Neurology & Pain Treatment, Ltd.

Patient Registration Forms

Date:_____

Patient Information:

Last:_____ First:_____ M.I._____

Address:_____City:_____ST:_____Zip:_____

Phone Number: (_____)_____-_____ Email Address:_____

Date of Birth:_____/_____/_____ Sex: Male☐ Female☐ S.S.#:_____

Primary/Ref. Dr. Name:_____ Phone:(_____)_____-_____

Work Status: Full Time☐ Part Time☐ Retired☐ Student☐ Marital Status: S☐ M☐ D☐ W☐

Employer:_____ Phone:(_____)_____-_____

Occupation:_____

Emergency Contact Information

Name:_____ Phone:(_____)_____-_____

Payment & Insurance Information (We need a Copy of your Insurance card)

Primary Insurance:_____ ID #:_____

Policy Holder Name:_____ Date of Birth:_____/_____/_____

Relationship to Patient (Circle one): Self Spouse Parent Other

Other Insurance or Attorney Name:_____

ID/Claim #:_____ Date of Accident/Injury:_____/_____/_____

Policy Holder Name:_____ Date of Birth:_____/_____/_____

Relationship to Patient (Circle one): Self Spouse Parent Other

Consent to Treatment
The undersigned acknowledges that he/she has requested healthcare services from Neurology & Pain Treatment, Ltd. I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment.

Disclosure of Information
All information provided to Neurology & Pain Treatment, Ltd. is strictly confidential except for the following circumstances: 1. Your insurance company requests information about your treatments in order to process a claim or certify care; 2. The patient authorizes the release of information by signing a release form naming the specific person to receive the information; 3. Certain circumstances where we are required by law to release patient information such as, but not limited to, court subpoena, suspected abuse, etc.

Acknowledgement and Agreement
I have read the above information and thoroughly acknowledge and agree to all of the above information.

_____	_____	_____
Printed Name of Patient Or Representative	Signature	Date

Notice of Privacy Practices (HIPPA) I acknowledge that I have received or was offered a copy of Neurology & Pain Treatment, Ltd.'s Notice of Privacy Practices.

_____	_____	_____
Printed Name of Patient Or Representative	Signature	Date

Guarantee of Payment
I understand that I am responsible for payment of all fees and services rendered. I have been advised that if my health insurance carrier declares that the services I receive are not considered reasonable and medically necessary; I will be responsible for payment of these services. I authorize payment of benefits from my insurance carrier directly to Neurology & Pain Treatment, Ltd. **Please note payment is required at the time of service. A $25.00 fee will be charged for returned checks. Also, there will be a $35 no show fee applied if the appointment is not cancelled prior to the appointment time.**
I have read and understand my financial responsibilities outlined in this document.

_____	_____	_____
Printed Name of Patient	Signature	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

NEW PATIENT QUESTIONNAIRE

Patient Name:_____ **Date:**_____

What is the reason for your visit today?_____
How long have you had the symptoms?_____days/weeks/months/years.
Does anything make your symptoms better?_____
Does anything make your symptoms worse?_____

MEDICATIONS: Please list all medications that you are currently taking & dosage.

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

ALLERGIES: Please list all medications that you are allergic or intolerant to.

_____

SOCIAL HISTORY:
Are you single, married, widowed or divorced?_____
How many biological children do you have? _____ Stepchildren?:_____
Do you smoke? Yes ☐ No ☐: If yes, how many cigarettes do you smoke per day:_____
Do you drink alcohol? Yes ☐ No ☐: If yes, how much & how often:_____

FAMILY HISTORY: Please state whether your parents are living or deceased. If living, list all health conditions. If deceased, list age & cause of death.
Mother:_____
Father:_____

PAST MEDICAL HISTORY:

_____
_____

Do you have a diagnosis of: HIV Yes ☐ No ☐ **Hepatitis** Yes ☐ No ☐ **Herpes** Yes ☐ No ☐

SURGICAL HISTORY: Please list all surgeries & year performed.

1._____ 4._____
2._____ 5._____
3._____ 6._____

REVIEW OF SYSTEMS
Please circle any of the following problems that you are now experiencing.

Associated/Constitutional: Loss of appetite
Endocrine: Diabetes, Thyroid, Weight change
Hematologic/Lymphatic: Anemia
Allergic/Immunologic: Allergies, Cancer
ENT: Decreased hearing, Difficulty swallowing, Ringing in ear, Sinus trouble
Eyes: Blurred vision, Cataracts, Double vision, Failing vision
Lungs/Respiratory: Asthma, Shortness of breath, Wheezing
Heart/Cardiovascular: Chest pain, Heart murmur, High blood pressure, Irregular pulse
ABD/Gastrointestinal: Abdominal pain, Constipation, Diarrhea, Heart burn, Hemorrhoids, Gout, Nausea, Vomiting
GENT/Genitourinary: Overnight urination, Urine infections
BJE/Musculoskeletal: Arthritis, Back pain, Gout, Joint pain, Neck pain
Skin: Itching , Lumps, Rash
Neuro: Headaches, Memory loss, Numbness, Seizures, Tremors, Weakness
Psych: Anxiety, Depression, Difficulty sleeping, Moodiness

PAIN DIAGRAM
Please mark the areas of injury or discomfort on the chart below.