Douglas Neurology Associates, P.C

New Patient History

Height:_____ Weight_____ Blood Pressure:_____

Name: _____Date of Birth: _____Age:_____Today's Date: _____

Referring Physician:_____Primary Care Provider:_____

Reason for Today's Appointment:

_____

_____

_____

Past Medical History:

___Stroke or TIA
___Diabetes
___High blood pressure
___High cholesterol
___Heart disease
___Peripheral vascular disease
___Seizures
___Concussion
___Migraine
___Anxiety
___Depression
___Hypothyroidism
___Lung disease
___Sleep apnea: Do you use CPAP? ____
___History of cancer: _____
___Kidney disease
___Bleeding disorder
___Reflux Ulcers
___Arthritis
___Cataracts
___Stroke

Other Conditions:

_____

_____

_____

Labs/Diagnostic testing (CT's, MRI's,EEG's, EMG/NCS)

_____

_____

_____

Prior Surgeries and Dates:

_____

_____

_____

_____

_____

Medication Allergies:

_____

_____

_____

_____

_____

Medications: (Include all prescriptions and over-the-counter medications, including vitamins, supplements, and herbs) Include Name, Dosage, & Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name and Phone Number: _____

New Patient History (Continued)

Patient Name:_____

Symptoms:

___Double Vision
___Hoarsness
___Ringing in Ears
___Hearing Loss
___Deacrese in Smell
___Deacrese in Taste
___Visual Loss
___Rash
___Neck Pain
___Chest Pain
___Palpitations
___Shortness of Breath
___Abominal Pain
___Bloody Stools
___Diarrhea
___Difficulty Swallowing
___Confusion/Disorientation
___Memory Loss
___Convultions
___Dizziness
___Fainting
___Slurred Speech
___Headache
___Falling Down
___Difficulty Sleeping
___Tingle of the Leg/sleep Discomfort
___Incoordination
___Numbess
___Tremor
___Tingling
___Back Pain
___Snoring
___Wheezing
___Stop Breathing During Sleep
___Excessive Day-Time Sleepiness
___Agitation

Family History:

Father: Alive / Deceased, Medical Condition: _____

Mother: Alive / Deceased, MedicalConditions: _____

Siblings: # of Brothers____ # of Sisters____ Medical Conditions:

_____

Children: # of Sons: _____ # of Daughters: _____ Medical Conditions:

_____

Does anyone in your family have symptoms similar to yours?

_____

Are any medical conditions prominent in your family?

_____

Social History:

Birth Place:_____ Education:_____Occupation:_____

Are You Pregnant? _____ If so, How far along: _____

Do you smoke? _____ – Packs per day:_____Number of Years Smoked:_____Date Quit:_____

Do you drink Alcohol? _____ – Amount per week: _____

Physician Signature:_____Date:_____

Douglas Neurology Associates, P.C

Demographics

Last Name: _____ Date of Birth: _____ Gender: M or F

First Name: _____ SSN:_____Language: _____

Address:_____ Race:_____ Ethnicity: _____

_____ Marital Status: _____

City: _____ State: _____Zip Code:_____ Primary Care Physician: _____

Home Phone: _____ Referring Provider: _____

Cell Phone: _____ Do you have an Advance Directive?: Yes Or No

Emergency Contact (Name/ Phone number/Relation) : _____

Do you wish to be added to our online patient portal?: Yes Or No

If yes, please provide your email address to be used for the patient portal: _____

Primary Insurance:_____Member ID:_____Group #:_____

Secondary Insurance:_____Member ID:_____Group #:_____

Tertiary Insurance:_____Member ID:_____Group #:_____

Policy holder:

Name: _____Relationship:_____DOB:_____

Is this related to a work or auto accident injury? Yes Or No If yes, date of injury: _____

Employer Name :_____Employer Phone Number:_____

Payment for services, including co-pays, are DUE AT THE TIME SERVICES are rendered unless payment arrangements have been approved and a signed Payment Agreement is on file with our billing department. A no-show fee of $20 ($50 for test) will be charged to your account for each appointment that you fail to appear. A fee of $20 ($50 per test) will be charged to your account for any appointment not canceled 24 hours prior to your appointment time. Returned Checks: In the event a personal check is returned unpaid from the patient's bank, their account will be charged a returned check fee of $25 for each check, and their account may be placed on a "cash only" basis for one year. Agreement and authorization for direct insurance payment

Signature:_____Date:_____

DOUGLAS NEUROLOGY ASSOCIATES, P.C

PATIENT POLICY AGREEMENTS

POLICY REGARDING TEST RESULTS

I understand my physician may order testing to further evaluate my illness or injury. A follow up appointment will be offered to me to go over the results of my test and discuss my future treatment plan. I understand it is very important that I keep my appointment to discuss the test results. I also understand that if my test results are abnormal, I will be notified by phone immediately and my appointment will be moved to an earlier date.

NO SHOW/CANCELLATION/RESCHEDULE POLICY

A "No Show" is defined as a patient who does NOT give 24 hour notice that they will not be attending their scheduled appointment. I am aware that Douglas Neurology Associates, P.C. requires at least 24 hours notice from me that I will not be able to attend my appointment. If I fail to give ample notice I will be charged a No Show Fee. This fee will be billed directly to me, not my insurance company. A "Cancellation" is defined as a patient who does not reschedule their appointment to another date. I understand that if I have 2 No Shows or Cancellations or 3 Reschedules within one year, I will be dismissed from the practice.

FORMS

If a form is to be completed by the physician, I am aware there is a $35 to $75 fee depending on the type of form to be completed. The staff will let you know the cost when you drop off the form.

AFTER HOURS COVERAGE

PLEASE BE AWARE THAT ALL CALLS ARE HANDLED DURING NORMAL BUSINESS HOURS. IF YOU HAVE AN EMERGENCY AFTER HOURS, PLEASE CALL 911 OR GO TO YOUR LOCAL EMERGENCY DEPARTMENT.

FINANCIAL POLICY FOR DOUGLAS NEUROLOGY ASSOCIATES, P.C.

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

If you are a SELF PAY patient, payment is expected in FULL at time of service. We accept cash, personal checks, VISA, DISCOVER, AMERICAN EXPRESS and MASTERCARD. Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you're having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.

INSURANCE: It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the insurance denies your claim for any reason, the charge will be patient responsibility and you will be advised to contact your insurance company and work to obtain a resolution.

REFERRALS: If your plan requires a referral, you must contact your PCP to make sure that a referral is obtained. We will notify the patient if a referral needs to be updated or extended.

DOUGLAS NEUROLOGY ASSOCIATES, P.C

PATIENT POLICY AGREEMENTS

DELINQUENT ACCOUNTS

FAILURE TO MAKE PAYMENT ON YOUR BALANCE WILL SEVER THE PHYSICIAN-PATIENT RELATIONSHIP. BILLS UNPAID FOR MORE THAN 90 DAYS WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY AND YOU WILL RECEIVE FORMAL DISCHARGE NOTICE FROM THE PRACTICE.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients, all charges are strictly your responsibility.

Patient Consent for Use and Disclosures of Protected Health Information

With my consent, Douglas Neurology Associates, P.C. may use and Disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Douglas Neurology Associates, P.C. reserves the right to review the Notice of Privacy Practices at any time. A revised notice may be obtained by forwarding a written request to Douglas Neurology Associates, P.C. Privacy Officers at 4586 Timber Ridge Dr. Suite 180 Douglasville, GA 30135.

With my consent, Douglas Neurology Associates, P.C. may mail or call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, patient statements, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I understand I have the right to request that Douglas Neurology Associates, P.C. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

TELE-HEALTH

Tele-health involves the use of electronic communications to enable health care professionals to connect with individuals using interactive video and audio communications. Tele-health includes the practice of medical health care delivery, diagnosis, consultation, treatment and referrals.

By signing this document, I am consenting to Douglas Neurology Associates, P.C. use and disclosure of my PHI to carry out TPO and that I have received a copy of Douglas Neurology Associates, P.C. Notice of Privacy Practices.

Also, by signing this document, I fully consent to and am completely aware of all the above Policies and Agreements between myself and Douglas Neurology Associates, P.C. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consents. If I do not sign this consent, Douglas Neurology Associates, P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian DOB

DOUGLAS NEUROLOGY ASSOCIATES, P.C

PATIENT POLICY AGREEMENTS

Medication Law & Policy Form

NARCOTICS:

Patients will be required to be seen in the office every 3 months. None of these medications will be issued if the patient misses or cancels their 3 month appointment.

If you are getting any of these medications filled by another physician's office, we will no longer fill the medications for you.

Our office will be required to review the Prescription Drug Monitoring Program before any refills on these medications can be issued. Due to the increased cost of enforcement of this new policy, the cost for the prescription fee will be $20

By signing below, I acknowledge that I am aware of the New Law and Office Protocol.

FOR ALL OTHER MEDICATIONS:

I fully understand that I must come in for a follow up appointment to have prescriptions refilled. I am aware that Douglas Neurology Associates, P.C. will not refill medications over the phone. I understand that a follow up appointment is necessary to review the course of my future treatment and evaluate current treatment results. I am also aware that during my appointment the physician will discuss the risks and benefits of the medications prescribed. I understand that it is imperative that I plan ahead when evaluating my supply of medication. Follow up appointments must be made prior to the end of the medication supply.

In the event that you have to Cancel or No Show for a regular scheduled appointment and then call the office wanting your medication refilled, there will be a $25 fee . This will only be done ONE time. You must come in for a follow up appointment to receive any more refills.

All fees for medications must be paid before a prescription will be given or called into the pharmacy. (Excluding schedule [I drugs)

I understand the above medication refill policy. I also understand that I must return for the follow up appointment as directed by my physician. Failure to follow my physician's advice may affect my health and well being.

** I AUTHORIZE DOUGLAS NEUROLOGY ASSOCIATES TO ACCESS MY MEDICATION HISTORY FROM MY PHARMACY**

_____

Print Name

_____ _____

Patients Signature Date

DOUGLAS NEUROLOGY ASSOCIATES, P.C

PATIENT POLICY AGREEMENTS

HIPAA Authorization Form

Douglas Neurology Associates, PC. has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy Policy & Accountability Act) DOES ALLOW us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

PLEASE SEE THE RECEPTIONIST WITH ANY QUESTIONS PRIOR TO SIGNING THIS AUTHORIZATION FORM.

I, _____am authorizing the person/people listed below to discuss medical information about myself. I understand that Douglas Neurology Associates, PC. is not responsible for the information provided as long as it is given to a person I have listed below.

This is not an authorization to release my medical records on file at Douglas Neurology Associates.

Date of Birth must be provided so that our office can verify that we are speaking with the correct person

1. Name: _____ Date of Birth: _____

2. Name: _____ Date of Birth: _____

3. Name:_____ Date of Birth: _____

4. Name: _____ Date of Birth: _____

Patients Signature:_____Date:_____

****

I, _____do not authorize Douglas Neurology Associates, PC. to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices

Patient's Signature:_____Date:_____