PLEASE PRINT AND ANSWER ALL QUESTIONS

Patient Name:_____ Home Phone:_____ Cell Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Sex:____ Age:_____ Birth Date:_____ Marital Status:_____ SSN:_____

Employer:_____ Phone:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Spouse/Guardian Name: _____ DOB:_____SSN:_____

Spouse/Guardian

Employer:_____ Phone:_____ Occupation:_____

Employer Address:_____ City:_____ State:_____ Zip:____

Purpose of visit: _____

Referring Physician's Name:_____

Have you ever seen a neurologist before?____ Who?_____ When?_____

Is your case Worker's Compensation?_____ Date of injury/accident:_____

Visit authorized by:_____ Phone:_____

Supervisor/Contact Person

Is your case being handled by an Attorney?_____ Attorney's Name:_____

Is this due to an auto accident?____ Attorney's Phone:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT/ PAYMENT OF SERVICES

I hereby assign and authorize Carolina Neurological Clinic to furnish information to carriers and medical professionals concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I agree to pay for services when rendered unless other arrangements have been made in advance with our bookkeeper.

_____ _____

Signature Date

Carolina Neurological Clinic
3531 Mary Ader Avenue, Suite A, Charleston, S.C. 29414
Phone: 843.723.0202 Fax: 843.723.1052
Initial Neurology Patient Data Base

___/___/___ _____ ____yrs Right/Left _____ Male/Female
DATE **NAME** **AGE** **HANDEDNESS** **RACE** **SEX**

Who referred you?_____ Who is your primary physician?_____

PAST MEDICAL HISTORY (Please list as appropriate):

1. Medication Allergies (list the medication and specify the type of adverse reaction):

_____

2. Current Medications (including any over the counter and herbal preparations):

_____

_____

_____

3. Past or current Medical and Psychological Illnesses:

_____

_____

_____

4. Surgeries/Traumas/Accidents:

_____

_____

SOCIAL HISTORY (Please complete/circle as appropriate):

1. Marital Status: Married Divorced/Separated Widowed Single/Never Married
2. Highest level of education (include number of years completed):
____ Grade School _____ High School/GED ____College ____Post Graduate
3. Employment: Retired Disabled (date:_____)/unemployed Employed
4. Cigarette Use: No/Never Yes(____packs/day x_____years) Quit ____/____(mo/yr)
5. Alcohol Use: No/Never Yes: rare social occasional frequent daily; amount_____
6. Caffeine Use: No/Never Yes: coffee tea soft drinks; amount/day_____
7. Illicit Drug Use: No/Never Yes: what and when_____
8. Overseas Travel: No/Never Yes: where and when_____
9. HIV risk factors: No Yes: homosexual activity IV drug use transfusion other:_____
10. Religious preference:_____

Reviewed by _____M.D./D.O.

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___/___/___ _____

DATE NAME

FAMILY HISTORY (List ages and medical problems. If any deaths have occurred, please list the age of death and cause if known):

1. FATHER: _____
2. MOTHER: _____
3. BROTHERS: _____
4. SISTERS: _____
5. SONS: _____
6. DAUGHTERS: _____
7. Any biological or "blood" relatives with the same or similar neurological problems as yourself? _____

REVIEW OF SYSTEMS (Circle all that apply):

CONSTITUTIONAL:

1. Recent fever or chills/sweats of significant weight gain/loss

EYES, EARS, NOSE & THROAT:

2. Vision: glasses/contacts, decreased vision, blurred, double, "spots" or "lines" eye pain/redness/discharge
3. Hearing: hearing loss/aides, Tinnitus (ringing/buzzing/clicking/abnormal sounds), ear pain
4. Swallowing problems, hoarseness, or sore throat; loss sense of smell or abnormal smells, or nosebleeds

CARDIOVASCULAR:

5. Chest pain/ angina or heart palpitations (beating fast, slow or irregular)
6. Swelling/Edema or Cyanosis (blue discoloration) of any extremity
7. Varicose veins

RESPIRATORY:

8. Difficulty breathing or Shortness of breath or exertion causing windedness
9. Cough
10. Snoring or Sleep Apnea (trouble breathing while sleeping)

GASTROINTESTINAL:

11. Recent nausea or vomiting, or indigestion/heartburn/reflux, Hiatal hernia, abdominal pain
12. Diarrhea or constipation or black/tar-like stools, or blood in bowel movements

GENITOURINARY:

13. Incontinence or loss of control of bowels or bladder
14. Burning or pain on urination, blood/pus in urine, or kidney/bladder/prostate/urine infections
15. Too frequent urination, blood/pus in urine, or kidney/bladder/prostate/urine infections
16. Impotence or inability to get or maintain adequate penile erection
17. Abnormal breast lumps or nipple discharge/milk production
18. Abnormal menstrual cycle

Reviewed by: _____

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___/___/___ _____

DATE NAME

MUSCULOSKELETAL:

19. Muscle pain, joint pain (arthritis, bursitis, or tendonitis), or bone pain
20. Neck pain, Thoracic spine pain, low back pain
21. Extremity (arm, leg, hand, foot) pain

DERMATOLOGIC:

22. Recent rash or abnormal/unusual lumps or skin/fingernail/hair changes
23. Large (greater diameter than a pencil eraser) moles or unusual (dark or irregularly colored) moles

NEUROLOGICAL:

24. Dizziness, Vertigo or "spinning" sensation, disequilibrium
25. Light-headed or "feel like going to pass out", fainting or blackout spell
26. Seizures or "spells" of periods of feeling "out of it"
27. Confusion or abnormal memory loss
28. Headache, facial pain or head injury
29. Muscle weakness or paralysis; use brace or ankle-foot orthotic device
30. Muscle cramps or Fasciculations or twitches, spasms or stiffness
31. Tremor or hand/arm/leg "shaking" or other involuntary movements
32. Speech problems
33. Numbness, tingling or "pins and needles" or "burning" or other abnormal sensations
34. Uncoordinated or balance difficulties
35. Ataxia, trouble walking or difficulty with ambulation; use of cane/walker/wheelchair

ENDOCRINE:

36. Abnormal fatigue
37. Abnormal heat intolerance or cold intolerance
38. Excessive thirst or excessive appetite or loss of appetite
39. insomnia or difficulty sleeping
40. Excessive daytime sleepiness/drowsiness

HEMATOLOGIC/IMMUNOLOGIC:

41. Easy bruising or anemia
42. Swollen/tender glands/lymph nodes

ALLERGIC/IMMUNOLOGIC:

43. Runny/watery/itchy eyes/nose
44. Hay fever/pollen allergies
45. Frequent colds/sore throats
46. Recurring infections (sinusitis, bronchitis, pneumonia, urinary tract, etc.)

PHYCHOLOGIC:

47. Depression or Mania/Bipolar or attention Deficit/Hyperactivity Disorder
48. Anxiety, nervousness or panic attacks
49. Hallucinations or paranoia
50. Behavioral or personality changes

Reviewed by: _____

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

3531 Mary Ader Avenue • Suite A Charleston, S.C. 29414 • (843) 723-0202 • Fax (843) 723-1052 • www.carolinaneurologicalclinic.com

HAMID R. BAHADORI, M.D.
JAMES L. BUMGARTNER, M.D.
CHARLES S. JERVEY, M.D.
ROY W. KING, D.O.

PRESCRIPTION MEDICATION POLICY

PATIENT N AME:_____

PHARMACY:_____

By signing below, the patient is ACKNOWLEDGING receipt and understanding of this policy.

IT DOES NOT MEAN THAT THE PATIENT IS REQUIRED TO RECEIVE CONTROLLED SUBSTANCES FROM THE PHYSICIANS OF CAROLINA NEUROLOGICAL CLINIC. **HOWEVER, FAILURE TO SIGN BELOW PROHIBITS THE PHYSICIANS OF CAROLINA NEUROLOGICAL CLINIC FROM PRESCRIBING ANY MEDICATIONS FOR THE PATIENT.**

It further indicates that the patient understands that if these guidelines are breached, the doctor will no longer prescribe these medications and that the patient may be discharged from the practice and the physician/patient relationship will be terminated.

- The patient agrees to use the listed pharmacy, AND ONLY THIS PHARMACY, for filling prescriptions. The patient is responsible for notifying Carolina Neurological Clinic if there is a change in their pharmacy.

- Narcotic and other controlled substance medications will be given as a 30 day supply or less in quantity at a time. It is the patient's responsibility to ration the medication during that month.
  - NO REFILLS WILL BE GIVEN UNTIL AT LEAST ONE MONTH'S DURATION IS COMPLETE.

- MEDICATIONS WILL NOT BE REPLACED UNTIL THE USUAL TIME FOR REFILL
  -It is the patient's responsibility to safeguard the medication from loss, theft or damage.

- THE PATIENT WILL NOT OBTAIN ANY SIMILAR MEDICATION FROM OTHER PRESCRIBERS OR OBTAIN CONTROLLED SUBSTANCES FROM ANYONE ELSE AS LONG AS THERE IS AN AGREEMENT HERE

- THE PATIENT WILL NOT USE ILLEGAL SUBSTANCES SUCH AS MARIJUANA OR COCAINE and AGREES TO PERIODIC RANDOM DRUG TESTING AT THE DISCRETION OF THE PHYSICIAN TO CHECK FOR COMPLIANCE WITH THESE GUIDELINES.

- MEDICATIONS WILL NOT BE CALLED IN AFTER-HOURS OR ON WEEKENDS.
  -It is the patient's responsibility to request refills as needed during regular business hours

- The patient authorizes the doctor and pharmacies to cooperate with their insurance companies, any city, state or federal law enforcement agency, including this state's Board of Pharmacy and South Carolina DHEC, in investigating any possible misuse, sale or other diversion of their medications.

PATIENT SIGNATURE: _____ DATE: _____

Carolina Neurological Clinic

FINANCIAL POLICY

The Physicians and staff of Carolina Neurological Clinic are please that you have given us the opportunity to manage your health care needs. You are important to us and we value the relationship we have with you. We want to work with you to manage the financial responsibilities you incur as our patient.

PARTICIPATING PROVIDER PLANS:

- Our Billing Department will file your insurance for services rendered.
- The patient is responsible for completing a patient information sheet and presenting all current insurance cards.
    - This will be done once each year and again anytime there are changes to insurance or personal information.
    - Failure to supply our office with current insurance cards and personal information, prior to your visit, may result in you being responsible for the visit and/or administration fee.

THE PATIENT IS RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND NON-COVERED SERVICES AT THE TIME OF SERVICE, *NOT* AFTER INSURANCE HAS PAID.

- Our contracts with these carriers require that we collect the co-pay at the time of your visit.
- To facilitate patient flow, we may ask that you pay your co-pay at the Check-In desk prior to being seen.
- All outstanding balances will be collected at the Check-In desk prior to being seen (*Unless other arrangements have been made in advance with our Billing Department)
- If your deductible has not been met, you must be prepared to pay at the time of service.
- If your deductible has been met we will collect the percentage you are responsible for (according to your Insurance Policy) at the time of service. This is usually 20%
- Secondary Insurance: We will file your secondary coverage as a courtesy; **however, if your secondary does not cover your primary carrier's deductible, co-pay, or non-covered service we will collect this at the time of service.**

The patient is responsible for insurance follow-up with their plan regarding annual employer claim forms, accident/injury information and terminated insurance plans.

We will file your claim twice to your insurance company. If there is no response the bill will become the patient's responsibility.

NON-PARTICIPATING PROVIDER PLANS:

- The patient is responsible for the full balance at the time of service, **(Unless other payment arrangements have been made in advance with our Billing Department.)**
- A receipt will be provided to you so that you may file and be reimbursed.

SELF-PAY PATIENTS:

Patients with no insurance coverage will be considered self-pay. Self-pay patients will sign this form indicating that they have NO insurance coverage. Self-pay patients are responsible for the full balance at the time of service, **(Unless other arrangements have been made in advance with our Billing Department.)**

COMPLETION OF VARIOUS FORMS:

- Completion of non-treatment paperwork such as disability and life insurance forms will be subject to a fee of $10.00 per page, due prior to the forms being returned.
- Forms requiring extensive physician involvement may incur higher fees.
- Medical records copied for patients use will need a medical release to be filled out by the patient and will be charged at $0.15 per page, due prior to the records being released.

COLLECTIONS

- Collections notice begin if the balance has not been paid within 90 days.
- All unpaid balances will be sent to an outside collector agency after all practice efforts have been exhausted. Patients with balances that have been turned over to an outside collection agency will not be seen until the account is settled.

PLEASE COMPLETE BELOW:

_____ **I DO NOT have Health Insurance Coverage**

_____ **I have Health Insurance Coverage with** _____
(Company Name)

****If you have a financial hardship and are unable to meet your obligations, our billing staff can help you set up a payment plan.**

_____ _____ _____
Patient/Guardian Signature **Date** **Print Patient Name**

If signature other than Patient: NAME _____ **Relationship** _____

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Carolina Neurological Clinic is pleased to announce the launch of our Patient Portal.

If you have already provided us your personal e-mail address, you will be receiving an e-mail to that account with an invitation to get started. This e-mail will contain your username and a one-time password. You will be provided with consent to proceed with enrollment and a disclosure notice for privacy purposes. You will be asked to change the initial password to one of your choosing.

Private information will not be contained in the e-mails sent to you from our office, but will rather direct you to log in to the Patient Portal to view the information.

**We ask for you to remember that the information contained in the Patient Portal WILL contain your private health information (PHI). Carolina Neurological Clinic is NOT responsible for the security of the e-mail account nor the password you have chosen. If the e-mail address you provide us is one you share with others (family), you may want to consider providing an alternative e-mail account to ensure your PHI is only accessible to those of your choosing. Please also note that by allowing others access to your Patient Portal, you are authorizing them to contact Carolina Neurological Clinic and conduct business on your behalf. If you do not wish to allow anyone, other than yourself, to communicate with Carolina Neurological Clinic regarding your healthcare, it is advised that you not share your private log-in information. We can only assume that any incoming information via the Patient Portal is from you or someone you have authorized to contact us on your behalf.

If you would like to continue with enrollment in the Carolina Neurological Clinic Patient Portal, please sign below.

By enrolling, I acknowledge understanding that:

- This enrollment is elective
- The e-mail account provided will contain instructions to access the Patient Portal
- The Patient Portal will contain my private health information (PHI)
- I am responsible for the privacy of this account and any associated access

Patient Name: _____ Date of Birth: _____

____ No, I do not want to have access to the Patient Portal (you may sign up at a later date, if desired)
____ Yes, I would like to sign up for the Patient Portal and will provide my e-mail address below.

E-mail Address for Carolina Neurological Clinic Patient Portal:

_____

_____ Date: _____
Patient Signature (or authorized representative)

Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

(Please provide information below)

For ongoing communication regarding your healthcare and for your privacy, you must complete this section to authorize this Practice to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service: _____ To date of service: _____

Name of person:	**Address:**	**Phone/Fax:**	**Relationship to you:**
Example: John Doe	3 Main St., ABC City, SC 29401	843-555-1212	Husband

Authorization, Assignment of Benefits, and Referral Medical Release

I consent to treatment and allow this Practice and their affiliates to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and is described in the Carolina Neurological Clinic Notice of Privacy Practices, which a copy has been made available to me.

I understand that my medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

I allow payment to be made directly to Carolina Neurological Clinic for all medical or surgical benefits otherwise payable to me under terms of my insurance.

I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informed of changes to my contact information; failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: _____

Signature of patient or representative:_____ **Date:**____/____/_____

Description of Representative's Authority:_____