HOLLIDAY NEUROSURGICAL
Spine & Peripheral Nerve

Dr. Peter O. Holliday, III, M.D.
420 Charter Blvd., Suite 402
Macon, Georgia 31210
Phone: 478-474-0394
Fax: 478-477-5509

Today's Date: _____

Dear: _____,

This letter is to remind you of your appointment scheduled for _____ and, to make you aware of our general office policies, office visit fees, and the items you are ***required to bring with you.***

Please contact our office immediately if you have had previous surgery on your neck or spine.

☐ ***You are required to have additional xrays. Please arrive 1 hour prior to your appointment and report to the Coliseum Northside Hospital registration desk on the first floor (just inside the main hospital entrance) before coming to our office.***

Please bring the following items with you:

1.) **PAPERWORK:** Complete the attached registration paperwork and bring it with you to your appointment,

2.) **INSURANCE:** Proof of active and effective health insurance coverage. (i.e. your insurance card, military ID, etc.). If you **DO NOT** have active and effective health insurance coverage, contact our office prior to your scheduled appointment to make payment arrangements, or you will not be able to be seen at your scheduled appointment, **NOTE: Dr. Holliday DOES NOT accept Medicaid insurance, even as a secondary policy.** Contact our office PRIOR to your visit if you are enrolled with Medicaid or you will not be seen at your scheduled appointment time.

3.) **PHOTO ID:** Picture Identification (i.e. driver's license)

4.) **PAYMENT:** insurance requires that Dr. Holliday to collect payment of co-pays and coinsurance at the time of service; if you cannot make payment of the required co pay or coinsurance as dictated by your insurance policy, please contact our office prior to your appointment.

5.) **TEST IMAGES:** if you have had any tests done relating to the problem for which you are seeing Dr. Holliday, you must bring the ACTUAL FILMS and/or IMAGES ON CD with you, as well as the corresponding reports. This includes MRI, CT, X-RAY, MYELOGRAM, etc. ***Please notify our office prior to your appointment if you are unable to get these images.***

Please Note: due to the specialty of our practice, and the fact that new patient consults are only available 2 days a week, you must contact our office 24 hours in advance if you are unable to make your appointment.

ANY NO SHOWS WILL BE CHARGED A $100.00 FEE.

We are located inside the Coliseum Northside Hospital in the north Macon area, which is separate from the main Coliseum Hospital located downtown. If you need directions to our location, or have any other questions regarding your appointment with our practice, please do not hesitate to call our office at the number listed on the bottom of this letter.

Kind Regards,
Tara Guidry
Medical Receptionist

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PATIENT REGISTRATION

Date: _____

_____
Last Name First Name Middle Name (full)

_____ - _____
Mailing Address City/State/Zip

SS #: _____ Date of Birth: _____ Age:_____Gender: M or F Height: _____

Home Phone (____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Marital Status: ___Single ___Married ___Divorced ___Widowed Race: □ African-American □Caucasian □Hispanic □Other:_____

PHARMACY INFORMATION

Pharmacy Name:	Phone: ( )
Address/City/State/Zip	

REFERRING MD INFORMATION

Referring Physician Name:	Phone: ( )
Address/City/State/Zip	*Do you want this physician to receive copies of Dr. Holliday's notes of your visit(s)?* □Yes □No

INFORMATION FOR SELF	Spouse-Name:
Occupation	Spouse-Date of Birth:
Employer	Spouse SS#: *(required if spouse's name is on insurance policy)*
Address/City/State/Zip	Employer Address:
If patient is a minor, please provide parent and/or guardian information Guardian Name:	City/State/Zip:
Contact Number: ( )	Telephone: ( )

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTE: Dr. Holliday and/or staff cannot speak to anyone, even immediate family members, regarding your visit(s) with Dr. Holliday unless their name is listed on this form.

I, _____, authorize Dr. Peter O. Holliday, III and staff to use and/or disclose my health information relating to my treatment/diagnosis to any healthcare provider involved in my current treatment/diagnosis. In addition, I authorize the following individual(s) complete access to my health information and account records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

To have any of your medical records released to yourself, your employer, disability insurance company, or any another physician, you must complete a HIPPA required release form located at the front desk of this office, which must then be authorized by Dr. Holliday before such release can occur.

*Any FORM required by your employer for medical leave, disability, Worker's Comp, SSA, VA, etc. are subject to an **$89.00 fee payable in advance.***

INSURANCE INFORMATION:

Do you have Medicare PART B? ☐Yes ☐No *if yes, ID number* _____ *Effective Date:* _____

Do you have Medicaid? ☐Yes ☐No *Please note: Dr. Holliday does NOT accept Medicaid insurance, even as a secondary policy. Contact our office prior to your visit if you have this insurance for authorization or you will not be seen at your scheduled appointment time.*

Primary Ins: _____

Claims Address: _____

_____

_____

Phone #: _____

Policy #: _____

Group #: _____

Effective Date: _____ CoPay:_____

Secondary Ins: _____

Claims Address: _____

_____

_____

Phone #: _____

Policy #: _____

Group #: _____

Effective Date: _____ CoPay:_____

Additional Insurance**:** _____ Phone #: _____

Claims Address: _____ Policy #: _____

_____ Group #: _____

_____ Effective Date: _____ CoPay:_____

WORKERS COMP INFORMATION:

Were you injured on the job? ☐Yes ☐No *if yes, employer at the time of injury*_____ *Date of Injury*_____

W/C Insurance Company:	Adjuster:	Phone: ( )
Address/City/State/Zip	ID #	FAX: ( )

Were you injured in an auto accident? ☐Yes ☐No *if yes, date of accident*_____

Please note: Dr. Holliday does NOT file to auto policies unless medical coverage is provided. Your health insurance policy will be billed and it is the responsibility of the patient to handle auto policy reimbursement to the insurance company. Contact our office prior to your visit if you do not have regular medical insurance and are being seen due to an accident to make payment arrangements.

Name of attorney handling your case: _____ ***Contact Number:*** _____

Name of person responsible for payment if other than patient:

_____ ***Address:*** _____

PATIENT HISTORY RECORD

CHIEF COMPLAINT - *(In your own words, briefly describe the symptoms you are currently experiencing)*

_____

_____

When did it start? _____ Is it accident related? _____

MEDICAL PROBLEMS: *Check any disease you have had, or now have, and the approximate date of occurrence*

__ None of these
__Anemia (low blood count)_____
__Ear infections or discharge_____
__Dry Mouth_____
__Difficulty Swallowing_____
__Facial or Mouth Sores_____
__Thyroid_____
__Lumps in neck_____
__Excessive thirst_____
__Swollen Lymph nodes (recently)_____
__Wheezing or asthma_____
__Shortness of breath with activity_____
__Chronic cough_____
__Pleurisy_____
__Blood in sputum_____
__Pneumonia_____
__Chest Pain_____
__Fast heart rate_____
__Heart attack_____
__Shortness of breath when lying flat_____
__Swelling of feet (edema)_____
__Frequent voiding during sleep hours_____
__Pain in legs with activity_____
__Ulcer, stomach, or duodenal_____
__Stomach pain_____
__Vomiting blood_____
__Blood in stool_____
__Black tarry stool_____
__Diverticulitis_____
__Hepatitis (Jaundice)_____
__Recent change in # of stools/day _____
__Constipation _____
__Diarrhea _____
__Pain when passing stool _____
__Difficulty urinating _____
__Frequent urination_____
__Urethral discharge_____
__Kidney infection_____
__Urethral trouble_____
__Prostate trouble_____
__Arthritis_____
__Rash_____
__Birth Marks_____
__Syphilis_____
__Recent change in body weight_____
__Night Sweats_____
__Fevers_____
__Excessive uterine bleeding_____
__Abnormal menstrual periods_____
__Tuberculosis/positive skin test_____
__Cancer_____
__Cold intolerance_____
__Heat intolerance_____
__Diabetes_____
__Kidney stones_____
__Hypertension_____

ALLERGIES TO MEDICATIONS: *Please list all medicines that you are allergic to, and what type of reaction*

MEDICINE	REACTION	MEDICINE	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS: *Please list all medications that you currently take, and the dosage if known. How much **alcohol and/or tobacco** per week do you use?*

_____
_____
_____
_____
_____

X-RAYS, TEST AND DATES

□Yes □No X-RAY: SKULL _____ □Yes □No X-RAY: NECK _____ □Yes □No X-RAY: CHEST _____

□Yes □ No EMG/Nerve Conduction: _____ □Yes □No EEG: _____ □Yes □No MYELOGRAM/Spinal Tap: _____

HOSPITALIZATIONS AND TREATMENTS FROM CHILDHOOD *Please list all hospitalization in your life (including mental hospitals and sanatoriums) & treatment by doctors, other than colds and minor illnesses-if more room is needed, use the back of this form.*

DATE	HOSPITAL/PHYSICIAN	REASON / DESCRIPTION OF PROCEDURE

Who is your Family Physician? _____ Address: _____

□Yes □No Have you ever consulted an orthopedist? if yes, whom_____

□Yes □No Have you ever consulted a psychiatrist? if yes, whom _____

□Yes □No Have you ever consulted a neurosurgeon? if yes, whom _____

□Yes □No Are you classified as disabled or partially disabled? if yes, by whom? _____ if no, do you plan to apply? □Yes □No

FAMILY HISTORY

□Yes □No Do you have family history of neurological disease? if yes, please describe_____

_____

	AGE *(CURRENT)*	AGE *(WHEN DIED)*	MAJOR ILLNESS
FATHER			
MOTHER			
BROTHERS			
SISTERS			
CHILDREN:			

NEUROLOGICAL SYMPTOMS CHECK LIST: *Please check any of the following that apply to <u>you</u>*

__ Headache
__ Neck Pain
__ Arm Pain
__ Leg Pain
__ Back Pain
__ Numbness
__ Tingling
__ Paresthesias
__ Abnormal sensations
__ Weakness
__ Paralysis
__ Fatigue easily
__ Muscle wasting
__ Muscle twitching
__ Muscle cramps
__ In coordination
__ Involuntary movements
__ Confusion
__ Abnormal feelings
__ Hallucinations
__ Personality change
__ Depression
__ Weight gain
__ Limping
__ Bladder incontinence
__ Bowel incontinence
__ Sexual malfunction
__ Abnormal menstrual period
__ Sterility
__ Nausea
__ Vomiting
__ Convulsions
__ Fits
__ Epilepsy
__ Seizures
__ Syncope
__ Fainting spells
__ Blackout spells
__ Dizziness
__ Wooziness
__ Memory impairment
__ Abnormal behavior
__ Difficulty sleeping
__ Poor judgment
__ Nervousness
__ Vertigo
__ Giddiness
__ Hearing loss
__ Ringing in ears
__ Noise in ears
__ Discharge from ears
__ Discharge from nose
__ Disturbance of smell
__ Disturbance of taste
__ Pupils unequal
__ Eyelids sagging
__ Double vision
__ Triple vision
__ Disturbance of vision
__ Disturbance of swallowing
__ Disturbance of speech
__ Difficulty saying words
__ Difficulty thinking of words
__ Abnormal thinking
__ Sleeping too much
__ Anxiety
__ Weight loss
__ None of these

I certify that the information contained in the patient History Record is true to the best of my knowledge.

_____ _____

Patient Signature Date

IMPORTANT NOTE: *The following authorizations must be signed by the patient, or by the parent or guardian in case of a minor, or by the nearest relative when the patient is physically or mentally incompetent.*

1. MEDICAL INFORMATION RELEASE AUTHORIZATION

I hereby authorize Peter O. Holliday, III, M.D. and his employees to furnish to any representative of any insurance company with whom I have coverage, to my attorney, or to any court, any and all information that Dr. Holliday, or his employees have or may hereafter have, either written or oral, pertaining to or in any matter connected with any disability, injury, illness, ailment, medical and/or personal history, treatment, examination, consultation, and operation, either past or present and to furnish these companies, my attorney, or to any court upon request, copies of my medical records, charts, and reports pertaining thereto; I further agree that no person, firm or corporation shall be held liable in any matter to furnishing or having furnished such information.

_____ _____

Signature Date

2. ASSIGNMENT OF INSURANCE BENEFITS TO PHYSICIAN

For value received, I hereby transfer, assign and set over to Peter O. Holliday, III, M.D. all insurance benefits of every kind and description for basic, surgical and/or major medical coverage of which benefits would be payable directly to me but for this assignment for his services as described. I understand and agree that I am responsible for any balance due after the insurance company pays.

_____ _____

Signature Date

3. AGREEMENT FOR SECURITY

I hereby grant Peter O. Holliday, III M.D. a security interest in all of the above described benefits together with any proceeds thereof to secure the payment for services provided by Peter O. Holliday, III, M.D. I authorize Peter O. Holliday, III, M.D. to file a financing statement signed by him or his office describing collateral, and to communicate with the parties paying such insurance benefits to me concerning the creation of this security interest. I hereby authorize joint payment of all drafts, checks or payments of such insurance benefits.

_____ _____

Signature Date

4. PATIENT FINANCIAL RESPONSIBILITY

I will be responsible to Peter O. Holliday, III, M.D. for all amounts and balances incurred on my account in accordance with the Terms of the Patient's Accounts as agreed in a separate document. I further authorize the sending of my medical records and bills to my attorney or insurance company, and in the event of recovery by trial or settlement to allow my attorney or insurance company to pay directly to Peter O. Holliday, III, M.D. an amount sufficient to cover these bills and to deduct the same from any recovery which may be due me. I recognize that not withstanding any anticipated recovery or insurance reimbursement that I continue to be fully and completely responsible for all amounts in my patient account and will remit timely payment without delay.

_____ _____

Signature Date

5. AUTHORIZATION FOR PRESENT AND FUTURE CREDIT INFORMATION RELEASE.

This authorization is a continuing authorization. I hereby authorize Peter O. Holliday, III, M.D., P.C., and/or his agents to make an independent investigation and access and obtain information available in my credit history file wherever stored or maintained, both now, and at any future time when my patient account is active with any debts due to owing, or in anticipation of incurring a debt on my patient account. I release Peter O. Holliday, III, M.D., P.C. and his agents and employees and any person or entity which provides information pursuant to this authorization release, from any and all liabilities, claims, or lawsuits in regards to the information obtained from any and all of the above referenced sources used.

_____ _____

Signature Date

WITNESS: *Please have a second party provide signed authorization below that they have witnessed your review, completion and signing of the above authorization sections. This second party can be someone living in your home (i.e. husband/wife).*

_____ _____

Signature Date

ASSIGNMENT AND DIRECT PAYMENT AUTHORIZATION

I hereby instruct and direct_____ Insurance Company to pay by check made out and mailed to:

Peter O. Holliday, III, M.D. , 420 Charter Blvd. Suite 402, Macon, GA 31210

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out a check to me and mail it as follows:

Peter O. Holliday, III, M.D., 420 Charter Blvd. Suite 402, Macon, GA 31210

For the professional and medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____this _____day of _____,20_____

_____ _____

Signature of Policyholder Witness

_____

Signature of the Claimant, if other than policyholder

RE: TERMS OF PATIENT ACCOUNTS

A. INTRODUCTION

Regardless of insurance coverage, a patient's account is his or her responsibility. All required office visit copays and/or co-insurance are required to be paid at the time of service. In the case of surgery, a patient's financial responsibility will be estimated PRIOR to surgery and is to be paid in full before surgery will be performed. Any patient not able to pay the estimated amount prior to surgery will be rescheduled until payment is satisfied. Normally, insurance companies will pay on patient accounts between 30 and 120 days after a claim for benefits is filed. If, after your insurance has paid, there is still a sizeable balance remaining, we will be glad to work with you on arranging a payment plan to suit financial condition. Accounts which are over 90 days old will have interest applied on unpaid balances at the rate of 18% per year (1 ½% month).

B. STATEMENT OF TERMS

All remaining balances on a patient's account will be satisfied within thirty (30) days after initial billing. Any agreements concerning repayment or special repayment terms are not binding unless entered into in a separate writing by the patient and this office, (hereto after "Special Forbearance Agreement"). Special Forbearance Agreements specifically include, but are not limited to, any oral agreements to delay collection pending Medicare payments, the proceeds of insurance settlements, or proceeds from civil judgments. Patient will pay all expenses accrued in the enforcement of any rights concerning any account including the sum of fifteen percent (15%) of the principle and interest due on the account as attorney fees if collected by law or through an attorney at law or under advice therefrom. No delay or waiver in collection of a delinquent account or any course of dealing between the patient and this office shall operate a waiver of any right to collect the account. Furthermore, any delay in the collections of a delinquent account shall in no way limit Dr. Holliday's right to exercise any and all legal remedies available to him at any time whatsoever after the account has become delinquent under the terms of this agreement.

C. ACKNOWLEDGEMENT BY PATIENT

Patient has reviewed the foregoing and accepts the terms for the establishment of a patient account for payment of said account.

Signature_____ Date_____

Witness Signature _____

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PATIENT CONSENT FORM

Patient Consent for Use/Disclosure of Health Care Information

Patient's Name: _____ Date of Birth_____

SSN:_____ Previous Name:_____

I understand that the patient's health information is private and confidential. I understand that Peter O. Holliday, III, M.D., PC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Peter O. Holliday, III, M.D., PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations.

Peter O. Holliday, III, M.D., PC has a detailed document called the "Notice of Privacy Practices". It contains information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Peter O. Holliday, III, M.D., PC may update this "Notice of Privacy Practices". If I ask, Peter O. Holliday, III, M.D., PC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Peter O. Holliday, III, M.D., PC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Peter O. Holliday, III, M.D., PC does not have to agree to my request. If Peter O. Holliday, III, M.D., PC does agree to my request, I understand that Peter O. Holliday, III, M.D., PC would follow the agreed limits.

I may cancel this consent in writing at any time by doing the following:

> *Writing, signing, and dating a letter to Peter O. Holliday, III, M.D., PC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care operations.*

If I revoke this consent, Peter O. Holliday, III, M.D., PC does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Peter O. Holliday, III, M.D., PC's "Notice of Privacy Practices". My signature means that I agree to allow Peter O. Holliday, III, M.D., PC to use and disclose the patient's person health information to carry out treatment, payment, and health care operations.

_____ _____ _____

Patient Signature or legally authorized individual signature Date Time

_____

Relationship to patient (if signed by anyone other than the patient)