INTAKE FORM: Sanjay Ghosh; Senta Neurosurgery; Pac Neuro; Premier Neuroimaging, Inc.

PLEASE COMPLETE THE FOLLOWING, it is required for your electronic file.

Last Name: ______________________________ First Name: _________________________ MI: _____

DOB: ________________ SS #: _______________________ Sex: ☐ M ☐ F

Address: ____

City/State: _______________________ Zip: _____________ Marital Status: ☐ M ☐ S ☐ D ☐ W

Home Phone: __________________ Cell Phone: __________________ E-mail:_____________________

*we do not guarantee confidentiality of information if you choose to engage in email exchange.

Work Phone: __________________ Occupation/Employer: ____________________________________

Prefer to be reached at: ☐ Home ☐ Cell ☐ Work Ok to leave detailed messages? ☐ Yes ☐ No

Race: ____________________ Ethnicity: _____________________ Language: ____________________

Primary Care MD: ____________________________________ Phone: ___________________________

Referring MD: _______________________________________ Phone: ___________________________

**HIPAA: Is there anyone you wish us to share your medical information with?

____

Emergency Contact: __________________________ Relationship: ___________ Ph: _______________

Guarantor/Person Responsible for Payment: ☐ Check here if patient is responsible

Name: ____ Relationship to Patient: _______________

Address (if different): ____

DOB: ________________ SS #: _______________________

Insurance Information:

Primary Insurance: _______________________________________ Effective Date: _________________

Member ID: ______________________________ Group # (if applicable): _________________________

Secondary Insurance: _____________________________________ Effective Date: _________________

Member ID: ______________________________ Group # (if applicable): _________________________

I hereby assign to the medical service corporations referenced above any and all contractual, legal and equitable rights that I may have to payment from my medical insurance carrier(s) for any and all medical services rendered to me by Dr. Sanjay Ghosh or by other medical professionals on behalf of those medical service corporations. I hereby direct that all payments by my insurance carrier(s) shall be made directly to those corporations. I authorize each of these corporations to release to my insurance carrier(s) any and all information necessary to process my claim for benefits and to take any necessary legal action as an assignee to collect those benefits from my insurance carrier(s). I understand that I am responsible for payment of all sums billed for medical services provided to me over and above the sums that are actually and promptly paid by my insurance carrier(s), and I shall promptly pay those sums if requested to do so.

Patient Signature: ____ Date: __________________

Senta Neurosurgery Patient Medical History

Patient Name: **Date:**
Date of Birth:

Reason for your visit today?

Check if you are currently experiencing					
Fevers		Cough		Abnormal bleeding	
Chills		Shortness of breath		Back pain	
Sweats		Coughing blood		Neck pain	
Loss of appetite		Chest pain		Numbness	
Fatigue		Palpitations		Paralysis	
Weight change		Loss of consciousness		Weakness	
Blurry eyes		Swelling in legs		Fainting	
Double vision		Nausea		Tremors	
Sudden vision loss		Vomiting		Dizziness	
Ringing in ears		Diarrhea		Memory loss	
Decrease in hearing		Abdominal pain		Mental illness	
Facial pain/pressure		Incontinence		Trouble breathing on exertion	
Sore throat		Pain during urination			
Trouble swallowing		Frequent urination			

Current Medications:	Strength:	Directions:
1		
2		
3		
4		
5		
6		
7		
8		
Pharmacy Name:		**Phone:**

Drug Allergies:	Reaction/Side Effect:

Patient Medical History

Patient Name: **Date:**

Do you or have you ever had any of the following: Y or N					
Tuberculosis		High Blood Pressure		Arthritis	
Asthma		High Cholesterol		Abnormal Bleeding	
COPD/Emphysema		Stroke		Anemia	
Sleep Apnea		Diabetes		Hepatitis	
Heart Disease		Migraines/Headaches		Gastritis, Reflux	
Congestive Heart Failure		Kidney Infection		Seizure	
Atrial Fibrillation		Bladder Infection		HIV	
Heart Attack		Ulcer		COVID-19	
Claustrophobia					
Cancer/Tumor:		Site and Treatment:			

Other Medical Illnesses		
1	3	5
2	4	6

History of Operations	
1	Year:
2	Year:
3	Year:
4	Year:
5	Year:
6	Year:
7	Year:

Family History	Y/N	Relationship
Heart Attack		
Cancer/ type		
Stroke		
Aneurysm		
Immunodeficiency		
Bleeding Disorder		
Hypertension		
Diabetes		
Hearing Loss		

Social History		
Do you smoke?	For how long?	Year quit?
Do you drink alcohol?	How much?	
Do you or have you ever used ilicit drugs? Please list:		

Patient Signature:

Patient Pain Drawing

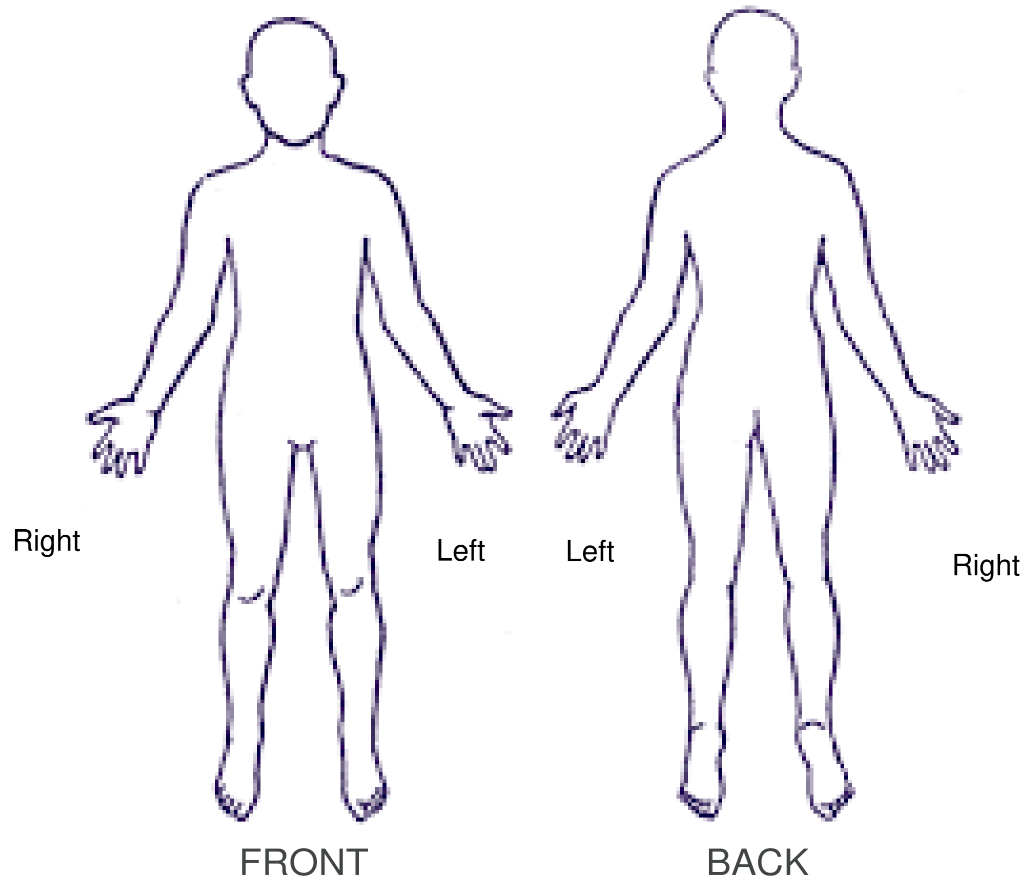
______________________________ ______________________

Name Date

Where is your pain now?

- Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
- Mark the areas of radiation and include all affected areas.
- To complete the picture, please draw in your face.

Aching	Numbness	Pins & Needles	Burning	Stabbing
^^^	===	000	xxx	///



How bad is your pain right now?

1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

No Pain Worst Pain

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SENTA
NEUROSURGERY

Sanjay Ghosh, MD
Scott P. Leary, MD
Alois Zauner, MD
Amanda Gumbert, PA
Felix Regala, PA
Deb Frantz, PA
Peter Schultz, NP

CORPORATE &
MAILING ADDRESS

MISSION VALLEY
3590 Camino Del Rio N
Suite 200
San Diego, CA 92108

PH: 619-810-1010
FX: 619-810-1011

OTHER LOCATIONS

LA JOLLA
9850 Genesse Ave
XiMED Building Suite 630
La Jolla, CA 92037

MESA COLLEGE
7625 Mesa College Drive
Suite 305A
San Diego, CA 92111

Acknowledgement of Receipt of Notice of Privacy Practices

SENTA Medical Clinic
Division of Neurological Surgery
3590 Camino Del Rio North #200
San Diego, CA 92108
Privacy Officer, Edith Smith, 619-810-1242

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

______________________________.

Signed: ________________________________ Date: ___________________________

Print Name: ____________________________ Telephone: ______________________

Date of Birth: __________________________

If not signed by the patient, please indicate:

Relationship:
____ parent or guardian of minor patient
____ guardian or conservator of an incompetent patient
____ beneficiary or personal representative of deceased patient

Name of Patient: ____

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Imaging Facility Notice

To my patients:

During the course of your treatment, you may require additional imaging studies. You may be referred to **SMI Imaging Center** for these tests. Please be aware that I own a financial interest in the aforementioned facility. There are other facilities available in our medical community where the same procedure(s) can be performed, and you have the option to use any of these alternate facilities. Some of these facilities are listed below. You will not be treated any differently by me regardless of the facility at which you choose to be treated.

Thank you for your cooperation.
Sanjay Ghosh, M.D.

Patient Name (print): ____

Signature: ________________________________Date: ____________

Alternate Facilities:
Imaging Healthcare Specialists, Sharp Grossmont Terrace, Grossmont Imaging, Scripps Memorial

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Controlled Substance/ Narcotic Agreement

This agreement is between the patient and Senta Neurosurgery. It is agreed that narcotic medication will be given by Dr. Sanjay Ghosh, D, Amanda Gumbert, PA-C, Felix Regala, PA-C, Deb Frantz, PA-C on a regular basis to the patient **ONLY** if the following terms are met:

1. By signing a contract for narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including side effects, and is agreeable to start this treatment under the terms set by Senta Neurosurgery.
2. I will take medications **only** as prescribed. I will not exceed the prescribed dose even if I perceive it to be necessary. **No early** refills will be given if I run out of medications early.
3. I am fully responsible for the safe keeping of my medication. Lost or stolen medications will **not** be replaced.
4. I will never share my medications with others.
5. I will **not** use illicit drugs or abuse alcohol.
6. No narcotic prescriptions will be refilled after hours or on weekends.
7. I will not drive a vehicle or use dangerous equipment while taking my pain medications. I am aware that if I have narcotics in my system while operating a vehicle I may be subject to a DUI.
8. I am aware that narcotic medications are addicting.
9. I am aware that suddenly stopping these medications may be dangerous.
10. I will inform Senta Neurosurgery of any new medications written by any other provider.

I fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in treatment of my pain. This has been fully explained to me, I have read it or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

____
Date

Patient Signature	**Print Patient Name**
Witness Signature (Office Staff Only)	**Print Witness Name (Office Staff Only)**

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Notice of Insurance Network Status of Dr. Sanjay Ghosh

Please be advised, Dr. Sanjay Ghosh is not contracted with any insurance entity. As such, Dr. Ghosh is out of network with all health insurance plans.

You may see Dr. Ghosh as an out of network provider.

Our staff will confirm with your health insurance company the presence of out of network benefits as prior authorization or other care management limitations may be required before providing services to you. Should you have out of network benefits, you may see Dr. Ghosh utilizing your health insurance. It has been the experience of this office that medical insurance payments for office visits are similar when seeing an out of network provider compared to an in-network provider.

Should your insurance coverage not provide you with out of network benefits, our office shall notify you of the costs of the office visit prior to your appointment, so that you may make an informed decision whether to proceed. Your consent to receive services from Dr. Ghosh is optional and you may instead seek care from an in network provider or facility where in network cost sharing will apply.

Should you choose to move forward with surgery with Dr. Ghosh, our office will provide the following information prior to surgery:

1. A written estimate of the fees charged by Dr. Ghosh for the surgery. The patient will be informed of their copayment responsibility for the surgery when performed by Dr. Ghosh.
2. A written estimate of what the insurance company may allow for the surgery for an -in-network provider. The patient will be informed of their copayment responsibility when an in-network provider performs the surgery.

Should you prefer to be treated by an in-network provider, please contact your health plan directly for a list of contracted providers. If you have any questions, please do not hesitate to reach out to management.

For more information on the No Surprises Act, please visit www.cms.gov/nosurprises.

With my signature below, I acknowledge receipt of this notice at least 72 hours prior to any surgery performed by Dr. Sanjay Ghosh. Should I require surgery within 72 hours, I waive the 72-hour requirement for this notice and acknowledge receipt of this notice no later than one business day after scheduling the service.

_______________________________________ ____

Patient Signature Patient Name

____

Date

1598246.1

Disclosure: Protections Against Surprise Medical Bills

Senta Neurosurgery is committed to helping you navigate issues and concerns that impact your physical and financial health. The No Surprises Act is a new federal law that impacts health care billing and protects you from certain surprise medical bills. California AB 72 also offers protections from surprise medical billing. The No Surprises Act and California AB 72 requires this disclosure to explain your rights and protections under the federal and state requirements. For example, when you get treated by an out-of-network provider at an in-network hospital/ambulatory surgical center, you are protected from surprise medical billing or balance billing.

Explaining Surprise Medical Billing and Balance Billing

When you see a doctor or other health care provider, you may owe certain out-of-network amounts, such as a copayment, coinsurance, or deductible. You may also have other costs or have to pay the entire bill if the provider you see or the health care facility that you visit does not participate in your health plan's network (an "out-of-network" provider or facility).

- What is out-of-network? Out-of-network describes health care providers and facilities that have not signed a contract with your health plan. Out-of-network providers or facilities may be permitted to bill you for the difference between what your health plan agreed to pay the provider or facility and the full amount charged for the health care service provided to you. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count towards your annual out-of-pocket limit. Surprise billing is sometimes also called balance billing.
- What is surprise billing? Surprise billing is an unexpected balance bill for a service provided by an out-of-network provider or facility. This can happen in situations where you cannot control who is involved in providing your care, such as in an emergency or when you schedule an appointment at an in-network facility but are unexpectedly treated by an out-of-network provider.

Surprise Billing Protections

You are protected from receiving a surprise medical bill in certain circumstances:

- Emergency Services. If you have an emergency medical condition and receive emergency services from an out-of-network provider or facility, the most that the provider or facility may bill you is your plan's in-network cost-sharing amount (such as a copayment, coinsurance, or deductible). You cannot be balanced billed for these emergency services. You also cannot be balanced billed for services you may get after you are in stable condition, unless you give written consent to give up your balance billing protections for these post-stabilization services.
- Certain Services at an In-Network Hospital or Ambulatory Surgical Center. When you receive services from an in-network hospital or an ambulatory surgery center, certain providers at the facility may be out-of-network with your health plan. In these situations, the most those providers may bill you is your in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network

facilities, out-of-network providers cannot balance bill you unless you give written consent and give up your protections.

Patient Protections

You are never required to give up your protections from balance billing. You also are not required to get care from out-of-network providers or facilities. You can always choose to receive care from a provider or facility that is in-network with your plan.

If balance billing is not allowed, you have protections, including:

- You are only responsible for paying your share of the cost, which is the copayment, coinsurance, or deductible that you would pay if the provider or facility was in-network. Your health plan is required to pay providers and facilities directly.
- Your health plan generally must:
    - cover emergency services without requiring advance approval (prior authorization) for the services;
    - cover emergency services provided by out-of-network providers and facilities;
    - determine what you owe the provider or facility (the cost-sharing amount) on what the health plan would pay an in-network provider or facility for the service and show that amount in your explanation of benefits; and
    - count any amount you pay for emergency or out-of-network services towards your deductible and out-of-pocket limit.

Applicable State Laws

Visit https://www.dmhc.ca.gov for a summary of applicable state balance billing laws.

Complaints and Grievances

If you believe you have been wrongly billed, you should first contact the provider or facility that sent you the bill as well as your health plan for an explanation of the charges. If they cannot resolve your concerns, you can contact the United States Department of Health and Human Services (https://www.cms.gov/nosurprises or call 1-800-985-3059) regarding potential violations of your federal protections or Department of Insurance Help (https://www.insurance.ca.gov or call 1-800-927-4357) for potential violations of your protections under CA state law.

For More Information

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights and protections against surprise medical billing under federal law.

Visit https://www.insurance.ca.gov for more information about your rights and protections against surprise medical billing under state law.

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Financial Policy

Your insurance plan is a contract between you and your insurance company. We cannot guarantee your benefits or eligibility with your insurance plan.

We will extend the benefit of filing the necessary paperwork and submit a claim for reimbursement to your insurance company for you.

Payment for non-covered services is expected at the time of the visit.

If your insurance company denies a claim, or a portion of a claim, they should provide an explanation to you, their policy holder. Denial or reduction of a claim does not relieve you of the financial obligation.

I have read the above and I understand and agree to the Senta Neurosurgery Financial Policy. I authorize the release of any medical information necessary to process insurance claims and to comply with medical reviews and audits. I further authorize payment of my benefits to be made to Sanjay Ghosh, M.D. for services provided to me. I understand that the ultimate responsibility for payment of services remains mine.

____
Print Patient Name

____
Patient Signature Date

____
Staff Witness Date

SENTA NEUROSURGERY

Notice of Appointment No Show & Late Appointment Cancellation Fees

At Senta Neurosurgery, we are dedicated to providing excellent patient care. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within 24 hours of the scheduled visit. This courtesy allows my office staff to schedule another patient who is also in need of medical care. For your convenience, you may reschedule an appointment at (619) 810-1010.

Please call us at (619) 810-1010 at least 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00 p.m. on Friday.

If prior notification is not given, you will be charged $75 for the missed appointment.

Please sign below to consent to these terms.

____

Client Signature

____

Date