LOUDOUN NEUROLOGY ASSOCIATES **DR. PARMINDER CHAWLA**

Last Name:_____ First Name:_____ MI:_____

Street Address: _____

City:_____ State: _____ Zip: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____

Email Address: _____ @ _____. _____

Social Security Number: _____-_____-_____ Sex: ____ Male ____ Female

Marital Status: _____ Single _____Married _____ Divorced _____Widowed

Date of Birth: _____/_____/_____

Employment Status: ____Full Time ____Part Time ____Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Student Status: ____Full Time _____ Part Time

Physician Who Referred You:

Name : _____

Group Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Primary Care Physician

Name: _____

Phone(____) _____-_____ Fax: (____) _____-_____

RESPONSIBLE PARTY INFORMATION

If the patient is the person responsible for paying any out of pocket expense, please mark "self". If you are not the subscriber on your insurance please fill out the subscribers information below.

Patient's relationship to the responsible party: ___ Self ____ Spouse ____Child

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (_____) _____-_____ ext_____

Social Security Number: _____-_____-_____ Sex: Male Female

Date of Birth: _____/_____/_____

Employment Status: Full-time Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Loudoun Neurology Associates PC

Parminder Chawla, MD

Today's Date _____

Name_____ **Age**_____ **Date of Birth**_____
Reason for seeing the doctor_____
Date when the problem started_____
List all past illness and surgeries:

_____
_____
_____
_____
_____

List all your medications, dose, how many times per day you take them, and the prescribing doctor

_____
_____
_____
_____
_____
_____

Pharmacy:
Name:_____ **Phone** (____)____-_____ **Fax** (____)____-_____
Allergies & Reactions:

_____
_____

List blood relative's illnesses and if deceased, approximate age at time of death

_____
_____
_____

Married_____ **Single**_____ **Divorced**_____ **Widowed**___ **# of Children**: _____
Occupation? _____ **Student**? _____ **Disability**? _____
Do you smoke? _____ **What and how much**? _____ **When did you quit**? _____
Do you drink alcohol? _____ **What and how much**? _____ **When did you quit**? _____
Do you drink caffeine? _____ **What and how much**?_____
Do you use street drugs or have you used them in the past? _____

Please circle if you have or have had any of the following:

Weight loss weight gain headaches vertigo vision loss double vision ringing in the ears hearing loss ear pain lightheadedness runny nose sinus trouble hay fever throat pain difficulty swallowing shortness of breath cough chest pain uneven or rapid heart rate constipation diarrhea urinary accidents increased frequency or urgency in urination inability to urinate frequent urinary tract infections a psychiatric diagnosis (depression, bipolar disorder schizophrenia panic attacks anxiety disorder) skin rashes birthmarks

Parminder Chawla, MD

PLEASE TELL US YOUR PREFERRED METHOD OF CONTACT

_____ **On my home answering machine:** _____
Phone Number

_____ **At my work place:** _____
Phone Number

_____ **On my cell phone:** _____
Phone Number

_____ **At the following number:** _____
Phone Number

PLEASE TELL US YOUR EMERGENCY CONTACT INFORMATION

NAME: _____ **NAME:** _____

PHONE : _____ **PHONE:** _____

RELATIONSHIP: _____ **REALTIONSHIP:** _____

_____
Patient's Signature Date of Birth

_____
Patient's Name Printed Today's Date

Loudoun Neurology Associates PC

Parminder Chawla, MD

MEDICAL RECORDS RELEASE AUTHORIZATION

I _____ HEREBY REQUEST _____ TO RELEASE MY ENTIRE MEDICAL RECORDS TO:

LOUDOUN NEUROLOGY ASSOCIATES
DR.PARMINDER CHAWLA M.D.
19420 GOLF VISTA PLAZA SUITE 340
LEESBURG, VA 20176
PHONE: 703-729-1900 FAX: 703-729-1550

Complete Health Records to be disclosed or (check appropriate boxes):
[X] All Medical Reports
[ ] History & Physical Exam [ ] Progress Notes [ ] Discharge Summary
[ ] X-rays/ Ultra Sounds [ ] Laboratory Tests [ ] Consultations

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may be a fee for preparing and furnishing thus information.

_____

Signature of Patient or Legal Representative Relationship to Patient Date Date of Birth

Loudoun Neurology Associates, PC.

Patient Financial Policy

All out-of-pocket balances (copayments, co-insurances and deductibles) are due at the time of service unless previous arrangements have been made in writing with the office. It is the Patient's/ Responsible Party's duty to know what their out-of-pocket expenses will be before seeking treatment.

Payment Options:

- You may pay your out-of-pocket costs at the time of service by Check, Cash, or Credit Card.
- There is a fee of fifty-five dollars ($55) for any check returned by your bank. (for any reason)

Past Due Accounts:

- If at any time you have a balance due which is more than 90 days old your account will be referred to an outside collection agency without notice.
- If we have to refer your account to a collection agency, you hereby agree to pay for all collection costs incurred.
- Furthermore, you understand that if your account is submitted to a collection agency, and thereby reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.
- We will also contact your insurance carrier informing them of your failure to uphold your agreement with them, which at their discretion, may result in termination of your policy.

Missed Appointment Fee:

- The second time a patient does not arrive on time for an appointment, or cancels with less than 24 hours notice, a missed appointment fee of twenty-five dollars ($25) may be charged.
- This fee must be paid before a new appointment is scheduled.
- Patients with three or more missed appointments without notifying the practice in advance will be terminated from the practice.

Pre-Authorization:

- Many insurance companies, such as HMOs, require pre-authorization and/or referrals prior to obtaining specialty care.
- It is your responsibility to contact your insurer and/or primary care physician (PCP) to determine the need for a pre-authorization and/or referral.
- Failure to obtain a pre-authorization and/or referral may result in lower reimbursement or claim denial from the insurance company, in which case you agree to be responsible for the charges.

Forms & Medical Records:

- From time to time, various forms (including but not limited to) workman's comp, disability or DMV forms need to be completed by our staff. There is a twenty dollar ($20) clinical administrative fee to complete each form.
- There are also fees associated with the copying of medical records. ($10 administration fee plus $0.25/page copying fee plus postage if necessary) Please inquire at the front desk by requesting a Record Release Form.

By signing this agreement, you attest to having read, understood and agree to comply with all of the terms and conditions contained herein.

Patient's Name:

Responsible Party (if patient is dependant):

Signature: _____ Date: ____ / ____ / _____

Revised 05/17/2011

Patient Responsibility Agreement/Waiver

Responsible Party/Patient Name:
Date of Service:

Please check if any of these apply to you and sign the bottom.

*****IF THESE DO NOT APPLY TO YOU PLEASE JUST SIGN THE BOTTOM TO AKNOWLEDGE THAT YOU READ THIS.********

SELF PAY WITH INSURANCE:
_____ I choose to pay for all services rendered today myself and not disclose my current health insurance status as of the time of service. I also agree not to seek reimbursement for any of the service(s) provided to me today by any third party payer that has an assignment agreement with Loudoun Neurology Associates, P.C.

NO INSURANCE:
_____I do not have any insurance coverage as of the time of service and will pay for all the services for this visit today. I also agree not to seek reimbursement for any of the service(s) provided to me today by any third party payer that has an assignment agreement with Loudoun Neurology Associates, P.C.

FORGOT INSURANCE CARD:
_____ I am a member of _____ and do not have any documentation indicative of membership in my possession at the time of service. If I do not give Loudoun Neurology Associates, P.C., a copy (front and back) of my insurance card within 24 hours of this office visit, I relinquish any rights or privileges to collect from the third party payer listed above, for this office visit and agree to pay all charges immediately.

INSURANCE REQUIRES REFERRAL, BUT I DON'T HAVE:
_____I am a member of _____ and do not have an authorized referral for this scheduled visit. I understand that the authorized referral is required prior to scheduling this visit in order to assure that it is a covered benefit. I acknowledge that I do not have a referral for today's visit but elect to receive care. I also understand and agree to that I will be responsible for payment of charges and will be billed directly. I accept that my (HMO/POS/QPOS/EPO/Managed Choice/Open Choice) Policy will not be responsible for any charges connected with this *unauthorized visit*. I agree not to seek reimbursement for any of the service(s) provided to me today by any third party payer that has an assignment agreement with Loudoun Neurology Associates, P.C.

DOCTOR DOES NOT PARTICIPATE WITH MY INSURANCE:

_____I am a member of _____ and understand that Loudoun Neurology Associates, PC does not currently participate with my medical insurance. I acknowledge that if I still choose to see Dr. Chawla today, that I will be responsible for all out-of-network expenses as determined by my insurance carrier. I accept that my insurance plan may decide to not be responsible for any charges connected with this visit and I still wish to receive care.

Signature of Patient/Responsible Party _____ Date _____

Loudoun Neurology Associates PC

Parminder Chawla, MD

ASSIGNMENT OF BENFITS & RELEASE OF INFORMATION

I authorize payment directly to Loudoun Neurology Associates, PC of any medical/testing benefits otherwise payable to me by insurance carrier for services as described. Also, I hereby authorize the release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statue or regulation.

NON-COVERED SERVICES

I accept responsibility for paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Dr. Chawla/ Loudoun Neurology Associates, PC and the insurance carrier. Furthermore, I acknowledge that it is my responsibility to obtain any necessary healthcare service plan authorizations/referrals before my visit takes place. Moreover, I agree that it is my responsibility to contact my insurance carrier to confirm if Dr. Chawla is in my network and/or plan, before my visit takes place.

PRACTICE FINANCIAL POLICIES

I recognize that payment for all co-pays, deductibles, co insurances and other pre-determined out of pocket expenses are expect at time of service. I acknowledge that it is my responsibility to know the amount of my out-of-pocket expenses and I agree to check with my insurance carrier before each visit to confirm any changes. I recognize that Loudoun Neurology Associates, PC reserves the right to charge me for finance charges at the rate of 1.5 % per month on my balance(s) after a period of sixty (60) days from the date of service. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

_____

Patient/Responsible Party Signature

____/_____/_____

Date of Signature