NEUROLOGY & PAIN MANAGEMENT CENTER, PLLC **PATIENT REGISTRATION**

Patient Name: _____ Date Of Birth: ____/____/____ Sex: [ ] M [ ] F

SSN# _____--_____--_____ Drivers License # _____ (copy is required)

Home Phone #: ___ _____ Cell Phone #: _____ Work Phone #: _____

Race: [ ] American Indian [ ] Asian [ ] African American [ ] Caucasian [ ] Native Hawaiian or Pacific Islander [ ] Other [ ] Patient Declined

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Patient Declined **Language:** [ ] English [ ] Spanish [ ] Other

Address: _____City: _____ State: _____ Zip: _____

Name of Spouse: _____ Ph#: _____

Name of Parent/Guardian: _____Ph#:_____

IN CASE OF AN EMERGENCY, I AUTHORIZE YOU TO NOTIFY THE FOLLOWING:

Name: _____ Ph#: _____

Is this visit the result of or related to an Auto Accident?

_____ Yes *_____ NO *If yes date of accident ____/____/____

Is this visit the result of or related to a Workers' Compensation claim?

_____ Yes* _____ NO *If yes date of accident ____/____/____

REFERRING DOCTOR INFORMATION

REFERRING DOCTOR NAME: _____PH#: _____

NAME OF PRACTICE: _____ CITY _____

INSURANCE INFORMATION We cannot file your insurance without complete information and a copy of your insurance cards.

PRIMARY INSURANCE COVERAGE

Policy Holder's Name _____ **Policy Holder's Gender:** [ ] Male [ ] Female

Policy Holder's DOB _____-_____-_____ **Policy Holder's SS#**_____-____-_____ **Policy Holder's Employer** _____

Patient's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other _____

SECONDARY INSURANCE COVERAGE

Policy Holder's Name _____ **Policy Holder's Gender:** [ ] Male [ ] Female

Policy Holder's DOB _____-_____-_____ **Policy Holder's SS#**_____-____-_____ **Policy Holder's Employer** _____

Patient's Relationship to Policy Holder: [ ] Self [ ] Spouse [ ] Child [ ] Other _____

SIGNATURE: _____DATE:____/____/____

PARENT/GUARDIAN SIGNATURE_____ _____ DATE: ____/____/____

HOW DID YOU HEAR ABOUT OUR SERVICES? : DOCTOR, ADVERTISEMENT, HOSPITAL, FRIEND, OTHER: _____

Patient Registration

Patient Name _____ **Date of Birth** _____

Preferred Contact Method: [ ] Phone [ ] Mail [ ] Email _____@_____

Financial Agreements and Authorization for Treatment: I hereby authorize Neurology & Pain Management Center and its physicians and other providers and staff to furnish and perform on me or the patient stated above ("Patient") such medical care, examination, and treatment as may be ordered by a Neurology & Pain Management Center provider. I hereby authorize direct payment to Neurology & Pain Management Center of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Neurology & Pain Management Center to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Neurology & Pain Management Center for charges not covered by this agreement, and I hereby guarantee payment to Neurology & Pain Management Center on demand for all such charges. I understand that all co-pays and self-pay monies are collected up front before services are rendered.

We are dedicated to providing you with the best possible care and services. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss without financial counselor.

Unless other arrangements have been made in advance by either you or your health care coverage, full payment is due at the time of service. For you convenience, we accept VISA, MasterCard and Care Credit.

Insurance

We will bill insurance which we have made arrangements with and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of the statement.

If you have insurance with a plan with which we do not have an agreement, we will prepare and send the claim for you, as a courtesy to you. In this case, you will be responsible for charges for your care and treatment at the time of service. This will need to be paid at our check-out window upon leaving.

We will also bill your health plan for all services that we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Patients with No Insurance

If you are a patient with no insurance, you will need to speak to our financial counselor before seeing the provider. The financial counselor will make protocol depending on treatment of how much services will be. At this time, you will be responsible for paying for this service. If for some reason charges will be more, this will be collected at check out upon leaving.

Minor Patients

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

After attempts by our office to collect outstanding balances, we reserve the right to use other means to collect this balance. Please call our office regarding any outstanding balances to avoid additional measures that may affect your credit.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. I authorize Neurology & Pain Management Center, PLLC to release any medical information necessary to process claims.

Signature _____ Date _____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Authorization to Release Information: I hereby authorize Neurology & Pain Management Center to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and /or treatment to any insurance company, government agencies and their agents, and professional review organizations with which I or the Patient stated above may have insurance coverage or which may be assisting in payment of the medical care provided by Neurology & Pain Management Center to me or the Patient stated above. I also hereby authorize Neurology & Pain Management Center to release any medical information to any licensed physician, health care provider, or medical facility to which I or the Patient stated above may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature _____ Date _____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Receipt of Notice of Privacy Practices: I understand and have been provided with a Neurology & Pain Management Center Notice of Privacy Practices, which provides a more complete description of how Patient health information may be used or disclosed. I understand that Neurology & Pain Management Center reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from any employee of Neurology & Pain Management Center.

Signature _____ Date _____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

FOR EMPLOYEE USE ONLY:

Received by: _____ **Date:** _____/_____/_____

Neurology & Pain Management Center, PLLC

Protected Health Information (PHI) release form

Please list the names and associated relationship to you that we may disclose information to you or those you have listed below. Please be aware Neurology & Pain Management Center, PLLC, does reserve the right to make disclosures of health information about you if required by law for various reasons that are addressed in our Notice of Privacy Practices and also in the event of an emergency. Please return this completed form today at the check-in desk.

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

a. _____ Relationship_____ Phone_____

b. _____ Relationship_____ Phone_____

c. _____ Relationship_____ Phone_____

**** PLEASE SIGN HERE IF YOU DO NOT WISH FOR US TO SHARE YOUR INFORMATION WITH ANYONE**

_____

Check all that may apply:

[ ] All my medical information

[ ] Information necessary to schedule appointments for me

[ ] Lab or test results

[ ] Information necessary to provide, call in or pick up prescriptions for me

[ ] Information necessary to help my family member(s) take care of me

[ ] Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me

[ ] Information necessary to bill for or submit claims for care provided to me to government or private insurance payors.

My consent will remain in effect as long as I am a patient of Neurology & Pain Management Center unless and until I notify Neurology & Pain Management Center in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

FOR EMPLOYEE USE ONLY:

Received by: _____ **Date:** _____/_____/_____

Neurology & Pain Management Center, PLLC

Cancellation Policy/No Show Policy

For Appointments and Procedures

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to

emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a

fifty dollar ($50) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients

and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the

appointment.

3.*Cancellation/ No Show Policy for Procedures*

Due to the large block of time needed for procedures, last minute cancellations can cause

problems and added expenses for the office.

If a procedure is not cancelled at least 24 hours in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance company.

4. *Cancellation/No Show Policy for Nerve Conduction Studies*

As outlined above procedures block large amount of time in regards to our schedule. It can causes added expenses for the office and prevent other patients from receiving the treatment they need.

If a nerve conduction study (EMG) or EEG is not cancelled at least 24 hours in advance you will be charge a twenty five dollar ($25) fee; this will not be covered by your insurance company.

_____ _____ ____/____/____

Print Name **Patient Signature Patient/Guardian** **Date**

FOR EMPLOYEE USE ONLY:

Received by: _____ **Date:** ____/____/____

Neurology & Pain Management Center, PLLC

PATIENT RIGHTS AND RESPONSIBILITIES

- Patient has the right to be treated with respect and recognition of his/her dignity and need for privacy.
- Each patient seeking advice and assistance has the right to be assisted in a prompt, courteous, and responsible manner.
- Each patient has the right to be provided with information concerning his/her diagnosis, treatment and prognosis in terms that are understandable. When it is not medically advisable or feasible to be given to the patient, the information will be made available to the next of kin or other person designated by the patient, except when existing laws do not permit the release of information without the written consent of the patient.
- Each patient has the right to decline treatment.
- Each patient has the right to have his/her medical record and all other information held confidential unless disclosure is required or permitted by Pain Management, the law, or if he/she consents to it's release.
- In the event of experimental/investigational procedures, the patient will be provided with an informed consent. No attempt will be made to persuade the patient to give consent if he/she is reluctant to participate.
- Each patient has the responsibility to be considerate and respectful to all treatment staff.
- Each patient has the responsibility to cooperate with his/her treatment plan.
- Each patient has the responsibility to keep all diagnostic/treatment appointments.
- Each patient has the responsibility to provide as much information as possible needed for his/her treatment plan (e.g., allergies)
- Each patient has the responsibility to inform treatment staff of all medications he/she is taking.
- Each patient has the responsibility to express opinions, concerns, or complaints regarding his/her health care, rights and responsibilities in a constructive manner to any Neurology and Pain Management Center staff member.

Signature:_____ **Date:**_____

FOR EMPLOYEE USE ONLY:

Received by: _____ **Date:** ____/____/____

Neurology & Pain Management Center, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN

ACKNOWLEGEMENT FORM

I, _____ have a received a copy of the Notice of Privacy Practices and understand that the notice describes certain rights I have under federal and state law and discusses how my medical information may be used by. I have been given an opportunity by Neurology & Pain Management Center to ask questions about the Notice.

Patient Name: _____DOB:_____CHART#_____

SIGNATURE: _____DATE:_____/_____/_____

PARENT/GUARDIAN SIGNATURE_____ DATE: _____/_____/_____

FOR EMPLOYEE USE ONLY:

Received by: _____ **Date:** _____/_____/_____

Neurology & Pain Management Center, PLLC

Name _____ **DOB** _____ Today's Date _____

MEDICAL HISTORY

Chief Complaint (Describe your problem and what treatment you have had)

_____

_____

PAST MEDICAL HISTORY (ex: High Blood Pressure, Heart Disease, and Diabetes)

List all major surgeries as well as illnesses and conditions you have ever been diagnosed with:

_____

_____

_____

_____

FAMILY HISTORY

Please list any serious medical conditions that run in your family

_____

_____

SOCIAL HISTORY

Do you smoke? ☐Yes ☐No Amount/How often? _____

Do you drink alcohol? ☐Yes ☐No Amount/How often? _____

REVIEW OF SYSTEMS (Have you had or are you having problems with any of the following?)

General	*Skin*	*Eyes*	*Respiratory*
__fevers	__rash	__blurry vision	__cough
__chills	__itching	__blindness	__wheezing
__sweats	__dryness	__eye pain/discharge	__coughing up blood
__fatigue	__suspicious lesions	__sensitivity to light	__shortness of breath
__weight change	*Gastrointestinal*	*Genitourinary*	*Ear/Nose/Throat*
__sleep disturbance	__constipation	__urinary frequency	__hearing loss
Cardiovascular	__*indigestion*	__painful urination	__earache
__palpitations	__nausea/vomiting	__blood in urine	__ringing in ears
__chest pain	__change in bowel habits	__bladder control	__nosebleeds
__fainting	__abdominal pain	__pelvic pain	
__ankle swelling	__bloody stool	*Neurologic*	***Other*** _____
__breathing difficulty	__jaundice	__numbness	_____
Musculoskeletal	*Hematologic/Lymphatic*	__paralysis	_____
__joint pain/swelling	__abnormal bruising	__seizures	_____
__muscle pain/weakness	__bleeding	__migraines/headaches	_____
__trauma/fractures	__enlarged lymph nodes	__memory loss	_____

MEDICATIONS- Also include non-prescription drugs with dosages (If you have your medication bottles, disregard)

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4. _____ **8.** _____

DRUG ALLERGIES **Allergic to shellfish or x-ray dye?** ☐Yes ☐No **Reaction:** _____

Latex allergy? ☐Yes ☐No **Reaction:** _____

1. _____ **2.** _____