



James W. Melisi, MD, FACS, PLLC

Last update: 10/08

Thank you for choosing our practice to provide your neurosurgical care. Our neurosurgeon specializes in spinal, intracranial, and peripheral neuropathy procedures. Our physician, along with our staff, will strive to provide you with the most competent, effective, and compassionate care possible when treating your condition. Please take a few moments to complete your paper work and familiarize yourself with our office policies and information below.

- **All visits** – We have an emergency based practice and you may experience delays. The nature of our practice is to give our patients the utmost in care and service. We kindly request that you please excuse any delays on your appointment day, as well as, when/if we reschedule an appointment for emergencies. We will give you the same careful attention as soon as possible. Thank you.
- **Your first visit** - Please remember to arrive to our office at least 10 minutes prior to your appointment in order for us to compile your medical records and prepare them for the doctor. If you arrive more than 15 minutes late for your appointment your appointment may have to be rescheduled. For follow-up visits we simply ask that you be on time. **Please remember to bring the following:** (most) current MRIs, CT Scans, X-Rays or other scans - please bring the actual films or CD and the written radiologist report with you to your visit; a list of your current medications; your insurance card(s) and a photo ID.
- **Parking** - Free parking is available at both of our office locations, however finding a parking space can sometimes be time consuming, so please allow enough time to secure parking.
- **Referrals** - We recommend that you call your insurance company to verify whether you need a referral in order to see a specialist. **It is always your responsibility to bring the referral with you to the appointment. If you arrive without your referral your appointment will be rescheduled or you will be considered *out of network* and subject to payment in full at the time of service.**
- **Co-payments** – You will need to bring cash, check, Visa or Master Card for your co-payment. Self pay patients will be asked to pay their visit in full. **Patients not prepared to pay their amount due will be rescheduled.** Post operative patients should be ready to pay any residual amount due after surgery.
- **Prescriptions** - If you need a refill for a prescription, please allow 24 hours for the doctor to review your request and your chart. **Prescription refill requests will be accepted Monday-Thursday 8:00a-3:00p.** Prescriptions will not be authorized after hours, on Fridays, holidays, weekends, or for prescription did not originate from this office, as the doctor must review your chart. **PLEASE NOTE: pain medications will only be prescribed for patients on the surgery schedule and post-operatively.**
- **Test Results** - If the doctor orders an MRI, CT Scan, X-Ray or any other imaging study please be sure to bring a copy of the films and the radiologist's report to your follow-up visit. Please note that if you arrive for your appointment without your films/CD we will have to reschedule your appointment.
- **Cancellations** - **Please note: due to the nature of our business there may be times that we may have to reschedule your appointment. Every effort will be made to notify you should we need to reschedule your appointment.** Please kindly notify our office 24 hours prior to your scheduled appointment time if you need to cancel or reschedule your appointment. Please call the day before your appointment to confirm the time and the location of your appointment if you do not have voice mail.
- **Forms** - We have a standard / generic work release, school release, and disability form. We no longer complete forms from insurance companies and/or employers. Please attach our standard form to any form that is required by a third party. **Non-surgery patients should have any required forms completed by their PCP or subject to a \$50.00 processing fee per request.**
- **Medical Records** - Patient's request for medical records fee is \$5.00 per request and 50 cents per page.

NSS BRAIN & SPINE CENTER

James W. Melisi, MD, FACS, PLLC

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First Name _____ **MI** _____ **Date of Birth** _____ **Appointment Date** _____
Last Name _____ **Age** _____ **Social Security #** _____ (REQUIRED*)
Address _____ **Sex:** M F **Marital Status:** S M D W

Home Phone: _____ Best # to reach
City _____ **State** _____ **Zip** _____ **Cell Phone:** _____ Best # to reach
Date of Injury or Onset of Problem _____ **Accident Related?** Work Auto Other
(If applicable) **Nature of accident** _____
Employer: _____ **Work Phone:** _____ Best # to reach
Address _____ **Occupation** _____
City _____ **State** _____ **Zip** _____ **Employer Contact** _____

Spouse Name _____ **Date of Birth** _____ **Social Security #** _____
Employer: _____ **Work Phone:** _____ **Cell #** _____

Responsible party _____ **Self** **Relationship to responsible party** _____
Address _____ **City** _____ **State** _____ **Zip** _____ **Phone** _____

► **REFERRING PHYSICIAN:** _____ **Phone Number** _____
 Referred by family/friend, but the above physician is following my illness/case

Emergency Contact: _____ **Phone Number** _____ **Relationship** _____

Primary Insurance _____ **Insured Name** _____ **Self**
Group # _____ **ID #** _____ **Address** _____ **City** _____
Insured Employer _____ **State** _____ **Zip** _____ **Phone** _____

Secondary Insurance* _____ **Insured Name** _____ **Self**
Group # _____ **ID #** _____ **Address** _____

► **CONSENT TO TREATMENT:** I consent to all non-surgical treatment, discussion of surgical options, surgery (if desired) and/or other related services suggested/given, by Dr. Melisi.
(Sign) _____

► **NOTICE OF PRIVACY:** I acknowledge receipt of *Notice of Privacy Practices*. _____ (Initial)

I CERTIFY THAT ALL OF THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT.

Patient Signature _____ **Witness Signature** _____ **Date** _____

AUTHORIZATION OF BENEFITS: I hereby assign all medical insurance benefits, on my behalf for covered services rendered, to Neurological & Spinal Surgery / James W. Melisi, MD / and also authorize the release of any medical records necessary to facilitate my treatment, to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event that my insurance company or financially responsible party does not pay for the services rendered, I will be financially responsible for payment. I further understand that should my account be placed with a collection agency or attorney, my account will be charged accordingly – to include, but not limited to interest, court filings and court appearance fees.

A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

► **All patients are required to sign this abbreviated authorization and a detailed financial agreement.**

Signature of patient, insured, or beneficiary

Date

INSURANCE REFERRALS: I understand that my insurance plan requires a referral for specialist office visits. I also understand that if I do not have a valid referral in hand, at the time of service my appointment will be rescheduled or I will be subject to the total cost of my office visit – **NO EXCEPTIONS** – and I will be considered out of network. I further understand that it is **NOT** the responsibility of Neurological & Spinal Surgery’s staff to obtain referrals by telephone, fax or any other method from my primary care physician.

(If applicable)

Signature of patient, insured, or beneficiary

Date

MOTOR VEHICLE ACCIDENT: I understand that Neurological & Spinal Surgery / James W. Melisi, MD / does not have an agreement with automobile insurance companies. I further understand that I am financially responsible for all services related to my accident, and that **payment is due when services are rendered**. I also understand that should I elect to use my health insurance, my benefits will be verified prior to my appointment for possible policy exclusions.

(If applicable)

Signature of patient, insured, or beneficiary

Date

WORKERS COMPENSATION: My case number _____ is for a specific injury. I understand that it is my responsibility to contact my case worker if I re-injure myself, injure another part of my body, or an extended amount of time has lapse since my last visit prior to making an appointment. **I also understand that my health insurance plan WILL NOT be billed for documented work related injuries.**

(If applicable)

Signature of patient, insured, or beneficiary

Date

* ► **Regarding Secondary Insurance:** This office submits to secondary insurance carriers for surgery charges only. Medicare patients are encouraged to give their secondary insurance information directly to Medicare for automatic claims submission. It is your responsibility to keep Medicare informed of any additions, changes, etc. with regards to your secondary carrier. We do not participate with any state assisted programs (Medicaid).

* ► **Regarding Social Security Number:** If you elect NOT to give this information to our office, we reserve the right to ask you to pay your entire bill upfront while we wait for your insurance to pay.

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James W. Melisi, MD, FACS, PLLC

HEALTH HISTORY

<i>Date Reviewed</i>	<i>Provider Signature</i>	<i>Date Reviewed</i>	<i>Provider Signature</i>

Dear Patient: To better understand your health status, please complete below. ► Date _____

Last Name:				First:		Birth Date		Sex:		Height:		Weight:	
Reason for visit:										Doctor Notes <i>Please do not write in this area.</i> ▼			
How long have you had the problem/illness?													
Date of most recent episode:													
Are you currently taking medication for this problem? Yes No													
Have you or any blood relative had any of the following:		YES	NO	WHO		YEAR							
Allergies, Hay Fever													
Anemia													
Alcoholism													
Arthritis													
Asthma													
Bleeding Problems/Blood Clots													
Birth Defects													
Cancer													
COPD (Pulmonary Disease)													
Diabetes													
Emphysema													
Epilepsy or Seizures													
Gallstones													
Glaucoma													
Heart Trouble													
Hepatitis													
HIV													
Hypertension													
Mental Illness													
Migraine Headaches													
Reflux/GERD													
Rheumatic Fever													
Stroke													
Suicide													
Thyroid Disease/Goiter													
Tuberculosis (or positive result)													
Ulcers													
Venereal Disease													
Are your childhood immunizations current?				Yes		No							
DATE OF INJURY: _____										(Please circle)			
Car Accident:		Yes		No		Work Related:		Yes		No			

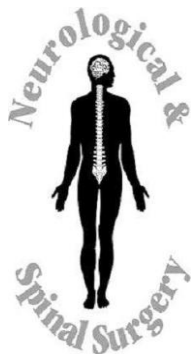
NSS Brain & Spine Center
HEALTH HISTORY

Patient Name: _____

Have you ever had bleeding problems? <i>(circle)</i> Yes No If yes, please explain -	Doctor Notes <i>Please do not write in this area.</i> ▼										
Have you ever had a blood transfusion? <i>(circle)</i> Yes No If yes, when -											
MAJOR ILLNESS OR INJURY (list any requiring hospitalization, prolonged care or use of medication): <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 20%; text-align: center;">Date</th> </tr> </thead> <tbody> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </tbody> </table>			Date								
		Date									
SOCIAL HISTORY		Yes	No	Answers							
Do you smoke?				# Pack/day:							
Do you chew tobacco?			#								
Have you ever smoked in the past?			Stop date:								
“Street” Drugs											
Do you eat at least 3 meals/day?											
Any diet preferences or restrictions?			Type:								
Number of caffeine drinks/day											
Number of alcoholic drinks/day											
Do you exercise regularly?			days/week:								
What exercise(s) do you do?											
Hobbies:											
Occupation:											
<i>(circle)</i> Single Married Divorced Widowed Living w/signif. other											
Do you have children? <i>(circle)</i> Yes No If yes, please list how many and their age(s)											
► If there are any special concerns you would like to discuss with the doctor, please continue below and on the reverse of this sheet. Thank you for providing us with this important information.											

► **Patient Signature** _____

_____ Date



Brain & Spine Center

Central Phone Line
(703) 796-1111

Reston Hospital Campus
1800 Town Center Dr.
Suite 418
Reston, VA 20190

Prince William Hospital
Campus
8644 Sudley Road
Suite 308
Manassas, VA 20110

James W. Melisi, MD

PAIN SELF ASSESSMENT

(Please complete all questions)

How bad is your pain now? Please circle the appropriate number below:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Is the above level of pain ► on medication without medication?

1. When did your present level of pain start? _____

2. Are you able to work? Yes No If no, last day of work _____

3. How long have you had this pain? _____Yrs _____Months _____Wks

4. What reduces this pain? (check all that apply)

Lying Down Sitting Walking Muscle relaxants

Aspirin/Anti-inflammatory pills Pain Medications _____

Heat Ice Physical Therapy Nothing

Other _____

5. What activities make your current pain worse?

Exercise (during) Exercise (after) Coughing Sneezing

Bending Forward Bending Backward No apparent cause

Other _____

6. What medications have you tried in the past for the pain?

7. When were the above medications used and for how long?

8. What other physicians have you consulted for your current pain?

9. Have you tried physical therapy for your current pain? Yes No

If yes, when? _____ Duration _____



(Print Patient Name)

(Signature)

Date Signed

Time

am/pm

JAMES W. MELISI, M.D., FACS, PLLC

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THE FOLLOWING INFORMATION CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make changes in our privacy practices, please contact our office using the information listed at the end of this notice.

USES & DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment and healthcare operations. We will disclose information about you for the following reasons:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare providers providing you with treatment.
- **Payment:** We may use and disclose your health information to obtain payment for services rendered to you.
- **Healthcare Operations:** We may use or disclose your health information in connection with other healthcare providers.

PATIENT AUTHORIZATIONS: You have the right to give us written authorization to use your health information or disclose to anyone for any purpose. If you give our office written authorization, you may revoke it in writing at any time. We cannot use or disclose your health information for any reason except those described in this notice.

- **Family & Friends:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons involved in your healthcare:** We may use or disclose health information to notify, or assist in the notification (including identifying or locating) of a family member, your personal representative or another person responsible for your care, of your location or general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such disclosures. In the event of your incapacity or emergency situation, we will disclose health information that is directly relevant to the persons involved in your healthcare. We will use our professional judgment and experience with common practices to make reasonable inferences in your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, medical records or other health information.
- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written permission.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **Abuse, Neglect, Emergency Healthcare or Legal Council:** We may disclose your healthcare information to the extent necessary to avert a serious threat to your health, safety or health and safety to others.
- **Appointment Reminders:** We may use or disclose health information to provide you with appointment reminders such as: voicemail messages, postcards or letters.
- **National Security:** We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances.

PATIENT RIGHTS: You have the right to look at or get copies of your medical records with limited exceptions. To obtain a copy or review your medical records, patients must submit a written request. The provider must respond within a reasonable amount of time but no longer than 30 (thirty) days. You may request that we provide copies in a format other than photocopies. We will use the format requested unless we cannot do so. We will charge you .50 (fifty cents) per page plus postage if you request your records to be mailed to you. Written information fees do not apply to x-rays, photos, diagnostic results, attorney dictated reports or disability forms. The cost of x-rays, photos, diagnostic results, attorney dictated reports, disability forms or duplication of patient records are an additional charge. Please contact the office for a full explanation of our fee structure.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).

Amendment: You have the right that we amend your health information. Your request must be in writing and explain why the information should be amended. We may deny your request in certain circumstances.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your healthcare information for purposes other than treatment, payment or healthcare operations. If you request an accounting more than one per year, we may charge you a fee for responding to each request.

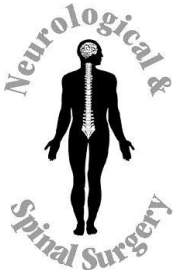
Alternative Communication: You have the right to request that we communicate with you about your healthcare by alternative means such as: email, voicemail or alternative locations. This request must be submitted in writing and specify the means and location. Also, provide an explanation on how payments will be handled under the alternative means and location that you request.

Electronic Notice: If you receive this notice by electronic means you have the right to receive a written copy.

PLEASE NOTE: A provider may not refuse to disclose health information for non-payment of a medical bill; however the healthcare provider may deny access to records if duplication fees are not paid.

QUESTIONS & COMPLAINTS: If you need more information regarding our privacy practices or have any questions, please contact our office directly. If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your healthcare information, you may complain to us using the contact information listed below. We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

James W. Melisi, M.D., FACS



James W. Melisi, MD, FACS, PLLC

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FINANCIAL AGREEMENT

I, the undersigned, hereby agree to pay to the above named doctors all fees due him for services rendered and /or expenses incurred by me, my spouse or any of my children or dependents. Payment is to be made at the time of service or incurring of expenses.

I understand that the payment of my bill is my legal obligation as the patient. All filings of insurance papers and confirmation of eligibility of benefits and/or confirmation of insurance payments to be made by my insurance company are my responsibility. Any assistance in this matter granted by the above doctors and/or staff is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation.

If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty-three and one third percent ($33\frac{1}{3}\%$) of the unpaid principal and interest that is or becomes due, plus all court costs, and interest in the amount of one and one half percent ($1\frac{1}{2}\%$) per month, beginning 30 days after the monies have become due or expenses have been incurred. In the event a payment plan is in place and the account is in default, interest at the above rate will begin on the default date, and the account balance will become due immediately, including the above costs of collection.

I understand and agree that the terms herein are reaffirmed each time services are received. I further agree to pay returned check charges of \$30 per returned check in addition to monies owed.

Undersigned agrees to pay a charge of \$20.00 of reserved appointment time when cancellation notice of at least 24 hours is not given. Undersigned also agrees that above terms are reaffirmed each time services are received by any family member receiving treatment.

Print Patient's Name

Patient and/or Responsible Party Signature

Date



Release of Medical Records

I, the undersigned, authorize Dr. Melisi and such assistants/designees to obtain any medical records that may pertain to my medical care. I understand that my records may (possibly) contain one or more of the following information regarding the diagnosis of or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released and thereby release *James W. Melisi, MD, FACS, PLLC* and their staff from all legal responsibility that may arise from the act hereby authorized.

Patients Signature

Date

Release of Private Health Information

I, the undersigned authorize Dr. Melisi and, and such assistants/designees to speak with the listed persons regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by *James W. Melisi, MD, FACS, PLLC* to the listed person(s) and thereby release *James W. Melisi, MD, FACS, PLLC* and their staff from all legal responsibility that may arise from the act hereby authorized. I further understand that I am responsible for updating this form with additions and/or deletions as they arise.

Authorized Person

Relationship to Patient

Phone Number

Authorized Person

Relationship to Patient

Phone Number

Patients Signature

Date