DR. STEFAN G. PRIBIL, M.D. FAANS NEUROSURGEON

NEW-PATIENT INFORMATION GENERAL INFORMATION

1. Last Name: ______________________________
2. First Name:______________________________MI:__
3. M F
4. Address: ______________________________ City:_____________________, State:_____ Zip Code: _________ SSN: ____ DOB: _____/______/_______ Please indicate phone number(s) where we may leave messages pertaining to appointment times, prescription information, and/or other Private Health Information. Home Phone: __________________ Msg OK? Y N Emergency Contact: ________________________ Work Phone: ___________________ Msg OK? Y N Relationship: _______________________________ Cell Phone: ____________________ Msg OK? Y N Phone: ___________________________________ Email: ____ ___ What is your preferred method of contact for an appointment reminder? e-mail text voice message 2. Is this visit due to a/an: Auto Accident Work-related injury Other injury No injury Date of Injury/onset of symptoms: _____/______/_______ (If you are unsure of the exact date, give the best guess of month and year) INSURANCE INFORMATION 3. Primary Insurance Company: ____ Phone#: ________________ Claims_ Address: ____ ID/Claim#: _______________Grp/Policy#:___________ Insured's Name: ________________________________ Insured's SSN: ____ Insured's DOB: _____/______/_______ 4. Other Insurance Company: ____ Phone#:_____________________ Claims_ Address: ____ ID/Claim#: ______________ Grp/Policy#:____________ Insured's Name: _______________________________ Insured's SSN: ____ Insured's DOB: _____/______/_______ 5. Have you retained an attorney or will you be retaining an attorney? YES NO If yes, please provide name, complete address and phone number below. Atty Name: ____ Phone#: ____________________ Atty Address: ____ I hereby request evaluation and treatment and grant this facility the authority to treat and examine me/my dependent and to order any examination or tests necessary to facilitate my examination or treatment. I understand that the practice of medicine is not an exact science and that there are no guarantees of the results and that every individual may respond differently to

a particular treatment regimen. I understand that there are certain risks associated with any examination or treatment and that those risks will be presented and explained to me during the course of my treatment. I hereby authorize this facility and/or its clinical staff to perform examinations and treatment as necessary for my care. Patient Signature: ____ Date: _____/______/_______ If you do not have a digital signature, you may print, sign and bring this form into Dr. Stefan G. Pribil, M.D.,with you. PATIENT QUESTIONNAIRE • Pain + • Numbness 0 • Pins & Needles # • Burning X • Stabbing / Using the scale, what is your pain TODAY? 0 No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

5. Please indicate on the diagram the areas where you are experiencing symptoms using the suggested marks below to describe your symptoms. Please list your symptoms in order of their severity, most significant or painful symptoms first. Symptom(s): 1. 2. 3. 4. 5. _____ / ______/_______ _____ / ______/_______ _____ / ______/_______ _____ / ______/_______ _____ / ______/_______ Date symptom(s) appeared: Yes No Can you relate your symptoms to any specific event/activity? If yes, please describe: Date of event/activity: ____ / ____/______ Yes No Are your symptoms related to an auto accident or work-related injury? Date of accident: ____ / ____/______ Which state: Date of work-related injury: ____ / ____/______ How did the injury occur? Yes No Have you received treatment for these symptoms in the past? If yes, please answer the following questions, beginning with your most recent treatment. 1. Name and location of provider: Dates seen: How many times? Treatment received: Imaging done: Which body parts? Prescriptions: 2. Name and location of provider: Dates seen: How many times? Treatment received: Imaging done: Which body parts? Prescriptions: If you do not have a digital signature, you may print, sign and bring this form into Dr. Pribil with you. REVIEW OF SYSTEMS CHECKLIST Are you currently experiencing any of these symptoms? Please check all that apply. Respiratory: Spitting up blood Shortness of breath Asthma or wheezing Frequent coughing None in this category Women Only: Irregular periods Painful periods Vaginal discharge None in this category Date of last menstrual period: _____/_____/________ Eyes and Vision: Wear glasses/ contacts Blurred or double vision Glaucoma Eye disease or injury None in this category Gastrointestinal: Stomach pain Blood in stool Change in bowel movements Nausea or vomiting Frequent diarrhea Constipation Painful bowel movements Loss of appetite None in this category Neurological: Frequent or recurring headaches Light headed or dizzy Convulsions or seizures Numbness or tingling sensations Tremors Stroke Have you ever had a head injury? Have you ever been in a car accident? None in this category Endocrine: Thyroid problems Diabetes Excessive thirst or urination Cold extremities Heat or cold intolerance Change in hat or glove size Dry skin Glandular hormone problem None in this category Skin and Breasts: Rash or itching Change in skin color Change in hair or nails Non-healing sores Change in appearance of a mole Breast pain Breast lump Breast discharge None in this category Genitourinary Sexual difficulty Kidney stones Burning or painful urination Blood in urine Change in force or strain with urination Incontinence or dribbling Frequent urination None in this category Musculoskeletal Joint stiffness or swelling Weakness of joints Muscle pain or cramps Muscle weakness Neck pain Upper or mid-back pain Low-back pain Joint pain Difficulty walking None in this category Mind/Stress: Nervousness Depression Sleep

problems Memory loss or confusion None in this category Heart & Cardiovascular Chest pains Sudden heartbeat changes Swelling of feet, ankles, hands Heart trouble None in this category Hematologic/Lymphatic Swollen glands Easily bruise or bleed Anemia Phlebitis Transfusion Slow to heal after cuts None in this category General (constitutional) Recent weight change Fever Fatigue None in this category Ears, nose, throat Bleeding gums Bad breath or bad taste Sore throat or voice change Swollen glands in neck Mouth sores Ringing in the ears Earaches or drainage Sinus problems Hearing loss None in this category Medical & Family History Please list any past surgeries or hospitalizations: Please list any prescription medications your currently take: Do you have any allergies (environmental, food, medications, latex, other)? Is there a family history of cancer or other disease? If yes, please list: HEALTH HISTORY I am: Male Female Age:_____ Height:____ ft. ____ inches Weight: ______ lbs. Right Handed Left Handed I am: Single Married Divorced Widowed Do you have children? Yes No List ages: _____ Yrs. _____ Mos. Yes No Yes No Yes No Yes No Yes No Are you pregnant? If yes, please provide a due date: _____/_____/_______ Do you currently have a primary care physician? Clinic/Name: ____ Are you currently being treated for health problems or and/or have chronic health problems? Please describe: Have you experienced prior accidents, injuries, falls and/or physical trauma to your neck/back? Pleases describe: Have you been hospitalized for any reason and/or had any prior surgeries? Please list: Date or age Reason for hospitalization Type of surgery Facility ________

____________________________________ ________________________

________________________ ________ ____________________________________

________________________ ________________________ ________

____________________________________ ________________________

________________________ Yes No

Are you currently taking any medications? Please list: ____ Are you allergic to any medications? Please list: ____ Are you allergic to: Iodine? Yes No | Shellfish? Yes No | Contrast? Yes No Do you Smoke? If yes, how many packs/cigarettes a day? _____ Packs Cigarettes For how long? ____________ Do you drink alcohol? How often? _____________ a day a week a month Do you use any drugs not subscribed by a provider? Please describe: ____ Are any of the following known to exist in your family-medical history? Rheumatoid arthritis/ osteoarthritis / Other Auto-immune diseases? Please list: ____ Other diseases/problems with your neck/back? Please describe: ____

____ __________________

____ __________________ My job title/occupation is:

____ My current employer is: ____ Have you missed any work as a result of your symptoms? If so, how many days? _______ Are there any other health problems you currently have and/or have been treated for that have not been identified or listed? Please describe:

____

______ Have you previously been treated by a provider at this office? Patient Signature: ____ Date: _____/______/_______ For office use only Drug: ____ Route: ____ Lot #/Exp: ____ Initials: ________________ MA:

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities ("payers"), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of, Dr. Stefan G. Pribil, M.D. or "Office") in the amount of the full charges incurred by me at the Office, past or future, including but not limited to, charges for treatment , supplies, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("my charges"). I further grant a contractual lien to Dr. Stefan G. Pribil, M.D. with respect to my charges. For the purposes of this Agreement , proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverage: individual/group health, disability, worker's compensation, medical payments benefits, personal injury protection, lost wages, lost services, no-fault benefits, general auto coverage, uninsured and under insured motorist coverage, liability coverage, and malpractice coverage. I further agree that, in the event a payer refuses to pay Dr. Stefan G. Pribil, M.D. , I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to : Dr. Stefan G. Pribil, M.D. , as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to Dr. Stefan G. Pribil, M.D. regarding my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request. I hereby authorize and direct Dr. Stefan G. Pribil, M.D. to file my claims with my health insurance, auto insurance, or third-party insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, med pay, attorneys, etc.), I hereby authorize and direct Dr. Stefan G. Pribil, M.D. to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment. I hereby direct all payers to

release to Dr. Stefan G. Pribil, M.D. any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Dr. Stefan G. Pribil, M.D. to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents for treatment received. I further authorize Dr. Stefan G. Pribil, M.D. to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition. I understand that I remain personally responsible for the total amounts due to Dr. Stefan G. Pribil, M.D. for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Dr. Stefan G. Pribil, M.D., for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees. This Agreement shall not be modified or revoked without the mutual written consent of Dr. Stefan G. Pribil, M.D. and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Dr. Stefan G. Pribil, M.D. and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. Patient Name (please print):
____ Date: ____ / ____ /______
Patient Signature:
____ Name of
Custodial Parent or Legal Guardian (please print):
____ Parent/Guardian's
Signature: ____ Date: ____ / ____ /
______ FINANCIAL POLICY It is the policy of Dr. Stefan G. Pribil, M.D., as a courtesy to you, to file insurance claims with your individual insurance company. You will be responsible for all deductibles, co pays, and co-insurance as outlined in your individual contract. Office deductibles and co-insurance amounts must be paid at the time of service, and all patients must pay their co pay before services are rendered. For those patients who are un-insured or under-insured our cash payment option offers re-priced amounts for services rendered. Payment must be made at the time of service in order to qualify. If payment is not made at the time of service, full usual and customary charges will be billed. Our billing department will be happy to help you with questions regarding your insurance or payment options, but YOU are ultimately responsible

for payment regardless of your insurance coverage. Please check with your insurance carrier prior to receiving services and be aware of any restrictions or clauses that could reduce your benefits such as, second opinions, pre-existing conditions, review for hospital admissions, referrals from your primary care physicians, etc. If you are a member of an HMO or PPO in which Dr. Stefan G. Pribil, M.D, physicians are providers; this does not waive your responsibility to confirm coverage. Your benefits could be significantly reduced for all out-of-network services which become your responsibility and payment required in full, using the Cash or Care Credit options outlined above. When an office visit or procedure has been pre-authorized or pre-certified, this does not guarantee full payment by your insurance company. Please contact your insurance company with any questions. In addition to Dr. Stefan G. Pribil, M.D. facilities and physician charges, you may receive charges from other entities including, but not limited to, anesthesia and outside diagnostic laboratory services. If you have retained an attorney and your case is being handled on a lien basis we still require that you provide our office with your health insurance information; however, the attorney lien will be considered the primary responsible party for your case until the time of your settlement or the termination of attorney/client relationship, whichever occurs first. By my signature, I confirm that I have read and understand the above information ; I understand that Dr. Stefan G. Pribil, M.D. , its physicians and/or staff are not responsible for my insurance coverage, pre-authorization, or any other insurance decisions. Please initial one of the following options: ____ This illness/injury is work-related. ____ This illness/injury is NOT work-related. Patient Signature:

____ Date: ____ / _____ /______