Neurosurgery Consultants, LLC
Dr. Matthew Burton
4150 Nelson Rd Ste C10
Lake Charles, LA 70605
Phone:(337)240-7280 Fax: (337)240-7288

ALL PATIENTS WILL BE REQUIRED TO PROVIDE A VALID ID AT THEIR VISIT TODAY

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Social Security Number: _____
Address: _____
City_____ State _____ Zip: _____
Primary Phone: _____Cell: _____ Emergency Contact: _____
Email Address _____
Pharmacy _____

INSURANCE

patients filing with their insurance will be required to provide a copy of their insurance cards at their visits
patients filing with their insurance will be responsible for any copays

Primary Insurance: _____ Member ID: _____
Secondary Insurance: _____ Member ID: _____
Are you being represented by an Attorney? YES NO
If yes, who? _____
Is this an injury that occurred at work? YES NO
If yes, please explain: _____
If yes, are you filing with Work Comp? YES NO

OTHER PHYSICIANS

Who referred you to see a Neurosurgeon: _____
Name of your Family Physician: _____
Name of your Cardiologist: _____
Do you see a Pain Management Specialist? YES NO If yes, Who? _____

HISTORY & PHYSICAL

Where is your pain located? _____
When did this problem start? _____
Did this problem arise from an injury or accident? YES NO
If yes, please explain: _____
On a scale of 1 to 10, 10 being the worst, how sever is the pain?_____
CIRCLE ALL THAT APPLY:

INCREASES PAIN: Sitting Lying down Walking Bending Weather Coughing/Sneezing

DECREASES PAIN: Sitting Lying down Walking Bending Weather

PAIN QUALITY: Sharp Aching Burning Shooting Constant Intermittent

ASSOCIATED SYMPTOMS: Weakness Numbness Tingling Pain wakes at night

PREVIOUS TREATMENT

Have you ever had this problem before? YES NO

If yes, did you seek treatment? YES NO If yes, with who? _____

Have you had any of the following testing done for this problem?

MRI: YES NO When? _____ Where? _____

CT: YES NO When? _____ Where? _____

EMG: YES NO When? _____ Where? _____

Bone Density: YES NO When? _____ Where? _____

Have you had any of the following treatment done?

Physical Therapy? YES NO

If YES: When? _____ Where? _____ How long? _____ Was it helpful? YES SLIGHTLY NO

Chiropractic? YES NO

If YES: When? _____ Where? _____ How long? _____ Was it helpful? YES SLIGHTLY NO

Injections or Nerve Blocks? YES NO

If YES: When? _____ Where? _____ Was it helpful? YES SLIGHTLY NO

Have you used any over the counter or prescription medication for this problem? YES NO

If **YES**, please list the medication, how long you tried the medication, if you are currently still taking the medication, and if the medication is helpul, slightly helpful, or not helpful at all.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL HISTORY

Pleas list all surgeries you have had and the date of the surgery:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please circle if you have ever been treated for of been told you have any of the following:

Diabetes	Osteoporosis	Stroke/TIA
HIV/AIDS	Asthma/COPD	Depression
Vascular Disease	High Blood Pressure	Anxiety
Heart Disease	Heart Attack	Sleep Apnea
Seizures	High Cholesterol	Hepatitis
Thyroid Disease	Glaucoma	Bleeding Disorder
Fibromyalgia	Pacemaker	Liver Disease
Anemia	Migraines	Cancer TYPE: _____
Reflux	Blood Clots	OTHER: _____

MEDICATIONS

List ALL the medications you are taking, including over the counter medications:

Medications	Dosage (mg)	Times per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Are you taking aspirin, including BC Powder? YES NO

ALLERGIES

List all medications you are allergic to:

_____

Other allergies:

_____

Are you allergic to LATEX? YES NO

Any history of reaction to anesthesia? YES NO If yes, explain _____

SOCIAL HISTORY

Marital status: _____ What is your occupation: _____

Do you smoke: YES NO QUIT: when _____

Illicit drug use: YES NO

Alcohol use: YES NO

AUTHORIZATON FOR THE RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

NAME:_____ D.O.B_____ Phone #:_____

RELEASE INFORMATION TO:

Neurosurgery Consultants, LLC
Matthew Burton, MD
4150 Nelson Road Ste. C10
Lake Charles, La 70605
Phone: 337-240-7280
Fax: 337-240-7288

Information to be released:

Check all that apply

___Clinical Notes
___Radiology Reports
___Radiology Images (on a CD)
___Pathology Reports
___Lab Results
___Other Diagnostic Testing Reports
___Operative Reports
___Other:_____

Dates of release: FROM _____-TO _____

Whom is to release records:

NAME: _____

ADDRESS: _____

PHONE #: _____

FAX #: _____

PATIENT/ AUTHORIZED SIGNATURE: _____

DATE: _____

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HIPPA
Receipt of notice of privacy practices
Written acknowledgement form

I, _____, have received and reviewed a copy of the Notice of Privacy Practices and Bill of Rights from Neurosurgery Consultants, LLC.

Our goal is to assure privacy and deliver care in the best possible manner. Our center uses the methods outlined in our Notice of Privacy Practices for patient identification purposes or to communicate your protected health information. Please indicate below any objections to the information contained in our Notice of Privacy Practices. (Alternative methods MUST BE GIVEN if you indicated any objections.) If necessary, my Protected Health Information may be released to the following person(s)

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship: _____

*If you would like anyone other than yourself to be able to call our office and discuss your account or medical information you must PRINT their name in the space provided above. This includes spouses.

_____
Signature of Patient or Legal Guardian

_____
Date

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Medication Policy

Pain medication must be taken only as prescribed. You should never increase the dosage or frequency without discussing it with your provider first. You will not receive a refill sooner if you take the medication more often than prescribed. Any lost or stolen medications will not be replaced.

No medications will be prescribed if the patient has not been seen within the last 90 days. If you have not been seen within the last 90 days a follow-up appointment will have to be made to discuss refills. Patients must keep all scheduled follow-up appointments and ordered imaging/ therapy appointments.

Patients must only use one provider for narcotic prescriptions. If you are already on a prescribed narcotic, you will be referred back to that physician for further medication needs. We will prescribe only postoperatively.

Post- operative medications will be prescribed as the prescriber sees fit. During the three week post-surgical time period the medication will be gradually reduced to help the patient avoid dependency to the drug.

If long- term pain management is required, the patient will be referred to his/ her choice of pain management physician or their primary care provider. It is the patient's responsibility to see who is in network with their insurance provider.

If you are already under contact with a pain management physician any further needs will need to be authorized by that provider. We will provide ONE postoperative narcotic prescription and then care will to resume with your primary provider. It is the patient's obligation to seek approval from their provider prior to filling any pain medication prescribed by our providers during treatment.

All requests for medication refills must be completed during office hours. No refills will be processed on Fridays. Please allow 24-48 hours for medication refills to be reviewed and sent. All medications will be e-scribed; no paper prescriptions will be issued.

I have thoroughly read this information and agree to the conditions discussed above. I understand that failure to comply with any of these terms will result in termination of services.

Patient Name: _____

Patient Signature: _____

Date: _____

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Office Policies

Welcome to Neurosurgery Consultants. Our practices main goals are quality patient care and patient satisfaction. We appreciate your selection of this office to serve your health needs. We hope the following information is useful for you.

Office Hours: Monday- Thursday 8AM-5PM, Friday 8AM-12PM

Appointments: **Office visits are by appointment only**. If you must cancel an appointment, **please give us 24 hours notice** so that we may offer your appointment time to another patient. We ask that our patients do their best to be on time for their appointments. Lateness is unfair to the other patients who are being seen that day. Occasionally, our providers will have emergencies that delay them. We ask for your patience and understanding.

Urgent Visits: We do our best to accommodate all urgent visits. **If your matter is urgent, please inform the receptionist when you call.**

Forms: Leave of absence, FMLA, disability paperwork, and school forms generally take **5-7** business days to complete. **There is a $25 fee to complete forms.**

Test Results: All advanced imaging and labs are reviewed during an office visit. No results will be given over the phone. Please call the office to schedule an appointment to review any testing.

Insurance: The insurance contract is ultimately between you and your insurance company. It is important for you to provide our staff with correct and complete insurance information.

By signing below, I acknowledge that I have received, reviewed understand, and will comply with the policies explained on this form.

Printed Name:_____

Signature:_____

Date:_____

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Dr. Burton covers all of his patients for the practice 24/7/365 unless he is out of town.

I understand that in the event that I have a neurosurgical emergency I am to contact Dr. Burton's office and have Dr Burton paged. Once I have received instructions from Dr Burton, I am to follow those instructions. If Dr. Burton is out of town, I understand I may be instructed to go to the nearest emergency room and will likely be seen by the neurosurgeon on-call for the hospital that is not associated with Dr. Burton's practice or will be transferred to the nearest facility with neurosurgery.

I understand that Dr. Burton does not practice inside of a group of neurosurgeons and as such, has no dedicated neurosurgeon cross coverage on a 24/7 cross coverage setting.

For all other emergencies such as chest pain or shortness of breath and other non-neurosurgical emergencies, I am to go to the nearest emergency room for emergency attention. I will notify Dr. Burton's office in those circumstances when the non-surgical emergency has been evaluated and treated.

Patient's signature

Date

PATIENTS' RIGHTS AND RESPONSIBILITIES

Neurosurgery Consultants LLC recognizes your rights while you are receiving medical care and asks that you respect our rights to expect certain behavior on the part of our patients. You may request a copy of the full text of this law from our admission representative or any employee of this facility. A summary of your rights and responsibilities follows:

Patient Rights:

The right:

- To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- To a prompt and reasonable response to questions and requests.
- To know who is providing medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To have a support individual present with patient unless contraindicated.
- To know what rules and regulations apply to his or her conduct.
- To be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- To refuse any treatment, except as otherwise provided by law.
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- To know if a patient who is eligible for Medicare pays request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To expect access to medical treatment or accommodations, regardless of race, ethnical origin, religion, handicap, or source of payment.
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- To express grievances regarding any violations of his or her rights, as stated in Louisiana law, through the grievance procedure of the health care provider or health care facility, which served him or her, and to the appropriate state licensing agency.
- To effective management of pain.
- To formulate, review and revise their Advanced Directives, including psychiatric.
- To file complaints about the Advanced Directive Policy with the State survey and Certification Agency.
- To have family and patient's own physician MD/DO promptly notified of the patients admission to the hospital.

Patient's, Patient's Parent's or Guardian's Responsibilities:

- To provide the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- To report unexpected changes in his or her condition to the health care provider.
- To report to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- To follow the treatment plan recommended by the health care provider.
- To keep appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- To know that the existence or lack of Advanced Directives do not determine the patients right to access care, treatment and services.
- To assume responsibility for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- To insure that the financial obligations of his or her health care are fulfilled as promptly as possible.
- To follow health care facility rules and regulations affecting patient care and conduct.