220 EXECUTIVE CENTER PARKWAY
FREDERICKSBURG, VA 22401
(540)899-2900 * (540)372-6928 FAX

Neurology Associates
Of Fredericksburg

REGISTRATION INFORMATION

Home Phone _____ Preferred Phone # ☐ Cell Phone _____ Preferred Phone # ☐ Date _____

Patient _____
Last Name First Name Middle Initial

Street Address _____

City _____ State _____ Zip Code _____

Male __Female __ Age ____ Birth date _____ Single __ Married __ Widowed __ Divorced __

Responsible Party (If a minor)
and/or **Insurance Policy Holder** _____
Full Name Date of Birth

Patient SSN _____ Responsible Party or Insurance Policy Holders SSN _____

Patient Employer _____ Work Phone _____

Spouse Name _____ Spouse Birth date _____

Spouse Employer _____ Spouse Work Phone _____

Primary Insurance Co. _____ | Secondary Insurance Co. _____

ID # _____ Group # _____ | ID # _____ Group # _____

Emergency Contact _____ Phone # _____ Relationship _____

Referring Physician _____ Phone Number _____

Please circle yes or no: Are you being seen for an injury related to employment? YES / NO ; related to an auto accident? YES / NO ; related to another type of accident? YES / NO
If yes, Date of accident ____/____/____ **State accident occurred in?** _____

ASSIGNEMENT AND RELEASE
I, the undersigned have insurance coverage with _____ and assign directly to Neurology Associates of Fredericksburg all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured / Guardian if a minor Date

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefit be made either to me or on my behalf to Neurology Associates of Fredericksburg for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of Medicare.

_____ _____
Signature of Insured / Medicare Beneficiary Date

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CONTRACT

In Consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (6) days after services are rendered **or** after response from the undersigned insurance company has been received; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit if filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned, as may be necessary.

The undersigned understands that Medical/Dental Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I

[ ] **am** an active duty member of the U.S. Armed Forces.

[ ] **am not** an active duty member of the U.S. Armed Forces.

_____ _____

Date Responsible Party Signature

If the above signed is not the patient:

_____

Printed Name

_____

Relationship to patient

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Authorization to Release Information
I authorize the release of any medical or other information to my insurance carrier(s) or to any entity necessary to determine insurance benefits or the benefits payable for related healthcare services and/or supplies provided by Neurology Associates of Fredericksburg.

Initial Here: _____

Assignment of Benefits
I authorize direct payment of all insurance benefits, including Medicare, to Neurology Associates of Fredericksburg for all covered healthcare services and supplies provided to me by Neurology Associates of Fredericksburg and/or its affiliated entities. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Neurology Associates of Fredericksburg and will constitute a continuing authorization, maintained on file with our office, which will authorize and allow for direct payment of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by Neurology Associates of Fredericksburg.

Initial Here: _____

Notice of Patient Privacy Practices
I acknowledge that I was provided the opportunity to review a summary of Neurology Associates of Fredericksburg's Notice of Privacy Practices (NPP). I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice and may receive a complete copy of the NPP upon request.

Initial Here: _____

HIPAA Consent
I understand that HIPAA requires Neurology Associates of Fredericksburg doctors and staff to verify identities when speaking with unknown family members and friends. I understand the doctors and staff of NAF may not have access to this disclosure information at certain times such as after-hours and on weekends, and I agree they should use their professional judgment and discretion at such times with respect to sharing my personal health information, including emergency situations where I may be unable to provide consent. I also understand that Neurology Associates of Fredericksburg may request and release information to and from treating providers as well as new referrals for necessary treatment.

Initial Here:_____

Disclosures related to my health or as needed for payment for health care services may be made to the following family members and friends:

NAME	PHONE NUMBER	RELATIONSHIP	DATE OF BIRTH

May we call you at your place of employment? **Yes / No**

May we leave a message on your office voice mail? **Yes / No**

May we leave medical information, such as testing results & medication changes, on your home voice mail? **Yes / No**

I acknowledge the above information has been explained to me and I understand

SIGNATURE	
PRINTED NAME	
DATE	

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MEDICATION INFORMATION

Date _____

Patient Name _____ Birth Date _____

Drug Allergies? _____

Pharmacy _____ Pharmacy Phone _____

DATE Rx	NAME OF MEDICATION	DOSAGE	DIRECTIONS	STOP DATE

B – BRAND ONLY **G – GENERIC ONLY**

NOTES _____

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NAME: _____ **AGE:** _____ **REFERRING DOCTOR:** _____

DATE: _____ **RIGHT OR LEFT HANDED:** _____

REASON FOR NEUROLOGICAL CONSULTATION: _____

NO.	PAST HISTORY	YES	NO	
1	DIABETES			**DRUG ALLERGIES:**
2	HYPERTENSION			_____
3	HIGH CHOLESTEROL			
4	CANCER			_____
5	STROKE			
6	HEART TROUBLE / HEART ATTACK			
7	THYROID PROBLEMS			
8	ARTHRITIS / GOUT			
9	CONVULSIONS / EPILEPSY			
10	BLEEDING TENDENCY			
11	ACUTE INFECTIONS			
12	VENEREAL DISEASE			
13	HEREDITARY DEFECTS			
14	ALLERGIES			
15	PSYCHIATRIC PROBLEMS			
16	GI / LIVER DISEASE			
17	PULMONARY DISEASE / PNEUMONIA			
18	HIV TESTING			**RESULT:**

FAMILY HISTORY – CHECK IF YES – EXPLAIN ABOVE

☐ HEART DISEASE ☐ NEUROPATHY/NUMBNESS ☐ ALZHEIMERS / DEMENTIA
☐ GAIT DISORDER ☐ SEIZURE / EPILEPSY ☐ TREMOR / PARKINSONS
☐ STROKE ☐ MULTIPLE SCLEROSIS ☐ MUSCLE DISEASE / WEAKNESS
☐ HEADACHES ☐ HEREDITARY ILLNESS ☐ OTHER MEDICAL ILLNESS _____

FATHER (AGE/HEALTH)_____
MOTHER (AGE/HEALTH) _____
SIBLINGS (AGE/HEALTH) _____

NEUROLOGICAL TESTING	YES	NO	DATE	RESULT
MRI SCAN				
CT SCAN				
X-RAYS				
ARTERIOGRAM/CAROTID				
EVOKED POTENTIAL STUDIES				
EMG/NCV				
ELECTROENCEPHALOGRAM (EEG)				

SOCIAL HISTORY

Occupation: _____ Tobacco: (amount)_____ Alcohol: (amount) _____
Marital Status: Single __ Married __ Separated __ Divorced __ Widowed __ Children: _____
Exposure to: Fumes __ Dust __ Solvents __ Air-Borne Particles __

CHRONIC ILLNESSES STATUS	PRIOR HOSPITALIZATIONS/SURGERIES/ILLNESSES DATE
1.	
2.	
3.	
4.	

_____ _____ _____
Patient Signature Date MD Signature

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REVIEW OF SYSTEMS (Please circle any symptoms that are NOW present)

- Constitutional Symptoms
  - Weight Loss
  - Weight Gain\\
  - Appetite Change
  - Fever
  - Severe Fatigue
  - Sleep Disturbance
- Eyes
  - Glaucoma
  - Cataracts
  - Changing Vision
  - Eye Pain or Redness
  - Double Vision
  - Visual Loss
  - Flashing Lights
  - Other _____
- Ears/Nose/Mouth/Throat
  - Hearing Loss
  - Ear Pain
  - Ringing in ears
  - Sinus disease
  - Loss of smell or taste
  - Vertigo (Spinning)
  - Swallowing Difficulty
  - Hoarseness of change in voice
  - Swollen Glands
  - Sore throat or mouth sores
  - TMJ disorder
  - Other _____
- Cardiovascular
  - Hypertension (high blood pressure)
  - High Cholesterol
  - Chest pain or angina
  - Heart murmur
  - Irregular heartbeat (palpitations)
  - Faintness/lightheadedness
  - Heart Failure
  - Other _____
- Respiratory
  - Shortness of breath
  - Cough
  - Coughing up blood
  - Asthma/wheezing
  - Other _____
- Gastrointestinal
  - Abdominal pain
  - Ulcer disease
  - Gastric reflux disorder
  - Hepatitis
  - Liver Failure
  - Blood in stool
  - History of GI bleeding
  - Constipation
  - Diarrhea
  - Loss of bowel control
  - Bausea/vomiting
  - Other _____
- Genitourinary
  - Blood in urine
  - Pain on urination
  - Frequent bladder infections
  - Problem controlling bladder function
  - Kidney stones
  - Sexual dysfunction
  - Other _____

  FEMALE: # of pregnancies ___ miscarriages ___
  Last menstrual period _____
  Birth control pills _____
  Hormone replacement therapy_
  Other_____
- Neurological
  - Headaches
  - Confusion
  - Memory Loss
  - Change in Speech
  - Difficulty walking
  - Weakness all over
  - Weakness in part of body_____(Where)
  - Difficulty with coordination
  - Muscle pain
  - Muscle spasms or cramps
  - Tremor
  - Convulsions/seizures
  - Numbness/tingling_____(Where)
  - Stroke or "TIA"
  - Head injury ("knocked unconscious")
  - Other_____
- Psychiatric
  - Nervousness
  - Worry
  - Depression
  - Mood Swings
  - Sleep Disturbances
  - Panic Attacks
  - Hallucinations
  - Learning disabilities
  - History of drug or alcohol abuse
  - History of counseling
  - Other_____
- Bones and Joints
  - Arthritis
  - Swollen joints
  - Gout
  - Back Pain
  - Neck Pain
  - Radiating pain into arm _____
  - Radiating arm into leg _____
  - Other_____
- Skin
  - Rash
  - Easy bruising
  - Varicose veins
  - Other_____
- Endocrine
  - Diabetes
  - Thyroid disease
  - Excessive or decreased sweating
  - Breast discharge
  - Other _____
- Hematologic
  - Anemia
  - History of blood clots (phlebitis)
  - DVT (deep vein thrombosis)
  - Past transfusions
  - Bleeding disorder
  - Other _____
- Allergy
  - List food allergies/reactions _____
  - _____
  - _____
  - List environmental allergies/reactions_____
  - _____
  - _____
  - Allergy Shots? _____
  - Drug/medication allergies _____
  - _____
  - _____