MIDTOWN NEUROLOGY, P.C.
PATIENT INFORMATION AND DISCLOSURES

Name

Gender
☐ Male
☐ Female

First: _____ Last: _____ Middle: _____

Phone

Home: _____ Work: _____ Mobile: _____

Home Street Address: _____

City/State/Zip: _____

Social Security#: _____ Birthdate: _____ Email Address: _____

Race : _____ Marital Status: ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Student

☐ This is **NOT** a work related Condition, injury or symptom. ☐ This **IS** a work related Condition, injury or symptom.

Patient's Occupation: _____ Employer Name: _____

Employer Address: _____

Emergency Contact : _____ Relationship to you: _____

Contact Phone : Home _____ Work : _____

Name of Primary Ins.Co _____ Are you the Policy Holder? _____

Name of Second Ins.Co _____ Are you the Policy Holder? _____

If policy holder is anyone other than the patient, please provide their Social Security Number and date of birth to the receptionist.

Please tell us how you heard about our practice: _____

PAYMENT / COPAYMENT IN FULL IS EXPECTED AT THE TIME WHEN SERVICES ARE RENDERED. PLEASE PROVIDE YOUR INSURANCE CARD(S) AND IDENTIFICATION TO THE RECEPTIONIST FOR VERIFICATION.

Authorization to Release Information: I hereby authorize Midtown Neurology, PC to release any medical or other information to my insurance company to ensure payment.

Assignment of Benefits: I hereby authorize payment of medical benefits to Midtown Neurology, PC. I understand it is my responsibility to inform this office of any change in my insurance coverage.

Responsibility of Patient: I do hereby expressly guarantee payment in full on any and all claims and charges in consideration for medical services rendered or to be rendered to the patient. All delinquent accounts will be subject to payment of costs of reasonable collection fees and attorney fees. I understand that a $50.00 no show fee be applied to my balance for any appointments that are missed without rescheduling or canceling within 24 hours of my appointment.

I also understand that a $75.00 no show fee will be applied to my balance for any procedure that is missed without rescheduling or canceling within 48 hours of my appointment.

Privacy Practices Acknowledgement: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____

Midtown Neurology Patient Medication List

Patient Name : _____

Drug Allergies: _____

Name of Your Pharmacy: _____

Pharmacy Address : _____

Pharmacy Phone # : _____

Pharmacy Fax # : _____

Current Medication(s)	Dosage per pill	#of pills taken per day	#of times taken per day	Reason for Taking	Effectiveness (Rate 0-100%)	Side Effects

Past Medication(s)	Dosage per pill	#of pills taken per day	#of times taken per day	Reason for Taking	Effectiveness (Rate 0-100%)	Side Effects

MidTown Neurology REVIEW OF SYSTEMS

Name: _____ Date: _____

Please check any symptoms you currently have

General Problems:
- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fever/chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Loss of energy

Skin Problems:
- ☐ Rash
- ☐ Hives
- ☐ Dry or sensitive skin
- ☐ Itching

Gland Problems:
- ☐ Tiredness
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Breast lump or discharge

Neurologic Problems:
- ☐ Headaches
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Memory problems
- ☐ Tremors
- ☐ Difficulty walking
- ☐ Pain
- ☐ Falls
- ☐ Weakness
- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Urge to move legs at night

Eye Problems:
- ☐ Diminished vision
- ☐ Blurring of vision
- ☐ Cataracts
- ☐ Watery eyes
- ☐ Eye pain
- ☐ Double vision
- ☐ Droopy eyelids

Blood problems:
- ☐ Blood transfusion
- ☐ Easy bleeding or bruising

Musculoskeletal:
- ☐ Back pain
- ☐ Neck pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Leg cramps
- ☐ Muscle aches

Ear/nose/throat problems :
- ☐ Recent cold
- ☐ Hearing loss
- ☐ Change in voice
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ Drooling
- ☐ Difficulty swallowing
- ☐ Sinus problems

Heart Problems:
- ☐ Light-headedness
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Passing out
- ☐ Shortness of breath

Stomach problems:
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Stomach pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool

Lung Problems:
- ☐ Coughing up blood
- ☐ Breathing problems
- ☐ Cough
- ☐ Wet Cough

Psychiatric:
- ☐ Tension/stress
- ☐ Sleep problems
- ☐ Irritability
- ☐ Worrying/Anxiety
- ☐ Hallucinating (seeing or hearing things)
- ☐ Decreased enjoyment of life
- ☐ Hearing voices

Genitourinary:
- ☐ Loss of bladder control
- ☐ Difficulty urinating
- ☐ Leaking of urine
- ☐ Burning with urination
- ☐ Sexually transmitted diseases

Men Only:
- ☐ Impotence (erectile dysfunction)

Women Only :
- ☐ Currently pregnant
- ☐ Heavy menstrual bleeding
- ☐ Menopause

Please indicate the chances of falling asleep in the following situations by marking the most appropriate number:

○ 0	○ 1	2	○ 3	Sitting and reading
○ 0	○ 1	○ 2	○ 3	Watching TV
○ 0	○ 1	○ 2	○ 3	Sitting, inactive in a public place (e.g. a theatre or a meeting)
○ 0	○ 1	○ 2	○ 3	As a passenger in a car for an hour(without a break)
○ 0	○ 1	○ 2	○ 3	Sitting quietly after a lunch without alcohol
○ 0	○ 1	○ 2	○ 3	While stopped for a few minutes in traffic
○ 0	○ 1	○ 2	○ 3	Sitting and talking to someone
○ 0	○ 1	○ 2	○ 3	Lying down to rest in the afternoon (when circumstances permit)

TOTAL:

Midtown Neurology Financial Policy

Self Pay

-Payment is due on the date of service if you are not covered by medical insurance.

Insurance

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles and Non-Covered Services:

*All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
*Please help us in upholding the law by paying your co-payment at each visit.
*Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Forms of Payment:

*We accept cash, checks, and all major credit cards (Visa, MasterCard, American Express, and Discover).
*We accept credit card payments over the phone and also have the ability to send you a bill electronically to pay with your credit card over the internet.
*We also offer a line of credit through our billing partner, CareCredit®. Interest-free payment plans are available for those who qualify.
*There will be a $35 fee for returned checks.

Medicare

*Medicare requires 20% of their allowed fee to be paid by the patient or by a supplemental policy.
*A deductible is also required by most Medicare policies.
*If you do not have a supplemental policy, you will be billed for the 20% not covered by Medicare as well as your deductible.

Referrals and Prior Authorizations:

*If your insurance requires a referral from your primary care physician or prior authorization for services, you are responsible to inform us and obtain this information.
*We will assist you with this process when possible.
*We will be happy to reschedule your visit if the insurance requirements have not been met.
*If you do not have prior approval, you may still see the doctor if you pay your visit in advance.

Workman's Compensation:

*All workers compensation companies require prior authorization. You cannot be seen until prior approval is obtained. **If you "no-show" for an appointment, you will be discharged from our practice.**

No-Show Policy

*Established Patients: Midtown Neurology, P.C. reserves the right to charge a $50 fee for a missed appointment and $75 for a missed procedure. We may require you to pay this fee prior to your next appointment.
*Workers Comp Patients: **If you fail to show up for your appointment and do not call ahead of time to cancel, you will be discharged from our practice**
*New Patients: Midtown Neurology, P.C. reserves the right to charge a $50 fee for a missed appointment and $75 for a missed procedure. Please pay this when you arrive at your rescheduled appointment.

Cancellations:

*Call us if you cannot keep your appointment.
*No fee will be charged for cancellations 24+ hours prior to appointments and 48+ hours prior to procedures.
*If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid, we may refer your account to a collection agency and you will be responsible for collection and attorney fees.
*Additionally, you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Fees for Forms:

*There is a $50 fee for each form that you request one of our providers to complete.
*Fees must be paid in advance.
*Please allow up to 1 week for the completion of forms.

I have read and understand this financial policy. I clearly understand that it is my responsibility to pay my bill in a reasonable time. If for any reason any portion of my bill is not paid by my medical insurance, I hereby agree to make immediate payment in full or to make arrangements for prompt payment. I further agree to pay all reasonable costs of collection including attorney fees, if any.

Signature: _____ Print Name: _____ Date: _____

Midtown Neurology Consent to Obtain External Prescription History

I, _____ , whose signature appears below, authorize Midtown Neurology, P.C. and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinicalWorks.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Signature: _____ Date: _____

Midtown Neurology Protected Health Information Authorization

Midtown Neurology, P.C. may leave messages and/or discuss protected health information (PHI) for the purposes of treatment, payment and /or health care operations with the following person:

Name: _____

Telephone: _____ Relationship: _____

_____ _____

Signature of Patient Date

_____

Patients Name (Printed)