DAVID MCKALIP, M.D.
BRAIN AND SPINE SURGEON
Board Certified Neurological Surgeon

David M. McKalip M.D. LLC
15 Bowens Ct.
Cartersville, GA 30120

New Patient Registration Form

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone (_____) _____ Work Phone (_____) _____

Mobile Phone (_____) _____ May we text you? [ ] Yes [ ] No

Email address (never shared or used for marketing): _____

Date of Birth: _____ Age: _____ Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Social Security #: _____ - _____ - _____

Driver License #: _____

Occupation: _____ Present Employer: _____

Employer's Address: _____City: _____

Primary Care
Physician: _____ Phone: (_____) _____

Address: _____Suite _____

City: _____ State: _____ Zip: _____

What is the reason for your visit? _____

_____

How did you hear about us?

- ☐ Saw your sign
- ☐ TV/Radio
- ☐ Newspaper
- ☐ Website: _____
- ☐ Friend: _____
- ☐ Doctor: _____
- ☐ Other _____

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Secondary Contact Information

Please list whom we may contact in case of emergency or in case of appointment change and we cannot reach you (for example: a friend or relative):

Name of Contact Person: _____

Relationship to the Patient: _____

Contact's Person's Address: _____

City: _____ State: _____ Zip: _____

Contact Person's Best Phone Numbers:

Phone #1: (_____) _____ Phone #2: (_____)_____

Primary Insurance

Insurance Company: _____ Policy#_____

Insured's Name ("Primary Subscriber"): _____

Relationship to the Patient: _____

Primary Subscriber's Date of Birth: _____ /_____/_____

Secondary Insurance

Insurance Company: _____ Policy/Cert.# _____

Insured's Name ("Primary Subscriber"): _____

Relationship to the Patient: _____

Primary Subscriber's Date of Birth: _____ /_____/_____

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Statement of Patient Responsibilities and Agreement

Patient Name: _____ DOB: _____

It is our sincere privilege and aim to provide you with the highest quality of specialty neurosurgical care. In order to make your appointment go as smoothly as possible and for you to receive the full benefit and maximum amount of time with your doctor, we would like to make you aware of our practice's policies regarding patient appointments and financial responsibility.

To be accepted as a patient of David M. McKalip, M.D. LLC ('the practice"), please INITIAL and SIGN to indicate that you agree to each of the following policies:

FINANCIAL POLICY

As a patient of our practice, you are responsible to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are responsible for providing us with your current insurance information and notifying us of any changes in your coverage. Payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Co-payments are due at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

_____ I have read the accept the above financial policy and agree to be financially responsible to the practice for all charges for medical services received. I agree to provide my current insurance information and notify the practice of any changes in a timely manner. I authorize my insurer to pay any benefits directly to David M. McKalip, MD, LLC on my behalf. I understand that all co-payments are due at time of service. I understand that I am responsible for amounts not covered by my insurance company. If I do not have insurance, or if my insurance is inactive or not accepted by the practice, I agree to make payment arrangements prior to being scheduled or seen for an appointment.

FILMS POLICY

_____I agree to arrange for my medical imaging ("films"), including MRIs, w/rays, CT scans, etc. to be delivered to David M. McKalip, MD LLC *prior to being scheduled* for an appointment, to provide sufficient time for doctor review. I understand the staff will make every reasonable effort to assist me in obtaining my films. It is my responsibility to confirm that my films have been received. If my films have not been received by the practice prior to my appointment,

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I understand that *my appointment may have to be rescheduled*, at the sole discretion of my doctor. If my doctor agrees to see me without my films, I will still be financially responsible for the office visit.

ON-TIME ARRIVAL POLICY

_____ I agree to arrive to my appointment at the designated time. If I am late for any reason, or if my completed paperwork is not ready at the start time of my appointment, I understand that I may have to be rescheduled, at the sole discretion of my doctor. If my appointment is rescheduled, I will not be charged for the missed appointment.

PAPERWORK POLICY

_____ I agree to complete and submit all registration forms and other required documents *prior to the scheduled time of my appointment.* If I plan to complete paperwork at the doctor's office, I agree to arrive 30 minutes early to my scheduled appointment time. If my paperwork is not complete by the time of my appointment, I understand that *my appointment will be rescheduled.*

CANCELLATION/NO-SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

_____ I understand if I am a no-show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

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CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize David M. McKalip, MD LLC, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize David M. McKalip, MD LLC to release to appropriate agencies, insurance companies, hospitals, doctors, and other health care providers any information acquired in the course of my or the above-named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Please sign the following if applicable:

Self-Pay

I do not have health insurance and will be responsible for services rendered here at David McKalip, MD LLC. I agree to pay David McKalip, MD LLC, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature _____ Date _____

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Acknowledgment of Notice of Privacy Practices

David M. McKalip, MD LLC reserves the right to modify the privacy practices outlined in the notice. written copy of our Notice of Privacy Practices is available upon request.

Please check:

❑ I have reviewed the Notice of Privacy Practices for David M. McKalip, MD LLC.

Name of Patient (Print): _____

Signature of Patient: _____ Date: _____

OR

Signature of Patient
Representative: _____ Date: _____
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient: _____

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Authorization for Release of Information to Individuals

I, (Patient name) _____ , grant permission to David M. McKalip, M.D. LLC to disclose and release my protected health information (PHI) to the following persons:

Name(s): _____ Relationship: _____

_____ _____

_____ _____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ My complete heath record, as above, with the exception of the following information: (Check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective (check one):

- ☐ For all past, present, and future periods, OR
- ☐ Until date or event: _____ unless I revoke it.
  (NOTE: You may revoke this authorization at any time by notifying us in writing.)

Signature of the Person Giving this Authorization: _____

Date: _____ Printed Name: _____

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Authorization for of Release of Information to Insurers and Healthcare Providers

I hereby authorize David M. McKalip, M.D. LLC to release my personal information, including Protected Health Information (PHI), to my insurance company or Workers Compensation carrier.

I also authorize David M. McKalip, M.D. LLC to release information to any hospital or physician that I may be referred to by this office.

Name of Patient: _____

Signature: _____ Date: _____

OR:
Patient's Authorized Representative:_____

Relationship to Patient: _____

Signature: _____ Date: _____

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Date: _____

Re: REQUEST FOR RELEASE OF MEDICAL RECORDS

To Whom It May Concern:

I hereby authorize the release of my medical records as follows:

Please send Medical Records, including H&P, Intake Forms, Progress Notes, Checkout sheets, and Operative Reports.

I request that they be faxed or mailed to:

David M. McKalip, M.D., LLC
15 Bowens Ct.
Cartersville, GA 30120

Fax: (770) 607-9095

_____ _____
Patient Name of Patient Date of Birth

_____
Social Security Number

_____ _____
Patient Home Phone # Patient Cell Phone #

_____
Signature of Patient or Guardian