Midwest Neurosurgery Associates

Providing Exceptional Neurosurgical Care For the Greater Kansas City Area

Your Appointment with Dr.________________

is scheduled for: ________________________

* If you are unable to keep your scheduled appointment, please contact our office as soon as possible to re-schedule. 816-363-2500.

Prior to your appointment:

□ **Complete Paperwork:** Please complete the attached paperwork and bring it with you to your appointment. You will also need to bring a picture ID and CURRENT Insurance Card with you.

□ **Obtain Films:** It is your responsibility to bring all relevant imaging studies (CT, MRI, X-ray, etc) with you to your appointment. The neurosurgeon will need the actual studies (a CD or printed films) in order to evaluate you on the day of your appointment. Please note that a printed *radiology report* is NOT sufficient and does not replace the actually study. If you do not have a copy of your study, contact the facility where it was performed and ask for a copy.

***** If you do not bring your Completed Paperwork AND Films with you, your appointment may be rescheduled to the next available date.**

□ **Re-scheduling for Emergency:** In the event your neurosurgeon is called to an emergency we may need to reschedule your office appointment. Our staff will contact you as soon as possible if this occurs and promptly re-schedule your appointment.

Mission Statement

The physicians and staff of Midwest Neurosurgery Associates are committed to providing the highest quality of neurosurgical care. Your health and comfort are our primary concerns.

Our goal is to provide outstanding care in a patient-centered environment. We take pride in being able to offer individualized care, state–of-the-art techniques, and close communication with referring and primary care physicians to ensure the best possible outcomes.

Our neurosurgeons will discuss surgical and non-surgical management options, so that patients and their families will be able to understand the potential risks and benefits and make an informed choice.

We are dedicated to providing comprehensive neurosurgical care and appreciate the trust you have placed in us. We will do everything in our power to merit your confidence.

Research Neuroscience Institute
6420 Prospect, Suite T411
Kansas City, MO 64132
816-363-2500

Office hours 9am-5pm Monday - Friday
Website: www.midwestneurosurgery.net

Rev 11/20/12

Patient History

Name____________________________ Birth Date: ____________ Age_______ Sex _______

Who requested that you see our physicians? ______________________ Phone _______________

Family Physician or Internist: ________________________________ Phone _______________

What is your major problem or complaint? ____

When did your problem start? ________ Was there a specific injury? _____ Date of Injury________

DO YOU CONSIDER THIS WORK OR AUTO RELATED INJURY? _____ Why?__________

Have you seen other doctors for this problem? ______ Who? ______________________________

Past Medical History ☐ MEDICAL HISTORY NEGATIVE

Cardiovascular (heart):
- ☐ Atrial fibrillation / arrhythmia
- ☐ Congestive heart failure
- ☐ Coronary Artery Disease
- ☐ Deep Vessel Thrombosis (DVT/ blood clot)
- ☐ Hypertension (high blood pressure)
- ☐ Peripheral Vascular Disease

Respiratory:
- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ Sleep Apnea / CPAP
- ☐ COPD

Gastrointestinal:
- ☐ GERD (reflux)
- ☐ Colon/ Rectal: ___________
- ☐ Irritable Bowel Syndrome
- ☐ Peptic ulcer
- ☐ Liver disease
- ☐ Hepatitis

Metabolic:
- ☐ Diabetes: Type I / Type II
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Thyroid dysfunction
- ☐ Obesity

Musculoskeletal:
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis

Cancer:
Indicate type, treatment, year
- ☐ Breast: Right/ Left
- ☐ Colon
- ☐ Lung
- ☐ Prostate
- ☐ Other: _____________

Neurologic / Psychiatric:
- ☐ Anxiety disorder
- ☐ Bi-polar disorder
- ☐ Depression
- ☐ Dementia (memory loss)
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Peripheral neuropathy
- ☐ Parkinson's disease
- ☐ Seizures: last seizure______
- ☐ Stroke

Infectious:
- ☐ Shingles
- ☐ Methicillin resistant staph aureus (MRSA)
- ☐ HIV / AIDS

Other:
- ☐ Chronic Kidney disease
- ☐ Glaucoma
- ☐ Other: ___________

Past Surgical History: *INCLUDE DATE(S)*

☐ NO PRIOR SURGERIES ☐ Tonsillectomy ___________ ☐ Appendectomy (appendix) _________ ☐ Cholecystectomy (gallbladder) _________ ☐ Laparoscopy _________ ☐ Vasectomy __________ ☐ Tubal Ligation __________ ☐ C-Section __________ ☐ D&C __________ ☐ Hysterectomy_________	☐ Other:________________________________ ☐ Other:________________________________ ☐ Other:________________________________ Do you have metal in your body? Yes / No If yes, is it MRI compatible (titanium)? Yes / No

NAME:________________________

Family Medical History:

Diseases in your family:	□ Heart Disease	□ Hypertension (high blood pressure)
	□ Diabetes	□ Cancer (type):____________________
	□ Hereditary Disorders:____________________________________	
	□ Other:____	
□ Adopted / Family history not available.		□ Family history negative.

Social History:

Marital Status: □ Currently married □ Divorced □ Single □ Widowed	Alcohol Use: □ No alcohol □ Consume: Beer / wine / hard liquor Amount / frequency: ____________ □ Social drinker □ Drink in moderation (2 drinks / day or fewer) □ Drink in excess (more then 2 drinks per day)
Number Of Children:	
Occupation:	
Tobacco History: □ Never a smoker □ Former smoker: Date quit______________ □ Current smoker: Packs per day__________ Number of years________ □ Chewing tobacco	Illicit or IV Drug Use: □ Never used □ Currently using illicit drugs □ History of illicit drugs □ Type/Frequency:__________________ □ Previously treated for substance abuse

Review Of Systems (check all present): ALL OTHER SYSTEMS NEGATIVE

Constitutional: □ Chills □ Fatigue □ Fever □ Weight Gain _____lbs □ Weight Loss _____lbs	Respiratory: □ Cough □ Coughing up Sputum □ Short of Breath □ Wheezing □ Home oxygen use (___L)	Musculoskeletal: □ Joint pain □ Muscle aches □ Muscle weakness
Eye: □ Blurry Vision □ Double Vision	Gastric: □ Abdominal pain □ Constipation □ Decreased appetite □ Diarrhea □ Difficulty swallowing □ Heartburn □ Nausea □ Vomiting	Neuro: □ Headache □ Dizziness □ Syncope □ Numbness / Tingling □ Claustrophobia
Ear Nose Throat: □ Earache □ Hoarseness □ Loss of Hearing □ Nasal Congestion □ Ringing in Ears □ Sinus Pain		Integument: □ Skin Rash
		Psych: □ Anxiety □ Depression □ Sleep disturbances
Cardiovascular: □ Chest Pain □ Edema (leg swelling) □ Palpitations (irregular heart beat)	Genital / Urinary: □ Dysuria (Pain on urination) □ Hematuria (Blood in urine) □ Nocturia (more then 2 urinations during night) □ Urinary frequency □ Urinary incontinence □ Urinary hesitancy □ Painful intercourse	Hematologic /Lymph: □ Anemia □ Excessive bleeding during surgery
Endocrine: □ Excessive Thirst □ Decreased Libido		Immune System: □ Impaired immunity
□ REVIEW OF SYSTEMS NEGATIVE		

Preventative Care

Did you receive the ***Flu Vaccine*** during flu season (between Sept 2012 – Feb 2013)? Yes / No
If you are a woman age 40-69, have you ever had a ***mammogram*** to screen for breast cancer? Yes / No
Have you ever received the ***Pneumonia Vaccine***? Yes / No

Height:	Weight: lbs

For office use:	BP= /	P=	T=

NAME:______________________________

Medications:

□ Not Currently Taking Any Medications

Include prescription, over-the-counter drugs, vitamins, herbals, etc.

Medication Name	Dose / Amount / Frequency	Reason for Taking	Prescribing Doctor

□ Please attach additional page, if more space is needed for complete medication list.

Drug Allergies and Reactions:

□ No Known Drug Allergies

Medication Name	Reaction / Date

Allergy to: □ Latex □ Betadine □ Shellfish □ IV Contrast / Dye □ Other: ______________________

Preferred Pharmacy:

Name:____________________ Address: ___________________ City, State:________ Phone:______________

Rev 11/20/12

Patient Name:____**DOB:**________________

Short-Form McGill Pain Questionnaire-2 (SF-MPQ-2)

This questionnaire provides you with a list of words that describe some of the different qualities of pain and related symptoms. Please put an **X** through the numbers that best describe the intensity of each of the pain and related symptoms you felt during the past week. Use **0** if the word does not describe your pain or related symptoms.

1. Throbbing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
2. Shooting pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
3. Stabbing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
4. Sharp pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
5. Cramping pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
6. Gnawing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
7. Hot-burning pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
8. Aching pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
9. Heavy pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
10.Tender	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
11. Splitting pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
12. Tiring-exhausting	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
13. Sickening	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
14. Fearful	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
15. Punishing-cruel	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
16. Electric-shock pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
17. Cold-freezing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
18. Piercing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
19. Pain caused by light touch	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
20. Itching	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
21. Tingling or "pins & needles"	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
22. Numbness	none	0	1	2	3	4	5	6	7	8	9	10	worst possible

Center for the Relief of Pain
6420 Prospect Ave., Suite T411-B
Kansas City, MO 64132
Phone: 816-363-2500

Pain Disability Index Sheet

Patient Name:____________________________________**DOB:**________________**Date:**____________

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Where does it hurt?

Patient Name:______________________________ Date:_________________

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

NUMBNESS

= = = =

PINS AND NEEDLES

0 0 0 0

STABBING

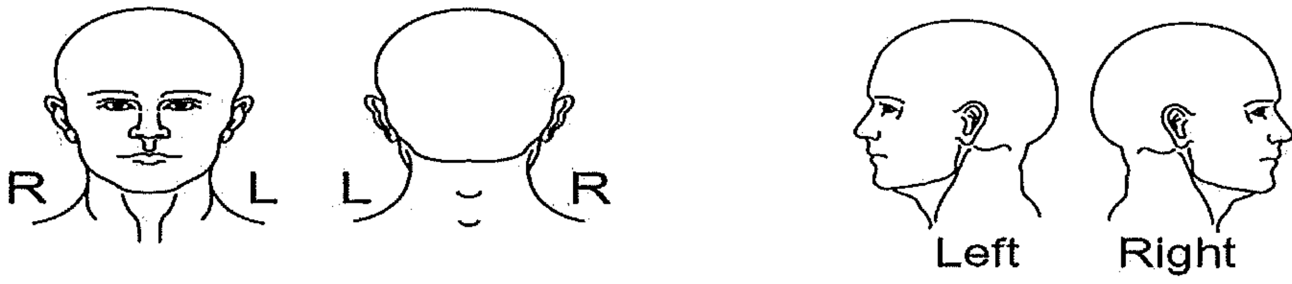
/ / / /

ACHING

^ ^ ^ ^

RIGHT LEFT

LEFT RIGHT



Please describe in detail the type of pain you are having and the exact location.

____

____

____.

Patient Registration Form (eCW)

PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ____________ **(First)** ____________ **(MI)** _____ **Previous Name** ____________

Address ____________

City, State ____________ **ZIP** ________ **E-Mail Address** ____________

Home Phone ____________ **Cell** ____________ **Work Phone** ____________ **Ext.** ______

Primary Care Doctor ____________ **Address** ____________ **Phone** ____________

Referring Doctor ____________ **Address** ____________ **Phone** ____________

How did you hear about our facility? ☐ Doctor ☐ Internet / Website ☐ Support Group ____________ ☐ Other ____________

Date of Birth ____________ **Sex** ☐ Female ☐ Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____ - _____ - _____ **Employer Name** ____________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Do you have a living will? ☐ Yes ☐ No

Preferred Pharmacy: ____________ **City** ____________ **Phone Number:** ____________

EMERGENCY CONTACT INFORMATION

Last Name ____________ First Name ____________ Emergency Contact Date Of Birth ____________

Emergency Contact Relationship to Patient ☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ ____________

Address ☐ Same as patient address above ____________

City, State ____________ ZIP ________ Home Phone ____________

Cell Phone ____________ Work Phone ____________ Ext. ________

INSURANCE INFORMATION

Auto related? ☐ Yes ☐ No **Work related?** ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____________ (______) ____________

Name of Policy Holder: ☐ Patient ☐ Same as Emergency Contact ☐ ____________

Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ ____________

Social Security Number of Policy Holder ____________ Date of Birth ____________

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____________ (______) ____________

Name of Policy Holder: ☐ Patient ☐ Same as Emergency Contact ☐ ____________

Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ ____________

Social Security Number of Policy Holder: ____________ Date of Birth ____________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ____________ ***Date*** ____________

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I_________________________________ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_______________________________________ ____________________

Signature Date

I authorize this facility to release information to (Please check all that apply and list complete name and phone numbers)

☐Spouse: ____

☐Children: ____

☐Other: ____

☐No One

_______________________________________ ____________________

Signature Date

Medicare Patients

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me; to release Medigap Insurer

_________________________________ any information needed to determine those benefits payable for related services.

_______________________________________ ____________________

Signature Date

Medicare Lifetime Authorization

HIC#___________________________

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians' services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Signed: _______________________________________ Date: ______________________________

Print Name: ____________________________________Title or relationship: ____________________

Witnessed by: __________________________________Address:____________________________

If signed by other than beneficiary, state reason the patient was unable to sign:

____

HCA Physician Services

Research Neuroscience Institute

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Research Neuroscience Institute **may include consent at satellite offices under common ownership.**

I, the undersigned, authorize Research Neuroscience Institute **to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.**

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: **I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to** Research Neuroscience Institute.

I acknowledge that can request a copy of the Research Neuroscience Institute **Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.**
Patient Initial: ___________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_________________________________ _______________

Patient (or Responsible Party) Signature Date

Center for the Relief of Pain

Missed Appointment Policy

At the Center for the Relief of pain, your time is valued. Our physicians strive to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that our physicians can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.

Please refer to the guidelines below to learn more about our Missed Appointment policy:

- It is your responsibility to provide us with a working telephone number to allow us to communicate important information, such as laboratory results, and provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important; please help us to maintain your records.
- Effective September 1, 2011, each missed appointment will be flagged and you will receive a notice that you have missed your appointment. In addition, your account will be accessed a $25 missed appointment fee. Please note that the fee will not be billed to your insurance.
- Accounts that accumulate three missed appointment fees may be dismissed from the practice.
- Any cancellation not made at least 24 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.
- If you arrive 20 minutes late for your scheduled appointment, without prior notification to our office, this may also be considered a "missed appointment." Please remember that communicating with our office is critical to us providing you with quality health care.
- We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible. We will waive the cancellation fee for this appointment as long as you do not have a history of cancellations. Our schedule fills up quickly, and this will allow other patients to fill those slots.

We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will make every attempt to let you know the status of our schedule.

Name of Patient:_________________________________ Date of Birth:______________

Signature of Patient: ____Date:________________