Patient Demographics:

Patient Name: _____ DOB: _____

Social Security Number (optional): _____

Primary Contact Number: _____ Secondary Contact Number: _____

Mailing Address: _____

Scheduled Neurologist or Nurse Practitioner: _____

Reason for Visit: _____

Next of Kin: _____ Contact Number: _____

Relationship to patient: _____

Primary Pharmacy (please include cross streets): _____

Primary Care Physician: _____ Referring Doctor: _____

Meaningful Use Stage 2 requires us to provide all our patients with access to our Patient Portal. We cannot make take any actions within your patient account without an e-mail address. If you do not have one, please provide the e-mail address of a relative, caregiver, etc. Our Patient portal allows us to send appointment reminders and allows you to communicate more easily with our staff.

Email: _____

Maryland law (Health General Sec. 4-304) allows physicians to charge patients (or the patient's "personal representative") a **fee for copying medical records.** The charges may be adjusted annually for inflation. Effective immediately, the fee remains as stated: (1) A fee for copying not to *exceed* **.76 cents for each page of the medical record, and (2) The actual cost of postage and handling.** CNS WAIVES the following FEE: Preparation fee of $22.88, if the records are sent to another provider. The federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient. Patient initials: _____

Insurance Authorization and Assignment Form

All professional services rendered are charged to the patient. If we do not accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, and it is customary to pay when services are rendered unless other arrangements have been made in advance with our office. You have to pay your co-payment and/or deductibles when services are rendered. It is the responsibility of the patient to secure the necessary referrals from his/her primary care physician. If you do not have the necessary referral at the time of your visit, the fee for the service rendered will be your responsibility and is expected to be paid at the time of your visit.

I hereby, authorize Dr(s) Rafiq, Strayhorn, Llanes, Martins and NP Ward, to diagnose, treat and manage the medical condition(s) presented at the time for the visit and to furnish all information to the insurance carriers concerning my illness and treatments. I hereby assign all my insurance payments to Comprehensive Neurology Services, PA for medical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance.

_____

Patient name (print) Patient name (sign)

HIPAA Acknowledgement and Disclosure Form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Comprehensive Neurology Services, PA to use and/or disclose certain protected health information (PHI) about me to other health care providers for treatment purposes, in special situations for law enforcement or judicial purposes as described by the Health Insurance Portability Accountability Act of 1996, and to the following individuals or entities:

Name: _____Relationship:_____ Phone: _____
Name: _____Relationship:_____ Phone: _____

This authorization permits Comprehensive Neurology Services, PA to use and/or disclose the following individually identifiable health information about me, including, but not limited to, date(s) of services, type(s) of service, physicians' notes, procedural results, etc.

This information will be used or disclosed if medically or lawfully necessary at the request of the patient. The practice, under normal circumstances, will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. Comprehensive Neurology Services, PA also provides a full-length description of the Health Insurance Portability and Accountability Act of 1996.

This form and the Notice of Privacy Practices are provided so that I can make an informed decision whether to allow release of the information. I do not have to sign this authorization in order to receive treatment from Comprehensive Neurology Services, PA. I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to retraction by the patient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization expires in one (1) year.

_____ _____

Patient (or Legally Authorized Representative) Signature (SEAL) Date

_____

Description of Legally Authorized Representative's Authority (POA, Guardian) (SEAL)

_____ _____

Signature of Witness Date

Addendum:

CNS makes every effort to ensure your privacy, including the use of data encryption of emails and secured messaging. However, we can only secure communications on our end, meaning we cannot ensure complete encryption end to end. Do you give permission, under select circumstances, for routine communications between CNS and you and/or your appointed representatives via email or texting (SMS), even if the email is unencrypted or texting is unsecured? (Initial one)

Yes_____ No _____

Financial Agreement

Thank you for choosing our practice for your patient care. We are committed to providing you with quality and affordable health care. Due to inquiries regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **Insurance**. Our practice participates with 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 don't 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, including if your plan requires a referral to be seen by our provider. Please contact your insurance company with any questions you may have regarding your coverage.

2. Copayments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. Non-covered services. 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.

4. Proof of insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. You may opt to pay our self-pay charges, which does vary depending on the level and type of service provided for your care.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that any or all balance left on your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. You may choose to pay our self-pay fee and file the claim at your own convenience.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within their contract, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, further action may be required. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better and the community by keeping your regularly scheduled appointment. Missed appointments prevent other patients from being cared for by our physicians.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature (SEAL) Date

Patient Release of Medical Records Form

(Please print or type)

I, _____ (patient's name) request and give my permission to release my Medical records to Comprehensive Neurology Services for the time period dating from _____ to _____.

The Medical Records as listed above are to be released to:

Comprehensive Neurology Services, PA

C/o Dr.(s) Shahid Rafiq, David Strayhorn, Natalia Llanes, Albert Martins, Stuart Goodman, & Corey Ward, NP

- ❏ 196 Thomas Johnson Drive Suite 120, Frederick, MD 21702 Fax: 240-566-3131
- ❏ 12800 Middlebrook Rd., Suite 114, Germantown, MD 20874 Fax: 240-702-0194
- ❏ 10313 Georgia Ave., Suite 101-A, Silver Spring, MD, 20902 Fax: 301-363-4367

Phone: (240) 566-3130

Comments: _____

_____

_____ _____ _____

Printed Patient Name DOB Social Security #

_____ _____

Patient's Signature Today's Date

Patient Name: _____ Date: _____

Medication List

Medication Name	Strength	Directions
1.		
2.		
3.		
4.		
5.		

**Add more if needed.*

Medical History

1.
2.
3.
4.
5.

**Add more if needed.*

Allergies

1.
2.
3.
4.
5.

**Add more if needed.*

Surgical History

1.
2.
3.
4.
5.

**Add more if needed.*

Hospitalizations

1.
2.
3.
4.
5.

**Add more if needed.*

Family History *(Check all that apply.)*

	Alive (Y/N)	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐

Lifestyle:

Part 1:

Did you have a drink containing alcohol in the past year?

- ❑ Yes
- ❑ No

If Yes: How often did you have a drink containing alcohol in the past year?

- ❑ Never
- ❑ Monthly or less
- ❑ 2-4 times a month
- ❑ 2-3 times per week
- ❑ 4 + times a week

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

- ❑ 1 or 2
- ❑ 3 or 4
- ❑ 5 or 6
- ❑ 7 to 9
- ❑ 10 or more

If "Yes": How often did you have six or more drinks on one occasion in the past?

- ❑ Never
- ❑ Less than monthly
- ❑ Monthly
- ❑ Weekly
- ❑ Daily or almost daily

Part 2:

Are you a:

- ❑ current smoker
- ❑ former smoker
- ❑ never smoker
- ❑ light tobacco smoker
- ❑ heavy tobacco smoker

If "current smoker": How often do you smoke cigarettes?

- ❑ every day
- ❑ some days, but not every day

If “current smoker”: How many cigarettes a day do you smoke?

- ❑ 5 or less
- ❑ 6-10
- ❑ 11-20
- ❑ 21-30
- ❑ 31 or more

If “current smoker”: How soon after you wake up do you smoke your first cigarette?

- ❑ within 5 min
- ❑ 6-30 min
- ❑ 31-60 min
- ❑ after 60 min

If “current smoker: Are you interested in quitting?

- ❑ Ready to quit
- ❑ Thinking about quitting
- ❑ Not ready to quit

If “former smoker”: How long has it been since you last smoked?

- ❑ <1 month
- ❑ 1-3 months
- ❑ 3-6 months
- ❑ 6-12 months
- ❑ 1-5 years
- ❑ 5-10 years
- ❑ >10 years