Dear Patient,

We would like to take this opportunity to welcome you to Midwest Neurosurgeons, LLC and to familiarize you with some of our policies. Enclosed you will find your new patient paperwork. Please complete it before you arrive for your appointment. Our office is open from 8:00AM to 5:00PM Monday, Tuesday and Friday. 8:00AM to 6:00PM Wednesday and Thursday. Evening and weekend hours only by appointment.

SPECIAL ASSISTANCE: If you require special assistance (wheelchair, transfer to exam table, language, etc.) please let our office know prior to your arrival for the appointment so that we may make arrangements to get you the assistance you need. If you have a Durable Power of Attorney, please bring a copy of it with you.

WAIT TIME/APPOINTMENT RESCHEDULES: Everyone here at Midwest Neurosurgeons understands that your time is just as valuable as ours. We make every effort to keep your wait to see the doctor to an absolute minimum and to not have to reschedule your appointment. However, from time to time, it may be necessary for us to reschedule your appointment date and/or time or the wait to see the doctor may be extended as our physicians are on-call for emergencies with the local hospitals. In these rare instances we kindly ask for your understanding and cooperation. These situations are unexpected and unpredictable but if one does occur please be assured that we will make every effort to minimize your inconvenience.

NOT KEEPING APPOINTMENTS: If you are unable to keep your scheduled appointment, please give our office at least 24 hours notice. Due to limited availability of appointments, you could be billed $100.00 as a "no-show" fee if you miss your appointment without the required 24 hour notice.

PAYMENTS AND INSURANCE: Full payment is required at the time of service and for patients whom we are not providers with their insurance. For your convenience, we accept cash, check, and MasterCard and Visa credit cards. As a courtesy to our patients, we file all insurance claims, even if we are not providers for the insurance. It is your responsibility to furnish our office with a current copy of your insurance card(s). For patients whose insurance has a co-pay, the co-pay must be paid on the day of service. For patients who have Medicare but no supplement, 20% of the office charges will be due at the time of service. For patients with no insurance or insurance that we are not providers for, payment in full is due at the time of service unless PRIOR arrangements are made with management.

We are participating providers for: BlueCross/BlueShield, Champus, Encompass, Ethix/MidRivere/ProAmerica, Great Rivers, Great West, Group Health Plan, HealthLink, MedAmerica, Healthnet Blue, Medicare, Medicaid, IDPA and many others.

ACCIDENTS (someone else may be responsible for payments): In accidents, legal cases, etc. where you the patient believes someone else is responsible for the medical expenses, YOU AS THE PATIENT ARE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. This office cannot be expected to wait for

court conclusions or disputed insurance settlements. We will, however, help with any paperwork, etc. needed for reimbursement from the third party believed to be liable for the medical expenses. We DO NOT file AUTO or THIRD PARTY liability insurance but we will provide you with a claim form to send to your insurance. If you are unsure if this policy applies to you please contact our office.

WORKERS' COMP: In case of Workers' Compensation, we must have an authorization from your employer or their insurance carrier to provide medical services. If your claim is denied you are responsible for payment of the services provided.

Thank you for selecting our office and we look forward to serving you in the future. If we may be of any further assistance, please contact our office at 573-651-1687.

Sincerely,

Midwest Neurosurgeons, LLC
65 Doctors Park
Cape Girardeau, MO 63703
Phone: (573) 651-1687
Fax: (573) 651-8734
ask@drfonn.com
www.midwestneurosurgeons.com

Midwest Neurosurgeons, LLC
NOTICE OF PRIVACY PRACTICES
FORM #10(A)

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

Who Will Follow This Notice

This Notice describes the privacy practices of Midwest Neurosurgeons, LLC ("MWN").

Our Pledge Regarding Your Medical Information

We understand that your medical information is personal and we are committed to protecting the privacy of your medical information. While you are a patient of MWN, we create records of the health care services that have been provided to you. We need these records to provide you with quality health care services and to comply with certain legal requirements. This Notice describes how we may use and disclose your medical information for purposes of treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights with respect to your medical information. "Medical Information" includes all paper and electronic records pertaining to your medical care and payment for your medical care.

Your Rights Regarding Your Medical Information

By law, you have the rights described below with respect to your medical information.

□ **Right to Review and Obtain a Copy of Your Medical Information.** You have the right to review and obtain a copy of your medical information. However, under certain circumstances and, if permitted by law, we may deny your request. To inspect and copy your medical information, you must submit your request in writing to our Privacy Officer. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage and supplies associated with your request, as permitted by law. You also may request a copy of your electronic health record, if we maintain an electronic health record and your medical information is readily producible in such form or format.

□ **Right to Request a Restriction on Uses and Disclosures of Your Medical Information.** You have the right to request a restriction on–uses and disclosures of your medical information for purposes of treatment, payment or health care operations or to individuals involved in your care. To request such restriction, you must make your request in writing to our Privacy Officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (e.g., disclosures to a certain family member). We are not required to agree to a requested restriction unless your request is to restrict disclosures for purposes of carrying out payment or health care operations to your health plan, which disclosures are not otherwise required by law, and the medical information pertains solely to the item or service for which you, or a party other than the health plan, have paid in full. We will notify you if we don't agree to your request for restriction. If we agree to your request for a restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. Even if we agree to your request for a restriction, we will still be permitted to disclose your medical information to the Secretary of the Department of Health and Human

Services and for other purposes described below when disclosure is permitted without your authorization (e.g., judicial proceedings, public health activities). We may terminate a previously agreed to restriction, except the restriction which we are required to accept as described above, in which case you will be notified of such termination.

□ **Right to Request Confidential Communications.** You have the right to request that we communicate with you by using a specified method or at a specified location. For example, you can ask that we only contact you at work or only by mail. To request confidential communications, you must submit your request in writing to our Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted and to what address we may send bills for payment for services provided to you. We will accommodate all reasonable requests for confidential communications.

□ **Right to Request Amendment of Your Medical Information.** You have the right to request an amendment of your medical information if you believe that the information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by us. Your request for amendment must be in writing, submitted to our Privacy Officer and provide a reason that supports your request. We may deny your request for an amendment if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment, is not part of the medical information about you kept by us, is not part of the information which you would be permitted to inspect and copy, or if we determine that your medical information is accurate and complete. If we accept your request, we will inform you about our acceptance and make the appropriate corrections. If we deny your request, we will inform you of this decision and give you a chance to submit to us a written statement disagreeing with the denial. We will add your written statement to your records and include it whenever we disclose the part of your medical information to which your written statement relates.

□ **Right to Request Accounting of Disclosures.** You have the right to request an accounting of certain disclosures we have made of your medical information. To request this accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period for which the accounting of disclosures is sought, which cannot be longer than six years prior to the date on which your request for accounting is made. The first accounting request within a 12-month period will be free. For additional requests, we may charge you for the reasonable costs of providing the accounting. We will notify you of the cost involved in advance and you may choose to withdraw or modify your request at that time before any costs are incurred.

□ **Right to Receive Breach Notice.** You have the right to receive notice in the event of a breach of your unsecured protected health information.

□ **Right to Obtain Copy of This Notice.** You have the right to obtain a copy of this Notice upon request. We will post a copy of this Notice in our medical offices and will have paper copies of the Notice available at our medical offices. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website: http://midwestneurosurgeons.com.

Our Responsibilities Regarding Your Medical Information

We are required by law to:

- Maintain the privacy of your medical information;
- Provide you with this Notice concerning our legal duties and privacy practices with respect to your medical information;
- Provide you with notice following a breach of unsecured protected health information; and
- Abide by the terms of this Notice.

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for medical information we already have about you, as well as any information we receive in the future. We will have paper copies of the revised Notice available in our medical offices. We will also post a copy of the current Notice on our website at http://midwestneurosurgeons.com. The Notice will specify the effective date of the Notice. Each time you visit our website, you will see a link to the current Notice in effect. Any new Notice will also be available to you by requesting that a copy be sent to you in the mail.

Permitted Disclosures of Medical Information Without Your Authorization

Unless otherwise prohibited by law, we may use and disclose your Protected Health Information as described below without obtaining an authorization from you (or your personal representative). We explain below each category of use or disclosure, but we do not list every use or disclosure in a category.

- **Treatment.** We may use and disclose your medical information to provide, coordinate or manage your treatment. For example, we may disclose your medical information to other doctors, nurses, hospitals and other providers and facilities involved in your care. We may also share medical information about you to provide you with various items and services, such as diagnostic tests or medications and to make arrangements for hospital care, home care, rehabilitation facilities or other health care services you may need. We may contact you to provide appointment reminders, patient registration information or to follow up about your medical care.

- **Payment.** We may use and disclose your medical information so that we may bill you or appropriate third party payors for the health care services we provide to you and receive payment for those services. For example, we may need to give your health plan information about treatment you received so your health plan will pay for your treatment or provide a prior approval of a particular procedure. We may also disclose your medical information to other health care providers so that those providers may receive payment for services provided to you.

- **Health Care Operations.** We may use and disclose your medical information for purposes of health care operations. Examples of health care operations activities include quality assessment and improvement activities, protocol development, case management and care coordination, business planning and development, conducting training programs, certification and licensing activities, conducting or arranging for medical review, legal services and auditing functions, peer reviews and audits of the process of billing you or a third party for health care services we provide to you. For example, we may use your medical information to review the quality of our health care services or we may disclose your medical information to other healthcare providers who treated you for quality assessment and improvement related activities. We may contact you regarding treatment alternatives and related functions.

□ **Family Members and Friends Involved In Your Care.** We may share your medical information with your family members, other relatives and close personal friends involved in your care or any other person identified by you, if we either obtain your agreement, provide you with an opportunity to object and you do not express an objection or reasonably infer, based on professional judgment, that you do not object to the disclosure. If you are not present at the time we disclose your medical information or the opportunity to agree or object to the disclosure cannot reasonably be provided because of your incapacity or emergent circumstances, we may, in the exercise of professional judgment, determine whether the disclosure is in your best interests and if so, disclose the medical information that is directly relevant to the person's involvement with your care or payment related to your health care. We may also use and disclose your medical information for the purpose of locating and notifying your relatives or friends of your location, general condition or death and to organizations that are involved in those tasks during disaster situations.

□ **Compliance With Law.** We will make your medical information available to you, disclose your medical information to the Secretary of the Department of Health and Human Services and disclose your medical information to the extent the disclosure is required to comply with Federal or state law.

□ **Public Health Activities.** We may disclose your medical information for public health activities to public health or other appropriate governmental authorities authorized by law to collect and receive such information in order to help prevent or control disease, injury or disability. This may include disclosing your medical information to report certain diseases, injuries, vital events such as births or deaths, child abuse or neglect, providing proof of immunization to school consistent with applicable law, reporting information to the Food and Drug Administration if you experience an adverse reaction from any of the drugs, supplies or equipment, to enable product recalls or disclosing medical information for public health surveillance, public health investigations or interventions.

□ **Health Oversight Activities.** We may disclose your medical information to government agencies so they can monitor, audit, investigate, inspect, discipline or license those who work in the health care system and engage in other activities authorized by law in order to provide for the proper oversight of the health care system or for government benefit programs for which health information is relevant to beneficiary eligibility.

□ **Workers Compensation.** We may disclose your medical information as authorized by and to the extent necessary to comply with laws related to workers compensation or other similar programs established by law to provide benefits for work-related injuries or illnesses.

□ **Judicial Proceedings.** We may disclose your medical information in the course of a judicial or administrative proceeding, in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request or other lawful process, subject to certain procedural requirements required by law.

□ **Law Enforcement.** We may disclose your medical information to law enforcement officials to report criminal conduct that occurred on premises of our medical offices, to locate or identify a suspect, fugitive, material witness or a missing person, to alert law enforcement if a death has resulted from a criminal conduct or to report crime in emergencies if we provide medical care in response to a medical emergency outside of our facilities to alert law enforcement to the commission, nature, location, victims and perpetuators of such crime. In addition, we may disclose medical information to law enforcement officials regarding a victim of a

crime, in response to a subpoena, court order or warrant, administrative request or similar process authorized under law or as otherwise may be required by law.

□ **Specialized Government Functions.** If you are a member of the Armed Forces, we may disclose your medical information as required by military command authorities to assure the proper execution of a military mission and with respect to foreign military personnel, to the appropriate foreign military authorities for the same purpose. We also may disclose your medical information for conducting national security and intelligence activities, including providing protective services to the President or other persons provided protective services under Federal law.

□ **Correctional Institutions.** If you are in the custody of law enforcement or a correctional institution, we may disclose your medical information to the law enforcement official or the correctional institution as necessary for your health, the health of others or certain approved operations of the correctional institution.

□ **Coroners, Medical Examiners and Funeral Directors.** We may disclose your medical information to coroners and medical examiners so that they can carry out their duties authorized by law and for purposes of identification of a deceased person or determining a cause of death. We may also disclose your medical information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to a decedent.

□ **Organ, Eye and Tissue Donation.** We may disclose your medical information to organ procurement organizations or other entities involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation and transplantation purposes.

□ **Research.** We may use or disclose your medical information for research purposes provided that we comply with applicable Federal and state legal requirements.

□ **Serious Threat to Health and Safety.** We may disclose your medical information as necessary to prevent or lessen a serious threat to health or safety of a person or the public.

□ **Abuse, Neglect and Domestic Violence.** We may disclose your medical or contact information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence, if we reasonably believe that you are a victim of abuse, neglect or domestic violence to the extent required or permitted by Federal or state law.

□ **Limited Data Sets.** We may use and disclose a limited data set (i.e., medical information in which certain identifying information has been removed) for purposes of research, public health, or health care operations. Any recipient of that limited data set must agree to appropriately safeguard your medical information.

□ **Business Associates.** We may share your medical information with third party business associates, which are various vendors that perform various services for us. For example, we may disclose your medical information to our vendors which provide to us billing, collection or information technology related services. To protect your medical information, however, we require our business associates to safeguard your medical information.

Uses and Disclosures of Medical Information Which Require Authorization

Obtaining your authorization is required for most uses and disclosures of psychotherapy notes, uses and disclosures of your medical information for marketing purposes (with the exception of our face to face communications with you and providing you with promotional gifts of nominal value) and disclosures which constitute sale of your medical information. In addition, for other uses and disclosures of your medical information beyond the uses and disclosures described in this Notice, we are required to obtain your written authorization. For example, you will need to give us your written authorization before we send your medical information to your life insurance company. Certain Federal and state laws may require special privacy protections for certain medical information, including information that pertains to HIV/AIDS testing, diagnosis or treatment, mental health services, alcohol or drug abuse treatment services, genetic information and testing, sexual assault or other types of medical information. Sometimes state or Federal laws prohibit disclosure of medical information that is otherwise permitted to be made without an authorization under the HIPAA privacy rules. To the extent any such laws require special protection to any of your medical information and do not permit disclosure of such information without obtaining your written consent, we will comply with those laws.

How You May Revoke Your Authorization

You may revoke your authorization to release your medical information if you notify us in writing at any time but we cannot take back any medical information that has already been disclosed by us in reliance of your prior authorization approving such disclosure. Your request to revoke your authorization must be sent to our Privacy Officer.

For More Information or to Report a Complaint

If you have questions or would like more information about our privacy practices, you may contact our Privacy Officer at 636-561-0871. If you believe your privacy rights have been violated, you may file a written complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint. Please direct your complaint to:

Privacy Officer
Midwest Neurosurgeons, LLC
65 Doctors Park
Cape Girardeau, MO 63703
573-651-1687

Effective Date: August 30, 2013

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FORM #10(B)

Name of Patient: _____

I hereby acknowledge that I have received Notice of Privacy Practices of Midwest Neurosurgeons, LLC.

_____ _____
Signature of Patient or Personal Representative Date

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:_____

Date:_____
The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

- ☐ **Patient refused to sign acknowledgement.**
- ☐ **Patient was unable to sign the acknowledgement because:**
  _____
  _____
- ☐ **Other reason (describe below):**
  _____
  _____
  Name of Employee Completing Form: _____

Signature:_____

Date: _____

PATIENT MEDICAL HISTORY:

Thank you for selecting us. To help us meet all of your healthcare needs, please fill this form out completely. If you have any questions, PLEASE ask and we will be happy to help.

YOUR NAME_____ TODAY'S DATE_____/_____/_____

DATE OF BIRTH: _____ FAMILY PHYSICIAN_____ PHONE: _____

Why are you here today?
When did your problems start? _____/_____/_____
What occurred at that time?
Have you ever had any similar problems in the past? □ YES □ NO
Have you had any work-related or any other significant disabling injuries or illness? □ YES □ NO
Please list the names of any other doctors you have seen for this condition:
What is your greatest concern?
Where is your pain located?
What does it feel like?
What makes it worse?
What makes it better?
Is your pain: □ Constant □ Intermittent □ Occasional
Please rate your pain on a scale of 0 (no pain) to 10 (worst):
Are you having any other problems? □ YES □ NO
What do you believe is causing your problems?
What tasks are most difficult for you?
Do you believe this injury was work related? □ YES □ NO
If "YES" who were you working for at the time of injury?
What was your Job?
How did it happen?

What is your work status now?
Do you have any work restrictions imposed by a physician? □ YES □ NO
Please circle if you have any of these symptoms: fever, weight loss, shortness of breath, chest pain, bowel or bladder incontinence, blurry vision, swallowing difficulties, diarrhea, rashes, bleeding problems, or hallucinations.
Do you smoke? □ YES □ NO
If yes, how many packs during an average day?
Did you smoke? □ YES □ NO
If yes, when did you quit? _____/_____/_____ How many years did you smoke? _____
Do you drink alcohol? □ YES □ NO
If yes, how many drinks during the week?
List any diseases that run in your family:
List any previous surgeries:
List any Other hospitalizations:
List any other medical problems below: (Diabetes, High Blood Pressure, Blood Disorders, etc.)
Since our office may need to order an updated MRI for you, please answer the following: A. Is there any metal, other than titanium, in your body? □ YES □ NO B. Are you claustrophobic? □ YES □ NO C. What is your weight? _____IBS. What is your height?_____ft. _____in

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such healthcare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or medical group insurance benefits otherwise payable to me. I understand that my health insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE: _____ DATE: _____

LATE CHARGES. *If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5 % on the balance then unpaid an owed will be assessed each month (if allowed by law). In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.*

Midwest Neurosurgeons, LLC
Review of Systems

Please check off any condition which you had or are currently experiencing

ALLERGIES	×	EYES	×	MUSCULOSKELETAL CONT…	×
Asthma		Blurred Vision		Arms	
Hay Fever		Crossed Eyes		Legs	
Skin Eruption		Double Vision		Swelling in…	
CARDIOVASCULAR		Vision Flashes or Halos		Hands	
Chest Pain		**GENITOURINARY**		Wrist	
Irregular Heart Beat		Bloating		Hips	
High Blood Pressure		Bowel Changes		Knees	
Low Blood Pressure		Constipation		Joints	
Poor Circulation		Diarrhea		Arms	
Rapid Heartbeat		Gas		Legs	
Swelling of Ankles		Hemorrhoids		**NEUROLOGICAL**	
Varicose Veins		Indigestion		Fainting	
Cold Hands		Nausea		Headache	
Cold Feet		Poor Appetite		Seizures	
CONSTITUTIONAL		Rectal Bleeding		Tingling of Hands	
Chills		Stomach Pain		Tingling of Feet	
Sweats		Vomiting Blood		Tingling of Arms	
Fever		**HEMATALOGIC/LYMPH**		Tingling of Legs	
Fainting		Swollen Lymph Nodes		Problems with Memory	
Forgetfulness		Easy Skin Bruising		Back Pain	
Headaches		Prolonged Bleeding from Tooth Extraction		Neck Pain	
Loss of Sleep		**INTEGUMENTARY**		**PSYCHIATRIC**	
Weight Loss		Skin Rashes or Eruptions		Anxiety	
Nervousness		Chronic Skin Itching		Depression	
ENT		Unusual Moles		Panic Attack	
Bleeding Gums		Poor Scarring		Restlessness	
Difficulty Swallowing		**MUSCULOSKELETAL**		**PULMONARY**	
Earache		Pain in…		Coughing up Blood	
Ear Discharge		Hands		TB	
Hearing Loss		Wrists		Chronic Cough	
Sinus Problems		Hips		Dizziness	
Nosebleeds		Knees		Shortness of Breath	
Persistent Cough		Joints		Smoker o YES o NO	
Ringing in Ears		Arms		If YES How many packs per day?	
ENDOCRINE		Legs		How Long have you been smoking?	
Rapid Weight Loss		Weakness in…		**Please write any comments below:**	
Rapid Weight Gain		Hands			
Intolerance to Warm Room		Wrists			
Multiple Broken Bones		Hips			
Cessation of Menstrual Periods		Knees			
Excessive Hunger		Joints			
Excessive Thirst		Arms			
Loss of Libido		Legs			
Spontaneous Nipple Discharge		Numbness in…			
		Hands			
		Wrists			
		Hips			
		Knees			
		Joints			

Rev. 09/20/2013

MIDWEST
NEUROSURGEONS, LLC

MEDICATION LIST

Patient Name_____ DOB: _____

PLEASE LIST ANY DRUG ALLERGIES:

_____
_____
_____

MEDICATION NAME:	DOSAGE:	PRESCRIBED BY: (DR.)	REASON FOR TAKING:

Pharmacy(s) used in the last year (Name and Phone number)

1. _____
2. _____
3. _____

MIDWEST
NEUROSURGEONS, LLC

PATIENT INFORMATION

1. Medication Policy:

All medication refills will be processed Monday through Friday with a mandatory 48 hour call in advance request for refill. There is a $10 administrative fee for all telephone refills. The fee is waved during post operative period of 90 days. The fee is waived if the refill is obtained during a regular office visit.

2. Privacy Policy:

Midwest Neurosurgeons, LLC complies with patient privacy regulations and a copy will be provided to you.

3. Disclosure:

You may be undergoing studies, procedures, and/ or surgeries in entities that our doctors have financial interest. You may be receiving medical supplies and/or implants that our doctors have financial interest.

I have read the above and I understand the policies and disclosure.

_____
Name of Patient/Guardian

_____
Signature Date

MIDWEST
NEUROSURGEONS, LLC

Patient Questionnaire

I. Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

_____
_____
_____

II. Please list the family members or significant others, if any, whom we may inform about your medical Condition ONLY IN AN EMERGENCY:

_____
_____
_____

III. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home number:

_____
_____
_____

- I am fully aware that a cell phone is not a secure and private line.

_____
Patient Name

_____
(Guardian if under 18 years)

_____
Patient/Guardian Signature Date

MIDWEST
NEUROSURGEONS, LLC

Sonjay Joseph Fonn, DO
Board Eligible in Neurological Surgery

Patient Name: _____ Date: _____
Employer: _____
Insurance Co.:_____
S.S.N. or Insurance ID #_____

I hereby instruct and direct_____insurance
Company to pay by check made out and mailed to: Midwest Neurosurgeons, LLC, 65 Doctors Park, Cape Girardeau, MO 63703.

Or, if my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make the check out to me and mail it as follows: Midwest Neurosurgeons, LLC, 65 Doctors Park, Cape Girardeau, MO 63703, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, and said balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjusters, physicians, assignees, and or beneficiaries or any attorneys involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Midwest Neurosurgeons this_____day of 20_____

_____
Signature of Policy Holder

_____
Witness

_____
Signature of claimant, if other than policy holder.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FORM #1

I hereby consent to the use and disclosure of my health information for treatment provided to me by Midwest Neurosurgeons, LLC ("Provider") or other health care providers, payment for services provided by Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways Provider may use and disclose my health information is contained in the Notice of Privacy Practices of Provider, a copy of which has been provided to me.

_____ _____

Signature of Patient or Personal Representative Date

MIDWEST
NEUROSURGEONS, LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("PHI")

Patient Identification

Patient's Name:_____ Date of Birth:_____

Address:_____

PHI To Be Released

☐ Entire Medical Record ☐ Lab & Test Results ☐ Surgical Records
☐ Imaging Studies ☐ Other:
_____

Date(s) of Service of PHI to be Released: (All dates of services unless otherwise specified here):
_____

Purpose of Disclosure

☐ Transfer of Care ☐ Consultation ☐ School
☐ Individual's Request ☐ Other: _____

Person(s) Authorized to Release PHI ("Releasing Organization"):

Person(s) Authorized to Receive PHI

Midwest Neurosurgeons, LLC
65 Doctors Park
Cape Girardeau 63703
Phone: (573) 651-1687
Fax: (573) 651-8734

Sensitive Information. If my medical or billing record contains information about drug and/or alcohol abuse, mental health/psychiatric care, sexually transmitted diseases, Hepatitis testing and/or treatment, HIV/AIDS testing and/or treatment and/or other sensitive information, I agree to its release. ***Check if you do not agree to release of sensitive information described herein:*** ☐ **Do Not Agree**

Revocation of Authorization. I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the Privacy Officer of Releasing Organization listed above and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.

Expiration of Authorization. Unless otherwise specified herein, this Authorization will expire one year from the date of the signature below:_____

Re-disclosure. I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements unless otherwise prohibited by law.

Signature of Patient or Personal Representative Who May Request Disclosure. I understand that I do not have to sign this Authorization and that my treatment, payment or health plan enrollment will not be denied if I do not sign this Authorization. I hereby authorize Releasing Organization to disclose the protected health information to Midwest Neurosurgeons, LLC as specified above.

_____ _____
Signature of Patient or Personal Representative Date

If this Authorization is signed by the patient's personal representative, describe such representative's authority to act on behalf of the patient:

_____

MIDWEST
NEUROSURGEONS, LLC

Patient Name: _____ Date: _____

Responsible Party/Guarantor: _____ Policy: _____

Relationship to Patient: _____ Group: _____

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD(S)

Fees for all professional medical services rendered are due at the time of service, unless other arrangements have been made in advance. I understand that I am legally responsible for any and all charges related to the care and treatment provided to me by Midwest Neurosurgeons, LLC (also referred to as MWNS). I also understand that MWNS may file for reimbursement from my insurance company, health plan or other payer as a courtesy, but failure on the part of the insurance company, health plan or other payer to make payment shall not relieve me of my obligation to pay MWNS.

By my signature on this agreement, I assign, and authorize payment be made directly to MWNS for, all benefits due me under Medicare, Medicaid or any other insurance policy, health plan or from any other payer providing benefits or reimbursement for services rendered by MWNS to me and/or my dependents. I must pay all amounts due MWNS which are not otherwise paid by my insurance company, health plan or other payer.

Further, I authorize MWNS to disclose, to the extent allowed by law, my medical and financial information as needed for my care, to obtain payment from my insurance provider, health plan or other payer, and as needed for MWNS to conduct its business. These authorized disclosures include, for example, disclosures to (a) my insurance company or health plan or their agents or employees; (b) any person or entity to whom I have been referred by MWNS or by my physician for continued care; (c) any physician treating, consulting or otherwise performing medical services for me, including their employees and agents; (d) certain government agencies.

In consideration of the services to be rendered, to the extent not expressly prohibited by law or agreed upon in a contract between MWNS and my insurance company or other payer, I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE TO MWNS AT THE USUAL AND CUSTOMARY CHARGE OF MWNS and agree to waive all claims of exemption. Should my account be referred to an attorney or collection agency for collection, I shall pay, in addition to other amounts due to MWNS, all reasonable attorney's fees and collection expenses regardless of whether a lawsuit is filed. Delinquent accounts and amounts (those not paid within 60 days from the date of service) shall bear interest on the unpaid amount up to the maximum amount allowed by law or contract.

I certify that I am the patient or that I am financially responsible for services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due. A copy or facsimile of this agreement shall be considered as effective and valid as the original.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU HAVE READ AND UNDERSTAND ITS CONTENTS.

PATIENT/GUARANTOR: _____ DATE: _____
WITNESS: _____ DATE: _____

****MWNS cannot help you with questions about your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier*.

Rev. 09/20/2013

MIDWEST
NEUROSURGEONS, LLC

_____ _____
Last Name First Name

Notice:

In consideration of the services that have been or will be rendered to the above name patient, I agree to pay for procedures performed at Midwest Neurosurgeons, LLC.

I understand that Midwest Neurosurgeons, LLC is under no obligation to file claims to any insurance or other third party liability payer not presented prior to date of service due to contractual limitations.

If it comes to our attentions these procedures are the results of an auto related accident, workers compensation, or any other liability in which you are being represented by an attorney, all discounts will become void. You will then be responsible for original procedure costs.

Should this account become delinquent and referred to a collections agency or attorney, I shall pay all reasonable collection expenses, court expenses, court costs, interest, and a reasonable attorney fee.

_____ _____
Signature Witness

_____ _____
Date Date

MIDWEST NEUROSURGEONS, LLC Patient Name_____
65 Doctors Park.
CAPE GIRARDEAU, MO 63703

Is this procedure due to:	(If yes, indicate date of injury) YES	NO
Work related accident?		
Motor-vehicle accident?		
Other 3rd Party liability?		
Do you have claim #?		
Do you have an Attorney?		

How were you injured?

_____
_____
_____
_____

If this is a work related injury, who is/was your employer? _____

- Contact information:
  - Claim Adjustor:_____
  - Phone # _____
  - Claim # _____

- Attorney information (required):
  - Name _____
  - Address:_____
  - City, State, Zip: _____
  - Phone: _____

- Other Health Insurance Info:
  - Company:_____
  - Address:_____
  - City, State, Zip:_____
  - ID# _____
  - Group # _____

- Do you want us to bill your personal health insurance? □ YES □ NO

PATIENT INFORMATION
PLEASE PROVIDE FIRST, MIDDLE NAME & LAST NAMES

First Name:	Middle Name:	Last Name:
*****We can NOT fill your medications if a PO Box is listed due to pharmaceutical laws. Please provide us with your Physical Address***** Physical Address:		
City: State: Zip:		
Home Phone:	Cell Phone:	Other Phone:
SSN:	Date of Birth:	Sex: Male Female
Marital Status: (please choose one) □ Married □ Single □ Divorced □ Widowed □ Other		
Employer Name: Phone: Address:		

Spouse or Responsible Party Name:		
Address if not same as above:		
City:	State:	Zip:
Home Phone:	Cell/Other:	
SSN:	Date of Birth	
Marital Status: (please choose one) □ Married □ Single □ Divorced □ Widowed □ Other		
Employer Name: Phone: Address:		
Referring Physician Name:	**Phone:**	**Fax:**
Family Physician Name:	**Phone:**	**Fax:**
Chiropractor:	**Phone:**	**Fax:**

EMERGENCY CONTACT INFORMATION

NAME:	RELATIONSHIP:
HOME PHONE:	CELL/OTHER:

IF WORKER'S COMPENSATION OR MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

DATE OF INJURY: _____

Work Comp Employer Name:		
Address:	City:	State/Zip:
Claim/injury#		Contact Person:
Phone:	Ext:	Fax:
Motor Vehicle Accident: Responsible Party Name:		
Address:	City:	State/Zip:
Claim/Injury #		Contact Person"
Phone:	Ext:	Fax:
ATTORNEY NAME:		
Address:	City:	State/Zip:
Claim/Injury#		Contact Person:
Phone:	Ext:	Fax:
Please list any other information you would like to share…		

Please provide us with your e-mail address

_____@_____