UPMC Hamot Neurosurgery & Neurointervention

120 East 2nd Street, 4th Floor, Suite 401, Erie, PA 16507

Phone: 814-877-7310 Fax: 814-877-7320

Patient Demographic Form

Dear Patient,

In order for us to serve you better and ensure completeness of your information, please take a moment to provide us with the below information.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security Number (**SSN**): _____ - _____ - _____

Marital Status: _____ Sex: _____ Race: _____

Ethnicity: Hispanic/Latino _____ Non-Hispanic/Latino _____ Not Specified _____ Decline _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Email Address: _____

Occupation: _____ Employer Name: _____

If Patient is a minor, please list Parent or Guardian Name: _____

Do you have any metal implants such as:

Stimulator: ___ Yes ___ No

Stents: ___ Yes ___ No

Pacemaker: ___ Yes ___ No

Metal Hardware: ___ Yes ___ No

If **yes** to stents:

Date of stent placement: _____

Manufacturer: _____

Type of stent: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Home: _____ Cell: _____

PCP: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Insurance Information:

Insurance Company Name: _____ PCP Copay $ ____ Spec Copay $ ____

Identification or Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ SSN of Policy Holder: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information:

Identification or Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Relationship to Patient: _____ SSN of Policy Holder: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Identification or Policy Number: _____ Group Number: _____

Signature: _____ Date: _____

Patient Name _____ Date of Birth _____

UPMC Hamot Physician Network

Auto / Worker's Compensation Claim Form

Injury Description

_____

_____

_____

Accident Date / Injury Date _____

Type of Claim Worker's Compensation ☐ Auto Claim ☐

State where accident occurred (Auto Only) _____

Worker's Comp / Auto Claim Number _____

Insurance Name _____

Contact Person / Agent Name _____

Phone Number _____ Ext _____

Address _____

City _____ State _____ Zip _____

Responsible Employer (Worker's Comp Only) _____

Employer Phone Number _____

UPMC

UPMC - CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO) IN PENNSYLVANIA

Imprint Patient Identification Here

UPMC, for the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of the UPMC system that are located in Pennsylvania.

I. CONSENT TO TREATMENT

This consent cannot be modified. Any hand written changes to the form shall not be legally binding or enforceable.

1. I, _____ (print or type name) on behalf of _____ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, mental health, drug and alcohol abuse treatment, medical treatment and/or admission to UPMC, including its hospitals, other health care facilities and physicians (all "affiliates"), which my physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask UPMC not to provide such care.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or by UPMC for education, as well as, health care operations purposes.
3. I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me at UPMC teaching facilities. These people may include but are not limited to residents, fellows, and medical/nursing students.
4. If applicable, I give UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be retrieved. I understand and agree that UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows UPMC to use specimens/tissue for research purposes without my authorization if my identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my specimens/tissue in research if my identity is linked to the specimens/tissue.
5. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.
6. I understand and agree that UPMC may at its discretion provide certain services to me by means called "telehealth" all of which are covered by this authorization. Telehealth may involve the secure transmission of video, audio, images, pictures and other types of information in real time or via a store and forward application. The provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse "telehealth" services.
7. When a physician orders home health, hospice, or ancillary services they will be directed to a UPMC provider unless otherwise requested or required by patient's insurance. UPMC honors patient choice among providers of healthcare.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Service or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me. My signature at the end of this consent acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my rights to request a review.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have been provided the UPMC Notice of Privacy Practices, either now or previously. _____ **Patient Initials (required)**
2. I give UPMC and its designees permission to use my information as described in the UPMC Notice of Privacy Practices.
3. UPMC may store information regarding me and my care in a variety of forms, including on computer systems, electronic media, paper, etc. Such information may include sensitive information such as HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent permitted under state and federal law, UPMC (including its hospitals, staff, physicians and other entities and programs) may access and share my medical and other information as is necessary for UPMC to provide treatment to me, seek payment for services it provides, or for UPMC's own healthcare-related operations. This includes my consent for UPMC to share my substance use disorder (SUD) treatment information from my UPMC licensed SUD program including dates of service, name of treatment provider(s) and diagnosis.
5. I understand that UPMC may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation referral and/or the provision of other treatment related healthcare services to me. However, in compliance with certain federal and state laws, I may be required to sign a separate consent in order for UPMC to release certain types of sensitive information – including HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for UPMC to release patient and educational information to my home caregiver.

6. I understand I may be contacted by UPMC by cellular phone, which may include the use of pre-recorded/artificial voice messages, and/ or an automated dialing device ("auto dialer") or by text message or e-mail in connection with any communication made to me or related to my accounts **Patient Initials** _____
7. I understand that my information may be released if required by local, state, or federal law.

V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates:

1. I authorize UPMC to bill my insurance carrier and request such payments to be made directly to UPMC. I certify that the information I have given about my insurance coverage or other payment sources is correct.
2. I assign to UPMC all rights to insurance payments or benefits to which I may be entitled for services provided to me by UPMC. I authorize UPMC to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
3. I authorize UPMC to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also authorize UPMC to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.
4. I assign all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services, and/or rehabilitation services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
5. I understand and agree that any hospital and physician charges not paid by my insurance are my responsibility. I understand that final billing will be made upon determination of all charges incurred, less any payments actually received, and/or allowed adjustments from insurers contracted with UPMC. I understand that it is my responsibility to pay UPMC all charges so incurred in accordance with UPMC's standard charges as set forth in UPMC's Charge Description Master (CDM). For more information regarding UPMC's Charge Description Master, please go to https://www.upmc.com/patients-visitors/paying-bill/services.
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and this section will not apply to such services.
7. If I make an application for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is permitted to provide information as is necessary to determine whether I am eligible for Medical Assistance/Financial Assistance.

VI. PATIENT VALUABLES

I relieve UPMC of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient. I further understand that UPMC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

VII. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in a County in which the care at issue is provided.

VIII. MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____,
I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person. _____ **Patient Initials (required if completing this section)**

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.).

Patient Signature (Witness is required for verbal consent)	Date	Time	Signature of UPMC Representative/Witness
Signature/Identify on behalf of patient/relationship Name	Date	Time	

UPMC LIFE CHANGING MEDICINE

Personal Representative Designation Form

This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities:

_____

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? Yes ____ No ____ If yes, please specify:		
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).		

REQUIRED SIGNATURES:

Personal Representative Signature:_____ Date: _____

Patient Signature: _____ Date: _____

Please return this completed form by mail to: UPMC Hamot Neurosurgery and Neurointervention

120 E 2nd St, Ste 401, Erie, PA 16507

Phone: 814-877-7310

or by fax to: 814-877-7320

Form Number (rev.12/2012)

2REP

UPMC LIFE CHANGING MEDICINE

Personal Representative Designation Form

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

Note that this form is <u>not applicable and cannot be used</u> for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to:

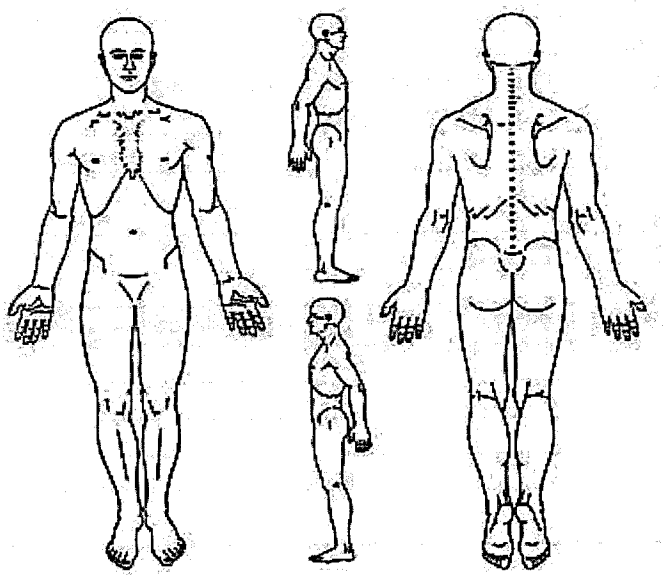
- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.

UPMC Hamot

Neurosurgery and Neurointervention

Patient History Form

New Patient:_____DOB : _____



Please mark the areas on your body where you feel the following sensation, using the symbols below:

(*) Numbness (O) Pins and Needles

(X) Burning (/) Stabbing

Is your pain (check all that apply): ☐Sharp ☐Dull

☐Aching ☐Stabbing ☐ Burning ☐Tingling ☐ Numb

Pain Severity- rate 1 (low) to 10 (high): _____

Have you had any loss of bowel/ bladder control or changes in Bowel/Bladder habits?_____

_____

When do you have pain? (check one)-

☐ Constantly ☐Daily ☐Weekly ☐ Monthly

When did the pain start?_____

Was this a result of: ☐ Car Accident ☐ Work ☐ Accident ☐Other _____

What makes pain worse? _____

What makes pain better? _____

CONSERVATIVE TREATMENT TRIED? ☐ Medication ☐Ice ☐Heat ☐Rest ☐ Other_____

HAVE YOU HAD PHYSICAL THERAPY? ☐ No ☐Yes If so, When ? _____

WHERE HAVE YOU HAD PHYSICAL THERAPY? _____

HAVE YOU HAD ANY INJECTIONS? ☐ No ☐Yes Last Date of Injection?: _____

Have you seen a Pain Specialist? ☐ No ☐Yes Physician Name:_____

Pain Medications: _____

Do you smoke?

- ☐ Yes, I smoke, _____packs of cigarettes per day for _____years.
- ☐ Yes, I smoke cigars or a pipe.
- ☐ No, I have never smoked.
- ☐ No, I quit ____years ago. At that time I was smoking ___ per day for___years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No but I used to ☐ Yes ☐ Daily

☐ 1 or more times a week ☐ 1 or more times a month

Drug Use?: _____

Are you at increased risk for HIV (e.g. sexual orientation, drug abuse, previous blood transfusion?

☐ No ☐ Yes, please explain: _____

UPMC Hamot

Neurosurgery and Neurointervention

Circle any of the following that apply to you:

Cardiac: Heart Attack Abnormal Rhythm Murmur Other _____

Pulmonary: Asthma COPD Emphysema Other _____

Endocrine: Diabetes Hypothyroid Pituitary Tumor Other _____

Circulatory: High Blood Pressure Stroke Aneurysm Other _____

Musculoskeletal: Arthritis Osteoporosis Osteoarthritis Rheumatoid Arthritis Fibromyalgia

Cancer: Type: _____ Date of Diagnosis: _____

Other: _____

DO YOU HAVE ANY BLEEDING DISORDERS? ☐ **No** ☐ **Yes** _____

HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA? ☐ **Yes** ☐ **No**

Surgeries/Hospitalizations	Year	Complications

Allergies: _____

Please list your medications below, if you prefer you may provide an up-to-date list or bring all of your medication bottles:

Current Medications	Dose	Frequency

Are you currently taking: ☐Aspirin ☐Coumadin ☐Plavix ☐Lovenox ☐ Pletal ☐Aggrenox ☐ Effient ☐Ticlid ☐Xarelto

Or any other blood thinners ☐ No ☐ Yes _____ Do you take Vitamin E? ☐ Yes ☐ No

Family History: Please check all that apply ☐ History Unknown (adopted)

	No History	Mother	Father	Sister(s)	Brother(s)	Children
Adverse Anesthesia Reaction						
Aneurysm						
Asthma						
Bleeding Disorders or Blood Clots						
Cancer						
Dementia						
Diabetes						
Heart Disease						
Hypertension						
Parkinsons						
Seizures						
Stroke						
Vascular Malformations						
Deceased- indicate age at time of death						

Other: _____

_____

UPMC Hamot

Neurosurgery and Neurointervention

Patient Name: _____ **DOB:** _____

Today's Date: _____

REVIEW OF SYSTEMS (Check all that Apply)

CONSTITUTIONAL		**RESPIRATORY**		**MUSCULOSKELETAL**		**NEUROLOGICAL**	
	Fever		Shortness of Breath		Joint Pain		Headaches
	Weight Gain		Wheezing		Joint Swelling		Seizures
	Weight Loss		Chronic Cough		Falls		Dizziness
	Malaise/ Fatigue		Hemoptysis- Coughing up blood colored mucous		Extremity Pain		Lightheadedness
	Night Sweats	**CARDIOVASCULAR**			Neck Pain		Extremity Weakness
	Weakness		Chest Pain		Lower Back Pain		Numbness/ Tingling
	Decreased Appetite		Claudication- leg cramping with activity		Thoracic Pain		Speech Difficulty
HENT			Leg Swelling		Difficulty Walking		Disturbances in Coordination
	Hearing Loss	**GASTROINTESTINAL**		**SKIN**			Confusion
	Tinnitus- Ringing in the ears		Difficulty Swallowing (Dysphagia)		Rash		Disorientation
	Throat Pain		Nausea		Skin Lesions		Facial Spasm
	Ear Pain		Abdominal Pain		Mole Changes		Facial Numbness
	Loose Teeth		Blood in Stool	**HEME/LYMPHATIC**			Facial Weakness
	Facial Pain		Bowel Incontinence		Cervical Adenopathy- Lumps in Neck		Loss of Balance
EYES		**GENITOURINARY**			Inguinal Adenopathy- Lumps in Groin		Loss of Smell
	Blindness		Bladder Incontinence		Easily Bruise or Bleeds		Loss of Taste
	Blurred Vision		Urgency	**ALLERGIC/ IMMUNOLOGIC**		**PSYCHIATRIC**	
	Double Vision		Frequency		Frequent Infections		Depression
	Eye Pain		Impotence		Environmental Allergies		Nervous/ Anxious
	Loss of Vision		Dysuria- pain with urination	**ENDOCRINE**			Memory Loss
Breast			Urinary Burning		Cold Intolerance		
	Nipple Discharge		Difficulty Urinating		Heat Intolerance		
			Amenorrhea- absence of menstruation		Polydipsia- increased thirst		

☐ **I am currently having no symptoms**

Patient Signature: _____ **Provider Initial:** _____

For Staff Use Only:

Height- _____ **Weight-** _____ **BP-** _____