Office use only: ☐ **LabCorp** ☐ **Quest** **MRN** _____

NORTH GEORGIA NEUROLOGICAL CLINIC PATIENT QUESTIONNAIRE

THIS FORM CANNOT BE ALTERED

Patient Name: _____ **Gender:** Male - Female **Age:** _____

Referring Physician: _____

What is the main reason for your visit today? _____

_____

If any medications are prescribed today, would you like: 30 day or 90 day

Do you have forms for the physician to fill out today (FMLA, Disability, etc.)? Yes or No

Have you recently been to the Emergency Room or hospitalized? Yes or No If yes, which hospital and why?

_____

Have you had any testing done by another physician? (MRI, CT, X-ray, EMG or EEG) Yes or No

If yes, what type and where was the test performed _____

_____

Have you seen another Neurologist? Yes or No (If yes, who and when) _____

_____

SOCIAL HISTORY		**FREQUENCY/QUANTITY**
Do you consume alcohol?	Yes or No	_____
Do you use tobacco?	Yes or No	_____
Have you ever used tobacco?	Yes or No	_____
Do you use recreational drugs?	Yes or No	_____

Are you pregnant? Yes / No **Planning pregnancy?** Yes / No N/A

Are you currently taking birth control? Yes **/** No **/** N/A

Has any blood relative experienced a neurological, mental or emotional illness? Please specify.

_____

Do you have any of the following health problems? Circle all that apply.

High Blood Pressure Stomach Ulcers Asthma Diabetes Heart Disease Kidney/Renal Failure
Glaucoma COPD Cancer Lung Disease Kidney Stones Liver Disease Other_____

Have you had any of the following symptoms in the last 6 months? Circle all that apply.

Significant weight *gain* Significant weight *loss* Chest Pain Diarrhea Anxiety Shortness of breath
Constipation Depression Visual Loss Vomiting Urinary Incontinence Bleeding Hearing loss
Nausea Rash Bruising

For existing patients: Have any of the following changed? Address / Phone number / Insurance Yes or No If yes, please update _____

I hereby authorize North Georgia Neurological, PC (NGNC) to provide necessary medical treatment and obtain my prescription history from the pharmacy(s) where I have sent my prescriptions to be filled.

Patient's Signature: _____ **Date:** _____

MRN _____

Pharmacy _____
Name Address Phone

Do you have any drug allergies? Yes or No _____

Please circle if you have any of the following allergies: Latex **/** Tape **/** Topical Iodine **/** CT/MRI Contrast

Do you currently take any medications? Yes or No
If yes, please list **ALL** of your current medications, vitamins and supplements including dosage and frequency.

Medication	**Dosage/Frequency**	**Medication**	**Dosage/Frequency**
Do you take a daily aspirin? Yes or No			

MRN _____

NORTH GEORGIA NEUROLOGICAL CLINIC AGREEMENT
THIS FORM CANNOT BE ALTERED

Controlled Substance Agreement and Informed Consent Form

In rare instances, during the course of your treatment, your doctor may recommend the use of controlled substance. There are Federal and State Laws regulating the prescribing of controlled substances which require your physician to closely monitor patients who receive these medications to avoid injury as a result of misuse, abuse, tolerance, dependency or addiction. Our policy below sets out the terms and conditions required to receive controlled substance medication and the consequences of non-compliance. This disclosure is not meant to scare or alarm you but an effort to make you better informed of our commitment to ensure that your pain is managed in a safe and effective manner.

1. I understand that I must keep all required follow-up appointments as recommended by my physician.

2. I understand that only one pharmacy may be used for filling my narcotic prescriptions. It is the local pharmacy that I have designated on my medical questionnaire.

3. I agree to allow up to 2 business days for prescription refills.

4. I understand that prescription refills requested after 2:00 pm will not be received until the next business day.

5. I understand prescriptions will **NOT** be phoned in after hours or on the weekends.

6. I agree to take all medication exactly as instructed. I am **NOT** allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.

7. I will notify the staff immediately if anyone other than myself will be picking up my prescription.

8. I will not give away, trade or sell medications.

9. NGNC will **NOT** refill prescriptions that have been lost, misplaced or stolen.

10. I will not combine any narcotic medications with the consumption of alcohol.

11. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive a vehicle, I could be charged with DUI.

12. The following are specific (but not exclusive) grounds for immediate termination from the practice:
    a) Obtaining narcotics from any other physician while under NGNC care.
    b) Altering or forging of a prescription. **This is a felony and will be reported.**

13. In order to ensure compliance, I understand that my physician may obtain medical records from prior treating physicians and a medication profile from my pharmacy or State database. NGNC reserves the right to perform random drug screen monitoring on patients who require prescription narcotic medications over an extended period of time, as required by law.

I have read and agree to the above policy. I understand that non-compliance results in dismissal from the practice and/or discontinuation of controlled substance prescriptions. I understand that if I do not sign this document, my physician will refuse to prescribe any narcotic medications.

Patient Name: _____ **Date of Birth:** _____
(Please Print)

Patient Signature: _____ **Date:** _____

MRN _____

NORTH GEORGIA NEUROLOGICAL CLINIC PATIENT INFORMATION

THIS FORM CANNOT BE ALTERED

Patient Name: _____
Last First MI

Gender: Male - Female **Date of Birth:** _____ **SS #:** _____

Marital Status: Married - Single - Partner - Divorced - Widowed - Minor

Race: _____ **Language:** _____ **Dominant Hand:** Left **or** Right

Mailing Address: _____
Street/PO Box Apt City State Zip code

Primary Phone #:_____ **Secondary Phone #**:_____

Emergency Contact: _____**Phone:** _____

Referring Physician, Name of Practice & Location

_____
First Last Phone # Name of Practice Location

Primary Care Physician, Name of Practice & Location

_____
First Last Phone # Name of Practice Location

Resident of a Hospice/Nursing Facility? Yes or No

*If yes, Facility Name and Phone: _____

Is your visit today related to an accident? Yes or No

*If yes, which one: Auto - Work - Sports - Other _____ Injury Date: _____

PARENT INFORMATION IF PATIENT IS UNDER 18 YEARS OLD

_____
Guarantor's Name DOB Gender

_____
Relationship to Patient SS#

_____
Phone Address (if different from above)

_____
Name of Adult Presenting Minor for Treatment Relationship

HEALTH INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
_____ Insurance Name	_____ Insurance Name
_____ Policy ID#	_____ Policy ID#
_____ Group/Account#	_____ Group/Account#
_____ Subscriber Name	_____ Subscriber Name
_____ Subscriber DOB Gender	_____ Subscriber DOB Gender
_____ Subscriber relation to patient	_____ Subscriber relation to patient

NORTH GEORGIA NEUROLOGICAL CLINIC CONSENT FORM

THIS FORM CANNOT BE ALTERED

I give permission to NGNC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job. I authorize NGNC to discuss my health information with other providers and facilities in order to provide necessary medical treatment.

I fully understand and accept the terms of this consent.

Patient's Signature: _____ Date: _____

HIPAA

I have been informed by North Georgia Neurological Clinic, PC (NGNC) of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been offered a copy of the Notice of Privacy Practices and I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that NGNC has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that as part of my healthcare, NGNC originates and maintains paper and electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and plans for future care of treatment. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or payment of healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

NOTE: As a patient, you may designate one or more personal representatives. A personal representative may request a copy of your medical records and/or receive Protected Health Information (PHI) about you. PHI includes information about your current medical condition and diagnosis, treatment and prognosis, and billing and payment information. A personal representative may be a spouse, relative or friend. You can request in writing to remove or add a personal representative at any time.

I give permission to NGNC to disclose my health information to the following persons:

Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number

Patient's Signature: _____ Date: _____

NORTH GEORGIA NEUROLOGICAL CLINIC FINANCIAL POLICY

THIS FORM CANNOT BE ALTERED

Insurance:

- It is your responsibility to read and understand your insurance policy.
- Since we **DO NOT** participate with all insurances, you **must** provide us with the most current insurance information at scheduling.
- We **DO NOT** participate with Medicare or Medicaid insurance, including Amerigroup, CareSource, Peach State, Wellcare, etc.
- You are responsible for all out of network services and all unpaid balances including non-covered services.

Self-Pay:

- Payment is due in the form of cash, debit or credit on the date of service.

Accident/Liability:

- A signed waiver is required. Payment in full is due in the form of cash, debit or credit at the time of service.
- Health insurance may be filed as a **courtesy.** Patient responsible for filing auto/liability claims.

Workers' Compensation:

- All workers' compensation companies require prior authorization. You cannot be seen until prior approval is obtained.
- Patient is not liable for **authorized** workers' compensation services.

Medicare

- We are not contracted with Medicare. A patient who is covered under Medicare insurance has the option to self-pay for services rendered with the physicians of North Georgia Neurological Clinic.
- If you have Medicare insurance and choose to self-pay, Medicare requires you to sign a contract agreeing these services will not be reimbursable by Medicare.

Co-Payments, Deductibles & Out of Pocket:

- Insurance co-payments, deductibles and/or any out-of-pocket patient responsibility are due at time of service.

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 prior to scheduling your appointment. We will assist you with this process when possible. If you do not have prior approval, you may still see the doctor if you pay for your visit on the date of service.

Office Policies:

- A $35 fee will be assessed for any returned checks.
- Our office uses TransWorld Systems for our patient billing. Outstanding balances not paid within 5 statements will be submitted to a collection agency and will incur a 25% collection fee to be paid by the patient
- Any refund due will be processed and issued in the form of a check within 45 days of posting to our system.

No-Show Policy & Cancellations:

- All appointments must be cancelled by 4:00pm the business day prior to appointment to avoid a same day cancellation fee either via call or text. All calls to cancel appointments must be made within the hours of 8:30a – 12:00p or 1:00p – 4:00p. NGNC office hours are Monday through Friday 8:00a – 5:00p.
- As a courtesy, we will contact you to confirm your appointment and notify you of financial responsibility 48 hours in advance.
- Your appointment may be rescheduled if you show up more than 20 minutes late to your appointment.
- We reserve the right to not reschedule any appointment due to excessive cancellations and/or no shows.
- New & Established Patient Appointments:
  - NGNC reserves the right to charge a $50 fee if you fail to show up for an appointment or cancel the same day.
- Procedures (EMG, EEG, etc.):
  - NGNC reserves the right to charge a $100 fee if you fail to show up for a procedure or cancel the same day.

Fees for forms: **Please allow up to 2 weeks for forms to be completed:**

- 1 Page Forms	$25	- 3-4 Page Forms	$55
- 2 Page Forms	$40	- 5+ Page Forms	$75

Fees for patient medical records saved to USB: $15 *additional $5 fee for USB/Printed copies that are mailed.

Fees for printed patient medical records:

- 1 – 5 pages	$5	- 16 – 20 pages	$20
- 6 – 10 pages	$10	- 21 – 50 pages	$25
- 11 – 15 pages	$15	- 50+ pages	$50

I have read and understand this financial policy. I understand that NGNC rates and fees are subject to change at any time without prior notice. Although I have requested NGNC to bill my insurance company on my behalf, I clearly understand that it is my responsibility to pay my bill in a reasonable time. Omitted insurance information will result in my financial responsibility. 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 Date