Southern California Institute of Neurological Surgery
Mark S. Stern, M.D.

ABOUT US

Information to New Patients

Dr. Mark S. Stern is the only board-certified neurosurgeon in Northern San Diego County. He is a graduate of the Albany Medical School. Dr. Stern completed his internship and residency at Georgetown University and the University of Southern California. He is a member of the San Diego Medical Society, the American Medical Association, the California Neurosurgeons Association, and the American Association of Neurosurgeons.

Dr. Stern has been practicing since 1984. He works very closely with Palomar Medical Center and also Tri-City Medical Center. Dr. Stern is frequently on trauma call at the emergency room in addition to the 1,200 active patients in his practice. Every Monday and every-other Tuesday and every-other Thursday he performs surgeries at the hospitals.

Because of the overwhelming number of patients from his practice and hospital follow ups, there may be a long wait time for your appointment. The doctor often has to leave to the hospital between office appointments to tend to our patients that are in critical care or trauma-call. Also, the hospital calls him frequently to obtain orders for his patients that are currently in our care. We are informing you of these unexpected time delays so that you can plan your day accordingly.

To assist our patients with these follow ups and when the doctor is away, is Dr. Stern's assistant; James H. Kimber, P.A. He spent 20 years in the U.S. Navy during which time he served as an Independent Duty Corpsman, retiring in 2002. He graduated in 2004 from Stanford University specializing in Neurological and Spinal Surgery. James joined our team in 2008.

Again, we apologize ahead of time for any inconvenience these delays may cause. We make every effort to notify our patients when a delay or reschedule is needed.

Sincerely,

The Staff and Physicians at Southern California Institute of Neurological Surgery

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Please Initial

MARK. S. STERN, MD.

REFERING M.D.______________________________
PHONE#______________________________

PATIENT NAME__________________________________BIRTH DATE_______________AGE_____

ADDRESS____
CITY ZIP

PHONE #______________________CELL#_______________________SSN______________________

EMPLOYER____PHONE#_______________________

ADDRESS____
CITY ZIP

SPOUSE NAME_________________________SSN_______________BIRTH DATE_______________

EMERGENCY CONTACT ___________________________________PHONE#___________________
(NOT LIVING WITH YOU)

INSURANCE INFORMATION

PRIMARY INSURANCE_____________________________ID#_________________GRP#__________

ADDRESS____PHONE#__________________
CITY ZIP CODE

SECONDARY______________________________________ID#________________GRP#__________

ADDRESS____PHONE#__________________
CITY ZIP

WORKMANS COMPENSATION INFORMATION

INSURANCE NAME____PHONE#__________________

ADDRESS____CLAIM#__________________

ADJUSTER'S NAME____PHONE#__________________

EMPLOYER AT TIME OF INJURY____________________________________DOI_______________

ATTORNEY INFORMATION

NAME OF ATTORNEY_____________________________________PHONE#____________________

ADDRESS____
CITY ZIP

Southern California Institute of Neurological Surgery

MARK S. STERN, M.D.
JAMES H. KIMBER, PA

FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Mark S. Stern, M.D. and any assistant physician for services rendered. I am financially responsible for all charges whether or not they are covered by insurance or rejected by workman's compensation. In the even of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize this physician to release all information necessary to secure the payment of benefits. I hereby authorize The Southern California Institute of Neurological Surgery to provide medical record information pertaining to the care rendered to any other Health Care Provider, Hospital or Insurance Carrier or Workman's Compensation Carrier for the purpose of evaluation, treatment and/or reimbursement of medical services. I further agree that a photocopy of this agreement shall be as valid as the original. This agreement will remain in effect until revoked by me in writing.

Insurance

In most cases we will accept your insurance benefits. Your portion of the bill (also known as co-payments/co-insurance) is to be paid at the time of service. We cannot waive or discount this fee due to our contracts with insurance companies. If not paid, we reserve the right to charge an interest of 1.5% to any unpaid balance. In the event of surgery, this will take effect 90 days after the date of surgery. The balance is your responsibility whether your insurance company pays or not.

We cannot file a claim to your insurance company unless you give us your insurance information. Please present your insurance card at the time of check-in. It is necessary for us to keep a copy of the card in your medical records chart.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and sometimes all, of the services provided may not be covered by your insurance.

In the event that a charge is not covered by your plan, you will be billed the balance after we obtain an Explanation of Benefits from your insurance carrier. Outstanding charges are due upon receipt. Accounts with unpaid charges 120 days from the original date a claim has been filed, are placed with a collection agency. You will be responsible for any collection cost.

Missed Appointments

We understand that schedules sometimes change with short notice, but we would appreciate the courtesy of a 24-hour notice if you need to cancel an appointment. If the appointment is not cancelled 24 hours in advance or you do not show up for a scheduled appointment, you will receive an invoice with a missed-appointment fee. We reserve the right to charge $25.00 for missed appointments and $250.00 for missed in-office procedures. Please help us serve you better by keeping your scheduled appointment. We try to confirm all appointments the day before; however, this is a courtesy. Not receiving a reminder from our office does not release a patient from the responsibility of remembering an appointment.

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PLEASE INITIAL (*page 1*)

Medical Records Requests

Copies of records will be released with written patient authorization in a timely manner. Please allow us one week to complete the request. The number of pages will determine the service fee between $15.00 - $35.00.

Disability/DMV Forms

There will be a charge of $35.00 to complete an initial disability form and $15.00 for DMV forms.

Returned Checks

There will be a $25.00 service charge for all returned checks.

Prescription Refills

If you need a medication refill please contact your pharmacy and have them fax a refill request to the office. All medication refills will be addressed within three business days of contacting the office of Dr. Mark Stern. Please give your pharmacy enough time to fax and receive an answer BEFORE you run out of your medication.

If you have not received a call back within three business days, please contact your pharmacy to see if you medication has been filled via phone or fax. If your pharmacy has not received confirmation of your refill please call our office.

If this is a pain emergency you should go to the nearest Emergency Room in your area, Dr. Mark Stern will be notified if you are admitted.

Consent For Treatment

I voluntarily consent to medical treatment under the professional judgment of Mark S. Stern, MD and his staff. I understand that the medical treatment performed is necessary or beneficial to my condition.

Patient Confidentiality

I have read this office's PRIVACY POLICY PRACTICES and have received a copy if I so desire. ____________

PLEASE INITIAL

X____ ________________________

Signature of Patient Date

X____ ________________________

Signature of Parent or Guardian Date

Southern California Institute of Neurological Surgery
Mark S. Stern, M.D.
James H. Kimber, PA

NAME: ______________________________ **AGE/ DOB**:________________ **TODAY'S DATE**:______________

PLEASE INDICATE ANY PROBLEMS BELOW:

GENERAL:
__ WEIGHT CHANGES
__ TEND TO BE HOT or COLD
__ CHANGE in APPETITE/THIRST
__ FATIGUE
__ SLEEPING DIFFICULTIES
__ SMOKING-___Per Day ___ Years
__ COFFEE/TEA- ___ Cups per Day
__ ALCOHOL- Amount__________

MUSCULOSKELETAL:
__ ACHING MUSCLES & JOINTS
__ BACK & SHOULDER PAIN

CARDIOVASCULAR:
__ HIGH BLOOD PRESSURE
__ RACING HEARTBEAT
__ CHEST PAIN/HEAVINESS
__ SHORTNESS OF BREATH
__ DIZZY SPELLS
__ SWOLLEN FEET & ANKLES
__ LEG CRAMPS
__ HEART MURMUR
__ HEART ATTACK

SKIN:
__ SKIN PROBLEMS
__ BLEEDS EASILY
__ BRUISES EASILY

FEMALE GENITAL:
__ MENSTRUAL TROUBLE
__ VAGINAL DISCHARGE
__ PREGNANCY PROBLEMS
LAST PAP SMEAR____________
LAST MAMMOGRAM_________

CURRENT MEDICATIONS:
HOW LONG? ___________________
____
____

MOOD:
__ LACK OF CONCENTRATION
__ POOR MEMORY
__ LONELY or DEPRESSED
__ DIFFICULTY RELAXING
__ EASILY ANNOYED
__ WORK/FAMILY PROBLEMS
__ SEXUAL DIFFICULTIES
__ DESIRE PSYCHIATRIC HELP

EYES, EARS, NOSE & THROAT:
__ WORSENING EYESIGHT
__ SEEING DOUBLE
__ SEEING HALOS
__ EYE PAIN/ITCHING
__ HEARING DIFFICULTY
__ EAR ACHES
__ BUZZING/RINGING in EARS
__ MOTION SICKNESS
__ NOSE BLEEDS

RESPIRATORY:
__ WHEEZES
__ CHRONIC COUGHING
__ COUGH or BLOOD
__ CHEST COLDS
__ LAST CHEST X-RAY:_______

SOCIAL HISTORY:
__ BIRTHPLACE
__ MARITAL STATUS
EDUCATION_________________
DAILY ACTIVITIES_____________
____

HOSPITLIZATIONS:
REASON & DATE: ______________
____
____
____
____

NEUROLOGICAL:
__ WEAKNESS-ARMS/LEGS
__ NUMBNESS______________
__ CONVULSIONS/SEIZURES
__ CHANGE in HANDWRITING
__ TREMOR

HEAD & NECK:
__ FREQUENT HEADACHES
__ NECK PAINS
__ NECK LUMPS/SWELLING

DIGESTIVE:
__ HEARTBURN
__ ABDOMINAL PAIN
__ NAUSEA
__ VOMITTED BLOOD
__ SWALLOWING DIFFICULTY
__ CHANGE in BOWEL HABITS
__ BLACK STOOLS
__ RECTAL BLEEDING

URINARY:
__ PROSTATE TROUBLE
__ BURNING with URINATION
__ DIFFICULTY in URINATION
__ FREQUENT URINATION

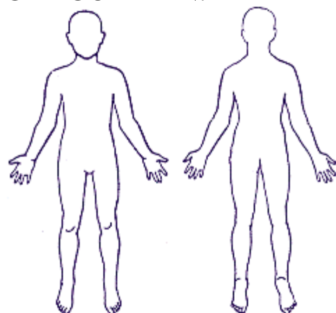
TRAVELS out of USA:
DATES/LOCATIONS: __________
____
____
____

SPECIAL PROBLEMS:______________
____
____
____
____
____

DRUG ALLERGIES & REACTION:
____
____
____
____

PLEASE LIST FAMILY MEMBERS' HEALTH PROBLEMS, IF DECEASED, AGES & CAUSE OF DEATH:
MOTHER____
FATHER____
SIBLINGS____
CHILDREN____

PLEASE INDICATE THE LOCATION OF YOUR PAIN:



QUESTIONS FOR MY DOCTOR

NAME: ________________________________ **DOB:** ______________

DATE: ______________________________ **TIME:** ________________

CHIEF COMPLAINT TODAY: ___________________________________

____

I **DO NOT** HAVE ANY QUESTIONS TO ASK MY DOCTOR ABOUT MY CONDITION:

____

Patient's Signature

I Have The Following Questions To Ask My Doctor:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____

My Doctor Has Answered All Of My Questions:

____

Patient's Signature

Southern California Institute of Neurological Surgery
Mark S. Stern, M.D.
James H. Kimber,PA

NOTICE OF PRIVACY PRACTICES

This notice describes how health information and records we have about you may be used and disclosed and how you can access this information. Please review it carefully.

If you have any questions regarding this notice, please contact the Privacy Officer at (760) 489-9490.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you health, health status, and the health care and services you receive in this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describe your rights and obligations regarding the use and disclosure of that information.

OUR RESPONSIBILITIES

Our privacy responsibility is to safeguard you personal health information. We must also give you this notice of our office privacy practices, and follow the terms of the notice that is currently in effect.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you, as well as information we receive in the future.

If you believe your privacy rights have been violated, you may file a complaint with our office. This complaint must be in writing in care of the Privacy Officer. There will be no retaliation to filing a complaint. You also have the right to complain to the Secretary of the Department of Health and Human Services.

HOW WE MAY USE & DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed consent to use and disclose you health information for the following purposes:

TREATMENT: We may use health information about you to provide you with medical treatment and services. We may disclose health information about you to other doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and you health.

PAYMENT: We may use and disclose health information about you so that the treatment and services you receive at our office may be billed to and payment collected from you, and insurance company or a third party. This may also include the disclosure of health information to obtain prior authorization for treatment and procedures from you insurance plan.

BUSINESS ASSOCIATES: There are some services provided in our office through contacts with business associates. We may disclose you health information to our business associates so that they can perform the job we have asked them to do. To protect you health information, we require our business associates to sign a contract that states they will appropriately safeguard you health information.

APPOINTMENT REMINDERS: We may use and disclose you health information to contact you as a reminder that you have an appointment for treatment of medical care at this office.

SPECIAL SITUATIONS

The following disclosures of you health information are permitted by law without oral and written permission from you.

ORGAN & TISSUE DONATION If you are an organ donor, we may release health information to persons that handle organ procurement, organ, eye and tissue transplantation, or to an organ donation bank.

MILITARY & VETERANS If you are a member of the armed forces, we may release health information about you as required by military command authorities.

WORKERS' COMPENSATION We may release health information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries.

AVERTING A SERIOUS THREAT TO HEALTH & SAFETY We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety, or the health and safety to another person or the public.

PUBLIC HEALTH ACTIVITIES We may disclose health information about you for the public health activities. These generally include the following reasons: a) in order to prevent or control disease, injury or disability; b) report births and deaths; c) child abuse or neglect; d) non-accidental physical injuries; e) reactions to medications; or f) problems with recalls of products.

HEALTH OVERSIGHT ACTIVITIES We may disclose health information about you to a health oversight agency for audits, investigations, and government programs in compliance with civil laws.

LAWSUIT AND DISPUTE If you are involved in a lawsuit, we may disclose health information about you in response to a court or administrative order subject to all applicable legal requirements. We may disclose health information about you in response to a subpoena.

LAW ENFORCEMENT We may disclose health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

CORONERS & MEDICAL EXAMINERS We may disclose health information about you to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death of a person.

LEGAL REQUIREMENTS We will disclose health information about you without your permission when required to do so by a federal, state, or local law.

INDIVIDUALS INVOLVED IN YOUR CARE We may disclose health information about you to a friend or family member who is involved in your medical care, unless you tell us in advance not to do so.

OTHER USES AND DISCLOSURES

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your permission. If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose any health information about you for the reasons covered by the written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. We may ask you to sign an authorization allowing us to use or disclose your health information to others for specific purposes.

Southern California Institute of Neurological Surgery
Mark S. Stern, M.D.
James H. Kimber, PA

Authorization for Use of Disclosure of Health Information

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Dr. Mark Stern cannot condition services on whether or not you sign this authorization except under limited circumstances, such as for services related to research, eligibility or enrollment determinations, or services performed solely to create information for an outside requestor (such as Worker's Compensation). In these circumstances, Dr. Mark Stern may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information leaves the office of Dr. Mark Stern, we will no longer protect that information, and the recipients of your information may not be legally required to protect your information.

AUTHORIZATION: I hereby authorize (Name & Address of facility or individual):
Dr. Mark S. Stern 705 East Ohio Avenue Escondido, CA 92025
□ to furnish to (or) □ to obtain from
(Name & Address of facility or individual):____
____
Health records and information pertaining to medical history, mental or physical condition, services rendered or treatment of: (Name of patient)____________________________________
DOB: __________________ Dates of Service: ____
Location of service: □ Dr's office □ Inpatient □ Outpatient □ Emergency □ Other:________________
I understand that this may include information relating to AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus) Infection, Psychiatric care and/or Treatment for alcohol or drug abuse. This authorization is limited to the following medical records and type of information:
□ Discharge Summary □ History & Physical Exam □ Consultation Report □ Progress Notes
□ Lab Tests □ X-ray Report □ Photographs, videotapes, digital images, or □ Other (Please specify and limitations):____

USES: The requestor may use the medical records and type of information authorized *only* for:
□ Continuing Care □ Inspection of Record ONLY □ Legal Matters □ Insurance Claim
□ Personal Copy □ Second Opinion □ Other (Please specify):____________________
____

DURATION: I understand that this authorization may be revoked in writing at any time according to the instructions of Dr. Mark S. Stern's Notice of Privacy Practices, except to the extent that action has been take in reliance on this authorization. Unless otherwise revoked, this authorization will expire within six months from the date of this authorization.

RESTRICTIONS: I understand that Dr. Mark S. Stern may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release <u>Dr. Mark S. Stern from any legal liability that may arise from the release of this information to the party named above.</u>

ADDITIONAL COPY: I further understand that I have the right to receive a copy of this authorization upon my request. (Civil Code S.56.11)

SIGNATURE:
Printed Name: ____________________________ Signature:________________________________
Date: __________________If signed by other than patient, indicate relationship:________________
Witness:____ Date:__________________________
(TDKC4/03)

DIRECTIONS TO THE OFFICE

705 E. Ohio Avenue Escondido, CA 92025

Peach-colored house with wrought iron fence and fountain in the front.

From I-15 South:

Exit I-15 at Valley Parkway and turn left
Stay on Valley Parkway which turns into 1-way (2nd Avenue)
Rt. lane past the police station on 2nd Avenue to a Y intersection
Bear Rt., around the corner where it turns to Grand Avenue. Palomar hospital will be on your Lt. Get into the Lt. lane to the bottom of the hill.
Turn Lt. at the light (Fig Street)
Turn Rt. 1 block on Ohio – on the corner with parking just around the corner.

From I-15 North:

Exit I-15 at Valley Parkway and turn right
Stay on Valley Parkway which turns into 1-way (2nd Avenue)
Rt. lane past the police station on 2nd Avenue to a Y intersection
Bear Rt., around the corner where it turns to Grand. Palomar hospital will be on your Lt. Get into the Lt. lane to the bottom of the hill.
Turn Lt. at the light (Fig)
Turn Rt. 1 block on Ohio – on the corner with parking just around the corner.

From 78 East:
(Toyota)

Continue on Highway-78 E until the freeway ends at Broadway

Cross Broadway and becomes Lincoln Avenue
2nd light ***after*** Broadway turn Rt. (Fig Street)
Go straight on Fig past **Mission, Washington, Valley Parkway, Pennsylvania Avenue**, and then to **Ohio** on the Lt. (you cannot turn Rt. at Fig and E. Ohio)
On the corner of Fig Street and E. Ohio Avenue - parking just around the corner.