PLEASE PRINT AND ANSWER ALL QUESTIONS

Patient Name:_____ Home Phone:_____ Cell Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Sex:____ Age:_____ Birth Date:_____ Marital Status:_____ SSN:_____

Employer:_____ Phone:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Spouse/Guardian Name: _____ DOB:_____SSN:_____

Spouse/Guardian

Employer:_____ Phone:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____ Zip:____

Purpose of visit: _____

Referring Physician's Name:_____

Have you ever seen a neurologist before?____ Who?_____ When?_____

Is your case Worker's Compensation?_____ Date of injury/accident:_____

Visit authorized by:_____ Phone:_____

Supervisor/Contact Person

Is your case being handled by an Attorney?_____ Attorney's Name:_____

Is this due to an auto accident?____ Attorney's Phone:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT/ PAYMENT OF SERVICES

I hereby assign and authorize Carolina Neurological Clinic to furnish information to carriers and medical professionals concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I agree to pay for services when rendered unless other arrangements have been made in advance with our bookkeeper.

_____ _____

Signature Date

Carolina Neurological Clinic
3531 Mary Ader Avenue, Suite A, Charleston, S.C. 29414
Phone: 843.723.0202 Fax: 843.723.1052

Initial Neurology Patient Data Base

___/___/___ _____ ____yrs Right/Left _____ Male/Female
DATE **NAME** **AGE** **HANDEDNESS** **RACE** **SEX**

Who referred you?_____ Who is your primary physician?_____

PAST MEDICAL HISTORY (Please list as appropriate):

1. Medication Allergies (list the medication and specify the type of adverse reaction):

_____

2. Current Medications (including any over the counter and herbal preparations):

_____

_____

_____

3. Past or current Medical and Psychological Illnesses:

_____

_____

_____

4. Surgeries/Traumas/Accidents:

_____

_____

SOCIAL HISTORY (Please complete/circle as appropriate):

1. Marital Status: Married Divorced/Separated Widowed Single/Never Married
2. Highest level of education (include number of years completed):
___ Grade School _____ High School/GED ____College ____Post Graduate
3. Employment: Retired Disabled (date:_____)/unemployed Employed
4. Cigarette Use: No/Never Yes(___packs/day x_____years) Quit ___/___(mo/yr)
5. Alcohol Use: No/Never Yes: rare social occasional frequent daily; amount_____
6. Caffeine Use: No/Never Yes: coffee tea soft drinks; amount/day_____
7. Illicit Drug Use: No/Never Yes: what and when_____
8. Overseas Travel: No/Never Yes: where and when_____
9. HIV risk factors: No Yes: homosexual activity IV drug use transfusion other:_____
10. Religious preference:_____

Reviewed by _____M.D./D.O.

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Initial Neurology Patient Data Base

__/__/__ _____

DATE **NAME**

FAMILY HISTORY (List ages and medical problems. If any deaths have occurred, please list the age of death and cause if known):

1. FATHER: _____
2. MOTHER: _____
3. BROTHERS: _____
4. SISTERS: _____
5. SONS: _____
6. DAUGHTERS: _____
7. Any biological or "blood" relatives with the same or similar neurological problems as yourself? _____

REVIEW OF SYSTEMS (Circle all that apply):

CONSTITUTIONAL:

1. Recent fever or chills/sweats of significant weight gain/loss

EYES, EARS, NOSE & THROAT:

2. Vision: glasses/contacts, decreased vision, blurred, double, "spots" or "lines" eye pain/redness/discharge
3. Hearing: hearing loss/aides, Tinnitus (ringing/buzzing/clicking/abnormal sounds), ear pain
4. Swallowing problems, hoarseness, or sore throat; loss sense of smell or abnormal smells, or nosebleeds

CARDIOVASCULAR:

5. Chest pain/ angina or heart palpitations (beating fast, slow or irregular)
6. Swelling/Edema or Cyanosis (blue discoloration) of any extremity
7. Varicose veins

RESPIRATORY:

8. Difficulty breathing or Shortness of breath or exertion causing windedness
9. Cough
10. Snoring or Sleep Apnea (trouble breathing while sleeping)

GASTROINTESTINAL:

11. Recent nausea or vomiting, or indigestion/heartburn/reflux, Hiatal hernia, abdominal pain
12. Diarrhea or constipation or black/tar-like stools, or blood in bowel movements

GENITOURINARY:

13. Incontinence or loss of control of bowels or bladder
14. Burning or pain on urination, blood/pus in urine, or kidney/bladder/prostate/urine infections
15. Too frequent urination, blood/pus in urine, or kidney/bladder/prostate/urine infections
16. Impotence or inability to get or maintain adequate penile erection
17. Abnormal breast lumps or nipple discharge/milk production
18. Abnormal menstrual cycle

Reviewed by: _____

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__/__/__ _____

DATE NAME

MUSCULOSKELETAL:

19. Muscle pain, joint pain (arthritis, bursitis, or tendonitis), or bone pain
20. Neck pain, Thoracic spine pain, low back pain
21. Extremity (arm, leg, hand, foot) pain

DERMATOLOGIC:

22. Recent rash or abnormal/unusual lumps or skin/fingernail/hair changes
23. Large (greater diameter than a pencil eraser) moles or unusual (dark or irregularly colored) moles

NEUROLOGICAL:

24. Dizziness, Vertigo or "spinning" sensation, disequilibrium
25. Light-headed or "feel like going to pass out", fainting or blackout spell
26. Seizures or "spells" of periods of feeling "out of it"
27. Confusion or abnormal memory loss
28. Headache, facial pain or head injury
29. Muscle weakness or paralysis; use brace or ankle-foot orthotic device
30. Muscle cramps or Fasciculations or twitches, spasms or stiffness
31. Tremor or hand/arm/leg "shaking" or other involuntary movements
32. Speech problems
33. Numbness, tingling or "pins and needles" or "burning" or other abnormal sensations
34. Uncoordinated or balance difficulties
35. Ataxia, trouble walking or difficulty with ambulation; use of cane/walker/wheelchair

ENDOCRINE:

36. Abnormal fatigue
37. Abnormal heat intolerance or cold intolerance
38. Excessive thirst or excessive appetite or loss of appetite
39. insomnia or difficulty sleeping
40. Excessive daytime sleepiness/drowsiness

HEMATOLOGIC/IMMUNOLOGIC:

41. Easy bruising or anemia
42. Swollen/tender glands/lymph nodes

ALLERGIC/IMMUNOLOGIC:

43. Runny/watery/itchy eyes/nose
44. Hay fever/pollen allergies
45. Frequent colds/sore throats
46. Recurring infections (sinusitis, bronchitis, pneumonia, urinary tract, etc.)

PHYCHOLOGIC:

47. Depression or Mania/Bipolar or attention Deficit/Hyperactivity Disorder
48. Anxiety, nervousness or panic attacks
49. Hallucinations or paranoia
50. Behavioral or personality changes

Reviewed by: _____

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

MEDICATION POLICY

Patient Name: _____ **DOB:**_____
Pharmacy Name: _____ **Phone #:**_____

_____I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ I agree to use the pharmacy listed above for filling my prescriptions for all of my pain medicine.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program medications and will be responsible for any costs associated with this testing. I understand that it is my responsibility to inform my provider's staff if my insurance requires the use of a particular lab.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I understand that I may be required to bring unused pain medicine to every office visit.

_____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

_____ _____
Patient Signature **Date**

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

Financial Policy

Patient Name: _____ ***DOB:*** _____

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- ✧ Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash, checks or credit cards (i.e.; VISA, Mastercard, Discover)

- ✧ **Patients with an unpaid balance of greater than 120 days will be forwarded to a collection agency subsequently terminating the physician/patient relationship. All outstanding balances must be paid or payment plan current to be seen by the physician or have medication refills addressed.**

- ✧ We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

- ✧ If your insurance requires a referral **it is your responsibility to provide the referral to our office prior to seeing the physician.** If unable to provide the referral prior to the visit payment in full will be required at the time of the visit. •

- ✧ If you have Medicare, PART B only you are responsible for your Medicare deductible and your 20% of the charges at the time of service. If you have a secondary insurance, we will send the claim to them also, but not all secondaries will pay for the Medicare deductible. If you are not enrolled in the Medicare QMB program, you will be responsible for any costs not covered by Medicaid.

- ✧ In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- ✧ We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

- ✧ **We understand that there are times when forms indirectly associated with your healthcare are requested by your employer or other entities, etc. There is a minimum $25 fee for review of these forms, however, the total cost for completion of such forms may be more. The patient will be notified and payment required in advance of the physician addressing these forms. All forms will require a minimum of 10-14 business days for review and completion once payment is received.**

Patient Signature: _____ **Date:** _____

CAROLINA NEUROLOGICAL CLINIC, LLP

PATIENT PORTAL

If you have already provided us your personal e-mail address, you will be receiving an e-mail to that account with an invitation to get started. This e-mail will contain your username and a one-time password. You will be provided with consent to proceed with enrollment and a disclosure notice for privacy purposes. You will be asked to change the initial password to one of your choosing.

Private information will not be contained in the e-mails sent to you from our office, but will rather direct you to log in to the Patient Portal to view the information.

**We ask for you to remember that the information contained in the Patient Portal WILL contain your private health information (PHI). Carolina Neurological Clinic is NOT responsible for the security of the e-mail account nor the password you have chosen. If the e-mail address you provide us is one you share with others (family), you may want to consider providing an alternative e-mail account to ensure your PHI is only accessible to those of your choosing. Please also note that by allowing others access to your Patient Portal, you are authorizing them to contact Carolina Neurological Clinic and conduct business on your behalf. If you do not wish to allow anyone, other than yourself, to communicate with Carolina Neurological Clinic regarding your healthcare, it is advised that you not share your private log-in information. We can only assume that any incoming information via the Patient Portal is from you or someone you have authorized to contact us on your behalf.

If you would like to continue with enrollment in the Carolina Neurological Clinic Patient Portal, please sign below.

By enrolling, I acknowledge understanding that:

- This enrollment is elective
- The e-mail account provided will contain instructions to access the Patient Portal
- The Patient Portal will contain my private health information (PHI)
- I am responsible for the privacy of this account and any associated access

Patient Name: _____ Date of Birth: _____

____ No, I do not want to have access to the Patient Portal (you may sign up at a later date, if desired)
____ Yes, I would like to sign up for the Patient Portal and will provide my e-mail address below.

E-mail Address for Carolina Neurological Clinic Patient Portal:

_____

_____ Date: _____
Patient Signature (or authorized representative)

Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

(Please provide information below)

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service: _____ To date of service: _____

Name of person:	**Address:**	**Phone/Fax:**	**Relationship to you:**
Example: John Doe	3 Main St., ABC City, SC 29401	843-555-1212	Husband
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Authorization, Assignment of Benefits, and Referral Medical Release

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and is described in the Carolina Neurological Clinic Notice of Privacy Practices, which a copy has been made available to me.

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Carolina Neurological Clinic for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to my contact information; failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Signature of patient or representative: _____ **Date:** ____/____/_____

Description of Representative's Authority: _____