



Nnamdi C. Dike, D.O.
Kaitlyn Jeffcott, NP

3388 Main St. #100, Frisco, TX 75033
www.affinityneurocare.com
P: 214-407-8580 | F: 214-407-8581

It is the responsibility of the patient to obtain a referral from your primary care physician prior to seeing our providers if you are enrolled in HMO insurance.

Co-payments, Co-Insurance, and Deductibles are due at the time of service.

Co-pays will be taken at every New Patient and Follow-up visit.

Please arrive 15 minutes before your appointment for registration.

We Look forward to seeing you!

Affinity Neuro Care Financial Policies

Your Visit

To expedite your visit, you should plan to arrive thirty (30) minutes before your New Patient Evaluation to speed up the registration process. We ask that you bring a current insurance card, or payment in full if you do not have insurance. Please remember that all co-pays are due at the time of services.

Payment/ Insurance policy

As a courtesy, **Affinity Neuro Care**, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of **Affinity Neuro Care** that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. After your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance for neurological services, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

Insurance claims are filed a maximum of twice, and then payment will be expected from the patient. To submit your claim, we must have a current copy of your insurance card on file. If you fail to make us aware of changes to your insurance carrier at the time of your visit, the responsibility for payment for the office visit and subsequent reimbursement from your new insurance carrier will be yours. All outstanding balances and co-pays will need to be paid before you can see the doctor at each office visit.

We highly recommend you also contact your insurance carrier and check into your coverage for Neurological services. Do not assume that you will not owe anything if you have more than one insurance policy.

Estimated Charges

To ensure that we accurately reflect and capture all charges provided during your visit, encounter forms are routinely reviewed for accuracy and appropriateness by trained coding staff. As a result, your charges for each visit are an estimate and are subject to change upon further review.

Cancelled Appointments

We require 24 hours' notice for cancellation of all doctors' visits. In the event of a missed appointment without prior notification, a cancellation fee of \$25 will be billed to your address. In the event of a missed procedure appointment without prior authorization the fee will be \$75 dollars.

Disability/FMLA

Any FMLA or disability paperwork will require 2 weeks to complete and is subject to a fee once it has been evaluated by the physician. There are no guarantees that the providers will complete this form.

Complete Insurance Information

To file your insurance, we must have complete insurance information including:

- Insured name
- Social Security Number
- Date of birth
- Group Number (if applicable)
- Subscriber/Policy Number
- Plan Address
- Plan Telephone Number

All the above information is listed on your insurance card, which will be asked for at every visit. If you are unable to provide us with an up to date insurance card, we will ask for payment in full before continuing your registration process.

Medicare Patients

If Medicare is your primary insurance, and you do not have a secondary insurance, you will be responsible for twenty percent (20%) at the time of service.

Changes in Insurance Coverage

If there is a change in insurance coverage, it is your responsibility to make sure we have all the new coverage information on file. Any medical expense not covered by your insurance will be billed to your address.

Non-Participating Insurance Plans

If Affinity Neuro Care does not participate with your insurance plan, several options are available. You may pay the balance in full today and request an itemized receipt of the visit and file it with your insurance company. The practice can file a claim to your insurance company on your behalf. If your insurance plan does not pay in full within 45 days, you will be responsible for the bill.

Primary care of Physician Referral

All patients must have a referral from a Primary Care Provider or from their referring physician before the appointment is set. If you are "self-referred," a Medical Records Request Form will be faxed to your most recent provider.

Insurance and Billing questions

For all billing questions or claims, please contact Affinity Neuro Care's billing department at billing@affinityneurocare.com.

MEDICATION REFILL POLICY

To provide excellent quality care, Affinity Neuro care adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our physician, allowing you to update our physicians on any changes in your medication regimen or advise of any new or ongoing symptoms.

- Lost, misplaced, or stolen prescriptions will not be replaced.
- Refilling of controlled substances will require an office appointment.
- Refills will only be addressed during regular office hours Monday - Thursday. Refill requests made Friday after 12 PM will not be processed until the following Monday.
- Approval of a refill may take up to 3 business days. I understand that it is my responsibility to contact the clinic in a timely manner.
- It is my responsibility to follow the medication in the dosage as prescribed. Early refill requests will not be approved.
- It is my responsibility to maintain my scheduled appointments with my provider. Repeated no shows and cancellations will result in a denial of refills.
- Early refills due to extenuating circumstances will be processed at the physician's discretion

Medical Equipment Policy-Patient Form

Our office is equipped with examining tables that are suitable to hold the weight of an average male/female. In the event a patient's physical weight exceeds that weight, we will make every effort to make alternative accommodations. If satisfactory alternative accommodations cannot be found and the patient wishes to proceed with medical examination on the examining table, the patient agrees that this office will not be held responsible or liable for any accident or injury the patient may sustain.

Rx Consent

By signing this consent form you are agreeing that your provider at Affinity Neuro Care may request and use your prescription medication history from other healthcare providers. This provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by your health care provider at Affinity Neuro Care, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information. I give **Affinity Neuro Care** consent to retrieve my past Rx history.

Acknowledgment to Receipt of Notice of Financial Policies and Consents

Our practice reserves the right to modify the financial policies outline above. I have reviewed this office's Notice of Financial Policies and consents. I understand that I am entitled to receive a copy of your Notice of Financial Policies.

Patient (print): _____ Date: _____

Signature: _____ Date: _____

Relationship of Patient Representative: _____

Signature: _____ Date: _____

Printed Name of Patient or Legally Authorized
(required if the patient is a minor or if the patient is unable to sign.)

New Patient Intake Forms

Name: _____ DOB: _____ Date: _____ Sex: M|F

Address: _____ Phone: _____

Email: _____ Pharmacy: (Name/Address) _____

PCP: _____ Phone: _____ Address: _____

Ref. Physician: _____ Phone: _____ Address: _____

-Have you been under the care of a neurologist within the last 5 years? No ___

___ Yes, Dr. _____ Phone: _____ Address: _____

-Have you been to the ER for this or any other neurological problem? No ___

___ Yes, Hospital _____ Phone: _____ Address: _____

Have you recently had any of the following?

Yes	No		date	where?	Normal	Abnormal
___	___	MRI Brain	_____	_____	_____	_____
___	___	CT Scan	_____	_____	_____	_____
___	___	EEG (brain wave recording)	_____	_____	_____	_____
___	___	EMG/NCV	_____	_____	_____	_____
___	___	Evoked Potential Study	_____	_____	_____	_____
___	___	Cerebral Arteriogram	_____	_____	_____	_____
___	___	Carotid Doppler	_____	_____	_____	_____
___	___	Echocardiogram	_____	_____	_____	_____
___	___	LP (Spinal Tab)	_____	_____	_____	_____
___	___	Myelogram	_____	_____	_____	_____

-Have you had any recent bloodwork done? Where? _____ Phone: _____

-May confidential messages be left on your home answering machine or voicemail? ___ Yes ___ No

-Who can we contact in case of an emergency? May we also release your medical information to the following people? Yes ___ No ___

Name relationship Phone

Name relationship Phone

Name: _____

Date of birth: _____ Date: _____

Chief complaint: _____

Allergies: _____

Current medications, alternatives, and vitamins: List name, dosage, and how often you take them.

Medical History: Please specify the date of diagnosis for each condition. If you have an illness not shown, please specify below.

- High blood pressure Date: _____
- Diabetes Date: _____
- High cholesterol/lipids Date: _____
- Heart disease Date: _____
- Thyroid disease Date: _____
- Tumor Date: _____
- Cancer Date: _____
- Stroke Date: _____
- TIA (mini stroke?) Date: _____
- Psychiatric disease Date: _____

Specify: _____

- Treatment by counselor Date: _____

Other: _____

Surgical, Injury History: Please provide dates of operations or injuries.

- Brain Date: _____
- Neck Date: _____
- Back Date: _____
- Sinus Date: _____
- Facial Date: _____
- Dental Date: _____
- Vascular Date: _____
- Heart Date: _____
- Lung Date: _____
- Implantations Date: _____

Please list dates of all hospitalizations/injuries (specify):

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Pregnancy history:

Are you currently Pregnant? Yes _____ No _____ N/A: _____

Neurological complaints during Pregnancy: _____

Number of pregnancies: _____ Live Births: _____

How many children do you have? _____

Family History: Please list age and significant medical illnesses in maternal and paternal mother and father, sisters or brothers, and in maternal and paternal grandparents.

Father: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

Mother: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

Sister: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

Brother: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

Son(s): Age: _____ Deceased _____ Alive _____

Medical Hx: _____

Daughter(s): Age: _____ Deceased _____ Alive _____

Medical Hx: _____

P. Grandmother: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

P. Grandfather: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

M. Grandmother: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

M. Grandfather: Age: _____ Deceased _____ Alive _____

Medical Hx: _____

Social History:

1. Do you smoke cigarettes? (or any form of tobacco)

Yes ___ No ___ Never ___ Daily ___ Quit date: _____

2. Any illicit drug use?

Yes ___ No ___ Never ___ Daily ___ Quit date: _____

3. Do you drink alcohol?

Beer | Wine | Liquor (circle)

Yes ___ No ___ Never ___ Daily ___ Quit date: _____

4. Do you drink coffee/caffeine?

Yes ___ No ___ Never ___

How many cups daily? _____

How many times a week do you exercise?

Who lives with you at home?

What is your marital status?

What is your occupation?

Have you traveled outside of the US in the past 6 months?

Have you had the FLU vaccine this year?

Have you been exposed to HIV or any other STD/STI?

What hand do you use for writing?

What is the highest level of education?

Name: _____ DOB: _____ Date: _____

Review of Systems

Check the box next to the symptoms that you have noticed over the last year.

Constitutional

No complaints _____

Poor Appetite__ Weight loss__ Fever__ Chills__ Night sweats__ Weight gain__ Fatigue__ Snoring__ Always tired__ Malaise__ Apnea__ Choking__ Restful sleep__ Blackouts__ AM Headaches__ Hot flashes__ Sleepiness__ Dizziness__

Other/Comments: _____

Eyes/Head

No complaints _____

Vision changes__ seeing spots__ Itchy eyes__ Watery eyes__ Headaches__ Double/vision__

Other/Comments: _____

Ear/Nose/Throat

No complaints _____

Hearing loss__ Ringing ears__ Ear pain__ Nasal polyps__ Nasal congestion__ Nasal drainage__ Change smell__ Nose bleed__ Sneezing__ Sinus pain__ Hoarseness__ Bad breath__ Sore throat__ Change in taste__

Other/Comments: _____

Cardiac

No complaints _____

Chest pain__ Leg swelling__ Heart skipping__ Heart murmur__ Passing out__ Heart fluttering__ Palpitations__ Waking up short of breath__ Shortness of breath while lying flat__ Other/Comments: _____

Respiratory

No complaints _____

Cough__ Pneumonia__ Phlegm__ Wheezing__ Chest tightness__ Chest injury__ Pleurisy__ Coughing blood__ Exposure to tuberculosis__ Shortness of breath at rest__ Shortness of breath with walking__

Other/Comments: _____

Gastrointestinal

No complaints _____

Indigestion__ Nausea__ Vomiting__ Bowel changes__ Constipation__ Belly pain__ Bloody stools__ Heartburn__ Tar-colored stools__ Choking on food__ Acid taste in mouth__ Diarrhea__ Pain Swallowing__

Other/Comments: _____

Musculoskeletal

No complaints _____

Arthritis__ Muscle pain__ Muscle weakness__ Joint stiffness__ Osteoporosis__ Back pain__

Other/Comments: _____

Genitourinary

No complaints _____

Bloody urine__ Frequent urination__ Burning with urination__ Incontinence__ Urination at night__ Recent Mammogram__ Recent pap smear__ Abnormal periods__ Vaginal discharge__ Decrease urine flow__

Other/Comments: _____

Skin/Breast

No complaints _____

Easy Bruising__ Nail changes__ Warts__ Acne__ Hair loss__ Hives__ Moles__ Itching__ Discoloring__ Bolls__ Rash__ Lesions__ Breast lump__ Nipple discharge__

Other/Comments: _____

Neurological

No complaints _____

Epilepsy__ Seizures ("fits")__ Paralysis__ Speech changes__ Tingling__ Numbness__ Memory problems__ Headaches__ Lack of concentration__ Poor balance__ Tremors__

Other/Comments: _____

Psychiatric:

No complaints _____

Depression__ Difficulty concentrating__ Insomnia__ Memory loss__ Confusion__ Nervousness__ Anxiety__

Other/Comments: _____

Would you like to report any abuse at this time?

YES | NO

Physical | Emotional | Mental | Financial

Endocrine

No complaints _____

Excessive thirst__ Frequent urination__ Increased appetite__ Heat intolerance__ Cold intolerance__

Other/Comments: _____

Herme/Lymph

No complaints _____

Anemia__ Easy bruising__ Swollen glands__ Hemophilia__ Easy bleeding__ Sickle cell disease__

Other/Comments: _____

Allergy/Immunology

No complaints _____

Nasal drainage__ Crusting__ Seasonal allergies__ Lupus__ Allergy shots__ frequent colds__ frequent infections__ autoimmune disease__

Other/Comments: _____

AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____

I, the undersigned, authorize the release of or request access to the information specified below from the Medical record, protected patient information to Affinity Neuro Care on the above-named patient.

- Patient information is needed for: (check one)

- Continuing Medical Care
- Social Security/Disability
- Insurance
- Legal Purposes
- School
- Personal Use

Other _____ Dates of service: _____

- Information to be released or accessed: (check one)

- Operative Reports
- Lab Reports
- All Consultation Reports
- Imaging Reports (MRA, MRI, CT Scans, etc.)

Other _____ Dates of service: _____

- I authorize **Affinity NeuroCare**: (check one)

- to **OBTAIN confidential information from:**

- to **RELEASE confidential information to:**

- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
- The information obtained or disclosed pursuant to this authorization may be subject to re-disclosure and I hold harmless **Affinity NeuroCare** and/or its representatives from liability resulting in the release or obtaining of the above protected health information.
- I understand that I may revoke this authorization in writing at any time prior to release of the protected health information specified above.
- I understand that the specified information to be released may include but not limited to history, diagnoses and or treatment of drug and alcohol abuse or use, psychiatric treatment, mental illness, communicable diseases which are protected by Federal Law 42CFR Part 2, Including HIV, AIDS, all sexually transmitted diseases.
- I understand that I may be charged a fee for copies of my medical records/protected health information according to Texas Hospital Licensing Law.

Signature: _____ Date: _____

Printed Name of Patient or Legally Authorized Representative