The Neurological Care Center of Montgomery

1315 MULBERRY ST.
MONTGOMERY, ALABAMA 36106
PHONE: 334-262-1113 FAX: 1-877-836-7673

HIPPA- Medical Information Release

Effective January 1, 2002

Due to **federal privacy guidelines under HIPPA,** we are required to have medical release information on file for each patient. This authorizes our office to release medical information to family members, caregivers and friends you have designated, about you or your minor children's **HEALTH INFORMATION.** Included would be all health and identifiable information. This authorizes us to share your health information after proper identification, by verbal or written communication, phone, fax mail, or e-mail as needed for your care to only those identifiable below. Powers of attorney would be listed separately.

In order for us to do this, please list names, date of births, and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

I, _____ (patient name or child's name) give my authorization to the following individual(s) listed below to discuss my medical care with you and or your staff on my behalf.

NAMES	**DOB**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

*******PLEASE LIST ANY PHYSICIAN OR MEDICAL OFFICE YOU WOULD LIKE YOUR MEDICAL RECORDS RELEASED TO, PLEASE PLACE DATE AUTHORIZED************

Any health information you do not wish to be given out please list below.

_____ _____
_____ _____
_____ _____

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed.

_____ I agree that messages may be left on my voicemail/answering machine from your office.

Signature _____ (relationship if minor) _____Date_____

Witness _____ Date _____

DISCLAIMER (Complete if you want no one else to have access to information)

_____I do not want you to discuss my medical care with anyone other than myself.

Signature _____

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CONSENT FOR TREATMENT

Authorization for treatment release of medical information, and assignment of insurance benefits,

AUTHORIZATION TO RELEASE: I hereby authorize The Neurological Care Center of Montgomery, P.C. of my attending physician, to release or disclose information from my medical record pertaining to my treatment to insurance companies and/or outpatient benefits programs as needed to process insurance claims. This includes labs and all other medical information pertaining to my care.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to The Neurological Care Center of Montgomery, P.C. benefits wherein specified and otherwise payable to me but not to exceed The Neurological Care Center of Montgomery, P.C. regular charges for medical treatment. I understand I am financially responsible for charges not covered by this authorization.

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER / PHYSICIAN: I certify that the information given by me applying for payment under XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnished the services or authorize such physician or organization to submit claims to Medicare for payment to me.

MEDICAID PATIENTS CERTIFICATION: I certify that I am a recipient of the Medicaid Title XLX Program and request the payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the EDS any requested information concerning medical, insurance, and financial records relating to my outpatient visits or hospital treatment. I hereby certify all insurance shall be assigned to The Neurological Care Center of Montgomery, P.C. or to my attending physician for services rendered. This office does not accept Medicaid as a Secondary Insurance.

CONSENT FOR TREATMENT: The undersigned authorized the physician assigned to furnished medical and surgical treatment by those means she considers necessary and proper in the treatment of patient identified below while a patient of The Neurological Care Center of Montgomery, P.C. This treatment may require diagnostic procedures including but not limited to laboratory test, blood drawing for those tests.

FINANCIAL AGREEMENT: For services rendered to the patient named below, I, the undersigned, agree to pay all professional, outpatients and/or hospital visits charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

VALUABLES: The undersigned hereby releases The Neurological Care Center of Montgomery, P.C., and/or its staff or employees for any responsibility due to loss or damage of any valuables that the patient may keep in her or her possession or that may be brought to his or her by other person.

TERM: The term of this Consent for treatment shall be as long as the patient is a patient of The Neurological Care Center of Montgomery, P.C. unless otherwise revoked.

_____ _____ _____

Printed Patient Name Signature Patient / Guardian Date

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FINANCIAL POLICY

1. **We accept cash and checks with proper ID. All returned checks will be charged a $40.00 fee. Payment is expected at time of service.**

2. **I understand and agree that I am responsible for all charges on my account. Insurance is filed, as a courtesy, by this office. If insurance does not pay within 45 days, I am responsible for the balance. Our office will gladly reimburse you when we have received the insurance payment.**

3. **I also understand that this office cannot make an exact estimate of the insurance benefits to be paid since it does not have access to all insurance company records and fee schedules. I am aware that after the insurance pays all neurological claims, there could be a balance that must be paid by me.**

4. **There will be a $25.00 fee for all cancellations and broken appointments if you do not give at least 24 hours notice. We reserve the right to dismiss a patient from our practice after three consecutive broken appointments, habitually canceled and rescheduled appointments, uncooperative patients and non-compliance of recommended treatment. We strive to provide quality neurological care for all patients and broken and rescheduled appointments hinder our efforts and desires to render those services.**

5. **There will be a 1.5% finance charge added to all accounts over 30 days past due regardless of whether the balance is outstanding insurance claims or co-payments due by the patients. To avoid this charge, you may pay your bills in full and we will gladly reimburse you upon receiving your insurance payment.**

6. **I am aware and understand that should my account be referred to an attorney for collection, I will be responsible for all attorney's fees and collection expenses incurred.**

_____ _____

Patient Signature **Date**

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THE NEUROLOGICAL CARE CENTER OF MONTGOMERY, P.C.
1315 MULBERRY STREET
MONTGOMERY, AL 36106

PLEASE PRINT **REFERRED BY:**

PATIENT: THIS SECTION REFERS TO **PATIENT ONLY**

NAME	SEX	AGE	DOB	MARITAL STATUS (CHOOSE ONE) ___SINGLE ___MARRIED ___DIVORCED ___SEPARATED
ADDRESS	SS#			
CITY **STATE** **ZIP**	**EMPLOYER**			
HOME PHONE ( )	ADDRESS			
WORK PHONE ( )	CITY STATE ZIP			
CELL PHONE ( )	EMERGENCY CONTACT AND PHONE			

BILLING: PLEASE COMPLETE IF PERSON RESBONSIBLE FOR BILLING IS OTHER THAN ABOVE PATIENT

NAME	RELATIONSHIP TO PATIENT	SS#
ADDRESS	OCCUPATION	
CITY STATE ZIP	EMPLOYER	
HOME PHONE ( )	ADDRESS	
WORK PHONE ( )	CITY STATE ZIP	

INSURANCE NO COVERAGE _____	BLUE SHIELD _____	UHC _____	TRICARE _____	MEDICARE _____	MEDICAID _____	WORKMAN'S COMP _____	CHAMPUS _____	OTHER _____

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please show all numbers on your card(s).

Primary carrier	**Secondary carrier**
name_____	**name**_____
address_____ _____	**address**_____ _____
Insured_____ _____ (name on ID card)	Insured_____ _____ (name on ID card)
Relationship to patient ___ self ____ spouse ____child ____other	Relationship to patient ____self ____spouse ____child ____other
Insured ID No._____	Insured ID No._____
Group No _____ or company name _____	Group No _____ or company name _____
Effective date: _____	Effective Date: _____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carriers.MEDICARE
Name of Beneficiary_____ HI Claim Number _____
I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by that physician. I authorize any holder of medical information about my to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
I hereby authorize Medicare to furnish the above name doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.
COMMERCIAL
I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED IN THE CLAIM.
I understand I am financially responsible for any balance not covered by my insurance carrier
A copy of this signature is as valid as the original.

Signature_____

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HISTORY &PHYSICAL

PLEASE COMPLETE FORM

Name: _____
DOB: _____
Age: _____
Referring Doctor or Person: _____
Primary Doctor: _____
Pharmacy: _____ Pharmacy Phone#: _____

HAVE YOU SEEN A NEUROLOGIST IN THE PAST, YES/NO
IF YES SO PLEASE PRINT
NAME: _____ Why did you stop seeing him/her? _____
When was the last time you saw him/her? _____

How did you know about us: ❑**TV** ❑**FACEBOOK** ❑**FRIEND** ❑**OTHER _____**

ARE YOU RIGHT OR LEFT HANDED (Please Circle)

CC: WHAT PROBLEMS BRING YOU TO THE DOCTOR?

_____

_____

_____

(FOR OFFICE USE ONLY) DO NOT WRITE ON THESE LINES

(HPI) _____

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(PMH) WHAT MEDICAL PROBLEMS DO YOU HAVE OR HAVE HAD? Check all that apply

❑Heart Attack ❑Heart failure ❑OsteoArthritis ❑Rheumatoid Arthritis ❑Asthma ❑Broken bones (list where)

❑High Blood Pressure ❑Heart Rythm problems ❑Ankylosing Spondylitis

❑Mental Illness ❑Alcoholism ❑Stroke ❑Seizures ❑Kidney Stones ❑Kidney Failure

❑Cancer, type_____ ❑Bleeding Disorders ❑Anemia ❑HIV

❑Blood Clot in Leg ❑Bloot Clot in lung ❑Stomach Ulcers ❑Liver Trouble ❑Hepatitis

❑Serious Injuries (explain) ❑Gout ❑Other_____ ❑None apply

******PLEASE INCLUDE ANY SURGERIES W/DATE *******

1) _____2) _____3) _____

4) _____5) _____6) _____

7) _____8) _____9) _____

(MEDS) What Medications do you take?

1_____2_____3_____

4_____5_____6_____

7_____8_____9_____

10_____11_____12_____

13_____14_____15_____

16_____17_____18_____

(ALLERGIES) DO YOU HAVE ALLERGIES TO ANY DRUGS? WHAT DOES THE DRUG DO TO YOU?

_____

(SH)

Do you smoke or have you ever smoked? ___Yes ____No **If yes,** how many packs do you smoke a day? _____

If you smoked in the past how long ago did you quit? _____

_____

How much did you smoke a day before quitting? _____How long did you smoke before quitting? _____

Do you drink alcohol or have you ever drunk? ____ Yes ____ No. **If yes,** how much do you drink in a week? _____

If you drank in the past, how much did you drink in a week and for how long? _____

What is your educational level? _____

What is your profession? _____

(Family History): please check the appropriate response

FM MEM (Living)/(Deceased)(Current Age Or Age of death) Medical Problems

Mother: __L_____/____D_____(_____)_____

Father: __L_____/____D_____(_____)_____

PLEASE LISIT ANY MEDICAL PROBLEMS OF FAMILY MEMBERS BELOW

FM MEM (How Many) / Medical Problems

Sister(s): (_____) /_____

Brother(s): (_____) /_____

Children(s): (_____) /_____

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(ROS) Y___/N___(FOR OFFICE USE ONLY)

(PREVIOUS TESTS) **PLEASE CIRCLE ANY TEST YOU MAY HAVE HAD IN THE PAST**

		(Approximate)
EMG: (Test of muscles and nerves)	yes no	**date**___/___/____ Where? _____
EEG: (Brain wave test)	yes no	date___/___/____ Where? _____
CAT scan (head or back)	yes no	date___/___/____ Where? _____
MRI scan (head or back)	yes no	date___/___/____ Where? _____
Recent blood tests	yes no	date___/___/____ Where? _____

PLEASE CICRCLE ALL THAT APPLIES ON ATTACHED SHEET ***(Please circle only those problems you frequently experience or have been treated for in the past.***

(PLEASE BRING COMPLETED QUESTIONNIARE WITH YOU WHEN YOU SEE THE DOCTOR)

Notice of Privacy Practices Acknowledgment

I, _____, acknowledge that I have received a copy of the notice of privacy practices.

_____
Name of Patient or Personal Representative (please print)

_____
Signature of Patient or Personal Representative

_____
Date

_____
Relationship to Patient (or other authority to serve)

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REVIEW OF SYSTEMS

PLEASE CIRCLE ONLY THOSE PROBLEMS YOU FREQUENTLY EXPERIENCE OR HAVE BEEN TREATED FOR IN THE PAST

GENERAL: RECENT WEIGHT GAIN OR LOSS | FEVER OR CHILLS | SKIN RASHES

HEAD/NECK: BLURRED VISION | GLASSES | GLAUCOMA | CATARACTS

EARS/NOSE/THROAT: LOSS OF HEARING | RINGING IN THE EARS | EARACHE | SORE THROAT | NASAL DISCHARGE | SINUS PAIN | NOSE BLEEDS

CARDIO VASCULAR: CHEST PAIN/DISCOMFORT | RHEUMATIC FEVER | HEART MURMUR | ENLARGED HEART

RESPIRATORY: SHORTNESS OF BREATH | PNEUMONIA | BRONCHITIS | EMPHYSEMA | ASTHMA | TUBERCULOSIS | CHRONIC COUGH | WHEEZING | COUGHING UP BLOOD | COUGHING UP SPUTUM | BLOOD CLOTS IN LUNG

GASTROINTESTINAL:
SWALLOWING PROBLEMS | POOR APPETITE | INDIGESTION/HEARTBURN
STOMACH ULCERS | LIVER PROBLEMS (HEPATITIS)
GALLSTONES | YELLOWING OF SKIN | BLOOD IN BOWEL MOVEMENT
DARK BLACK BOWEL MOVEMENTS | DIARRHEA
CONSTIPATION | CHANGE IN BOWEL HABITS
ABDOMINAL PAIN

GU: KIDNEY STONES | KIDNEY DISEASE | BLADDER INFECTIONS
PAIN WITH URINATION | BURNING WITH URINATION
DIFFICULTY HOLDING URINE | DIFFICULTY STARTING OR STOPPING STREAM
PROSTATE PROBLEMS

MUSCULOSKELETAL:
PAINFUL JOINTS | FREQUENT BACKACHES

NEUROLOGICAL:
BLOCKED ARTERIES IN THE NECK | WEAKNESS IN THE ARMS OR LEGS
NUMBNESS IN THE ARMS OR LEGS | SEIZURES
FAINTING | NEAR FAINTING | SEVERE HEADACHES
MEMORY LOSS | DIZZINESS | TREMOR

PSYCHOLOGICAL:
DEPRESSION | ANXIETY | NOT SLEEPING AT NIGHT

ENDOCRINE: DIABETIS | THYROID PROBLEMS | SENSITIVITY TO HEAT AND COLD
FREQUENT URINATION | FREQUENT THIRST

HEMATOLOGIC:
ANEMIA | BLEEDING PROBLEMS | BLOOD TRANSFUSION
EASY BRUISING

PERIPHERAL VASCULAR:
VARICOSE VEINS | LEG CRAMPS | SWELLING IN ANKLES
PAIN IN CALVES WITH EXERCISE

REPRODUCTIVE:

FEMALE LAST MENESTRAUL PERIOD:_____ | GONE THROUGH MENOPAUSE
AGE AT MENOPAUSE_____
TAKING BIRTH CONTROL PILLS_____

MALE IMPOTENCE

NAME:_____ DATE:_____

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Authorization for Release of Medical Information

Patient Name: _____

Date of Birth: _____

The undersigned herby authorizes _____ to release information from the medical record.

The foregoing is subject to such limitations as indicated below: (please check one)

1) Confined to records regarding admission and treatment for the following medical injury _____ occurring on or about (date) _____

2) Covering records for the period from _____ to _____

3) Confined to the following specific information: _____
_____

4) No limitations. I understand that the information released upon authority of this authorization may contain information regarding treatment for alcohol, drug abuse, a psychiatric condition, or HIV test results, and AIDS diagnosis, or AIDS related conditions.

_____ _____
(DATE) **(SIGNATURE OF PATIENT)**

_____ _____
(DATE) **(SIGNATURE OF AUTHORIZED PERSON)**

The records are to be released to:

_____

_____ _____
(DATE) **(SIGNATURE OF PATIENT)**

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URINE DRUG TESTING

Urine drug testing is a useful tool in providing safe patient care and provides valuable objective information to assist in diagnostic and therapeutic decision making. This test confirms that patients are taking their prescribed medications as directed and provides therapeutic drug monitoring (drug concentrations) to help determine if the medication is effective. Urine drug testing is considered one of the mainstays of compliance and adherence monitoring, in combination with prescription monitoring programs and other screening tools.

This office, as part of its controlled substance agreement policy requires a baseline urine drug test at the first office visit and subsequent visits as needed. Please note that the FDA Schedule II-IV drugs will require quarterly random urine drug screens and FDA Schedule V drugs will require semi-annual random urine drug screens. Additionally, more frequent urine drug testing will be required to confirm inconsistent urine drug test results, when changing medications, when there is a sudden change in the patient's condition, or when medication abuse or diversion is suspected.

Certain neurological conditions require urine drug screens to properly diagnose and manage the condition. These include, but are not limited to memory loss, altered mental status, abnormal gait, dizziness, movement disorders (including tremors), syncope, seizures, headache, and stroke.

FDA Drug Schedule:

Schedule II drugs:
Adderall (Dextroamphetamine/Amphetamine), Norco (Hydrocodone/Acetaminophen), Ritalin/Concerta (Methylphenidate), Vyvanse (Lisdexamfetamine), Methadone, etc.

Schedule III drugs:
Fioricet (Butalbitol/Acetaminophen/Caffeine), Stadol (Butorphanol), Tylenol with Codeine (Codeine/Acetaminophen), Ketamine, Testosterone, etc.

Schedule IV drugs:
Ativan (Lorazepam), Klonopin (Clonazepam), Halcion (Triazolam), Lunesta (Eszopiclone), Nuvigil (Armodafinil), Provigil (Modafinil), Sonata (Zaleplon), Ambien (Zolpidem), Tranxene (Clorazepate), Ultracet (Tramadol/Acetaminophen), Ultram (Tramadol), Valium (Diazepam),etc.

Schedule V drugs:
Briviact (Brivaracetam), Luminal (Phenobarbital), Lyrica (Pregabalin), Vimpat (Lacosamide), etc.

Other Drugs of Concern (may become FDA Scheduled drugs or metabolizes to a FDA Scheduled drug)**:**
Gralise (Gabapentin), Horizant (Gabapentin), Neurontin (Gabapentin), Mysoline (Primadone)

This list is not all-inclusive and other neurological medications may be added as the FDA continues to change classes of medications and as new medications are approved by the FDA.

NAME:_____ **DATE:**_____