The Center for Neuroscience

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Date:_____

Patient Name:
(Last)_____(First)_____
Date of Birth:_____SocialSecurity#_____
Street Address:_____City/State:_____Zip_____
Home Phone:_____Cell:_____
Work_____
Email Address:_____
Race:_____Language:_____EthnicGroup:_____
Latino:_____Height:_____Weight_____

EMERGENCY CONTACT:_____
Phone: (If other then above)_____Relationship:_____

INSURANCE: Primary: Aetna, Blue Card, Blue Cross/Shield, Keystone HPE, Medicare, Personal Choice, United Healthcare, etc...._____
Other:_____ID#_____
Name of Insured (If patient is not the subscriber):_____
Insured Date of Birth:_____Insured Social Security#:_____
Relationship to Patient: Self Spouse Parent Other
Insured Address: (If different from above):_____
Secondary: None or Other (Name):_____
ID#:_____Group:_____

Primary Physician:_____
Address:_____
Phone:_____Fax:_____

Referring Physician:_____
Address:_____
Phone:_____Fax:_____

Pharmacy Name:_____Address:_____
Phone:_____Fax:_____

REASON FOR TODAY'S VISIT:

_____

Current Medications and Dosage (include vitamins and supplements)

_____

_____

Medication Sensitives....Allergies (type of reaction)_____

_____

Medical Conditions (Diabetes, Heart Disease, Asthma, ETC)

_____

_____

_____

Past Surgeries: Years:

_____

_____

Have you smoked >100 cigarettes in your life? Yes or No
Current smoker? Yes or No Former Smoker? Yes or No
Do you drink Alcohol? Yes, or N
Family History (First Degree relatives:) Relations: Medical problems
Mother: _____
Father: _____
Siblings: _____
Children: _____

Do you have significant problems with any of the following?

__Weakness	__Anxiety	__Fatigue	__Diarrhea
__Numbness	__Depression	__Insomnia	__Memory Loss
__Muscle Cramps	__Skin Rash	__Fever/Sweats	__Hearing Loss
__Headaches	__Easy Bruising	__Weight loss	__Dizziness
__Blood Clots	__Weight Gain	__Double Vision	__Trouble breathing
__Neck Pain	__Speaking	__Chest Pain	__Nausea/Vomiting
__Swallowing	__Palpitations	__Back Pain	__Appetite
__Abdominal	__Constipation		

CENTER FOR NEUROSCIENCE

Financial Responsibility Form

Co-pays are to be paid at the time of service. A $15.00 fee will be charged for any unpaid Co-pays.

If your insurance requires a referral or prior authorization service, and you do not have one at the time of your appointment, you must:

1. Reschedule your appointment.
2. Pay for the appointment/service out of pocket.

IF YOU RECEIVE SERVICES THAT ARE NOT COVERED BY YOUR INSURANCE AND/OR ACCORDING TO YOUR BENEFITS, YOU WILL BE HELD RESPONSIBLE FOR ANY PAYMENTS INCURRED FOR THOSE SERVICES. KNOWING YOUR BENEFITS ARE YOUR RESPONSIBILITY.

There will be a$75.00 charge for all no-show and appointment cancellations with less than 36 hours' notice. Also, a charge of $250.00 for all no-show and cancelled appointments for EEG, EMG and Neuropsychological testing with less than 36 hours' notice.

There is a $25.00 charge for completing all forms (work, disability, school, etc....) This must be paid in advance before the doctors fill them out.

Your insurance policy is a contract between you and your insurance company. Filing insurance claims is a service provided to you without charge. We will allow sixty (60) days for your insurance to process and settle your claim. If there is no response from your insurance company after that time, the payment will be your responsibility.

I,_____(responsible party), acknowledge and understand the above statements and agree to be financially responsible for he treatment rendered to _____(patients name) if it is not covered by insurance.

Signed:_____ date:_____

Name:_____ Relationship:_____

Guardian/Responsible Party

Center for Neuroscience

INSURANCE CONSENT AND RELEASE
ASSIGNMENT AND RELEASE

I, the undersigned, certify and I (or my dependent) have insurance coverage with the following insurance companies and assign directly to the Center of Neuroscience all insurance benefits, if any, otherwise payable to me for services and/or materials rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I herby authorize the neurologists, psychologists, neuropsychologists and their respective assistants to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Insurance #1: _____

Insurance #2: _____

Insurance #3: _____

Patient Name: _____

Responsible Party Name, if other than patient: _____

Responsible Party Signature: _____

MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits be made on my behalf to The Center for Neuroscience for services furnished me by The Center Neuroscience. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance "is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services, Coinsurance and the deductible are based upon the charged determination of the Medicare carrier.

Beneficiary Name: _____ Date: _____

Beneficiary Signature: _____

Center for Neuroscience

HIPAA Compliance Patient Consent Form

Neuropsychology and Psychology

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please circle YES or NO

May we phone or email to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____