Neurology Institute of Huntsville Inc.

2006 Franklin St., Suite 202A, Huntsville, AL 35801
O: 256.489.0976 F: 256.489.0977

Patient Intake Form

Date: _____

Personal Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work/Home Phone: _____

SSN: _____ Gender: M or F Age: _____ Date of Birth: _____

Marital Status: _____ Email: _____

Current Employer: _____ Occupation: _____

Preferred Pharmacy: _____ Mail Order Pharmacy: _____

Reason for Visit:

Chief Complaint (Why are you here?): _____

Primary Care Physician: _____ Referring Physician: _____

Emergency Contact Information:

Name of Person: _____

Phone: _____ Relationship with the person: _____

Insurance/ Billing Information:

Primary Insurance: _____ Policy/Contract Number: _____

Group Number:_____ Subscriber's Name:_____

Subscriber's Date of Birth:_____ Relationship to Patient: _____

Secondary Insurance : _____ Policy/Contract Number:: _____

Group Number:_____ Subscriber's Name: _____

Subscriber's Date of Birth:: _____ Relationship to Patient: _____

Signature of Responsible Person: _____ Date: _____

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Medical History Form

Date: _____

Patient's Name: _____ **DOB:** _____

Past Medical History: (Circle all that apply):

Hypertension	Hyperlipidemia	Diabetes
Stroke/TIA	Seizure	Neuropathy
Coronary Artery Disease	Congestive Heart Failure	Atrial Fibrillation
Hypothyroidism	Chronic Kidney Disease	COPD/Asthma
Depression/Anxiety	Bipolar Disorder	Cancer

List here if not mentioned above: _____

_____

Medications:

Name of Medication	Strength	How many times a day

Past Surgical History:

_____ _____

_____ _____

Allergies: No Drug Allergies (Circle it if no drug allergies)

_____ _____

_____ _____

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Social History: (Circle all that apply)

- Tobacco: Current smoker Used to smoke Never smoked
- Alcohol: Drink daily Drink socially Never drank
- Illicit Drug use: Active Tried in past Never done drugs
- Employment: Currently working Not working Retired Disabled

Family History:

Relationship	**Condition**
Father	
Mother	
Brother	
Sister	
Children	

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Review of Symptoms Form

Date: _____

Patient's Name: _____ **DOB:** _____

Symptoms in last 6 months (Mark √ if symptoms present):

No	System	Symptoms	Yes
1	**General**	Fatigue	
		Fever	
2	**Allergies**	Rash	
		Watery Eyes	
3	**Eyes**	Droopy Eyelid	
		Double Vision	
4	**Ears, Nose, Throat-ENT**	Difficulty Chewing	
		Decreased Hearing	
5	**Endocrine**	Weight Gain/Loss	
		Heat/Cold Intolerance	
6	**Respiratory**	Cough	
		Shortness of Breath	
7	**Cardiology**	Chest Pain	
		Palpitations	
8	**Gastroenterology**	Constipation/ Diarrhea	
		Nausea/ Vomiting	
9	**Hematology**	Easy Bruising	
		Swollen Glands	
10	**Genitourinary**	Foul Smelling Urine	
		Swelling Of Feet	
11	**Extremities**	Redness on Legs	
12	**Skin**	Itching	
		Lesions	
13	**Neurologic**	Syncope	
		Tremors	
		Seizures	
		Lower Back Pain	
		Memory Loss	
		Tingling/ Numbness	
14	**Psychiatric**	Mood Swings	
		Anxiety	
		Depression	

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Patient Name: _____ Date of Birth: _____

Financial Policy

- Copays, deductibles and outstanding balances are due upon arrival. Payments are due at the time services are rendered. We accept Cash, Credit/Debit Cards, HSA Cards, and Checks. There will be a **$35 service charge** for NSF of a returned check.
- It is the patient's responsibility to inform our office if you need to cancel or reschedule an appointment at least 24 hours in advance. There will be a **$50 No Show/ Same Day Cancelation** fee if done without a 24-hour notice.
- Patients are responsible to pay for any test/injections or procedures that insurance does not cover.
- It is the patient's responsibility to verify with their insurance about what service and treatment plans are covered by their insurance. If we submit claims and insurance rejects or denies the claim, the patient will be responsible for the payment.
- All payments and balances due must be paid within 30 days of receiving a statement in the mail. No new appointment can be created until this balance is paid in full. If payment is not paid within 3 billing cycles, then the patient will be discharged from the practice. Once a patient has been discharged from this practice, he cannot be treated by this office any longer. This includes but is not limited to medication refills and filling out any paperwork.
- If we turn the pending balance on account to the collection agency, the fees associated with the collection agency will be the responsibility of the patient.
- There is a **$50 charge** for ALL forms needed to be filled out by the doctor.

Medication Refills

- We can not fill any medication refills if you do not come for your follow-up appointment.
- Due to the high volume of telephone refill requests, we ask all patients to have all of their medicines refilled at the time of their visit. If you call us after your visit, **a fee of $25** will be charged.
- All referrals/pre-certifications and authorizations will be called in by our nurse 48 hours after your appointment.

Updated Patient Information and Insurance

- You must bring all your insurance cards to your appointment. We re-verify insurance coverage at every visit.
- Please be sure to inform staff of any changes to your address, phone number, or insurance as soon as possible. We can not give you any important information regarding your health if we do not have this.
- If you have new insurance, please call our office as soon as you get your new ID number so that we can verify BEFORE you come to your next appointment. This allows us to get you in quicker as less time will have to be spent on verifying your insurance. It is the patient's responsibility to verify that our office accepts their insurance. If your insurance denies any payment, it is the patient's responsibility to pay for their visit.

Photo Consent

- By signing this form, you are authorizing our practice to obtain photo documentation so that we may be able to properly identify you for medical treatment.

Patient or Responsible Person: _____ Relationship: _____

Signature of Patient or Responsible Person: _____ Date: _____

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Due to recent federal privacy guidelines (HIPAA), Neurology Institute of Huntsville, Inc is not allowed to release information to anyone other than the patient (or guardian of the patient) unless there is explicit authorization given to authorize Neurology Institute of Huntsville Inc. permission to discus personal medical information with someone other than the patient or guardian of the patient. Please fill this form in order to allow us to discuss your information with the people of your choosing as listed below.

I, _____ give Neurology Institute of Huntsville permission to release/ discuss personal health information, which includes the pick up of prescriptions and/or financial information to/with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that I may revoke this authorization at any time by sending a written notification to Neurology Institute of Huntsville. **By signing this form, all previous lists of allowable contacts become invalid.**

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I, _____ decline to give Neurology Institute of Huntsville Inc. permission to release/ discuss my personal health and/or financial information to anyone other than myself.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Patient DOB: _____ Address: _____ City: _____ State: _____ Zip: _____
Social Security Number: _____ Telephone: _____

I hereby AUTHORIZE Neurology Institute of Huntsville Inc to

☐ **Release Information to** **AND/OR** ☐ **Obtain Information from**

Name of Person/Company: _____
Phone Number: _____ Fax Number: _____
Address: _____ City: _____ State: _____ Zip: _____

Please Select Information to be Disclosed:

☐ All of my PHI (medical records) ☐ Lab Reports ☐ Progress Notes ☐ Diagnosis
☐ History and Physical ☐ Billing/ Financial Information ☐ Medication List
☐ Other: _____

Purpose of Disclosure of Information:

☐ Continuation of Care ☐ My Personal Use ☐ Litigation ☐ Other: _____

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before they received my written notice of revocation.

By signing this authorization, I hereby authorize the entities listed above to disclose my personal health information. I understand that information contained in my PHI may include information related to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. By signing this authorization, I understand that my PHI described herein may be disclosed by the entities above to receive and use my PHI and that my PHI described herein may no longer be protected by federal privacy regulations.

Patient Name: _____

Patient Signature: _____ Date:_____

Legal Representative: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

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ASSIGNMENT OF BENEFITS, AGREEMENT, AND GUARANTY

I authorize Neurology Institute of Huntsville Inc (NIH) to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to NIH. If the check must be made out to me, I understand the check must be sent to this address: 2006 Franklin St. Suite 202A, Huntsville, AL 35801. I understand that NIH must collect for all charges not covered by insurance payments. Payment for all collection costs, ssecuring, or attempting to collect necessary otherwise is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

BLANKET AUTHORIZATIONS

I understand that the following authorizations are to be used by Neurology Institute of Huntsville, Inc. and all the physicians associated therewith to affect the collections on my behalf. These authorizations become effective on the date of the first service rendered on my behalf and remain in effect until specifically revoked in writing by me. Copies of this agreement will be valid as this original.

PATIENT PORTAL

I understand that the patient portal is mandatory. I will receive access to this account to view my labs, notes, and imaging that are ordered by the practice. If there are any questions regarding this, I may contact the practice to schedule a follow up appointment. Practice will not be liable for any delay in results as well as abnormal results, if I decide to not obtain access.

NIH NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I acknowledge that a copy of the Notice of Privacy Practices for NIH has been made available to me. In connection with the notice, I also acknowledge that I have been provided with an opportunity to ask any questions regarding the notice and its contents.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE

I agree in order for NIH to service my account or collect monies I owe NIH their/our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which can result in charges to me. NIH may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing divides as applicable. I have read this disclosure and agree that NIH, its employees, and/or agent may contact me as described above.

Patient/ Legal Rep Signature: _____ Date: _____

Legal Rep Relationship to Patient _____ Date: _____

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Patients Rights and Responsibilities

Please Keep For Your Records

1. Care shall be provided impartially without regard to race, creed, sex, or national origin.
2. Patients are entitled to considerate, respectful, and dignified care at all times.
3. The patient has the right to receive care in a safe setting.
4. Patients are entitled to personal and informational privacy as required by law. This includes the right to:
    a. Refuse to see or talk with anyone not officially affiliated with NIH;
    b. Wear appropriate personal clothing, religious, or other symbolic items that do not interfere with prescribed treatments or procedures;
    c. Examination in reasonably private surroundings, including the right to request a person of one's own gender present during certain physical examinations;
    d. Have one's medical records read and discussed discreetly.
    e. Confidentiality regarding one;s individual care and/or payment sources;
    f. Data Privacy Rights as described in the Notice of Privacy Practices.
5. Patients and/or patients legally designated representatives have the right of access to information contained in the patient's medical record, within the limits of the law and in accordance with NIH policies.
6. Patients of NIH have the right to know the identity and professional status of all persons participating in their care.
7. Patients are entitled to know the status of their condition including diagnosis, recommended treatment and prognosis for recovery.
8. Patients have the right to be free from physical restraints which are not medically indicated or necessary.
9. Patients have the right, in collaborating with their physicians to make decisions involving their health care, including acceptances or refusal of medical care or treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
10. Patients are entitled to formulate advance directives and appoint a surrogate to make healthcare decisions on their behalf of the extent permitted by law.
11. Patients are entitled to receive an itemized detailed explanation of charges related to services rendered on their behalf.
12. Patients will not be transferred to another facility or location without explanation of the necessity of such action.
13. A patient's guardian, next of kin, or legally authorized responsible person may exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been judged incompetant in accordance with the law, or procedure, or is unable to communicate his/her wishes regarding treatment, or is a minor.
14. Patients have the right to appropriate assessment and management of pain.
15. Patient have the right, subbjext to the patient's consent, to receive visitors whom they designate, including, but not limited to, a spouse, domestic partner (including same-sex domestic partner), anothe rfamily memeber, or a friend. Patients have the right to withdraw or deny any such consent at any time.
16. Ents are responsible for providing NIH with complete and accurate information regarding present and past illnesses and operations, hospitalizations, medications, and other health related issues, including any unanticipated changes in their condition.
17. Patients are responsible for following recommended treatment plans prescribed and/or administration.
18. Patients who refuse prescribed treatments or do not follow their practitioner's instructions assume full responsibility for the consequences of such actions.
19. Patients are responsible for ensuring prompt and complete payment of their account at NIH.
20. All patients must follow NIH rules and regulation relative to patient care and conduct. This includes consideration and respect for the rights and property of other patients and NIH providers and statt, as well as responsibility for the actions of their visitors and guests.