Neurology Specialists, a division of Neurology Consultants of Tidewater, PLLC

Patient Information

Last Name	First Name	Middle Initial	Social Security No.

Address	City	State	Zip Code

Sex	Marital Status	Date of Birth	Email address	Occupation
☐ M ☐ F	☐ S ☐ M ☐ D ☐ W	/ /		

Home Phone:	Cell Phone:	Work Phone:
☐ OK to leave medical information on voicemail?	☐ OK to leave medical information on voicemail?	

Spouses Name	Date of Birth

Employer	Employer Address

Race			Ethnicity	Preferred Language
☐ Native Hawaiian or Pacific Islander	☐ White/Caucasian	☐ Other race	☐ Not Hispanic or Latino	
☐ Black/ African American	☐ Hispanic	☐ Decline	☐ Hispanic or Latino	
☐ American Indian or Alaskan Native	☐ More than one		☐ Decline	☐ Decline

Emergency Contact Name	Relationship	Phone

Privacy

HIPAA Acknowledgements: all patients must initial all that apply:

_____ I hereby acknowledge that I have been provided with a copy of the NCT Notice of Privacy Policies.

_____ I hereby acknowledge that I have been provided with a copy of the NCT Notice of Privacy Policies but declined to accept at this time.

_____ I give permission for the physicians and staff of NCT to discuss medical and/or financial information with the following people:

Name & Relationship	Name & Relationship	Name & Relationship

Insurance

Primary Insurance	Secondary Insurance

Please provide our office with advance notice if you should need to cancel your appointment. Failure to show for your scheduled appointment may result in a fee that is not covered by your insurance plan.

Rx/Care Team

Referring Doctor	Phone	Primary Care Doctor	Phone

Pharmacy Name & Address	Phone

Is this visit related to an auto accident YES / NO	A work-related Injury Yes / No
Date and Time of Injury:	Attorney Name:

Signature of Patient/Responsible Party:	Relationship	Date

Consent, Agreements & Signature

Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - Financial Agreement

Under Virginia law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize treatment by any NCT provider. Such treatment may include injections and/or other procedures they deem necessary.

I authorize NCT to release my medical records to other healthcare professionals involved in my medical care

I agree NCT may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes

We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or cell phone number you consent to receive electronic messages by such means.

I have authorized treatment to patient by any NCT provider. I further authorize release of any medical and/or billing information as is necessary for third party reimbursement from my insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines does not constitute covered services as well as attorney's fees of 33 1/3%, interest and any other related costs of collection should such action become necessary.

Signature of Patient/Responsible Party:	Relationship	Date

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Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy.

To ensure our system is set up accurately, we ask that you complete our registration form and provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients. Any remaining balance will be the patient's responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be the patient's responsibility. Services may require a referral or authorization prior to being seen. Unless valid insurance is presented, patients will be responsible for payment in full at the time of visit. All copayments are to be paid at the time service is rendered.

Please be aware that some visits performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

To ensure accurate processing of prescriptions, we ask that all refill requests are processed through your pharmacy. Your pharmacy can still request the refill even if you have no refills remaining. Routine refill requests may take up to 48 hours.

We are happy to provide you with a copy of your medical record. We have contracted with BACTES, a HIPAA certified release of information service company, to process all medical record requests. BACTES does charge a fee in accordance with Virginia law and this fee must be paid by the patient to BACTES before the medical records can be released. If you request your records for continuation of care to another physician or healthcare provider, BACTES will process that request at no charge. A Medical Records Release Form is required for all requests and is available at the office or in the forms section of our website. Please allow 2 weeks for requests to be processed.

We recognize that from time to time, you may need to have a medical form completed. We do charge a fee for this service that varies according to the amount of pages that need to be completed. To ensure we are able to meet the appropriate deadlines, please ensure that we receive this form as soon as possible. Depending on the information needed on the form, it could take several days for us to complete it. Payment is required in advance of forms being completed.

Should you arrive late for an appointment, please be aware that you may be asked to reschedule or you may have to wait to be seen between or after the other patients who have arrived at their scheduled time.

Your appointment is very important to us. If you are unable to make your scheduled appointment, unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee. Please help us serve you better by keeping your scheduled appointments.

I have read, understand and agree to the policies of Neurology Specialists.

Signature ______________________ Date ______________

FOR MEDICARE PATIENTS ONLY:

MEDICARE ONE TIME (LIFE TIME) PAYMENT AUTHORIZATION - I request that payment of authorized Medicare benefits be made either to me or on my behalf to Neurology Consultants of Tidewater for any service furnished me by that supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient/Legal Representative ______________________ Date ______________

Patient Name:____

Date: ______________________________ Age: ______________________________

Chief Complaint: ____

Medications (name and dose):

1.______________________________ 6. ______________________________

2.______________________________ 7.______________________________

3.______________________________ 8. ______________________________

4______________________________ 9. ______________________________

5.______________________________ 10.______________________________

Drug Allergies: ____

Past Medical History (circle):

High Blood Pressure	Cancer	Heart Problems
Rheumatic Fever	Anemia	Stomach Ulcers
Depression	Diabetes	Thyroid disease
Kidney Disease	Arthritis	Lung Problems
Sleep Problems	Asthma	Trauma

Other:____

Operations: ____

____

____

Family Medical History (diseases or cause of death):

Mother:_________________________ Father: ______________________________

Grandparents:____

Brothers/Sisters: ____

Children: ____

Social History:

Occupation: ____

Marital Status: ____

Smoke? N Y _____ packs/day Alcohol Use: N Y _____ drinks/day

Review of Systems: **Please circle any symptoms you are experiencing**

1. NEURO - Headaches, numbness/tingling, seizures, memory problems, walking problems, tremors

2. EYES - Double vision, blurring, drooping eyelids, loss of vision

3. ENT - Hearing loss, ringing, speech, swallowing problems

4. CARDIO - Fainting, dizziness, chest pain

5. RESP - Cough, shortness of breath, wheezing

6,7. GI/GU - Bowel/Bladder control, abdominal pain, diarrhea, blood in stool or urine, sexual dysfunction

8. MUSCULOSKELETAL - Back/neck pain, weakness

9. SKIN - rashes, birth marks

10. PSYCH - Hallucination, depression, anxiety, stress

11. CONSTITUTIONAL - fever, weight loss or gain

12. ENDOCRINE - Thyroid, diabetes

13. ALLERGIC - environmental

14. HEME - anemia, adenopathy, bruising

*DO NOT WRITE BELOW THIS LINE*____

P=1-5, E=6-11, D=12+, C=all

General * BP___________ Pulse___________ Ht.___________ Wt.___________

VA uncor/cor OD___________ OS___________

Appearance * WDWN

CV (1 of 3 for C)
*Carotids
*Heart
*PVS - pulse, temp, edema

MS
* O x 3
* Memory
*Attention
* Aphasia
* Knowledge

CN
II-XII (=8)
*Ophthal

Sensation *

Motor
*Strength
* Tone
* Gait & Station

Coordination *FNF, HKS, RAM

Reflexes *

____
M.D. Signature/Date