



New Patients: Please complete & present insurance cards & ID

Name (Last, First, MI): _____ Today's Date: _____

Date of Birth: _____ Circle: MALE or FEMALE

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____

Office may leave a detailed message with medical information on my voicemail above. YES or NO

Email Address: _____ Marital Status: _____

Pharmacy Name: _____

Pharmacy Address or Phone: _____

Referring Physician, if applicable: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Primary Health Insurance: _____ Policy or ID: _____

Referral Required from your primary care physician: Yes or No

Secondary Insurance: _____ Policy/ID: _____

Ethnicity: Hispanic or Latino Non-Hispanic/Non-Latino Declined to Specify

Race: African American or Black Asian White/Caucasian Other Declined to Specify

Medical History: Please check all medical conditions.

- Checkboxes for medical conditions: Anxiety, Asthma, Atrial Fibrillation, Cancer Type, COPD, Depression, Diabetes, Heart Disease, High Cholesterol, Hypertension, Kidney Stone, Migraine, Sleep Apnea, Stroke, Thyroid Dysfunction, None of above

Others: _____

Allergies to Medication: Please list any medications allergies below or check if none.

None

Surgeries: Please check any previous surgeries.

- Checkboxes for surgeries: Brain Surgery, Cardiac Stent, Carpal Tunnel, Cervical Spine, Lumbar Spine, C-Section, Gallbladder, Hysterectomy, Knee, Pacemaker, Shoulder

None of Above

Others: _____

Please continue →

1) Have you recently been hospitalized in last 6 months? Circle Yes or No

If yes, please list name of hospital name & approximate dates: _____

2.) Social History: Please indicate

Never Smoked _____

Current Smoker _____

Former Smoker _____

If you are a *current smoker*, how much do you smoke per day or week? _____

If you a *former smoker*, APPROXIMATE START DATE: _____ APPROXIMATE END DATE _____

How much did you smoke per day or week in the past? _____

2) Circle how often you drink alcohol? NONE, RARELY, SOCIALLY, OCASSIONALLY, OFTEN, DAILY

4.) Please list if there any neurological conditions in your family?

Medications: Please list all prescriptions, over the counter medications, and supplements. Or provide a separate list of medications or medication bottles, if you have.

Name	Dose	Frequency

Height: _____ Weight: _____

Only If Automobile Accident: Auto Insurance: _____ Date of Accident: _____

Claim #: _____ Adjuster/Phone: _____

Please continue →

Involvement of Care

Patient Name: _____

I hereby request that the following individual(s) be allowed to participate in my care or payment decision process. I understand that these individual(s) may be given health and/or payment information about me if I am not available or unable to communicate. Senzon Neurology will act on this information until I revoke or amend the authorization in writing.

Name	Relationship	Date of Birth (if known)	Phone Number

My complete medical record can be released to above individual(s): YES: _____ NO: _____

If no, I hereby authorize the release of all my medical record with the **exception** of the following information:

Mental Health, Communicable Diseases (including HIV and AIDS), Alcohol and/or Drug Abuse Treatment

Other, please specify: _____

Note: In the event this individual(s) is to be involved in healthcare decisions for this patient, a healthcare proxy must be completed in accordance with the related policy.

Authorization to Treat

- 1) I, or the person acting on my behalf of the patient listed above, do hereby authorize the rendering of such care, which may include diagnostic procedures and such medical treatment as deemed necessary by the physician or provider in charge of my care.
- 2) I understand that the practice of medicine and surgery is not an exact science and that diagnoses, and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as the result of examination or treatment by this facility.
- 3) It is customary, absent emergency or extraordinary circumstances, that no procedures are performed upon a patient unless he or she has had an opportunity to discuss with physician or provider in charge of their care to the patient's satisfaction. Each patient has the right to consent or refuse consent to any procedure or therapeutic course. No patient will be involved in any research or experimental procedures without his or her full knowledge and consent.
- 4) This is a lifetime financial consent concerning outpatient service records, which shall continue in effect until I revoke it in writing. I authorize payment directly to Senzon Neurology any benefits payable under the terms of my insurance/third party payer. I understand that I am finally responsible for any charges or remaining balances not

covered by my insurance/3rd party payer. I authorize Senzon Neurology to release all pertinent medical information for purposes of obtaining payment for services rendered, reviewing, or evaluating patient care, and/or preparing continuing care.

My signature below indicates I have also been provided Notice of Privacy Practices (HIPPA).

*Signature: _____ Date: _____

Please continue →

Patient Financial Responsibility Policy

Thank you for choosing Senzon Neurology as a healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies. The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care. Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office. While the filing of insurance claim is a courtesy that we extend to our patients, **it is your responsibility to:**

- Bring insurance card to each visit & notify our office of any changes to your insurance or primary care physician's office.
- Know your coverage, benefits, co-pay and be prepared to pay at each visit at check-in.
- Determine if doctor(s) are network providers prior to first visit.
- Pay for any amounts not covered by your insurance according to their fee schedule (copays, out of pocket expenses, deductibles, and co-insurances).
- **Patient is responsible for ALL necessary referrals & authorization**, if required from insurance for each office visit. If we do not have your necessary referral at time of visit, patient is responsible for the bill without proper authorization/referral.

Patients may incur, and are responsible for the payment of additional such as but not limited to:

- Charge for returned checks or missed appointment without 24 hours advance notice
- Charge for extensive phone consultations requiring diagnosis, treatment.
- Charge for extensive forms completion (i.e. Disability Forms). All forms require an appointment.

I have read, understand, and agree to the provisions of Senzon Neurology's Statement of Patient Financial Responsibility. Senzon Neurology reserves the right to change or amend this statement at any time and at its discretion. I hereby authorize payment to be made directly to Senzon Neurology a Division of Neuroscience Consultants LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered by the insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments, co-insurances and non-covered services. After receipt of a statement, if payment is not received by the next billing cycle, it is subject to a monthly finance charge. If an account is referred to an outside agency for collection, the patient agrees to pay all costs related to such action.

Printed Name: _____

*Signature Patient *or Guardian*: _____ Date: _____

Carequality/Commonwealth Patient Opt-Out Info (Optional)

Carequality/Commonwealth is a nationwide health information exchange (HIE). The HIE allows doctors, nurses, pharmacists, other health care providers to securely share a patient's vital medical information electronically. The purpose is to improve patient care by making sure doctors, hospitals and other health care providers have a complete and recent picture of your health when and where it is needed for your treatment or care. You have the right to ask that your medical information not be disclosed or shared by the Carequality/Commonwealth Framework. Your choice to opt-out of the health information exchange will not affect your ability to access medical care. If you wish to opt-out, please sign below. If you do not choose to opt-out you will be defaulted to opt-in . I choose to Opt-Out

Please present insurance cards & ID with completed forms. Thank you.