance companies or other persons. It is your responsibility to provide accurate insurance information. You are also responsible for payment of your health care within a reasonable time - regardless of the status of the claim. In circumstances where a claim is pending or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated.

Private Insurance: please provide our office with all insurance information including your insurance card(s). If you are not the primary cardholder for your insurance we will need the primary cardholder's name, address, date of birth and social security number.

Workers' Compensation: if your visit is covered by Workers' Compensation, please verify the information we have in your file is correct and your visit has been approved by your adjuster.

Automobile/Third Party Liability: If your visit is covered by an auto or other insurance policy, please provide us with the name and number of the insurance responsible for your visit.

Legal: our office accepts legal cases on a case by case basis. Please provide our office with the name, address and phone number of your attorney. Your visit must be approved by the physician's staff and your attorney prior to receiving services.

Reduction or Rejection of your Claim:
Your insurance policy is a contract between you and your insurance company. It is important to understand its provisions. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Billing:
An itemized statement covering all health care services received will be mailed to you on a monthly basis. Payment in full is due within 30 days. Charges and payments for services received during the last few days before your billing date may appear on the following monthly statement.

By my signature on the patient registration form I attest I have read the above Credit Policy and understand and agree with its terms. I also authorize the release of the medical information necessary to process my claim with my insurance company and authorize my insurance company to pay directly to Alexandria Neurosurgical Clinic the amount due me in my pending claim for medical/surgical treatment for me or my beneficiary of this policy. I understand I'm financially responsible for any balance not covered by my insurance carrier.

Alexandria Neurosurgical Clinic

Authorization for individual to obtain medical information from Alexandria Neurosurgical Clinic.

This form is intended to allow our patient's the opportunity to list relatives or friends as representatives that may speak to our staff on the patient's behalf.

In an effort to protect patient privacy the patient must give permission for specific individuals to speak to our office staff on the patient's behalf. This notice will be kept in the patient's chart from the date of receipt. It is the duty of the patient to update this form accordingly in the event of necessary changes. Without written notice of a change in authorized persons, the employees of Alexandria Neurosurgical Clinic have authority to transfer requested information to the listed individuals by phone, mail, fax, etc. after verification of the claimed person is established and matches the listed individuals.

Please note: A patient is not obligated to list any individual on this form. If the patient chooses not to list any individuals, our office staff will not be able to give any information about the patient for any reason. (This includes other physicians, insurance companies, etc.)

Name (please print) and Relationship	Phone numbers
_____	_____
_____	_____
_____	_____
_____	_____

By signing below, I authorize the listed individuals to obtain information about my personal health records. I understand that this notice will stay in effect until I make written notice of change for documentation in my file.

_____ _____

Patient Signature Date

_____ _____

Signature of Employee Receiving notice Date

Alexandria Neurosurgical Clinic
Initial Evaluation
Dr. Gregory Dowd

Patient Name:_____ Age:_____

Please state briefly the main issue for your visit:_____

_____

Have you ever had **SPINAL SURGERY?** **YES** or **NO**
If so, what type and when? _____

_____

Injury? Yes No At Work? Yes No Auto Accident? Yes No
Date of Injury? _____

Right or Left Handed: _____

SURGICAL HISTORY

_____ Heart **Type:**_____ **Year:**_____ Other: _____
_____ Knee
_____ Hysterectomy
_____ Gall Bladder
_____ Appendectomy

MEDICAL HISTORY:

_____ Diabetes
_____ High Blood Pressure
_____ Bleeding Problems
_____ Stroke
_____ Heart Condition
_____ Cancer **Type:** _____ **Treatment:**_____

Other: _____

Are you on any Anti-Coagulants/Blood Thinners?
(Coumadin, Plavix, Aspirin, Pradaxa, Pletal?) **YES** or **NO**

Have you taken Steroids/Cortisone in the past 6 months? **YES** or **NO**

Current Medications:

_____
_____
_____
_____
_____

Allergy?

Pharmacy:

Patient Name:_____ Date:_____

Review of Systems

Please indicate if you have problems with any of the following:

HEAD
- ☐ Frequent headaches
- ☐ Dizzy spells
- ☐ Fainting spells

EARS
- ☐ Deafness
- ☐ Earaches or drainage
- ☐ Noise in ears

GENERAL
- ☐ Weakness/lethargy
- ☐ Sleeping difficulties
- ☐ Fever

EYES
- ☐ Double vision
- ☐ Wear glasses
- ☐ Floaters in visual field

ENT
- ☐ Hoarse voice
- ☐ Decreased sense of smell
- ☐ Difficulty Swallowing

RESPIRATORY
- ☐ Home Oxygen use
- ☐ Wheezing/coughing spells
- ☐ Shortness of breath
- ☐ Exposed to TB

CARDIOVASCULAR
- ☐ Chest pains
- ☐ Heart racing/palpitations
- ☐ Swollen feet or ankles
- ☐ Bruise easily

GASTROINTESTINAL
- ☐ Change in bowel habits
- ☐ Heartburn
- ☐ Nausea

GENITOURINARY
- ☐ Sex difficulties
- ☐ Dribbling with cough
- ☐ Difficulty urinating
- ☐ Urinary incontinence

NEUROLOGIC
- ☐ Weakness
- ☐ Memory problems
- ☐ Numbness / tingling

Alexandria Neurosurgical Clinic

Neurological Surgery
M. Lawrence Drerup, M.D., FACS, FICS
Troy M. Vaughn, M.D., FACS
Gregory Dowd, M.D.
Paul V. Birinyi M.D.

Family Practice
Stephen D. Downs, M.D.

Administration:
Penny Allemand, CPC,CPPM - Office Manager

Patient Name: _____ Date: _____

DOB: _____

Do you have an Advanced Directive: Yes_____ No _____

If yes, please check all that apply:

____ Do Not Resuscitate

____ Do Not Resuscitate not on file in our office

____ Living Will on file

____ Living will not on file in our office

____ Power of Attorney on file

____ Power of Attorney not on file in our office

Please note, if you mark that you have an Advanced Directive not on file in our office, you must bring it to your next appointment so we can have a copy in your chart

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