

PATIENT REGISTRATION FORM



PATIENT INFORMATION

Last Name			First Name			MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security Number			Date of Birth			Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP		
Race			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			Language if other than English		
Home Address			E-Mail Address			Pharmacy Name and Address		
			Home Phone					
City	State	Zip	Cell Phone			Pharmacy Phone		
Employer Name and Address			Preferred Method of Communication <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-Mail			Emergency Contact Name		
			Work Phone			Emergency Contact Phone		
			Primary Physician Name			Referring Physician Name		

INSURANCE INFORMATION

Primary Insurance Name				Secondary Insurance Name			
Insurance Phone #				Insurance Phone #			
Subscriber's Name & SSN				Subscriber's Name & SSN			
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

APPOINTMENT REMINDER AUTHORIZATION FORM

We offer appointment reminders via text message in addition to email reminders. Please initial bellow if you would like to receive appointment reminders via text.

_____ (*initials*) I authorize NOVA Neurology center to send appointment reminders via text message to the following cell phone number:
 _____ . I understand that standard text messaging rates from my mobile carrier may apply.

DISCLOSURE TO FAMILY MEMBERS AND FRIENDS

Please list any person that you would like to grant permission to your provider to discuss your Medical Record and/or Plan of Care

Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone
Patient/Guarantor Printed Name _____			
Patient/Guarantor Signature _____		Date _____	

AUTHORIZATION FOR TREATMENT

_____ (*initials*) I hereby authorize treatment by NOVA Neurology center and/or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren.
 The possibility exists (during treatment) for the healthcare workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

_____ (*initials*) I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to insurance payers, HMOs, workers compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record. I hereby authorize a query of medication history and formulary information within the Electronic Medical record in order for drug eligibility and coverage.

PRESCRIPTION HISTORY CONSENT

_____ (*initials*) NOVA Neurology Center uses an electronic medical record system (EMR) in which the physician is able to prescribe medications electronically. I give permission to NOVA Neurology Center to send my prescription(s) electronically. Also, I agree that NOVA Neurology Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

FINANCIAL POLICY

_____ (*initials*) I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgements or verdicts in favor of the undersigned from third party claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fee's costs and interest) due hereunder is to be made to NOVA Neurology Center for any charges not covered by my insurance, including but limited to co-payments, deductibles and fee for non-covered services.
 _____ (*initials*) The patient and/or undersigned guarantor are primarily liable for payment of the patient's account and NOVA Neurology Center will send all appointment reminders and billing information to the person responsible for the payment of my bill.
 _____ (*initials*) It is the patient and/or undersigned guarantor's sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above. Some insurance plans require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.
 _____ (*initials*) I understand that co-pays, co-insurances and deductibles are due at the time of service. Patients who do not have insurance must pay the self-pay fee at the time of service.
 _____ (*initials*) Failure to notify the office 24 hours prior to the appointment time to cancel or re-schedule it will result in a \$50.00 charge. The returned check fee is \$35.00

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

_____ (*initials*) Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that NOVA Neurology Center may take action to collect its fees. I agree to pay all costs incurred by NOVA Neurology Center for collecting its fees equal to the thirty percent (30%) of the unpaid bill and if applicable, all attorneys' fees.

ACKNOWLEDGMENTS

_____ (*initials*) NOTICE OF PRIVACY PRACTICES. I acknowledge that I have received, have previously received or have been offered but declined to receive the NOVA Neurology Center Notice of Privacy Practices.
 _____ (*initials*) By providing my E-mail address, I authorize NOVA Neurology Center to use the address for the purpose of communicating health-related information or services. I acknowledge that I may opt-out of such communication at any time by providing a written notice.
 _____ (*initials*) It is the patient's responsibility to know their insurance carrier's patient responsibilities and procedures. If proper procedures are not followed, the patient may be liable for full payment of the bill. If the insurance carrier requires a referral and/or prior authorization, contact your primary care physician prior to your appointment. The patient is responsible to verify the referral is valid for the follow-up visits.

Thank you for choosing NOVA Neurology Center as your health care partner

Patient Name (please print) _____

Patient/Guarantor Signature _____ Date _____

MEDICARE PARTICIPANTS ONLY

I request that the payment of authorized Medicare benefits be made on my behalf to NOVA Neurology Center for any services furnished to me. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for payable related services. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____

HEALTH HISTORY QUESTIONNAIRE

Name (Last, First ,MI)	<input type="checkbox"/> M <input type="checkbox"/> F	DOB
Previous/Referring Doctor	Reason for Today's Visit	

List your prescribed drugs and over-the-counter drugs such as vitamins and inhalers

Name of the Drug	Strength of Medication	Frequency taken

List any medical problems that other doctors have diagnosed

Allergies to medications

Name of the Drug	Reaction you had

Surgeries

Year	Type of Surgery and Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother Maternal		

HEALTH HABITS AND PERSONAL SAFETY

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			<input type="checkbox"/> Cigarettes pks/day	<input type="checkbox"/> Chew #/day
	How many drinks per week?			<input type="checkbox"/> Cigars #/day	<input type="checkbox"/> Pipe #/day
				<input type="checkbox"/> # of years	<input type="checkbox"/> year quit
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

WOMEN ONLY

Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Pregnancies	Number of live births
------------------------------------	--	-----------------------	-----------------------

SYMPTOMS EXPERIENCED IN THE PAST 6 MONTHS (CHECK ALL THAT APPLY)

Neurological	General	Eyes/Ears	Cardiac
<input type="checkbox"/> Headache <input type="checkbox"/> Double Vision <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Imbalance/Unsteady gait <input type="checkbox"/> Falls <input type="checkbox"/> Abnormal movements <input type="checkbox"/> Tremor <input type="checkbox"/> Memory loss <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> weakness <input type="checkbox"/> Seizure <input type="checkbox"/> Cramps/Spasms	<input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Weight gain/loss <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> vivid dreams	<input type="checkbox"/> Visual loss <input type="checkbox"/> Blurred vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Double vision <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitation <input type="checkbox"/> Syncope/Passing out <input type="checkbox"/> Heart murmur
		Throat/Sinus <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Sinus pain <input type="checkbox"/> Nose bleeds	
Vascular <input type="checkbox"/> Swollen leg(s) <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Recent Transfusions	GI <input type="checkbox"/> Swallowing difficulty <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	Pulmonary <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Dry cough <input type="checkbox"/> productive cough	Musculoskeletal <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle aches