Welcome to Neurosurgical Services, PLLC.

To make sure Neurosurgical Services, PLLC (NSS) has current patient information, you will be asked to review and sign the most current demographic sheet at each visit. This will assist us in meeting your medical needs.

As a new patient, you will be asked to provide you personal information (Name, physical and mailing address, and working phone number), guardian information if applicable, reason for visit, employment information (if currently employed), and current insurance information.

First Visit

Please arrive 15 minutes prior to your appointment time. Please bring any MRI/CT/XRAYS that you may have been asked to bring. Please bring any pertinent medical information and a **CURRENT** medications list.

Payment will be expected at the time of service (co-pays, balances due, etc.)

Protected Health Information

You will be required to complete a HIPAA form. This is the consent form for use and disclosure of health information to other physicians, medical facilities and health insurance companies who are providing your medical care and health coverage. Please read the HIPAA form closely. **NO INFORMATION WILL BE PROVIDED UNLESS THE NAME OF THE PERSON INQUIRING IS FOUND ON THE FORM SIGNED BY YOU.**

Appointments and Scheduling

We strive to accommodate your schedule. To change an appointment, please call the office. Patients are considered late if they do not arrive by their check in time. If you are 30 minutes late, you will be considered a No Call, No Show and will be rescheduled.

Prescription Refills

Please carefully read and sign the Contract for Controlled Substance Prescriptions.

Medical Records

To request a copy of your medical record, you will be required to sign a release of information and indicate the specific information you are requesting. The first copy is free, additional copies will require payment at the time of request. There is a $10.00 Service Fee and medical records are $0.50 per page. The turnaround time is a maximum of 30 days. Our office will contact you when the records are ready to be picked up. If you wish the documents be mailed, postage will be an additional $6.20 for priority mail. This is payable by credit card prior to mailing.

Disability

We do not fill out short term or long term disability forms. We will provide a letter to your insurance carrier stating your current status. FMLA forms will be completed after a non-refundable $50.00 fee is paid. There is a turnaround time of 10 days. These will not be completed prior to any procedure.

Insurance/Payment Information/Billing Questions

As a courtesy, claims will be directly submitted to your insurance carrier(s). It is your responsibility to contact your insurance company to see if Dr. Barry is participating with your plan, to verify referrals are in-network, find out if your deductible has been met for the calendar year and what your co-pay is. Patients are responsible for deductibles and co-pays at the time of service.
Neurosurgical Services, PLLC understands some patients experience hardship. If you need to establish payment arrangements, please contact our billing office at 405-292-5500. You may be required to disclose financial information.

Visitors

We understand from time to time our patients will have family or friends accompany them to their appointments. We have a very small patient lobby. We do not provide day care nor do we have any kind of entertainment for small children. Kindly make appropriate arrangements for small children if needed.

Directions

Our office is located in Christman Park, 1257 E. 33rd Street, Edmond, OK 73013. I-35 North, exit E. 33rd, turn left, heading west. Christman Park is located between Bryant and Boulevard. From Broadway Extension, turn right on E. 33rd, heading east. Christman Park will be on your left, after Broadway.

Neurosurgical Services PLLC — Patient Information

**Please complete all information*

Name ______________________ First ______ Middle ______ Last ______ M F Sex ___/___/___ DOB ______ Age

Address ______________________ Street Address ______ City ______ State ______ Zip

Home Phone ( ) - ______ Cell Phone ( ) - ______ Social Security # ___-___-___

Patient Employer ______________________ Job Title ______________________

Employer's Address ______________________ Street Address ______ City, State ______ Zip ______ Employer Phone ( ) -

If Patient is a Minor, Responsible Party

Name ______________________ Social Security # ___-___-___

Address ______________________ Street Address ______ City, State ______ Zip ______ Phone ( ) -

Employer ______________________ Occupation ______________________

Employer Address ______________________ Street Address ______ City, State ______ Zip ______ Employer Phone ( ) -

Health Insurance Information

Insurance: ______________________ Policy Holder : ______________________ **Policy Holder Name** ______ **Soc Sec #** ______ **Date of Birth**

Insurance Address: ______________________ Street Address ______ City, State ______ Zip ______ Phone ( ) -

Policy # ______________________ Group # ______________________

Are you claiming this as an on-the-job injury? ☐ Yes ☐ No Date: ______________________

Was the problem caused by an accident? ☐ Yes ☐ No Date: ______________________

Do you have an attorney handling this claim? ☐ Yes ☐ No Whom: ______________________

Were you referred to our office? ☐ Yes ☐ No By whom: ______________________

If not, how did you learn about us? ______________________

Who should we contact in case of an emergency? ______________________

______________________ Address ______ City, State ______ Zip ______ Phone ( ) -

Required Authorizations

**Please take a moment to complete all of the following required consents*

Benefits to Physician: I hereby authorize payments directly to Neurosurgical Services PLLC of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (patient or parent of minor) ______________________

Release of Information: I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signed (patient or parent of minor) ______________________

I have received a Notice of Privacy Practices from the office of Neurosurgical Services PLLC

Signed ______________________ Date ______________________

I have signed the patient consent for use and disclosure of protected health information from the office of Neurosurgical Services PLLC

Signed ______________________ Date ______________________

HIPAA) I authorize practice/billing company to contact me about my bill by reaching me via (Note: If all boxes are checked "no" we will require prepayment on all services)
Phone: yes ☐ no ☐ Cell phone: yes ☐ no ☐ Work phone: yes ☐ no ☐ Mail: yes ☐ no ☐

You may speak with the following person/s about my bill regarding medical services provided:

Name ______________________ Relationship ______________________ Phone ( ) -

You may not speak with the following person/s about my bill regarding medical services provided:

Name ______________________ Relationship ______________________

Name__________________________ Age________ Date______________

Referring Physician______________________ Primary Care Physician______________________

Chief Complaint____

Date Pain Began______________ Describe onset or event ______________________

Please describe your pain:

Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation by using arrows and include all affected areas.

NUMBNESS:

______
______
______

PINS AND NEEDLES:

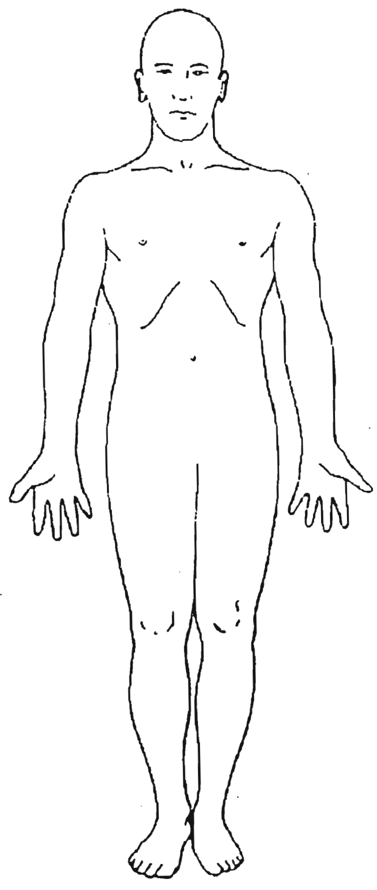
OOOOO
OOOOO
OOOOO

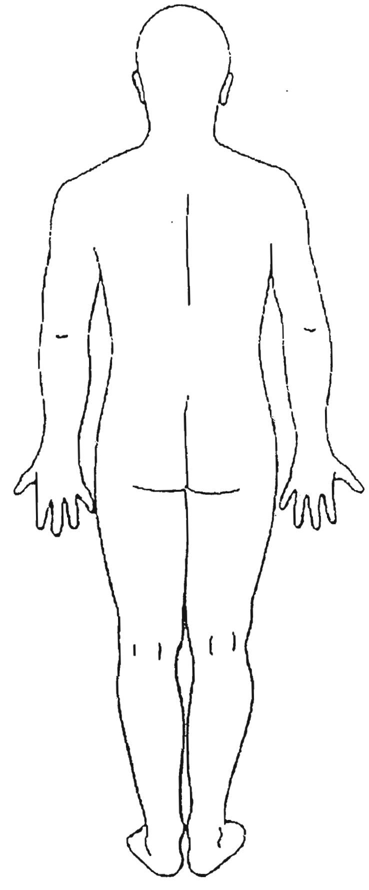
BURNING:

XXXXX
XXXXX
XXXXX

STABBING:

///////
///////
///////





		Location of pain			Location of pain
Burning	Y N	______	Tingling/ Pins and Needles	Y N	______
Aching	Y N	______	Coldness	Y N	______
Throbbing	Y N	______	Numbness	Y N	______
Sharp	Y N	______	Skin Discoloration	Y N	______
Dull	Y N	______	Muscle Spasm	Y N	______
Shooting	Y N	______	Muscle Tightness	Y N	______
Stabbing	Y N	______	Bowel/Bladder Problems	Y N	______
Swelling	Y N	______	Other______		

Using Pain Scale of 0-10, Rate your pain. 0 = No pain 10 = worst pain ever

At its Worst:	0	1	2	3	4	5	6	7	8	9	10
At its least:	0	1	2	3	4	5	6	7	8	9	10
At its usual:	0	1	2	3	4	5	6	7	8	9	10
Today:	0	1	2	3	4	5	6	7	8	9	10

How do the following affect your pain? B = makes better W = makes worse N = no effect

Relaxation	B	W	N	Standing	B	W	N
Heat	B	W	N	Walking	B	W	N
Cold	B	W	N	Lying Down	B	W	N
Alcoholic Drinks	B	W	N	Exercise	B	W	N
Medication	B	W	N	Sexual Activity	B	W	N
Sitting	B	W	N	Coughing/Sneezing	B	W	N

Have you been hospitalized for your pain? Yes No
If Yes, please give the date, facility and physician who cared for you: ______________________________

____

What time of the day is your pain at its worst? ______________________________
On average, how many hours do you sleep? ______________________________
How has your appetite changed with your pain? increased______ decreased_____ no change______

If you have low back and leg pain, indicate percentage: back__________% leg___________%

Previous Treatments:

Injections or Blocks Y N If yes, please give the date, facility and physician name:

____

If yes, please list date and treatment facility name:

Physical Therapy	Y	N	______________________
Chiropractor	Y	N	______________________
Acupuncture	Y	N	______________________
Hypnosis	Y	N	______________________
TENS Unit	Y	N	______________________
Mental Health	Y	N	______________________

Testing:

If yes, please list date and treatment facility name:

Lumbar MRI/CT	Y	N	______________________
Cervical MRI/CT	Y	N	______________________
Thoracic MRI/CT	Y	N	______________________
Myelogram	Y	N	______________________
EMG	Y	N	______________________
Discogram	Y	N	______________________
Bone Scan	Y	N	______________________

Medical History (Do you have or have you ever had the following?)

Condition			Condition		
Arthritis	Y	N	Anticoagulant Therapy	Y	N
Glaucoma	Y	N	Lung Disease	Y	N
Cataracts	Y	N	COPD/Emphysema	Y	N
Back Trouble	Y	N	Jaundice	Y	N
Blood Disease	Y	N	Paralysis	Y	N
Stroke	Y	N	Thyroid Disease	Y	N
HIV/AIDS	Y	N	Psychiatric Disorder	Y	N
Depression	Y	N	Abnormal EKG	Y	N
Cancer	Y	N	Anxiety	Y	N
Epilepsy/Seizures	Y	N	Muscle Weakness	Y	N
High Cholesterol	Y	N	High Blood Pressure	Y	N
Heart Attack	Y	N	Fracture of Facial Bones	Y	N
Heart Murmur	Y	N	Kidney Disease	Y	N
Hepatitis	Y	N	Stomach Disorder	Y	N
Mononucleosis	Y	N	Asthma	Y	N
Fracture	Y	N	Muscular Disorder	Y	N
Diabetes	Y	N	Bone Disease	Y	N
Blood Transfusion	Y	N	Infection	Y	N

Past Surgical History:

____

____

____

Any hospitalizations in the past year other than for above surgery? Y N If yes please give details:

____

____

List all PAIN medications:

Medication	Dose	Frequency	Prescribing Physician

List all other medications, including over the counter medications, vitamins and herbal supplements:

Medication	Dose	Frequency

Do you take any blood thinning medications such as Plavix, Coumadin, Warfarin, Aggrenox, Heparin or Aspirin?

Y N If yes, please list:______________________________

Prescribed by: ______________________________

Medication Allergies: ______________________________

Medical Problems that run in your family: ______________________________

Social History:

Do you object to a blood transfusion? Y N
Drink alcohol? never occasionally frequently daily
Use street drugs or have a history of addiction or abuse? Y N
Use tobacco? Y N If yes, packs per day: ________ smokeless tobacco? Y N
Are you now or is there a possibility of you being pregnant? Y N Maybe NA
Number of Children________
Marital Status Married____ Single____ Divorced____ Widowed____ Separated____
Occupation:______________________________

Are you currently working? Y N If not, last day worked: ______________________________

Do you currently have:

Fever	Y	N	Wheezing	Y	N
Coughing	Y	N	Muscle Aches	Y	N
Hearing Loss	Y	N	Heartburn	Y	N
Sore Throat	Y	N	Sinus Problems	Y	N
Chest Pain	Y	N	Vomiting	Y	N
Headaches	Y	N	Paralysis	Y	N
Urinary Pain	Y	N	Blood in Urine	Y	N
Excessive Dry Skin	Y	N	Numbness	Y	N
Diarrhea/Constipation	Y	N	Skin Rash	Y	N
Joint Pain Swelling	Y	N	Fatigue	Y	N
Irregular Heartbeat	Y	N			

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e., narcotics, tranquilizers, etc.) are very useful. However, they have a potential for misuse or abuse and therefore are closely monitored and controlled by state and federal government agencies. We are required by law to monitor the Prescription Monitoring Program. Clinical evidence does not support the effectiveness of taking pain medications everyday y for an extended period of time in the treatment of chronic pain. In fact, the opposite is true. The longer the period of time in which a patient has taken daily narcotic and anxiety medications, the greater their sensitivity to painful stimuli and the less responsive they are to effective anxiety and depression, mood swings, decreased libido, altered mental status and a decreased motivation for participating in usual activities. Furthermore, there can be organ damage which can occur within the stomach, liver and kidneys, particularly with medications containing acetaminophen (Tylenol).

Because we prescribe such medications to help manage post operative pain while you are healing, we want to guard against abuse or inappropriate use. We require that you agree to the following conditions:

1. We DO NOT automatically assume or prescribe medications when patients see us for their initial evaluation visit. You and your referring physician or primary care physician must understand that we prescribe medication for the treatment or postoperative pain. We do not prescribe medication for chronic pain conditions, nor for residual pain after the healing period.
2. Prescription refills **ARE NOT A MEDICAL EMERGENCY. DO NOT CALL THE OFFICE REQUESTING MEDICATION REILLS. PLEASE ASK YOUR PHARMACY TO FAX A REFILL AUTHORIZATION TO OUR OFFICE AT 405-813-2633. THE REQUEST WILL BE REVIEWED WITHIN 24 HOURS OF RECEIPT. IF YOU HAVE NOT BEEN SEEN BY DR. BARRY OR A MEMBER OF HIS CLINICAL STAFF IN THREE MONTHS OR YOU ARE REQUESTING A MEDICATION CHANGE, YOU WILL BE REQUIRED TO BE RE-EVALUATED PRIOR TO ANY PRESCRIPTION REFILLS OR CHANGES.**
3. Our office will not provide early prescriptions; replace lost, stolen, or damaged prescriptions.
4. Our office will not provide prescriptions on weekends or holidays.
5. You will take your medication as prescribed.
6. You will not request or accept controlled substance medication from any other physician or prescriber, this includes but is not limited to emergency departments, dentist offices, AM/PM clinics, or individuals while you are receiving controlled substance medications from Dr. Barry.

We adhere strictly to our policy. We do not tolerate medication abuse or misuse, or activities which are suspicious for diversion or controlled substances. Patients who demonstrate patterns of behavior indicative of this type of abuse or misuse will no longer receive controlled substance prescriptions from our office and may be evaluated for discharge from our practice.

You understand that once the postoperative healing period is complete, you may need medication to manage chronic pain conditions and that medication will have to be obtained from a provider who specializes in narcotic medication management. We will not be responsible for long term medication management.

I have read this contract and have had the opportunity to ask questions regarding the contract. My questions have been answered and I understand. In addition, I fully understand the consequences of violating these requirements.

Patient Signature:______________________________ Witness:____________________

Print Name:______________________________ Date:____________________

CONSENT FORM FOR USE AND DISCLOSURE OF HEALTH INFORMATION

We may release your health information to other physicians, medical facilities and health insurance companies who are providing your medical care and health coverage. **PLEASE READ THIS CLOSELY.**

Kindly list individual(s) and/or organization(s) that you allow your health information to be released and/or discussed with. If we do not see their names on the list, **NO INFORMATION WILL BE PROVIDED.** This includes **ALL** family members.

NEUROSURGICAL SERVICES, PLLC, MAY DISCUSS MY HEALTH INFORMATION WITH THE FOLLOWING:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

PLEASE REQUEST ANY SPECIFIC RESTREICTION(S) you may have to the use and/or disclosure of your health information: ____

You have provided us contact numbers. Which number do you prefer to be contacted on:
____________ **PLEASE WRITE THE NUMBER.**

If you have an answering machine or voice mail, may we leave a message?

YES **NO** (please circle one)

OUR STAFF DOES NOT AND WILL NOT REPLY TO EMAIL REGARDING YOUR CARE.

OUR STAFF DOES NOT AND WILL NOT REPLY TO TEXT MESSAGES OR ANY SOCIAL MEDIA REGARDING YOUR CARE.

Your signature below will verify your consent of above information and that you have received a copy of our Privacy Policy.

____
Printed Name of Patient or Legal Representative

____
Signature of Patient or Legal Representative

____
Date

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Christopher J. Barry, M.D., and Oklahoma Heart Hospital, we are pleased to inform you of the following:

1. Christopher J. Barry, M.D. has ownership interest in Oklahoma Heart Hospital, a physician owned hospital.
2. In addition, other physicians that may treat you at Oklahoma Heart Hospital may have an ownership interest in the hospital.
3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Oklahoma Heart Hospital. You will not be treated differently by Dr. Barry or his staff if you choose to use a different facility. If desired, Dr. Barry can provide information about alternative providers.
4. Christopher J. Barry, M.D. also uses several surgical instruments and surgical implants that he has either designed or consulted on their design. In addition, he has ownership interest in several medical device companies which design, manufacture and distribute surgical hardware and implants. In doing so, Dr. Barry is able to provide an extra level of quality assurance to his patients, ensuring that they receive the highest quality of medical devices and care.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask Dr. Barry or his staff. For a full list of our physician owners and additional information regarding the Oklahoma Heart Hospital, please visit okheart.com.

By signing this Disclosure of Physician Ownership, you acknowledge that have read and understand the foregoing notice and hereby understand that Dr. Barry has an ownership in Oklahoma Heart Hospital and medical device companies.

____

Signature of Patient/Parent or Guardian

____

Print Name of Patient/Parent or Guardian

____

Date

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Neurosurgical Services PLLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Neurosurgical Services PLLC reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Practice Officer at:

Robin Barry, R.N. Neurosurgical Services PLLC

1257 E. 33rd Street, Edmond, OK 73013

Telephone

With my consent, Neurosurgical Services PLLC may call my home or another designated location and leave a message (on voicemail, answering machine or in person) in reference to any items that assist the practive in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, Neurosurgical Services PLLC may mail tomy home or another designated location any items that assist the prective in carrying out treatment, payment and healthcare operationssuch as appointment reminder cards, correspondence and billing statements.

Email

With my consent, Neurosurgical Services PLLC may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Neurosurgical Services PLLC restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form).

I understand that 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 consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Neurosurgical Services PLLC.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Neurosurgical Services PLLC may decline to provide treatment to me.

______________________	______________________	______________
Print Name	Signature of patient or legal guardian	Date

Attention Privacy Office: If a patient wishes to limit, how they are contacted by our practice or the release of their information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.

Neurosurgical Services PLLC

Christopher J. Barry, MD
Neurosurgeon

November 2, 2016

NOTICE TO ALL PATIENTS

I, patient ____attest that I am not requesting to be evaluated by Neurosurgical Services, PLLC for ANY complaint related to a motor vehicle accident of any nature. I attest that I am not requesting to be evaluated by Neurosurgical Services, PLLC for ANY complaint related to a work related injury.

_____________________________DATE___________

PATIENT SIGNATURE

Phone: 405.813.2600 • Fax: 405.813.2633 • www.nssokc.com
1257 E. 33rd Street • Edmond, OK 73013