Neurology
Specialists of Charleston
www.NeurologyCharleston.com

This form must be completed every **SIX** months or at any time your **PERSONAL** or **INSURANCE** information changes. This requirement meets with Federal Guidelines.

General Patient Information			
Patient Last Name:	Patient First Name:	Patient Middle Name:	Sex: M F
Street Address:	Mailing Address:	City, State, Zip Code:	
Date of Birth:	Marital Status:	Social Security #:	
Home Phone #:	Cell Phone #:	Email Address:	
Would you like to receive quarterly emails with News & Events from our Practice? □ *Yes* □ *No*			
Employer Name:	Name of Primary Care Physician:	Where did you have your last MRI?	
Work Phone #:	Name of Referring Physician:	Date of your last MRI:	
Insurance Information:			
Primary Insurance Provider Name:	Secondary Insurance Provider Name:	Tertiary Insurance Provider Name:	
Is your insurance in someone else's name – such as a spouse, parent or family member? If so, please complete that person's information below:			
Insured Name:	Insured Social Security #:	Insured Date of Birth:	
If this is a Workers Compensation case, please include your Adjuster's contact information:			
Adjuster Name:	Adjuster Phone #:	Claim #:	
If you have an Attorney, please include your Attorney's contact information:			
Attorney Name:	Attorney Phone #:		
Pharmacy Information:			
Pharmacy Name:	Pharmacy Phone #:	Pharmacy Address:	
Person to Notify In Case of Emergency:			
Name:	Telephone #:	Relationship	
Address, City, State, Zip Code:			

Patient Name:		
Patient Date of Birth:	Patient Height:	Patient Weight:
I am: □ **Right-handed**	□ **Left-handed**	□ **Ambidextrous**
Occupation:	Date, if retired:	
Education: □ High School	□ College	□ Professional
Please list all of your allergies:		

LIST ALL OF YOUR MEDICATIONS & DOSAGES:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Are you taking any of the following blood thinners?

□ ASPIRIN
□ PLAVIX (CLOPIDOGREL)
□ COUMADIN (WARFARIN)
□ PLETAL (CILOSTAZOL)

□ TRENTAL
□ AGGRENOX
□ PRADAXA (DABIGATRAN ETEXILATE)
□ XARELTO (RIVARONXABAN)

Are you taking any over the counter (OTC) medications not listed above?

PAST MEDICAL HISTORY

Please check boxes if you have had or currently have any of these problems:

- ☐ Angina
- ☐ Asthma
- ☐ Blindness, part or full
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Double vision
- ☐ Fainting
- ☐ Head trauma
- ☐ Headache
- ☐ Hearing problem
- ☐ Heart attack
- ☐ Heart failure
- ☐ Hepatitis
- ☐ Herniated disc
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beats
- ☐ Nervous breakdown
- ☐ Numbness
- ☐ Polio
- ☐ Psychiatric conditions
- ☐ Sciatica
- ☐ Seizures (epilepsy)
- ☐ Speech problems
- ☐ Stroke
- ☐ Swallowing problems
- ☐ Ulcers
- ☐ Venereal infections
- ☐ Vertigo
- ☐ Walking problems

☐ OTHER: _____

_____

SURGERIES, HOSPITALIZATIONS and/or ILLNESS

Please list all past surgical procedures, hospitalizations, significant illnesses or injuries

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____ Year: _____
5. _____ Year: _____
6. _____ Year: _____
7. _____ Year: _____

Your Visit Today

1. What is the primary reason you are coming to see a Neurology Specialist?

   _____

   _____

2. Describe your problem: _____
3. When did the problem start? _____
4. What are some of the primary symptoms associated with this problem?

   _____

   _____

5. How long do the symptoms last? _____
6. Have you ever had a brain or spinal injury? _____

   If yes, please explain: _____

7. Was your injury work related? _____

   If yes, what was the date of your work injury? _____

8. Have you had a prior neurological consultation for this problem? _____

PRIOR DIAGNOSTIC TESTING

Please mark your experience with the following tests. If you have had any of these tests, please remember to bring FILMS and REPORTS to review at your appointment:

- □ Angiogram of the brain (MRA)
- □ CT Scan (CAT scan)
- □ DAT scan
- □ EEG (brain wave test)
- □ EMG (nerve-muscle test)
- □ Spinal tap
- □ Skull X-ray
- □ Spine X-ray
- □ MRI (Magnetic Resonance Imaging)
- □ PET scan

□ **OTHER:** _____

CHECK SYMPTOMS IF YOU *HAVE* or *HAVE HAD* ANY OF THE FOLLOWING SYMPTOMS:

GENERAL
- □ Chills
- □ Unusual fatigue
- □ Fever
- □ More than 15lb weight change in past 6 months

RESPIRATORY
- □ Difficulty breathing
- □ Persistent cough

GENITOURINARY
- □ Bladder incontinence
- □ Frequent urination
- □ Urinary urgency
- □ Burning with urination
- □ Erectile dysfunction

MUSCULOSKELETAL
- □ Joint pain
- □ Joint swelling
- □ Back pain
- □ Neck pain
- □ Neck stiffness
- □ Muscle spasms

GASTROINTESTINAL
- □ Constipation
- □ Diarrhea
- □ Nausea
- □ Vomiting

SKIN
- □ Frequent bruising
- □ Rashes

EYES, EARS, THROAT
- □ Blurred vision
- □ Loss of vision
- □ Double vision
- □ New hearing loss
- □ Dizziness

CARDIOVASCULAR
- □ Chest pain or pressure
- □ Lightheaded on standing
- □ Heart palpitations (skipped heart beats)

PSYCHIATRIC
- □ Anxiety
- □ Depression
- □ Hallucinations
- □ Insomnia
- □ Thoughts of suicide

NEUROLOGIC
- □ Trouble swallowing
- □ Confusion
- □ Tremor (shaking hand or head)
- □ Memory loss
- □ Balance problems
- □ Changes in your gait or walk
- □ Difficulty with speech (voice changes)
- □ Headaches
- □ Migraines
- □ Fainting/Loss of consciousness
- □ Numbness / Tingling face or extremities
- □ Weakness in your arms or legs
- □ Falls or other recent trauma
- □ Trouble swallowing

HABITS:

Check any of the following that you have used and state amount:

- □ Caffeine – How much per day?
- □ Alcohol – How much per day?
- □ Tobacco – How much per day?
- □ Recreational drugs – type / amount?

Do you exercise regularly? □ Yes □ Np How often? _____

FAMILY HISTORY:

Have any of your relatives had any of the following?
If yes, indicate relationship (e.g., father, mother, brother):

- □ Alcoholism
- □ Cancer
- □ Diabetes
- □ Heart Disease
- □ Mental Illness
- □ Migraine
- □ Seizures
- □ Stroke
- □ Tuberculosis

Are there any other diseases that run in the family? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor(s) or any members of their staff responsible for any errors or omission that I may have made in the completion of this form.

Signature: _____ Date: _____

Clinical Trials of South Carolina

Clinical Trials of South Carolina is an independent, multi-therapeutic outpatient clinical research site, which conducts Phase II, III and IV clinical trials. Are you interested in learning about and/or participating in Clinical Trials with Clinical Trials of South Carolina? Please check the area of diagnosis in which you apply:

- □ Arthritis
- □ Back Pain
- □ Headaches
- □ Pain After Shingles
- □ Constipation Caused By Pain Medications
- □ Pain Medications
- □ Movement disorders
- □ Diabetes

Financial Policy Agreement

Thank you for choosing Neurology Specialists of Charleston for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health; as with any type of medical care, understanding the financial impact and responsibilities associated with that treatment is also important. **It is important that you read this financial policy agreement before receiving treatment**

Neurology Specialists of Charleston accepts cash, check, VISA and MasterCard. We will also bill your insurance carrier as a courtesy to you.

To be treated by Neurology Specialists of Charleston, you must understand, agree to and initial the provisions set forth below:

__ I understand that if I need to reschedule my appointment, I must call Neurology Specialists of Charleston to reschedule at least 24 hours before said appointment. I understand that a $25 fee will be applied to all office visit consultation appointments and a $75 fee will be applied to all office visit procedure appointments not cancelled within a 24 hour period.

__ I understand that my healthcare policy is an agreement between myself and the insurance company. If the insurance company has not paid my bill in full within 60 days of treatment, I agree to contact them to facilitate payment.

__ I understand that insurance copayments and deductibles are due prior to receiving treatment.

__ I agree that any payments sent directly to me are the property of the Provider. I agree to immediately forward to Provider all payments, explanation of benefits and correspondence sent directly to me from all Third Party Payors related to the care rendered by the Provider. I agree that failure to do so will make me responsible for the entire billed charge (unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing).

__ I understand that all treatment charges are my responsibility whether the insurance company pays or not. I understand that not all services are a covered benefit and that I am financially responsible for and agree to pay all charges not paid by my insurance or Third Party Payor within 60 days from time of service. This includes, but is not limited to, deductibles and co-insurance unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing.

__ I understand that I am financially responsible for any increased co-pays, deductibles and non-covered services provided on an out-of-network basis. As a courtesy to our patients, Neurology Specialists of Charleston will obtain any pre-authorization and/or pre-certification required prior to services performed; HOWEVER, I understand that it is my responsibility to ensure these pre-authorization and/or pre-certifications are obtained. This is not the responsibility of my Provider. I also acknowledge that no guarantees have been made by any employee of the Provider, physician or other party about my treatment including whether it will be paid for by any Third Party Payors and/or whether Provider is in or out of my network with my Third Party Payors.

__ I agree to fully cooperate with Providers to assist in their efforts to get claims paid on my behalf. It is my sole responsibility to verify the status of my healthcare benefits directly from my Third Party Payors. It is my sole responsibility to determine what portion of the care rendered by the Provider will be covered by my Third Party Payors and that by receiving said care; I agree to pay any and all charges not paid for by my Third Party Payor within 60 days of receiving said care. I unconditionally guarantee payment of these charges.

__ I agree to promptly notify Provider of any changes in my health insurance plan and/or coverage including changes to my address and/or phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of the Provider. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from presentation of my bill and that Providers are not required to honor any limiting notations I make on a payment.

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by phone or in person.

ASSIGNMENT AND RELEASE: I authorize payment to be made directly to Neurology Specialists of Charleston and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

_____

Responsible Party (Please Print) Date

_____

Responsible Party Signature Witness Initials

HIPAA RELEASE & NOTICE OF DISCLOSURE

Neurology Specialists of Charleston is authorized to release protected health information about the above named patient to the entities named below.

May we leave appointment reminders, prescription information, and messages to call our office back on your answering machine or voicemail?

☐Yes ☐No

May we share information with your Attorney?

☐Yes Attorney's Name: _____ ☐No ☐N/A

May we share information with your spouse, caretaker, or child(ren)?

☐Yes ☐ No

If yes, please list their name(s): _____

May we share information with your employer? ☐Yes ☐No

If yes, please list the contact person at your employer: _____

Rights of the patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by sending a written notification to Neurology Specialists of Charleston. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoke by the patient.

Acknowledgement of Receipt of Notice of Privacy Practice: I hereby acknowledge that I received a copy of the Neurology Specialists of Charleston Notice of Privacy Practices. Copies follow this form.

_____

Patient or Patient Representative Signature

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient or Patient Representative Signature

PATIENT'S BILL OF RIGHTS for NEUROLOGY SPECIALISTS OF CHARLESTON

Neurology Specialists of Charleston endorses a Patient's Bill of Rights. It is an expectation that compliance with the Patient's Bill of Rights can contribute to an effective program for the patient.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from their credentialed practitioner complete and current information concerning the diagnosis, proposed treatment, and expected prognosis in terms that the patient may reasonably be expected to understand. When it is not advisable to give to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.
3. The patient has the right to receive the necessary information for medical decision making and the granting of informed consent from the treating credentialed practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment to be used, who will perform the procedure or treatment, what are the likely benefits from the procedure or treatment, what alternatives exist if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and length of probably duration of incapacitation if any is expected.
4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of this action.
5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by a court to breach confidentiality.
6. The patient has the right to examine and receive an explanation of the bill for professional services rendered.
7. The patient has the right to request contact with the Clinical Manager or Chief Operations Officer to express suggestions and complaints and grievances, including those required by state and federal regulations.

Grievance Information:

For any complaints, please contact our office at (843) 818-1181 and speak with our Chief Operating Officer

You may also contact the State Department of Health at (803)898-DHEC(3432) or the website for the Medicare Ombudsman at www.medicare.gov/claims-and-appels/file-a-complaint/complaints.

All neurology treatments are to be provided with an overriding concern for the patient, and above all, with the recognition of the patient's dignity as a human being.

_____ _____

Signature of Patient or Responsible Party Date

PATIENT GUIDELINES FOR NEUROLOGY SPECIALISTS OF CHARLESTON

Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. It is an expectation that the patient's compliance with the Patient Guidelines can contribute to an effective program for the patient.

- **After Hours Contact:** Neurology Specialists of Charleston is an outpatient specialty practice that does not follow after hours "call" – any messages left on our voicemail during the evenings or weekend will be returned the next business day. Please utilize your local ER or call 911 with any medical emergencies.
- **Patient Conduct:** It is the patient's responsibility to be respectful of all the health care providers and staff, as well as other patients.
- **Cancellations:** If you are unable to keep an appointment, kindly call our office at least 24 hours prior to your appointment. We can then reschedule your appointment to a more convenient time. A $25 fee will be applied to all Office Visit appointments not canceled within the 24 hour period or if you fail to keep your appointment. A $75 fee will be applied to all Procedure appointments not canceled within the 24 hour period or if you fail to keep your appointment.
- **Tardiness:** Please arrive 15 minutes prior to your appointment time. Please complete your New Patient forms completed prior to your appointment. If the forms are not completed when you arrive, please allow at least 20 additional minutes prior to your scheduled appointment time to complete your forms. Note –if you arrive without ample time to complete your paperwork OR if you are more than 15 minutes late for your appointment, you WILL need to be rescheduled for a later date.
- **Repeated Missed Appointments and/or Late Appointments:** We will be unable to schedule future appointments for patients having two (2) missed appointments and/or cancellations without appropriate notice; particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.
- **Co-Payments:** Co-payments and deductibles must be paid at the time of check-in. We accept cash, checks and debit cards Visa, MasterCard and Discover
- **Medication Refill Policy:** To ensure your medication needs are met in a timely manner, we request a 48-hour notice for refill requests, and no refill requests can be taken after 12 PM on Fridays.
- **Patient Phone Calls:** All patient phone calls or requests will be addressed by a nurse within 24 hours. We regularly check the Nurse's voicemail throughout the day and will contact the patient as quickly as possible.
- **Patient Information Changes:** If you have a change to your insurance, claims adjustor, attorney, primary treating physician, or any other changes to your personal information, please supply us with the new information within 10 days of the change so we can keep your records up-to-date.
- **Insurance:** You are responsible for knowing the coverage & benefits of your insurance carrier. If you are unsure of these requirements, please verify your coverage & benefits prior to obtaining medical services. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

_____ _____

Signature of Patient or Responsible Party Date