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

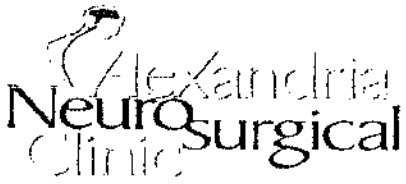
Automobile/Third Party Liability: If your visit is covered by an auto or other insurance policy, please provide us with the name and number of the insurance responsible for your visit.

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.



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

Neurological Surger
M. Lawrence Drerup, M.D., FACS, FIC
Troy M. Vaughn, M.D., FAC
Gregory Dowd, M.D

Family Practic
Stephen D. Downs, M.D

Administration
Penny Allemand - Office Manage

OFFICE POLICY
Troy Vaughn, M.D.

Prescriptions:

1. Requests for prescription refills are usually only taken on Mondays and Tuesdays, except in cases of medical emergencies.
2. No prescriptions for narcotics (pain medicines) are refilled on Weekends (Fridays, Saturday and Sunday).
3. The order may not be available for 24 to 48 hours after requested.
4. Narcotics can no longer be called to the pharmacy; the prescription has to be picked up at the office.
5. Do not repeatedly call the office to check on the status of your prescription refill. This will only slow the process of placing the order.
6. It is usually better to check with your pharmacy to see if the order for your prescription had been placed before calling the neurosurgery office.
7. Most medicines used to treat pain are controlled substances regulated by both state and federal agencies. As such, these medicines should only be prescribed by a single physician who is monitoring your utilization of these medicines.
8. You must notify this office if you receive any prescriptions for pain medications from other physicians. Failure to do so will result in the ability of this office to provide you with additional medications.
9. You should not share your medicines with anyone else and you should always keep them in a safe place. Lost or stolen medications will not be replaced.
10. Narcotics (pain medications) are frequently provided as one component of a pain management program. If you are prescribed narcotics to assist with managing your pain you could potentially develop drug dependence possibly requiring a drug rehabilitation program or counseling if these medications ever need to be stopped.
11. You have been given the option of being treated without narcotics (pain medications).

Forms:

Dr. Vaughn charges a fee for completing disability related forms. This is not included in the charges for an in office visit for the charges for completed surgical procedures. The current fee is **$25.00 per form** and must be paid in advance. Forms will not be completed or forwarded until the fees are collected.

Patient Cancellation & Missed Appointments:

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. If you need to reschedule or cancel an appointment, we require a **minimum of 24 hrs** notice. Please call the office at 318-443-4576.

"Missed Appointments" or last minute cancellations also leave empty appointment times, as well as other patients waiting to receive medical care. For that reason, patients that do not notify the office of a cancellation and are not present for their scheduled appointment will be charged a **cancellation fee of $40.00** which must be paid in cash before an appointment can be rescheduled.

We realize that on a rare occasion, emergencies may arise and we will address these situations with you at that time.

Acknowledgement of Office Policies

Your signature on this document indicates your understanding and acceptance of our office policy. If you should have any questions regarding the policy, Dr. Vaughn's office will be happy to discuss them with you.

Patient Name: _____ Date: _____

Signature: _____

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

3704 North Blvd., Suite C • Alexandria, Louisiana 71301-3606
Ph: (318) 443-4576 • Fax: (318) 449-5579 • www.alexneuro.com

Alexandria Neurosurgical Clinic
INTITIAL VISIT

Patient Name: _____ Date: _____

Patient Age: _____

Reason for Office Visit

1. Circle those that apply:

   Back Pain Neck Pain Arm Pain Leg Pain

   Other: _____

   _____

2. Were you injured: Yes ☐ No ☐ At work? Yes ☐ No ☐

   Auto Accident? Yes ☐ No ☐ Date of injury? _____

3. Have you been treated for this current problem by another doctor? Yes ☐ No ☐

   Name of physician: _____ Date last seen: _____

4. Have you ever had Neck/Back problems before? Yes ☐ No ☐

   If so, what kind? _____

   When? _____

Past Medical History

Please indicate which of the following problems you have been diagnosed with or treated for in the past:

- ☐ Blood Disorders (Anemia, Free Bleeding, Sickle Cell)
- ☐ Pneumonia
- ☐ Chronic Lung Disease (Asthma, Emphysema)
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Liver Problems
- ☐ Seizures
- ☐ Cancer: What kind? _____
- ☐ Ulcers
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Meningitis
- ☐ Bowel Problems
- ☐ Vascular Disease

Patient Name: _____ Date: _____

Past Surgery History

1. Have you ever had spinal surgery? Yes ☐ No ☐
   If so, what kind and when? _____
   _____
2. Please list any other surgery you have had: _____
   _____

Social History

1. Marital Status: Married Separated Widowed Single Divorced
2. Education: Grade School High School College Post Grad Vocational
3. Number of children: _____
4. Do you smoke currently? Yes ☐ No ☐ Have you smoked in the past? Yes ☐ No ☐
   If yes, indicate how many packs per day: _____ How long? _____ Date Quit: _____
5. Do you currently or have you used in the past illegal drugs? Yes ☐ No ☐
   If so, what kind? _____ Date Quit: _____
6. Do you drink alcohol currently? Yes ☐ No ☐ In the past? Yes ☐ No ☐ Date Quit: _____
   If yes, please indicate type and average amount: _____
7. Occupation (Please give a brief description) _____
   _____
   When did you last work a full day? _____

Family History

Please indicate if any family members (mother, father, brother, sister, children) have had any of the following problems: If so, who?

Blood Disorders: _____
Lung Disease: _____
Heart Trouble: _____
Hypertension: _____
Vascular Disease: _____
Kidney Disease: _____
Stroke: _____
Diabetes: _____
Seizures: _____
Cancer: _____
What kind? _____

Patient Name: _____ Date: _____

Review of Systems

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

GENERAL:
- ____ Chills
- ____ Fever
- ____ Weight Gain
- ____ Weight Loss

OPHTHALMOLOGIC
- ____ Double Vision
- ____ Diminished Vision

ENT
- ____ Hoarse Voice
- ____ Decreased Hearing
- ____ Decreased Sense of Smell
- ____ Difficulty Swallowing

RESPIRATORY
- ____ Asthma
- ____ Cough
- ____ Shortness of Breath

CARDIOVASCULAR
- ____ Chest Pain
- ____ High Blood Pressure
- ____ Palpitations
- ____ Dizziness
- ____ Heart Murmur
- ____ Irregular Heartbeat

PSYCHIATRIC
- ____ Anxiety
- ____ Depressed Mood
- ____ Suicidal Thoughts
- ____ Difficulty Swallowing
- ____ Substance Abuse

GASTROINTESTINAL
- ____ Nausea
- ____ Constipation
- ____ Diarrhea
- ____ Vomiting

GENITOURINARY
- ____ Sex Difficulties
- ____ Difficulty Urinating
- ____ Frequent Urination
- ____ Urinary Incontinence

MUSCULOSKELETAL
- ____ Neck Pain
- ____ Back Pain
- ____ Spasm
- ____ Painful Joints
- ____ Swollen Joints
- ____ Leg Cramps

NEUROLOGIC
- ____ Weakness
- ____ Dizziness
- ____ Fainting
- ____ Headache
- ____ Tingling/Numbness
- ____ Balance Difficulty
- ____ Coordination
- ____ Memory Loss
- ____ Seizures
- ____ Tremor

Patient Name: _____ Date: _____

Medication History

1. Please list all the medications you are currently taking (prescription and non-prescription and any supplements or herbals) and dose of each:

Name/Dosage

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Do you use blood thinners (ex: Aspirin, Plavix, Coumadin, BC Powder)? Yes ☐ No ☐

3. Are you allergic to any medications? Yes ☐ No ☐
If yes, please list them below and describe reaction:

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Are there any pain medications you know you cannot take? Yes ☐ No ☐
If yes, please list them below and give reason:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____