

**Craniospinal Institute of Georgia, LLC**

Daniel W. Moore, M.D., F.A.C.S.

Vidyadhar S. Chitale, M.D., F.A.C.S.

Please fill out the following:

Name:

\_\_\_\_\_

How Were You Referred?

\_\_\_\_\_ Doctor Referral - \_\_\_\_\_  
*(name)*

\_\_\_\_\_ Friend/Family - \_\_\_\_\_  
*(name)*

\_\_\_\_\_ calladoctor.net

\_\_\_\_\_ Other website \_\_\_\_\_  
*(name)*

\_\_\_\_\_ Yellow Pages \_\_\_\_\_  
*(on-line or paper edition?)*

\_\_\_\_\_ Our Website ([www.craniospinal.net](http://www.craniospinal.net))

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Drug or Food Allergies: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Employer's Name: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Staus: (circle) M. D. S. W

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Name of Referring Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is your condition the result of auto accident? \_\_\_\_\_ Workman's Comp? \_\_\_\_\_ Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance: \_\_\_\_\_ Policyholder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim/File #: \_\_\_\_\_ Adjustor: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If you have an attorney please provide complete name(s) and address below:

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructions: *Please fill out the information requested below as completely as possible. This information will be used to assist the doctor in the diagnosing and treatment of your medical problem(s). The doctor will review this form and you will be asked for additional information during your visit.*

What are your current problems/complaints? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If this is a work related injury or due to an auto accident please describe the nature of the injury/accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any similar previous injuries or symptoms? \_\_\_\_\_ If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Current Medical History:**

Disease	Yes or No	Date
Diabetes		
High Blood Pressure		
Heart Attack/Angina		
Stroke		
Cancer		
Kidney Failure		
Bleeding		
Arthritis		
Liver Disease		
Back/Neck Problems		

Are there any other conditions not listed above that you have been diagnosed with? \_\_\_\_\_ If yes, please specify what condition and when you were diagnosed:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Previous Hospitalization or Surgery:

Date	Reason

**Family History:** have any of your relatives had any of the following diseases? If so, please indicate which relative(s) was (were) affected:

Disease	Family Member(s)
Diabetes	
High Blood Pressure	
Heart Attack	
Other Heart Disease	
Stroke	
Cancer	
Kidney Failure	
Arthritis	
Inherited Disease	
Other	

Father: Living (circle) Yes No (cause of death)

\_\_\_\_\_

Mother: Living (circle) Yes No (cause of death)

\_\_\_\_\_

Brother(s): Number Living? \_\_\_\_\_

Number Deceased? \_\_\_\_\_

Cause of Death: \_\_\_\_\_

Sister(s): Number Living? \_\_\_\_\_

Number Deceased? \_\_\_\_\_

Cause of Death: \_\_\_\_\_



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## For Your Information

(Please read and sign/date)

Our office is open Monday through Friday from 9:00 a.m. to 5:00 p.m. On the days that Dr. Moore and Dr. Chitale are seeing patients, the staff will be taking emergency calls only. All other calls will be returned as soon as possible. Thank you for your patience.

Any diagnostic tests such as MRI, CT scan, X-rays, etc., or pain management referrals that the physician has ordered will be scheduled by our office as soon as all the necessary documentation is received to pre-cert with our insurance carrier or schedule with referred physician. Depending on the circumstances it could take up to seven days for us to get all the information required. You will be notified by this office regarding the place, the date and the time of your test. If the appointment time we have scheduled is not convenient or if you cancel the appointment, it will be the patient's responsibility to reschedule. Medications that have been prescribed for a pain until the time of any tests will not be refilled if the patient fails to keep the appointment.

Please call this office to schedule a follow up visit after your test has been scheduled. This will prevent long waits to schedule your appointment. **BRING FILMS WITH YOU!** if applicable. **Without the films, the Doctor will be unable to evaluate your condition and we will ask you to go back for the films before seeing the Doctor.**

All non-emergency calls will be forwarded to the appropriate voice mail. Every effort will be made to return the call before the end of the day.

Because we are a specialty practice, we often see patients with complex problems or medical histories that have to be thoroughly assessed and may take more time than we could have anticipated. We are also required to see a high volume of emergencies referred from other doctors and area hospitals. As a result, we sometimes have delays in our schedule that are unavoidable. We will make every effort to see you at your appointment time.

We will file your insurance for you; however updates and complete information must be provided.

If you have been given a prescription for lab work or physical therapy, please keep these and present them to the facility where you are scheduled. We will be glad to recommend some facilities, however it is the patient's responsibility to schedule the appointment and confirm that the facility is covered by their insurance. **Please call this office to schedule a follow up visit after you have completed your physical therapy and/lab work.**

**\*\*\*\*\*Disability forms will be filled out for a \$25 advanced payment. These will be completed as soon as possible and forwarded appropriately.\*\*\*\*\***

**There will be a \$50 charge for not showing for your scheduled appointment unless 48 hours notice is given.**

Please call ahead for any medical records and/or films that need to be picked up or mailed. Please allow up to 5 business days for all requests to be fulfilled. Please be aware that all requests may be subject to a fee.

If you are a member of a managed care plan and your insurance carrier requires a referral, it will be the responsibility of the patient to obtain the referral. We will be unable to treat the patient if the referral is not received by the time of visit. Any charges denied because the visit was not approved, will be the responsibility of the patient.

In case of an emergency after hours, please call our main office number (770) 424-2025 and your call will be handled accordingly.

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Patient Signature

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Date

## **Craniospinal Institute of Georgia, LLC**

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### **Medication Agreement and Refill Policy**

As part of your treatment, our physicians may order medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and your help to make sure your treatment is the best that it can be.

It is the patient's responsibility to ask the Doctor at the time of their visit for any prescriptions. We will be unable to honor phone requests unless previously discussed with the Doctor. You may call our office between the hours of 9:00 am and 5:00 pm and leave a message on the prescription line to request a refill. Because the Doctor is in surgery at least three days out of the week, we may not be able to get an approval for a couple of days. For this reason, it will be necessary for you to call 3 days in advance to allow for the delay. **Approved** refills will be called into your pharmacy or the prescription will be available for pick up at our office. **NO PRESCRIPTIONS WILL BE HONORED AFTER HOURS.**

1. Upon discharge from Craniospinal Institute of Georgia, I agree not to request prescriptions for any type of pain medication, sedative, antidepressant, etc., from Craniospinal Institute of Georgia.
2. I agree to follow the dosing schedule prescribed by my doctor.
3. I agree to always keep my medications safeguarded and within my control. Craniospinal Institute of Georgia cannot replace prescriptions earlier than originally written.
4. I agree to notify Craniospinal Institute of Georgia if I experience any adverse effects of dosage problems with my prescribed medications. I will not discard any unused medication. Before new medication can be prescribed, I must bring the unused medication to Craniospinal Institute of Georgia office.
5. I agree to receive all pain-related medications from Craniospinal Institute of Georgia or an appropriate designated clinic.
6. I agree to use only one pharmacy for my pain-related medications.
7. I understand that medication refill prescriptions involving opiod medicine requires a scheduled office visit when my Craniospinal Institute of Georgia physician is on duty in the office. Opioid medication refills will not be called into a pharmacy nor will opioid pain medications be increased over the phone.
8. I agree to keep all scheduled visits. I am assured of having sufficient medication when I go to all scheduled appointments. If I miss an appointment without prior notification to Craniospinal Institute of Georgia, I understand that my refill prescriptions will not be issued until my next scheduled appointment.
9. I understand that medication refills cannot be made after hours or on weekends. Please expect a 48-72 hour turnaround time for prescription referrals.
10. I agree to bring my medications to Craniospinal Institute of Georgia at the time of my appointment.
11. I understand that I should not drive an automobile or operate heavy equipment while I am taking pain medications or sedatives.

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12. I understand that my therapy at Craniospinal Institute of Georgia may require a monthly office visit so my doctor can properly evaluate my progress an/or appropriate opiod medications every 30 days.
13. I understand that abusive behavior or harassment toward any member of the Craniospinal Institute of Georgia staff will not be tolerated. Harassment includes, but is not limited to, more that 2 telephone calls to the office in one day.
14. I will not come to Craniospinal Institute of Georgia seeking medication refills.
15. I understand that a forged or falsified prescription will result in immediate dismissal from the Craniospinal Institute of Georgia practice.
16. I understand that if I do not follow the medication agreement, I may be dismissed from the Craniospinal Institute of Georgia practice.

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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The following is a statement of our Financial Policy. We require that you read and sign prior to any treatment. All patients must complete our patient and insurance information forms before your first appointment with our doctors, nurse, physical therapist, Nerve Conduction Studies, or any medical equipment or supplies are dispensed.

## **ALL COPAYMENTS ARE DUE PRIOR TO BEING SEEN.**

For your convenience, we accept cash, check, Visa and Mastercard

### **Insurance**

We cannot accept assignment of your insurance unless all insurance information is given at the time of each visit. If you have a secondary or supplemental insurance, please provide that information also. It is imperative that we make copies of your current insurance cards for accurate billing. If your insurance has not paid within 45 days, you may receive notification in the mail requesting your assistance in determining why the delay in payment.

It is extremely important that you educate yourself about your individual insurance benefits. Please be aware that you are responsible for deductibles as well as copayments.

*(Medicare patients do have a yearly deductible and a 20% copayment each visit. You will be billed when Medicare pays their allowable amount.)*

To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits, coverage, and deductibles. Patient balances 90 days past due may be sent to a collection agency.

### **Referrals**

If your insurance requires a referral, it is your responsibility to obtain a current referral from your primary care physician. Please check with our front desk to see if your referral has been received preferably before your scheduled appointment or bring your current referral with you the day of your appointment. If your insurance denies payment because of no referral, you will be responsible for payment.

## **\*\*\*\*\*IMPORTANT – PLEASE READ\*\*\*\*\***

### **Self Payments**

If you do not have insurance you are expected to pay **prior** to being seen by our staff.

### **FMLA/DISABILITY AND MISCELLANEOUS FORMS**

There is a charge of \$10 for FMLA forms and \$25 for Disability Forms and any other miscellaneous forms payable in advance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this policy.

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

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## **Insurance Authorization and Assignment**

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Craniospinal Institute of Georgia and Spinal Institute for services furnished to me by that party who accepts assignment physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information)

\_\_\_\_\_  
Patient or Authorized Signature

\_\_\_\_\_  
Date