CNS
COMPREHENSIVE NEUROLOGY SERVICES

PATIENT'S DEMOGRAPHICS

Patient's Name: ____

DOB: ____

Social Security Number: _________________________________

Primary Contact Phone Number: ___________________________

Secondary Contact Phone Number: _________________________

Mailing Address: ____

Scheduled Neurologist, Physician Assistant or Nurse Practitioner: _________________________

Reason for Visit: _______________________________________

Next of Kin: ____

Contact Phone Number: __________________________________

Relationship to patient: __________________________________

Primary Pharmacy (please include cross streets): _______________________________________

Primary Care Physician (PCP): (Include first and last name) _____________________________

PCP Office Phone Number: _______________________________

Referring Doctor: (Include first and last name) ____________________________

Referring Doctor Office Phone Number: _________________________________

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.

Preferred Email: ____

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IMPORTANT PATIENT INFORMATION

- Patient Paperwork: MVA, FMLA, Workers Comp and other official forms, require an appointment if you have not been seen within the past three (3) months. If you have been seen within this time frame but do not wish to schedule an appointment, forms may be filled out for a fee of $50, no exceptions.
- Insurance and Billing: If you have authorized us to bill your insurance on your behalf, we will submit a claim within the timely filing required by your insurance. All outstanding balances will be billed to the patient. If no response or payment is received, accounts will be sent to a third-party collection agency. Please contact us as soon as you know of any changes to your insurance policy. You cannot be scheduled for an appointment until your balance is cleared or payment plan is set with collection agency.
- Cancellation Policy: Please be advised that we have a 24-hour cancellation policy for all appointments. A fee will be assessed at $1/minute for the length of the appointment. (e.g., a 20-minute appointment cancellation fee would be $20.00). ***PLEASE NOTE, WE RESERVE THE RIGHT TO FORMALLY DISCHARGE PATIENTS WITH A MINIUM OF 3 NO SHOWS.
- Medication Refills: Please contact our office at least one (1) week in advance to allow adequate approval and review for all medication refill requests. If your medication requires a prior authorization, we will work to obtain this as quickly as possible but may require additional time. For your safety, if you have not been seen in the past year, medication refill requests will not be processed without an appointment.
- Medication Changes: Effective 01/15/2017, medication changes <u>will not</u> be made over the phone.
- Your Follow-up Appointment: Please bring your photo ID, insurance cards, a medication list, and any recent labs or radiology results to every appointment. Please do not drop off CDs or films in advance of your appointment as we will not be able to hold onto these for you.
- Labs, MRIs and other Radiology Results: If your results our normal, you will not receive a call, and your results will be reviewed at your next appointment. If results are abnormal, our providers or medical assistants will reach out to you. Depending on the performing facility, results are received in approximately one week.
- EMG/NCV Study: Please do not wear any lotions, oils, or other moisturizers on your skin for this test. If you are on blood-thinners, please make sure our staff and providers are aware. Continue taking your medications as normal.
- PAP Machines: Please bring a recent compliance report, or the chip from your machine for download, to every appointment.
- Botox Injections: If you have been submitted as a candidate for Botox injections, please allow a 6–8-week turnaround-time for approval from your insurance. Injections are done on a preselected day of the month. Once approval is given from insurance and Botox is received, you will receive a call from our office to schedule your appointment on that day. On the day of injection, please do not wear excessive makeup.

I have read and understand the policies listed above:

______________________________ __________________________

Patient's Signature Today's Date

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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. 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.

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 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 a24 hour period. 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. ***PLEASE NOTE, WE RESERVE THE RIGHT TO FORMALLY DISCHARGE PATIENTS WITH A MINIUM OF 3 NO SHOWS.

______________________________ _________________________

Patient's Signature Today's Date

HIPAA ACKNOWLEDGEMENT & 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.

We participate in Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide electronic health information exchange (HIE). The other CRISP participants and we share information about patients for treatment, payment, or other health care operations, as permitted by law. The purpose of CRISP is to provide better coordination of care and assist providers in making more informed treatment decisions. You may opt out and prevent CRISP participants from having the ability to search your information through HIE, however, even if you opt out, we will send your medical information to the HIE and our physicians who order diagnostic tests on you will be able to review results that the testing facility provides to CRISP. You may opt out by contacting CRISP on the internet at www.crisphealth.org or by phone at 1-877-95-CRISP.

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 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's (or Legally Authorized Representative) Signature (SEAL) Today's Date

____ ________________

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

____ ________________

Signature of Witness Today's Date

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INSURANCE AUTHORIZATION & 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 must 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, Brosbe, Burke, PA-C Ohsann, PA-C Fraser and CRNP 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's Name (print)	Patient's Signature)	Today's Date

PATIENT RELEASE OF MEDICAL RECORDS FORM

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, Laura Brosbe, Sean Burke, Corey Ward - CRNP, Patrick Ohsann - PA-C, and Danyelle Fraser - PA-C.

- ❏ 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
- ❏ 10301 Georgia Ave., Suite 206, Silver Spring, MD, 20902 Fax: 301-363-4367

Comments:

____

____

________________________ ________________ ____________________

Patient's Name (print) DOB Social Security #

________________________ ________________

Patient's Signature Today's Date

COMPREHENSIVE NEUROLOGY SERVICES

Patient's Name: ___________________________ Today's Date: ___________________________

Medication Name	Strength	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ADD ADDITIONAL MEDICATIONS ON THE BACK OF THIS PAGE IF NEEDED

Allergies (Please include reaction to allergy if known)

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________

Previous Medical Conditions or Diagnosis (What have you been medically diagnosed with by another physician?)

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________

Surgical & Hospitalization History (Please include Date & Location if known)

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________

Fall Risk Screening

Have you had any major falls that resulted in injury or required medical attention within the last 12 months? Check one. ____ Yes ____ No If yes, how many falls total? ____

Have you had the flu shot? Please list month and year if known: ___________

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Family History (Check all that apply)

Family Member	Alive or Deceased	Diabetes	Hypertension	Heart Problems	Stroke/TIA	Mental Illness	Cancer
Father							
Mother							
Siblings							
Children							
Grandparents							

For Siblings: How many brothers? ______ How many sisters? ________
(Both alive and deceased)

For Children: How many sons? ______How many daughters? ______
(Both alive and deceased)

Social History

ALCOHOL USE

Have you had any drinks containing alcohol in the past year? ____Yes ____ No
IF YES, How often do you have a drink containing alcohol? (Check one)
____ Never ____ Monthly ____ Two to four times a month
____ Two to three times a week ____ Four or more times a week
How many drinks with alcohol do you have on average? (Check one)
___ 1 or 2 ___ 3 or 4 ___ 5 or 6 ___ 7 to 9 ___ 10 or more
IF you answered more than 5 or 6 drinks, how often do you consume 5or 6 drinks with alcohol? (Check one)
___ Less than monthly ___ Monthly ___ Weekly ___ Daily

TOBACCO USE

Are you a smoker? ____ Current ____ Former ____ Never
If current smoker, how many cigarettes per day? ___________
If current smoker, how soon after you wake up do you have your first cigarette? ______
If current smoker, are you interested in quitting? _________
If former smoker, how long as it been? ____________