Virella
NEURO SURGERY
Complex Spine & Brain Specialists

WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION

Patient's Name ______________________ Marital Status ______________

Date of Birth ______________ SS# ______________ Sex: ☐M ☐F

Primary Doctor ______________ Referring Doctor ______________

Address ______________________________

City ______________ State ________ Zip ________

Home # ______________ Cell # ______________

Occupation ______________________________

Employer ______________ Employer Phone # ______________

Email ______________________________

INSURANCE INFORMATION

Primary Insurance Company ______________________________

Subscriber's Name ______________ Subscriber's Birth Date ______________

Subscriber's ID # ______________ Co-Pay $ ______________

Secondary Insurance Company ______________________________

Subscriber's Name ______________ Subscriber's Birth Date ______________

Subscriber's ID # ______________ Co-Pay $ ______________

IN CASE OF EMERGENCY

In the event of an emergency, who should we contact?

Name ______________________ Relationship ______________

Home # ______________ Work # ______________ Cell # ______________

The above information is true to the best of my knowledge. I authorize and request my insurance company to pay directly to Dr. Virella insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature ______________________ Date ______________

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability.

Date ____

Patient's Name____ **Birthdate** ____________________________________

Chief Complaint____

HISTORY OF PRESENT ILLNESS:

Where is the pain/problem? ____

How severe is the pain/problem on a scale of 1-5? *(5 being the most severe, circle one)* 1 2 3 4 5

Does the pain/problem occur at a specific time?____

What other associated problems have you been having? ____

____

How long have you had this pain/problem?, or, When did it start? ____

Where were you at the onset of this pain/problem? ____

What makes this pain/problem worse/better?, or, Any previous episodes? ____

PAST MEDICAL HISTORY:

Have you had the following: *(circle "yes" or "no", leave blank if uncertain)*

Condition			Condition			Condition			Condition		
Measles	no	yes	Anemia	no	yes	Back Trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chicken Pox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray ________			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes			
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	____________________		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	____________________		
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Tranfusions	no	yes	Stroke	no	yes	____________________		

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES: When? Hospital, City, State

____ ____________ ______________________________

____ ____________ ______________________________

____ ____________ ______________________________

MEDICATIONS: *(Include nonprescription)* **ALLERGIES:**

____ ____

____ ____

____ ____

PATIENT SOCIAL HISTORY:

Marital Status : ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Children: ☐Yes ☐No How Many? ______________________

Use of Alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of Caffeine: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of Tobacco: ☐Never ☐Previously, but quit ☐Current packs/day

Use of Drugs: ☐Never Type/Frequency ____

FAMILY MEDICAL HISTORY:

	Age	Diseases	If Deceased, Cause of Death
Father	________	____________________	____________________
Mother	________	____________________	____________________
Siblings	________	____________________	____________________
	________	____________________	____________________
	________	____________________	____________________
Spouse	________	____________________	____________________
Children	________	____________________	____________________
	________	____________________	____________________
	________	____________________	____________________

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MEDICAL INFORMATION QUESTIONNAIRE

General Medical Review of Systems

ALLERGIES

- ☐ Asthma
- ☐ Hay Fever
- ☐ Skin Eruption

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ High/Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

CONSTITUTIONAL

- ☐ Chills/Sweats/Fever
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Weight Loss

EARS, NOSE, MOUTH & THROAT

- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Ringing in the Ears
- ☐ Sinus Problems

ENDOCRINE

- ☐ Rapid Weight Loss/Gain
- ☐ Multiple Broken Bones
- ☐ Cessation of Menstrual Period
- ☐ Excessive Hunger/Thirst
- ☐ Loss of Libido

EYES

- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Double Vision
- ☐ Vision Flashes or Halos

GENITOURINARY

- ☐ Blood in the Urine
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL

- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Rectal Bleeding
- ☐ Stomach/Abdominal Pain

HEMATOLOGIC/LYMPHATIC

- ☐ Swollen Lymph Nodes
- ☐ Easy Skin Bruising
- ☐ Prolonged Bleeding

INTEGUMENTARY

- ☐ Skin Rashes or Skin Eruptions
- ☐ Chronic Skin Itching

MEN

- ☐ Breast Lump
- ☐ Lump in Testicle
- ☐ Penis Discharge
- ☐ Sore on Penis

MUSCULOSKELETAL

Do you experience **pain, weakness, numbness, or swelling** *in any of the following?*

- ☐ Hands
- ☐ Wrists
- ☐ Hips
- ☐ Knees or Joints
- ☐ Arms or Legs

NEUROLOGICAL

- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Restlessness

RESPIRATORY

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Night Sweats
- ☐ Wheezing

WOMEN

- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse

Last Menstrual Period: ____________________

Last Pap Smear: ____________________

Last Mammogram: ____________________

Are You Pregnant? ____________________

Number of Children ____________________

Ages ____________________

____

____

____

____

____

ANTHONY A. VIRELLA, M.D.
DIPLOMATE, AMERICAN BOARD OF NEUROLOGICAL SURGERY
1250 La Venta Drive, Suite 200 • Westlake Village, CA 91361
office **805.449.0088** • *fax* **805.449.0046**

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

At our office, we care about your privacy. The following outlines how we handle and protect confidential information about personal and health information about you. This Notice of Privacy Practices applies only to our office and not to any other entity that may also be handling your medical care. It describes how we may use and disclose information about you in administering your care, and it also outlines your rights regarding this information. We are required to provide you with this notice and to follow the terms of the notice currently in effect.

Definition: **Personal Information:** Any financial, health, and other information about you that is nonpublic, and that we obtain so we can interact with other entities such as your insurance company, out billing services and other medical services (laboratories and other medical offices).

Health Information: Any information that identifies you and relates to your medical history and care, as well as the amounts received as payments for your medical care.

Use and Disclosure of Information: In order to provide you with the best of medical care, we obtain medical information from you, your insurance, and other medical entities. We may use and disclose this information for:

Treatment: We may disclose your personal and health information to other medical entities (consultants , laboratory, and other ancillary services) needed for the continuation, improvement or supplementation of your care.

Financial: We may disclose your personal and health information to other entities such as our billing service and your health insurance, among others, in order to assure payment. The information may be required for authorization of services, claim review, determination of covered services, external reviews, etc.

Healthcare Operations: We may use or disclose personal or health information to other entities for purposes such as credentialing, quality assessment, licensing, accreditation, outcome assessment, health services research, preventative health, disease management and care coordination among others.

Others: Administration, research (providing a separation disclosure and consent are provided for individual projects), industry regulations, law enforcement, legal proceedings, public welfare: We may disclose your personal or health information to a relative, friend, the subscriber of your health benefit or any other person you identify, provided the information is directly relevant to that person involvement with your health care or payment for that care.

Your Right:
• In all situations other than described above, we will ask you for your written authorization before using or disclosing personal information about you. If you have given us authorization, you may revoke it at any tine in writing. If we have not already acted on it.

• You have the right to stop or limit this kind of disclosure by letting us know in writing the extent of the limitations and the person/persons affected.

• If you are a minor, you may have the right to block parental access to your health information in certain circumstances., if permitted by state law.

The federal privacy regulations also give you the right to make certain requests health information about you. You may ask us in writing to:

• Communicate with you in a certain way or location.

• Restrict the way we use or disclose your health information in connection with your treatment, payment, and health operations. We will consider, but may not agree, to such a request.

• Obtain a copy of personal or health information that is in your records. This request must be in writing, a reasonable fee for producing and making this information available to you will be charged to you. In certain cases, we may deny the request.

• Amend the information that is in your records. The written request must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
·Provide a list of certain disclosures of health information to the government.

You also have the right to file complaint to the proper authorities, if you think your privacy rights have been violated. This notice is subject to change. We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all the information that we already have about you, as well as any information that we may receive in the future.

Please note that we do not destroy personal or health information about you when you are no longer an active patient of this office. It may be necessary to use and disclose your personal and health information even after you no longer are an active patient of this practice. Policies and procedures will remain in place to protect against inappropriate use or disclosure of your personal and health information.

ANTHONY A. VIRELLA, M.D.
DIPLOMATE, AMERICAN BOARD OF NEUROLOGICAL SURGERY
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office **805.449.0088** • *fax* **805.449.0046**

Notice of Privacy Practices
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy of Practices. Our Notice of Privacy Practices provides information about how we use and disclose health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our "Notice", you may obtain a copy of the revised " Notice" by contacting our office at (805)449-0088.

If you have any questions about our Privacy Practices, do not hesitate to contact our office.

I acknowledge receipt of the Notice of the Privacy Practices

Patient Name_______________________________________ Date of Birth ____________________

Patient Signature ___________________________________ Date ___________________________

Protected Health Information (PHI) Disclosure Record

In general, the HIPPA privacy rules give an individual the right to request a restriction on uses and disclosures of the Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI is made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner:

Home Phone _____________________

Cell Phone _______________________

Work Phone ______________________

Notice to Consumers:
Medical doctors are licensed and regulated by the:
Medical Board of California
(800) 633-2322 • mbc.ca.gov

Patient Signature: ______________________________

Would you prefer us to leave a call back number only, or is it ok to leave a message with a call back number? ____________________________________

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Payment Policy

It is the policy of our practice to receive payment in full at the time services are rendered unless other arrangements have been made in advance. Please be aware that Dr. Virella is NOT contracted with many providers. **In many instances, you will directly receive a check from your provider for professional services rendered by Dr. Virella (surgical procedures) . It is your legal responsibility to forward ALL such checks to our office staff within 72 hours. Failure to do so may result in legal and collection action and significant civil fines and penalties.**

If you wish our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D. / subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of the employer.

Enrollment in an insurance plan is NOT a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Our office does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan before services are rendered. This also applies to any facility or provider your doctor may refer you to. Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, non-covered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment ***is the responsibility of the patient or responsible party.*** It is the policy of this medical group to receive payment in full 30 days from the date of service.

HMO's and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered.

Authorization does not guarantee payment by the insurance company.

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 30 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, checks, money orders, Visa, MasterCard,, or Discover as your method of payment.
The fee for a returned check is **$35.00.**
I have read the above policy and understand I am financially responsible for all medical services rendered.

Signature of Patient or Responsible Party:____

Print Name: ____

Date: ________________________