PATIENT REGISTRATION FORM

NOVA Neurology Center

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Last Name | First Name | MI | Gender ☐ M ☐ F |
| Social Security Number | Date of Birth | Marital Status ☐ M ☐ S ☐ W ☐ D ☐ SEP | |
| Race | Ethnicity ☐ Hispanic ☐ 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 ☐ Home Phone ☐ Cell Phone ☐ 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 ID # | Insurance ID # |
| Subscriber's Name & SSN | Subscriber's Name & SSN |
| Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other | Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ 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 _____

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## 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 _____

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# HEALTH HISTORY QUESTIONARE

| Name (Last, First ,MI) ☐ M ☐ 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 |
|---|---|---|
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## List any medical problems that other doctors have diagnosed

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## Allergies to medications

| Name of the Drug | Reaction you had |
|---|---|
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## Surgeries

| Year | Type of Surgery and Reason | Hospital |
|---|---|---|
| | | |
| | | |
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## Other Hospitalizations

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
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| | | |

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# FAMILY HEALTH HISTORY

| | Age | Significant Health Problems | | Age | Significant Health Problems |
|---|---|---|---|---|---|
| Father | | | Children | □ M □ F | |
| Mother | | | | □ M □ F | |
| Sibling | □ M □ F | | | □ M □ F | |
| | □ M □ F | | | □ M □ F | |
| | □ M □ F | | Grandfather Paternal | | |
| | □ M □ F | | Grandmother Paternal | | |
| | □ M □ F | | Grandfather Maternal | | |
| | □ M □ F | | Grandmother Maternal | | |

## HEALTH HABITS AND PERSONAL SAFETY

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed

| | | | | | |
|---|---|---|---|---|---|
| Alcohol | Do you drink alcohol? | □ Yes □ No | Tobacco | Do you use tobacco? | □ Yes □ No |
| | If yes, what kind? | | | □ Cigarettes pks/day | □ Chew #/day |
| | How many drinks per week? | | | □ Cigars #/day | □ Pipe #/day |
| | | | | □ # of years | □ year quit |
| Drugs | Do you currently use recreational or street drugs? | | | □ Yes □ No | |
| | Have you ever given yourself street drugs with a needle? | | | □ Yes □ No | |

## WOMEN ONLY

| | | | |
|---|---|---|---|
| Are you pregnant or breastfeeding? | □ Yes □ No | Number of Pregnancies | Number of live births |

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

**Neurological**
- □ Headache
- □ Double Vision
- □ Slurred Speech
- □ Imbalance/Unsteady gait
- □ Falls
- □ Abnormal movements
- □ Tremor
- □ Memory loss
- □ Numbness/Tingling
- □ weakness
- □ Seizure
- □ Cramps/Spasms

**General**
- □ Fevers
- □ Chills
- □ Night sweats
- □ Excessive fatigue
- □ Weight gain/loss
- □ Trouble sleeping
- □ Trouble staying asleep
- □ vivid dreams

**Throat/Sinus**
- □ Nasal congestion
- □ Sinus pain
- □ Nose bleeds

**Eyes/Ears**
- □ Visual loss
- □ Blurred vision
- □ Eye pain
- □ Double vision
- □ Hearing loss
- □ Ringing in ears

**Psychiatric**
- □ Depression
- □ Anxiety
- □ High levels of stress
- □ Hallucinations
- □ Uncontrollable laughter/crying

**Cardiac**
- □ Chest pain
- □ Palpitation
- □ Syncope/Passing out
- □ Heart murmur

**Urinary**
- □ Frequency
- □ Incontinence
- □ Urgency
- □ Incomplete bladder emptying

**Neck**
- □ Neck stiffness
- □ Swollen lymph nodes

**Vascular**
- □ Swollen leg(s)
- □ Easy bruising or bleeding
- □ Recent Transfusions

**GI**
- □ Swallowing difficulty
- □ Constipation
- □ Diarrhea

**Pulmonary**
- □ Shortness of breath
- □ Dry cough
- □ productive cough

**Musculoskeletal**
- □ Joint pain
- □ Muscle aches