NEUROLOGY CENTER
FOR EPILEPSY AND SEIZURES

PRACTICE POLICIES & DISCHARGES

Thank you for choosing our practice. We are committed to providing you with quality and affordable epileptological- related and other neurological related healthcare. Below is information to answer frequently asked questions regarding patient and insurance responsibility for serviced rendered. Please read it and ask us any questions that you may have and sign/ initialize in the space provided. A copy will be provided to you upon request. Thanks, so much for being our patient.

Co-payments, Co-insurance, and deductible payments are due at the time of service unless payment arrangements have been requested and approved in advanced. You are expected to pay according to the arrangement.

Insurance- We participate with most insurance plans except in the NJ Medicaid program (with Medicaid insurance being the primary insurance). We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay. It is the insurance company that makes the final determination of your eligibility.

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 the balance of your claim is your responsibility whether or not your insurance company pays for your claim. Your insurance benefit is a contract between you and your insurance company.

Referrals- If you have an insurance plan with which we contracted and you need a referral authorization from your primary care physician/ pediatrician to be seen by NCES, it is your reasonability to have the referral sent to us via fax, mail or provided to us directly via documentation from the referring provider at the time of service. If we have not received a referral prior to your arrival at the office, it will be your responsibility to call your primary/ pediatrician physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled to another time after the referral documentation has been received.

All Co-payments, Deductible, and Co- Insurance must be pain at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance- All patients must complete our patient information form before seeing our providers. 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.

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.

Methods of Payment- We accept payments by cash, check, debit card, via MasterCard, American Express, and Discover.

Patient Statements- If you have an unpaid balance you will receive a statement by mail every 30 days. If the statement amount is due upon receipt of the statement, it is your responsibility to pay the full amount or arrange an agreement with NCES, at NCES's discretion for reasonable payment plan. If not, arrangement is made with NCES in advance, before the 90 day past due date, any balances over 90 days will be turned over to an attorney for filing collection in NJ small claims court or to an agency for collections. All payments made go to the oldest outstanding balance(s).

No show Fee- Please cancel/ reschedule your visits with 24-hour notice. If you do not call to cancel an appointment within 24 Hours, there will be a "No Show Fee" charged to your account: $25.00 (follow up appointments) $50.00 (Routine EEG's) $100.00 (Ambulatory EEG's) $250.00 (In office Video EEG'S).

Collection Fees- Balances that have not had payment made within 90 days will be turned over to small claims court or collections. Guarantor will be responsible to pay all costs of collections including reasonable interest, reasonable attorney's fees and reasonable collection agency fees not to exceed 33 1/3%.

Patient's Name: _____

Responsible Party (if any): _____

Signature: _____

Date: _____

PROTECTED HEALTH INFORMATION

I, _____, (Patient/ Guardian Name) understand that I am or may be responsible for all charges associated with today's visit and any subsequent visits relating to the diagnosis, testing and treatment of any medical/Neurological conditions.

- **NO INSURANCE/INCORRECT INSURANCE PROVIDED:** You will be responsible for all charges associated with all visits. As a courtesy to our patient, we offer a **SELF-PAY fee of $250 per initial visit and $150-$200 per follow up visit. All fees must be paid before the time of the visit.** If you do not have your insurance information but do have valid insurance, we can provide you with an itemized bill that you can submit to your insurance for possible reimbursement.

CHANGES IN INSURANCE. Please be sure to provide us with the proper insurance information for all subsequent visits. **Please be advised that all copays and fees are due in full at the time of visit.**

I authorize medical treatment as deemed necessary and appropriate by the provider of Amor Mehta M.D. - Neurology Center for Epilepsy and Seizures, LLC (NCES) and their employees participating in my care. With my consent, (NCES) may use and disclose Protected Health Information about me to carry treatment, payment and healthcare operations. My home or other designated locations may be called, and a voicemail message may be left in my reference to any items that assist to my clinical care, including laboratory results among other as well as mail sent to you directly to the address, I have provided this practice.

Initials: _____

I understand that if I do not give NCES a 24-hour notice of cancellation for my scheduled physician's appointment, I will be charged a fee of $25. I understand that if I do not give NCES a 24-hour notice of cancellation for my scheduled routine EEG appointment, I will be charged a fee of $50. I understand that if I do not give NCES a 24-hour notice of cancellation for my ambulatory EEG study, I will be charged a fee of $100. I understand that if I do not give 48-hour notice of cancellation for my long- term Video EEG, I will be charged a fee of $250.

Initials: _____

I understand that there is a $15 per page fee for any forms that need to be filled out by NCES. I understand that there is a $20 per page fee for any letters that need to be written by Dr. Mehta on my behalf that are not related to any legal matters.

Initials: _____

With my consent, I authorize (NCES), to release medical information regarding the care and treatment, payment or healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does it is bound by this agreement.

Initials: _____

I understand that there is a $1 per page printing charge for records that I, the patient, require. This does not include records getting sent to a different doctor's office or attorney's office. This is not to exceed $100 after each record is printed. There is also a $30 charge for Routine EEG recordings on a CD and a $50 charge for Video EEG recordings.

Initials: _____

I authorize my provider to release pertinent information to my healthcare insurance companies required in the course of my examination and treatment. I revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If I do not sign this consent, (NCES) has the right to decline and provide treatment to me.

Initials: _____

By signing this form, I am consenting Amor Mehta M.D. - Neurology Center for Epilepsy and Seizures use and disclose any of my personal health information to carry out treatment, payment and health care options.

_____ _____ _____

Printed Name Signature Date

Confidential Record: Information contained here will not be released unless patient authorizes us to do so.

Today's Date: _____

Last Name: _____First Name: _____ Middle Initial: _____

DOB: _____/_____/_____ Age: _____ Social Sec #: _____

Marital Status(circle): SINGLE MARRIED WIDOWED DIVORCED Sex: MALE FEMALE TRANSGENDER

Address:_____

City: _____ State: _____ Zip Code: _____

Primary Phone: (_____)_____ Secondary Phone: (_____)_____

E-Mail: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone: (_____)_____

Primary Care Physician (PCP): _____

Address:_____

Phone: (_____)_____ Fax: (_____)_____

Referring Physician: _____

Phone: (_____)_____ Fax: (_____)_____

Pharmacy: _____ Phone: (_____)_____

Pharmacy Address:_____

Other physicians who should receive correspondence regarding your care:

1. Name: _____
   Address: _____

2. Name: _____
   Address: _____

Anyone under the age of 18, please fill out the following:

Parent 1 Name: _____ Phone: (_____)_____

Address:_____

Occupation: _____ Marital Status: _____

Parent 2 Name: _____ Phone: (_____)_____

Address:_____

Occupation: _____ Marital Status: _____

REASON FOR YOUR VISIT TODAY: _____

_____

_____

DO YOU HAVE QUESTIONS FOR THE DOCTOR TODAY? Please list below:

1. _____
2. _____
3. _____

RISK FACTORS:

1. BIRTH HISTORY:

a. How were you born? (circle one) Normal Vaginal Vaginal delivery w/ forceps C- Section

b. Any complications after birth? YES NO

c. Any seizures immediately after birth? YES NO

d. Difficulty breathing or latching? YES NO

e. Jaundice after birth? YES NO

2. Do you have history of any of the following:

a. Cerebral Palsy YES NO

b. Meningitis or encephalitis YES NO

c. Febrile seizures (fever related) YES NO

d. Staring spells/lost time YES NO

e. Head trauma YES NO

f. Epileptic seizure YES NO

g. Dizziness/fainting spells YES NO

h. Tics/tremors YES NO

i. Other _____

HANDEDNESS:

With what hand do you write? (circle one) Right Left Ambitextrous

If ambidextrous, which side is the predominant side? Right Left

PAST MEDICAL HISTORY:

Have you had or do you have any of the following conditions? (circle yes or no)

Alcoholism	YES	NO	High Blood Pressure	YES	NO
Arthritis	YES	NO	Headache	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO
Cancer	YES	NO	Heart Attack	YES	NO
Chest Pain	YES	NO	Jaundice	YES	NO
Colitis	YES	NO	Kidney Disease	YES	NO
Depression/Anxiety	YES	NO	Other Cardiac Disease	YES	NO
Diabetes	YES	NO	Rheumatic Fever	YES	NO
Drug Addiction	YES	NO	Stomach Ulcers	YES	NO
Emphysema	YES	NO	Thyroid Disease	YES	NO
Kidney Infection	YES	NO	Sleep Disorder	YES	NO
Gallbladder Disease	YES	NO	Chronic Pain	YES	NO
Gout	YES	NO	Suicidal Thoughts	YES	NO

Other Past medical history:_____

SURGICAL HISTORY:

Procedure	Approximate Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: Do any of your blood relatives currently have, or have had in the past, any of the following?

			RELATIVE
Epilepsy	YES	NO	_____
Migraine	YES	NO	_____
Suicide	YES	NO	_____
Febrile, infantile, or childhood seizures	YES	NO	_____
Mental retardation	YES	NO	_____
Kidney Stones	YES	NO	_____
Stroke	YES	NO	_____
Cancer (type) _____	YES	NO	_____
High Blood Pressure	YES	NO	_____

CURRENT MEDICATIONS: Please list all medications that you are currently taking, including seizure medications and supplement.

MEDICATION NAME	STRENGTH	DOSAGE/FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: (please list medications ONLY)

If yes, please list all medications and the reactions you have had to them.

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Do you drink alcohol? YES NO

If yes, please answer the following:

How often do you drink? Regularly Socially

Do you drink Hard liquor? YES NO

If yes, how many per day? _____

Do you drink Beer? YES NO

If yes, how many cans/bottles per day? _____

Have you ever been a heavy drinker? YES NO

Do you smoke Cigarettes? YES NO

If yes, how many per day? _____

Have you smoked cigarettes in the past? YES NO

Do you or have you used recreational drugs? YES NO

If yes, what have you used? _____

When did you last use? _____

EDUCATION/OCCUPATION:

Highest grade completed? _____

Did you have trouble in school? YES NO

Did you need resources in class? YES NO

Are you currently going to school? YES NO

Are you presently employed? YES NO

If yes, what type of work:_____ If no, how long since you last worked? _____

Are you on disability? YES NO

Do you currently drive? YES NO

REVIEW OF SYSTEMS:

Please indicate for each category if you are experiencing any of symptoms listed, by checking in the circle prior to the symptom. If you are not having any difficulties, please check "No Problems". You may list any additional symptoms not listed in the specific category.

GENERAL HEALTH : ◯No Problems ◯Lack of Energy ◯Unexplained Weight Gain or Loss ◯Loss of Appetite ◯Fever ◯Night Sweats ◯Pain in Jaw when Eating ◯Scalp Tenderness ◯Prior Diagnosis of Cancer ◯Other_____

EAR, NOSE, AND THROAT: ◯No Problems ◯Difficulty with Hearing ◯Sinus Problems ◯Runny Nose ◯Post-Nasal Drip ◯Ringing in Ears ◯Mouth Sores ◯Loose Teeth ◯Ear Pain ◯Nosebleeds ◯Sore Throat ◯Facial Pain or Numbness ◯Other_____

CARDIOVASCUAR (Heart & Blood Vessel): ◯No Problems ◯Irregular Heartbeat ◯Racing Heart ◯Chest Pains ◯Swelling of Feet or Legs ◯Pain in Legs when Walking ◯Other_____

RESPIRATORY: ◯No Problems ◯Shortness of Breath ◯Night Sweats ◯Prolonged Cough ◯Wheezing ◯Sputum Production ◯Prior Tuberculosis ◯Pleurisy ◯Oxygen at Home ◯Coughing up Blood ◯Abnormal Chest XRAY ◯Other_____

GI (Stomach and Intestines): ◯No Problems ◯Heartburn ◯Constipation ◯Intolerance to Certain Foods ◯Diarrhea ◯Abdominal Pain ◯Difficulty Swallowing ◯Nausea ◯Vomiting ◯Blood in Stool ◯Unexplained changes in Bowel ◯Incontinence ◯Other_____

GU (Kidney & Bladder): ◯No Problems ◯Painful Urination ◯Frequent Urination ◯Urgency with Urination ◯Prostate Problems ◯Bladder Problems ◯Impotency ◯Other_____

MS(Muscle, Bones, & Joints): ◯No Problems ◯Joint Pain ◯Aching Muscles ◯Shoulder Pain ◯Swelling of Joints ◯Joint Deformities ◯Back Pain ◯Other_____

INTEGUMENTARY (Skin, Hair, & Breast): ◯No Problems ◯Persistent Rash ◯Itching ◯Skin Lesion ◯Change in Skin Lesion ◯Hair loss or Increase ◯Breast Changes ◯Other_____

NEUROLOGIC: ◯No Problems ◯Frequent Headaches ◯Double Vision ◯Weakness ◯Change in Sensation ◯Walking/Balance Difficulties ◯Dizziness ◯Tremors ◯Loss of consciousness ◯Uncontrolled Motions ◯Episodes of Visual Loss ◯Other_____

PSYCHIATRIC: ◯No Problems ◯Insomnia ◯Irritability ◯Depression ◯Anxiety ◯Recurrent Bad Thought ◯Mood Swings ◯Hallucinations ◯Compulsions ◯Other_____

ENDOCRINOLOGIC (Glands): ◯No Problems ◯Intolerance to Heat or Cold ◯Menstrual Irregularities ◯Frequent Hunger/Urination/Thirst ◯Changes in Sex Drive ◯Other_____

HEMATOLOGIC (Blood/Lymph): ◯No Problems ◯Easy Bleeding ◯Easy Bruising ◯Anemia ◯Abnormal Blood Tests ◯Leukemia ◯Unexplained Swollen Areas ◯Other_____

ALLERGIC/IMMUNOLOGIC: ◯No Problems ◯Seasonal Allergies ◯Hay Fever ◯Itching ◯Frequent Infections ◯Exposure to HIV ◯Other_____

FILL OUT THIS PAGE IF YOU HAVE A HISTORY OF EPILEPSY, SEIZURES, OR SPELLS

SEIZURE HISTORY:

1. At what age did you have your first seizure/spell(s)? _____
2. Describe the first seizure/spell you had and what caused it, if know. _____

_____

3. Please describe your current seizure/spell activity and how do these events occur. _____

_____

4. How do you feel after a seizure/spell (tired, confused, back to normal, etc.) and how long do the symptoms last?

_____

_____

Do you ever wake up in the morning with a sore tongue?	YES	NO
Do you ever wake up with urinary incontinence?	YES	NO
Do you experience any auras or feelings prior to having a seizure/spell?	YES	NO

Please explain:_____

_____

PREVIOUS SEIZURE WORK UP: Have you had any MRIs, CT Scans, EEGs, VEEGs, PET CTs, Craniotomy and/or Tests? If yes, list where and when these were done.

Type of Scan:	Where/When:
_____	_____
_____	_____
_____	_____

PAST ANTI-EPILEPTIC DRUGS (AEDS): Please circle ALL epilepsy medications you have tried in the past, not including current medications. For those that are circled, please indicate the reason for discontinuation, and highest dosage tried. (If available)

Acustat	Diastat	Klonopin	Oxcarbazepine	Tiagabine
Aptiom	Diazepam	Lacosamide	Oxtellar	Topamax/Topirimate
Ativan	Dilantin	Lamictal	Phenobarbital	Tranxene
Briviact	Ethosuxomide	Lamotrigine	Phenytek	Trokendi XR
Carbamazapine	Felbamate	Levetiracetam	Phenytoin	Trileptal
Carbatrol	Frizium	Lorazepam	Cannabidoil	Valium
Celontin	Gabapentin	Lyrica	Pregabalin	Valproic Acid
Clobazam	Epidolex	Methosuximide	Primidone	Vimpat
Clonazapam	Eslicarbazepine	Mysoline	Sodium Valproate	Zarontin
Clorazepate	Gabitril	Neurontin	Tegretol	Zonegran
Depakote (ER)	Keppra	Onfi	Tegretol XR	Zonisamide

SEIZURE MEDICATION	REASON FOR DISCONTINUATION	HIGHEST DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Acknowledgement of Receipt of Notice of HIPAA Privacy

I, _____, acknowledge that I Have been provided with a copy of the notice of HIPAA privacy. I understand a copy of the Privacy Practices is available upon my request (please ask our front desk staff).

Date: _____

Patient's Name: _____

Date of Birth: _____

Signature of Patient/ Parent/ Guardian: _____

Please allow the release of my information ONLY to:

1. Name: _____ Relation: _____
   Tel:_____
2. Name: _____ Relation: _____
   Tel:_____
3. Name: _____ Relation: _____
   Tel:_____
4. Name: _____ Relation: _____
   Tel:_____
5. Name: _____ Relation: _____
   Tel:_____