MBSP

Specialists in peace of mind and relief of pain

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Annapolis, MD 21401
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(First National Bank Building)
Email: info@mbsp.com
Web Address: mbsp.com

Dear: _____

Appointment date: _____ Arrival time: _____Appointment time: _____

Appointment is with _____

In preparation for your visit please complete and bring the New Patient Forms.
If you are unable to complete the paperwork, please arrive 20 mins prior to your appointment time to complete in the office.

If you are more than 5 mins late for your appointment you may be asked to reschedule.

A **$50 charge** will be applied for no show appointments or appointments that are not cancelled within 24 hours.

Due to unforeseen emergencies, our physicians may be called to surgery and your appointment may be rescheduled.

You will be asked to sign a lien that protects our financial rights related to providing care.

Co-pays are due at the time of your appointment and will be collected before you see your provider.

Please bring the following to your appointment:

- Driver's License
- Insurance Cards
- Co-pay
- Imaging CD and report
- If this is a Workers Compensation or Auto Accident, prior to your appointment, please provide us with the Insurance carrier name, address, claim number, adjustor's phone number, date of injury and body parts injured.

Is visit related to (circle one if applicable) Work or Auto Accident? Yes__ No__

First, MI, Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell/Work Phone: _____

Sex: M____F_____ Date of Birth: _____ Marital Status: M___S___D___W___Other_____

Social Security# _____-_____-_____ Email: _____

Emergency Contact: _____Relation:_____Phone:_____

Primary Physician Name: _____

Referring Physician Name: _____

Primary Pharmacy & Address: _____

Primary Insurance Company Name: _____

Group #: _____ Policy #: _____

Employer Name: _____

Subscriber Name: _____

Relationship to Patient: _____ Subscriber Date of Birth: _____

Secondary Insurance Company Name: _____

Group #: _____ Policy #: _____

Subscriber Name: _____

Relationship to Patient: _____ Subscriber Date of Birth: _____

Workers Comp/Auto Information:

Date of Injury: _____ Claim #: _____ Body Part Injured: _____

Workers Comp/Auto Carrier Name: _____

Claim/Billing Address: _____

Employer (Company) Name: _____

Name of Adjuster: _____ Phone #: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

CONSENT FOR ASSIGNMENT OF BENEFITS

I consent to allow this practice to apply for benefits from my primary insurance carrier and any secondary insurance carrier and authorize payment to be made directly to MARYLAND BRAIN, SPINE and PAIN for services rendered by the physician (s) in this practice. If I am a self-pay individual (meaning I have no insurance), I will immediately inform MBSP so that special arrangements can be made for payment. Medicare Only: I request that payment of authorized Medigap benefits be made on my behalf to MARYLAND BRAIN, SPINE & PAIN for any services furnished to me by physician(s). In this practice, I authorize any holder of medical information about me be released to Medigap insurer, any information needed to determine those benefits or benefits payable for related services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of medical information required by my insurance carrier (or, in the case of Medicare Part B benefits, to the Social Security Administration and the Health Care Financing Administration) or its designated review agent, or (if applicable) my employer's Workers Compensation insurance carrier to determine benefits to which I may be entitled, or to designated agents of this practice. This authorization may be revoked either by me or by the above carrier at any time in writing.

FINANCIAL AGREEMENT

I hereby assume financial responsibility and agree to make payments in full to this practice, for all charges for services or medical supplies received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Payments are to be made within 30 days as statements are presented with settlement in full, or payment arrangements may be made with the Billing Office. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, MARYLAND BRAIN, SPINE and PAIN to investigate all financial information given concerning this or related claims. I further understand that this practice reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees and/or court costs incurred by this practice during the collections process.

I also agree to notify the practice of any changes in my billing address or telephone and/or my health insurance carrier information as they occur. This entire consent is valid for all episodes of care rendered by all and any providers associated with the practice. I permit a copy of this consent and agreement to be used in place of the original.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patients Name

Maryland Brain, Spine and Pain

I hereby give my consent for Maryland Brain, Spine and Pain to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

(The Notice of Privacy Practices provided by Maryland Brain, Spine and Pain describes such uses and disclosures more completely)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Maryland Brain, Spine and Pain 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 the Office Administrator.

With this consent, Maryland Brain, Spine and Pain may call my home, cell or other alternative number and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results.

With this consent, Maryland Brain, Spine and Pain may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential". I have the right to request that Maryland Brain, Spine and Pain restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Maryland Brain, Spine and Pain to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the practice has already made disclosures in the reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patients Name

Welcome to Maryland Brain, Spine and Pain

Please check the appropriate circles. Name _____

Past Medical History

Have you had or do you currently suffer from any of these illnesses or conditions?

◯ Anemia	◯ Epilepsy	◯ Migraines
◯ Alcoholism	◯ Fibromyalgia	◯ Pacemaker
◯ Asthma	◯ Gout	◯ Pneumonia
◯ Bleeding Disorder	◯ Heart Disease	◯ Prostate
◯ Cancer	◯ Hepatitis	◯ Smoking
◯ COPD	◯ High Blood Pressure	◯ Stroke
◯ Depression	◯ High Cholesterol	◯ Thyroid
◯ Diabetes	◯ HIV/AIDS	◯ Tremors
◯ Drug Dependence	◯ Kidney Disease	◯ Tuberculosis
◯ DVT/PE	◯ Liver Disease	

Family History

Have your parents or siblings suffered from any of these illnesses or conditions. Please enter the family member on the line.

◯ Alcoholism	◯ Depression	◯ Kidney Disease
◯ Anemia	◯ Diabetes	◯ Liver Disease
◯ Asthma	◯ Epilepsy	◯ Migraines
◯ Bleeding Disorder	◯ Heart Disease	◯ Stroke
◯ Cancer	◯ High Blood Pressure	◯ Thyroid
◯ COPD	◯ High Cholesterol	◯ Tremors

I am taking the following Medications:	Dosage:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name _____

Medication Allergies:	**Reaction:**
_____	_____
_____	_____
_____	_____

In addition to this medication/allergy list, I have recorded my medical history on Maryland Brain, Spine and Pain's Clinical Intake Questionnaire (Neuro Consult) to the best of my ability. I know this is used by Maryland Brain, Spine and Pain to facilitate my treatment and is also used to monitor my outcome to assure I am getting the best therapy. I am aware that, at any time, I may be asked to answer the same scaled or graded questions or to update my Questionnaire. I have been assured my medical record is confidential.

_____	_____
Patient Signature	**Date**

Past Surgical History

Procedure	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____