

# 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<br><input type="checkbox"/> M <input type="checkbox"/> F  | Marital Status<br><input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W |            | Date of Birth<br>/ /  |  | Email address       |  | Occupation |  |          |
|  | Home Phone:   |   |            | Cell Phone:   |  |                     | Work Phone:  |            |  |          |
|  | <input type="checkbox"/> OK to leave medical information on voicemail?  |   |            |   | <input type="checkbox"/> OK to leave medical information on voicemail? |                     |  |            |  |          |
|  | Employer  |   |            |   | Employer Address   |                     |  |            |  |          |
|  | Spouses Name  |   |            |   |  | Date of Birth       |  |            |  |          |
|  | Race<br><input type="checkbox"/> Native Hawaiian or Pacific Islander<br><input type="checkbox"/> Black/ African American<br><input type="checkbox"/> American Indian or Alaskan Native  |   |            | <input type="checkbox"/> White/Caucasian<br><input type="checkbox"/> Hispanic<br><input type="checkbox"/> More than one |  |                     | Ethnicity<br><input type="checkbox"/> Other race<br><input type="checkbox"/> Decline |            | Preferred Language<br><input type="checkbox"/> Not Hispanic or Latino<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Decline |          |
|  | Emergency Contact Name  |   |            |   | Relationship   |                     | Phone  |            |  |          |
|  | <p><b>HIPAA Acknowledgements: all patients must initial all that apply:</b></p> <p><input type="checkbox"/> I hereby acknowledge that I have been provided with a copy of the NCT Notice of Privacy Policies.</p> <p><input type="checkbox"/> 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.</p> |   |            |   |  |                     |  |            |  |          |
| Primary Insurance  |   |   |            |   | Secondary Insurance  |                     |  |            |  |          |
| <p><b>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.</b></p>  |   |   |            |   |  |                     |  |            |  |          |
| 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       |  |          |
| <p style="text-align: center;"><b>Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - Financial Agreement</b></p> <p>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.</p> <p>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.</p> <p>I authorize NCT to release my medical records to other healthcare professionals involved in my medical care</p> <p>I agree NCT may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes</p> <p>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.</p> <p>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.</p> |   |   |            |   |  |                     |  |            |  |          |
| Signature of Patient/Responsible Party:  |   |   |            |   | Relationship   |                     |  | Date       |  |          |

Patient Information

Privacy

Insurance

Rx/Care Team

Consent, Agreements & Signature

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

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

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 \* WDN

CV \* Carotids  
(1 of 3 \* Heart  
for C) \* 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

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_ DOB: \_\_\_\_\_ 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



