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D. MICHAEL HEMBD, M.D.
CHRISTOPHER O. NEUBUERGER, M.D.
PRUDENCIO S. BALAGTAS, D.O.
CONOR W. O'NEILL, M.D.
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THOMAS R. BRUDZ, P.A.-C.
WENLI BRINDLE, P.A.-C.

NORTHERN CALIFORNIA SPINE & REHABILITATION Associates

NCSRA Medical Corporation
2801 K Street, Suite 410
Sacramento, CA 95816

(916) 389-7100 phone line
(916) 389-7140 fax line

Dear Patient,

You have been referred to NCSRA Medical Corporation for an evaluation. We would like to take this time to welcome you to our practice and look forward to assisting you in your health care needs.

## Before your appointment:

**Step 1:** Create your Patient Portal account, log in and select "Update Medical History".

**Step 2:** Complete the appropriate paperwork below and hand carry it to your appointment.

**You will need to bring:** Current insurance card or complete Worker's Compensation information. You will also need to hand carry any diagnostic studies and the reports that are relating to your present condition, such as MRI, CT, Bone Scan, and EMG/NCV studies.

## About our office

***NCSRA is HIPAA compliant.*** You may review a copy of the Privacy Policy to read upon check in, if you choose a copy will be provided to you. If you have any questions we would be happy to answer them when you arrive.

**Directions:** For directions please call 916-389-7100 ext. 6.

**Parking (cash only):** Our building contains a parking garage, the entrance is on K street. The cost is $1.00 for 20 minutes.

**Appointment cancellation policy:** Please notify our office 24 hours prior to your appointment time. Failure to do so may result in a fee.

**Prescription refill policy:** Medication refills must be done at the time of your scheduled visit or by calling your pharmacy. For medical and legal reasons, we do not refill medications on Fridays, weekends, or by telephone.

**Disabiltity and Insurance Forms:** The fee for completion of most forms is $5.00 per page and payment is required in advance. Please complete your portion before mailing or bringing your form to the office.

**Payment for services rendered:** Co-pays, PPO deductibles and HSA deductibles are due at the time of service. We accept cash, checks, Visa or Mastercard and will bill your insurance plan whenever possible, however, please remember that the primary responsibility for payment is yours, not the insurance company. Not all physicians at NCSRA Medical Corporation are on all plans or the same plans.

**Preferred provider with your insurance?** Please check with your carrier to see if our physician is a member of your insurance plan, if not you may be required to pay in full for services.

**Returned check:** A $35.00 fee is due and payable by cash, money order or credit card and must be paid before the next visit.

# NCSRA MEDICAL CORPORATION * PATIENT REGISTRATION

## PATIENT DEMOGRAPHICS:

**Full Name:** _____

**Address/City/St/Zip:** _____

**DOB:** _____ **Age:** _____ **Gender:** M F **Marital Status:** S M W D DP **SSN:** _____--_____--_____

**Home:** _____ ☐Okay to leave a message? **Cell:** _____ ☐Okay to leave a message?

**Email:** _____ **Reminder preference:** ☐Phone call ☐Text message ☐Email

**Emergency contact:** _____ **Phone:** _____

**Primary Language:** ☐English ☐Spanish ☐_____ **Do you need an interpreter?** Yes No

**Primary Care MD:** _____

**Referring MD:** _____

**INSURANCE COVERAGE: *Cards must be presented at time of service***

| | |
|---|---|
| Primary: _____ | Secondary: _____ |
| Subscriber: _____ | Subscriber: _____ |
| DOB: _____ Relationship: Self Spouse Child | DOB: _____ Relationship: Self Spouse Child |
| Mem ID: | Mem ID: |

**WORKER'S COMPENSATION COVERAGE:**

Date of injury: _____ Employer at the time of injury: _____ body part(s): _____

Insurance Carrier/Address: _____

Claims adjuster: _____ Claim number: _____

**HIPAA (Health Insurance Portability and Accountability Act):** You may IList a personal contact whom may request and/or pick up information on your behalf:

**List full name(s) only: _____ ☐ None

_____ (Initial) **Noticy of Privacy Practices:** I hereby acknowledge that I received a copy or have access to a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Dyann Wolfe, Administrator (916) 389-7100-Privacy Officer

_____ (Initial) **Assignment of Benefits, Release of information:** I hereby assign all necessary medical and/or surgical benefits to which I am entitled, including private insurance and any other plan to NCSRA Medical Corporation for all services rendered by its medical providers and representatives. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid for by said insurance according to contract or regulations. I hereby authorize NCSRA or its representatives to release or obtain necessary medical records for treatment purposes and/or to secure payment.

Patient or Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian full name (Please Print): _____

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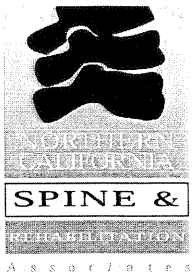


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# We are excited to invite you to sign up for our Patient Portal

STEP 1: Provide the office with your home email address and obtain your account number.

STEP 2: Check your email inbox for an invitation to create your online account. (This can take up to 24 hours).

STEP 3: Create your online account by following the directions in the email.

STEP 4: Send a secure message to the office to verify that your account has been created and is working.

a. Select "Message Center" icon.
b. Select "Inbox".
c. Select "Account verification" and follow the instructions.

Enjoy access to online features that allow you to send and receive information to and from the office such as:

- Receive office notes, orders, work status, and/or summaries of visits.
- Update address, phone numbers and/or provide new insurance information.
- Request a copy of your medical records.
- Send secure messages to the medical records staff.
- Request your doctor to complete a new or supplement State Disability Insurance Form.
- Fill out a patient history questionnaire.
- Many more new features will be added in the future.....

After you create your account you can gain access by going to the following website:

https://www.exscribepatientportal.com/NCSRA/

Thank you for your patience during this transition period.

NCSRA Medical Corporation