

SOUTH SHORE NEUROSPINE GROUP, LLC



Stephen H. Johnson, MD, FACS

Katharine Bills Woods, PA-C

780 Main Street

South Weymouth MA 02190

781-331-0250/F 781-340-0506

www.ssneuro.com

Dear Patient:

Welcome to South Shore NeuroSpine Group, LLC. Please bring the following with you to your appointment:

- Insurance cards – Primary and/or Secondary Insurances.
- Co-payment. We accept cash, check, Visa, MasterCard and debit cards.
- MRI films or other imaging studies. **Please bring FILMS only – we cannot read disks (CDs).**
- Completed Medical History form and Registration form. Please visit our website for all forms.
- Worker's Compensation insurance information if applicable.
- Personal Injury Protection (PIP) exhaust letter if applicable.

It is very important that you bring your MRI films to this appointment. If you DO NOT have your MRI films, please call the facility where you had your MRI performed and make arrangements to pick up the films **PRIOR** to your visit. **If you had your MRI films sent to our office, please call to confirm that we have received them.** If you do not have your MRI films at the time of your appointment you will have to reschedule to another day. **If you had your MRI or other imaging studies performed at South Shore Hospital, you DO NOT need to bring the films to the office as we have access to these studies through the hospital electronic medical records system.**

Please call your Primary Care Physician to obtain an **INSURANCE REFERRAL** if needed to comply with your insurance plan.

If you need to reschedule or cancel your appointment, please call within 48 hours so that others may benefit from this appointment.

We look forward to providing your medical care. If you have any questions, please call our office.

Sincerely,

South Shore NeuroSpine Group, LLC

DIRECTIONS: *From the South:* Travel North on Route 3 to Exit 16 – Route 18 South.
Go through two traffic lights.
Just after the second light, turn left into the parking lot
at the South Shore Hospital Out Patient Services building.
Our office is on the Lower Level, at the end on the right.

From the North: Travel South on Route 3 to Exit 16B – Route 18 South.
Go through two traffic lights.
Just after the second light, turn left into the parking lot
at the South Shore Hospital Out Patient Services building.
Our office is on the Lower Level, at the end on the right.

South Shore NeuroSpine Group, LLC

Patient Medical History - Please Complete This Form Accurately As It Will Become A Part Of Your Medical Record

Name _____ Age _____ Today's Date _____

Your job description _____

Are you currently working (circle)? YES NO Stopped working on: _____

Have you ever had heart surgery (circle)? YES Date: _____ NO

Are you taking a blood thinner (circle)? YES Name of drug: _____ NO

Have you ever had spinal or brain surgery (circle)? YES NO

If yes please list date(s), type(s) of surgery, and surgeon's name.

Have you ever had anesthesia (circle)? YES NO Anesthesia complications? YES NO

Allergies (Medications or Dyes): _____

Medications (With Doses): _____

Pharmacy Name and Phone: _____

Are you being treated for any of the following? Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recreational Drug Use |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer - Type _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Hepatitis - Type _____ |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Aneurysm of Brain or Abdomen | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Other _____ | <input type="checkbox"/> CPAP |

Please estimate your: Height _____ Weight _____

Have you recently experienced any of the following?:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Weight Loss |

Do you smoke cigarettes? _____ Did you ever? _____ When did you quit? _____

Do you drink alcohol, beer or wine (circle)? YES NO Daily Weekly Occasionally

Does anyone in your immediate family have any of the following problems? Please identify family member relationship.

- | | |
|--------------|----------------------|
| Cancer _____ | Diabetes _____ |
| Stroke _____ | Heart Disease _____ |
| | Spine Problems _____ |

Patient Signature: _____

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FIRST NAME: _____ M.I. _____ LAST NAME: _____

ADDRESS: _____

CITY OR TOWN: _____ STATE: _____ ZIP CODE: _____

TELEPHONE HOME: _____ WORK: _____ CELL: _____

GENDER: _____ DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ TELEPHONE: _____

PRIMARY INSURANCE: _____ POLICY ID: _____

SUBSCRIBER'S NAME: _____ DOB: _____

SUBSCRIBER'S EMPLOYER: _____ COPAY: _____

SECONDARY INSURANCE: _____ POLICY ID: _____

SUBSCRIBER'S NAME: _____ DOB: _____

SUBSCRIBER'S EMPLOYER: _____ COPAY: _____

WORKERS COMPENSATION

AUTO ACCIDENT

If work related or related to an auto accident, you will be given another form to fill out.

IMPORTANT REFERRAL NOTICE

If you have health insurance that requires referrals from your primary care physician for services by a specialist, it is your responsibility to provide this office with a referral for all services.

I authorize the release of all medical information necessary to process insurance claims for my services.

I also authorize payment of medical benefits directly to South Shore NeuroSpine Group, LLC.

Patient Signature

Date

Printed Name

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NOTICE OF PRIVACY POLICIES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

We may use your information in the daily operation of our practice. As example, in scheduling, in payments, in your treatment, and when required to do so by law.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

NOTICE OF PRIVACY POLICIES

Your rights regarding your health information.

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Stephen H. Johnson, MD, 780 Main Street, South Weymouth, MA 02190 Phone: 781-331-0250.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Stephen H. Johnson, MD, 780 Main Street, South Weymouth, MA 02190 Phone: 781-331-0250.
5. You have the right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Stephen H. Johnson, MD, 780 Main Street, South Weymouth, MA 02190 Phone: 781-331-0250.
6. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Stephen H. Johnson, MD, 780 Main Street, South Weymouth, MA 02190 Phone: 781-331-0250. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

**If you have any questions regarding this notice or our health information privacy policies,
please contact Stephen H. Johnson, MD, South Shore NeuroSpine Group, LLC
780 Main Street, South Weymouth, MA 02190 Phone: 781-331-0250**

The signature below acknowledges receipt of a copy of the Notice of Privacy Policies created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature

Date

Printed Name

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OFFICE POLICIES

Dear Patient:

Welcome to South Shore NeuroSpine Group, LLC. In our continuing effort to provide you with the best medical care, we ask that you familiarize yourself with the following office policies. This document must be signed by you and will be kept in your chart. We will also provide you with a copy, if requested, for future reference.

Due to scheduling conflicts, unforeseen emergencies and routine physician rotations, you may be treated by a provider of our group that you may not have seen before. Please be assured that we will provide continuity of care and that the results of your visit will generally be forwarded to your referring physician.

If it is determined that you need further testing or a procedure, our staff will make the necessary arrangements. It is imperative that you follow through with the treatment plan that was agreed upon. If, for any reason, you decide not to comply with the scheduled test or procedure, it is your responsibility to call our office and inform us of any such decision. When all scheduled tests have been completed, your physician will go over the results with you at your scheduled follow-up visit. If you are not going to, or have not kept your follow-up appointment and have not heard from the doctor after the (10) days following completion of all testing, you must call our office to discuss each and every one of the results with the physician who ordered them.

If your physician refers you for treatment to the Pain Clinic at South Shore Hospital, our office staff will make the initial appointment. We will notify you with the details of that appointment as well.

Often, when a patient begins to feel better, they decide they do not need to come back for scheduled follow-up care. We strongly advise against this. We cannot stress enough the importance of complete compliance with follow-up care. You and your physician together will decide when it is in your best interest to discontinue or change your treatment plan.

As part of our Office Policy, your relationship with our practice may be terminated for reasons of treatment noncompliance, follow-up noncompliance, office policy noncompliance, verbal abuse, and/or nonpayment of medical bills.

As always, your care is our first priority. If you have any questions, or if we can be of any assistance, please call us. Thank you.

Sincerely,

The Physicians and Staff of South Shore NeuroSpine Group, LLC

Patient Signature

Date

Printed Name

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NOTICE REGARDING HMO AND INSURANCE COMPANY REFERRALS

We are providing you with this notice to inform you of our office policy regarding HMO and insurance company referrals.

If you have an HMO or insurance carrier that requires a referral in order to be seen by a specialist, it is **your responsibility** to ask your primary care physician to provide you or our office with that referral prior to your appointment in our office.

Each HMO and/or insurance carrier may have a different referral process. It is your responsibility to be sure that you have a valid referral prior to each of your visits to our office.

It is in your best interest to be aware of how your particular insurance carrier provides appropriate referrals.

If you do not have a referral in place, you may be financially responsible for the visit.

Please feel free to call if you have any questions regarding the referral process.

Patient Signature

Date

Printed Name

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AUTHORIZATION TO FURNISH MEDICAL INFORMATION

This authorizes the physicians of South Shore NeuroSpine Group, LLC, to release to any hospital and all medical attendants involved in my care, full and complete reports and information that may be requested by and/or to any of those entities.

This authorization also includes examination and/or release of all hospital or office records, MRI films, x-ray films, tests, test results, and any other written documentation related to my medical care.

Additionally, South Shore NeuroSpine Group, LLC is authorized to release any and all information compiled by them relevant to my continued medical care that may be requested of them after services have been provided.

A photocopy of this authorization may be accepted with the same authority as the original.

Unless specifically terminated, this consent will extend for an unlimited period of time while the below signed individual is under the care of South Shore NeuroSpine Group, LLC.

Patient Signature

Date

Printed Name

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PRESCRIPTION POLICY

If prescription medications are prescribed for you as a part of your treatment plan, it is your responsibility to be aware of the hazards and precautions for their use. We can provide detailed information if requested.

Pain medications and sedation medications should not be used while operating a vehicle or machinery and may cause drowsiness or constipation. Narcotics are controlled substances that are carefully monitored by the U.S. Drug Enforcement Agency, and as such, are carefully prescribed and handled by this office.

Requests for refills of prescribed medications must be phoned in during office hours (Monday through Friday, 9:00 a.m. to 4:00 p.m.). Off-hours and weekend requests may be denied.

Every effort will be made to fill your prescription on the day the request is received. However, as surgeons, we may not be able to get to the office for that task. In cases where the surgeon is unavailable, you should contact your PCP for the medication.

It is agreed by you, and your treating physician that you will not receive narcotics from other physicians (except your PCP as outlined above) while you are receiving prescriptions from this practice. If there is evidence of multiple physicians prescribing medications, your prescriptions from South Shore NeuroSpine Group, LLC may be terminated.

Please report any and all side effects from the medication you are taking as soon as possible. If we are unavailable, please contact your PCP.

I acknowledge receipt of this policy and agree with the terms and conditions as stated above.

Patient Signature

Date

Printed Name

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NOTICE AND AGREEMENT REGARDING PATIENT'S

FINANCIAL RESPONSIBILITY

South Shore NeuroSpine Group, LLC (SSNG) will process all billing matters for medical services rendered by SSNG. We will file claims for services with your insurance company on your behalf. If you have made prior arrangements to establish a Self Pay account, we will bill you directly.

We will obtain authorizations for surgical services, in advance, from your insurance carrier. It is your shared responsibility to also contact your insurance carrier to confirm that the prescribed services are covered by your plan. In the rare event that authorized procedures are later denied for payment by your insurance carrier, we will attempt to resolve the matter on your behalf. If your insurance carrier denies reimbursement after our attempt to resolve the claim, you will be responsible for all balances due.

It is your personal responsibility to pay all co-pays, deductibles, co-insurance and outstanding balances that are due after your claim has been processed by your insurance carrier, or if your claim is denied by your insurance carrier. We will issue invoices and statements to you identifying all amounts due from you that are not covered by your insurance carrier. Payment of any amount invoiced must be received within thirty (30) days of invoicing. In the event of financial hardship, eligible patients may make arrangements to set up a payment plan for balances due, by contacting SSNG upon receipt of an invoice. Eligibility for a payment plan and arrangements regarding payment will be determined at the sole discretion of SSNG.

You hereby agree to pay SSNG's costs and expenses, including but not limited to reasonable attorneys' fees, incurred in connection with enforcing this agreement and collecting unpaid balances due, to the extent not prohibited by applicable law.

Patient Signature

Date

Printed Name