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, Name of Practice & Location

____

First Last Phone # Name of Practice Location

What is the main reason for your visit today? ____

Have you been seen by another Neurologist? Yes or No (if yes, who and when) ______________________________

Do you have forms for the physician to fill out today? Yes or No

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

Pharmacy ____

Name Address Phone

Please list **ALL** of your current medications including dosage and frequency. **(continue on next page)**

Medication	Dosage/Frequency	Medication	Dosage/Frequency
Do you take a daily aspirin? 1. Yes or No		4.	
2.		5.	
3.		6.	

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

Have you recently been hospitalized? Yes or No (if yes, which hospital, date and why) ___________________________

____

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

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 ____________________________

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

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 _______________

NORTH GEORGIA NEUROLOGICAL CLINIC MEDICATION LIST

Medications (continued)

Medication	Dosage/Frequency	Medication	Dosage/Frequency

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 (Government Census): White - African American - Asian - Hispanic - Other

Ethnicity (Origin): Not Hispanic or Latino - Hispanic or Latino **Primary Language:** ______________

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

MRN ____________

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

- **Credit Card Transactions:**
  - All credit card transactions must be a minimum of $10.00.
- **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 is responsible for filing auto/liability claims.
- **Insurance:**
  - It is your responsibility to read and understand your insurance policy.
  - You must provide us with the most current insurance information because we **Do Not** participate with all insurances.
  - We **Do Not** accept new Medicaid patients to include Amerigroup, CareSource, Peach State and WellCare.
  - You are responsible for all out of network services and all unpaid balances including non-covered services.
- **Co-Payments, Deductibles & Out of Pocket:**
  - Insurance co-payments, deductibles and/or any out of pocket are due at check-in.
  - If you are unable to pay on the day of your appointment, we will be happy to reschedule your appointment.
- **Refunds:**
  - Any refund due will be processed and issued in the form of a check within 45 days of posting to our system.
- **Medicare:**
  - Medicare requires a yearly deductible and/or coinsurance of 20% to be paid by the patient or a supplemental policy.
  - We will file your charges to Medicare for you, however, if there is no supplemental policy, the deductible and/or 20% coinsurance will be collected at the time services are rendered.
- **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 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.
- **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.
- **No-Show Policy & Cancellations:**

  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.
- **Office Policies:**
  - Please provide at least 24 hours' notice for appointment cancellations. Calls to cancel appointments must be made within the hours of 8:30-12:00 or 1:00-4:00. NGNC office hours are Monday through Friday 8:00am – 5:00pm.
  - As a courtesy, we will call you to confirm your appointment and notify you of financial responsibility 48 hours in advance. A confirmation is **required** to avoid cancellation of your appointment.
  - 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.
  - A $35 fee will be assessed for any returned checks.
- **Fees for forms**: **Please allow up to 2 weeks for forms to be completed.**

- One-page forms and tax statements	$10	- Medium forms (3-4 pages)	$30
- Short forms (2 pages)	$25	- Copy of records – minimum of	$15

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

MRN ______________

NORTH GEORGIA NEUROLOGICAL CLINIC, PC

Yazan Houssami, MD   M. Todd Williamson, MD   David A. Krendel, MD

THIS FORM CANNOT BE ALTERED

*** OPTIONAL ***

If you do not wish to give permission for us to have your credit card information on file simply return this page to the receptionist unsigned.

Permission to use Credit Card on File

Our office has implemented a policy which will help to reduce the cost of healthcare for both you and the practice. As a benefit to you, we will ask for a credit card number to be held securely until your charges have been processed. Once we have confirmed with your insurance company the amount owed by you, the credit card on file will be charged. A copy of the receipt will be mailed to you for your records.

This will not compromise your ability to dispute a charge nor question your insurance company's determination of payment. Co-payments, Deductibles and/or any Out of Pocket are due at the time of service.

Please circle: **HSA /FSA   Visa   MasterCard   Discover   AMEX**

Card Holder's Name ____

Card Holder's Billing Address ____

____

Credit Card Number ____

Exp Date________________   **3-Digit Security Code** _____________

I authorize North Georgia Neurological Clinic to use my credit card for payment on the balance on the account for ____

Name of Patient

Authorized Signature _________________________________   **Date** ___________________

If the balance due is greater than $100.00, your credit card will be charged monthly installments, not to exceed $100.00 per installment, until the balance is paid in full with the exception of the HSA/FSA cards which will be charged for the full amount.