CARING NEUROLOGY, LLC

New Patient Registration Form

Last Name:_____Middle Initial:_____First Name:_____

Address:_____City:_____State:_____Zip:_____

Phone#:_____Work#:_____Cell#:_____

Email:_____SS#:_____DOB:_____

Patient Age:_____Patient Height:_____Patient Weight:_____ Sex: ❑ Male ❑ Female

Referring Doctor/Primary Doctor:_____ Phone:_____

Address:_____
(Street) (City) (State) (Zip)

Pharmacy:_____ Phone:_____

Address:_____
(Street) (City) (State)

Employer (or Parent/Guardian Employer):_____Phone:_____

Address:_____
(Street) (City) (State)

Emergency Contact:_____Relationship:_____Phone:_____

Parent/Guardian of Child:_____DOB:_____Phone:_____

Do you have an Advanced Directive/Living Will?:_____

Insurance Information

Name of Insured Subscriber:_____SS#:_____DOB:_____

Insurance Company:_____Phone:_____

Address:_____
(Street) (City) (State)

Group#:_____ID#_____Relationship to Patient:_____

Secondary Insurance Company:_____ Phone:_____

Name of Insured Subscriber:_____Subscriber DOB:_____

Employer:_____Phone#:_____Relationship to Patient:_____

Group#:_____ID#_____

Workers Compensation:_____

PLEASE NOTE: INSURANCE CONTRACTS ARE MADE BETWEEN YOU AND THE INSURANCE COMPANY. WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. PAYMENT OF ANY CHARGES ARE PRESUMED TO BE YOUR RESPONSIBILITY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I UNDERSTAND THAT CARING NEUROLOGY, LLC REQUIRES PAYMENT AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN AGREED UPON.

I HEREBY AUTHORIZE CARING NEUROLOGY, LLC TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO MY INSURANCE COMPANY, ATTORNEY, SCHOOL, OR OTHER TREATING PHYSICIAN.

Signature of Responsible Party:_____**Date**:_____

Name:_____
(Print Name)

CARING NEUROLOGY, LLC

New Patient History Form

Date:_____

Patient Name:_____ **Age:**_____ **DOB:**_____

Referring Physician:_____ **Primary Care Physician:**_____

Please describe, in detail, your main compliant for seeking neurological evaluation and the duration you have had symptoms:

_____

_____.

PLEAE COMPLETE ALL PAGES OF HISTORY FORM

Past Medical History: Please circle NO or YES to each below:

Anemia	NO	YES	Emphysema	NO	YES	Lyme Disease	NO	YES
Asthma	NO	YES	Head Trauma/ Concussion	NO	YES	Pneumonia	NO	YES
Bleeding Tendency	NO	YES	Heart Disease	NO	YES	Stroke	NO	YES
Cancer	NO	YES	High Blood Pressure	NO	YES	Thyroid Disease	NO	YES
Diabetes	NO	YES	High Cholesterol	NO	YES	Ulcers	NO	YES

Review of Systems: Please circle NO or YES to each below:

CONSTITUTIIONAL SYMPTOMS		
Recent Weight Change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Night Sweats	NO	YES
EYES:		
Eye Disease or Injury	NO	YES
Wear Glasses or Contacts	NO	YES
Blurred Vision or Double Vision	NO	YES
Glaucoma	NO	YES
EARS/ NOSE/ MOUTH/ THROAT		
Hearing Loss or Ringing	NO	YES
Earaches or Drainage	NO	YES
Chronic Sinus Problems or Rhinitis	NO	YES
Frequent Colds	NO	YES
Nose Bleeds	NO	YES
Mouth Sores	NO	YES
Bleeding Gums	NO	YES
Sore Throat or Voice Changes	NO	YES
Swollen Glands in Neck	NO	YES

MUSCULOSKELETAL		
Joint Pain or Swelling	NO	YES
History of Broken Bones	NO	YES
Weakness in Muscles or Joints	NO	YES
Muscle Pain or Cramps	NO	YES
Neck or Low Back Pain	NO	YES
Cold Hands or Feet	NO	YES
Arthritis or Bursitis	NO	YES
INTEGUMENTARY (SKIN /BREAST)		
Rash or Itching	NO	YES
Change in Skin Color	NO	YES
Change in Hair or Nails	NO	YES
Varicose Veins	NO	YES
Breast Lumps	NO	YES
Breast Discharge	NO	YES
NEUROLOGICAL		
Frequent Recurring Headaches or Migraines	NO	YES
Lightheaded or Dizziness	NO	YES
Convulsions or Seizures	NO	YES
Numbness or Tingling Sensation	NO	YES
Tremors	NO	YES
Memory Loss	NO	YES
Trouble Walking or Gait Disturbance	NO	YES

Physician Initials:_____

Date:_____

Patient Name:_____ **Age:**_____ **DOB:**_____

Review of Systems: Please circle NO or YES to each below:

CARDIOVASCULAR		
Chest Pain or Angina Pectoris	NO	YES
Palpitations	NO	YES
Shortness of Breathe While Walking	NO	YES
Shortness of Breathe While Laying Flat	NO	YES
Swelling of Hands, Feet or Ankles	NO	YES
GASTROINTESTINAL		
Loss of Appetite	NO	YES
Nausea or Vomiting	NO	YES
Frequent Diarrhea	NO	YES
Painful Bowel Movements or Constipation	NO	YES
Rectal Bleeding or Blood in Stool	NO	YES
GENITOURINARY		
Frequent Urination	NO	YES
Burning or Painful Urination	NO	YES
Blood in Urine	NO	YES
Incontinence or Dribbling	NO	YES
Kidney Stones	NO	YES
History of Venereal Disease	NO	YES
Male - Testicular Pain	NO	YES
Female - Painful or Irregular Periods	NO	YES
Female - Vaginal Discharge	NO	YES
Female - # of Pregnancies		
Female - # of Miscarriages		

PSYCHIATRIC		
Nervous Breakdown	NO	YES
Nervousness or Anxiety	NO	YES
Depression	NO	YES
Insomnia	NO	YES
ENDOCRINE		
Glandular or Hormone Problem	NO	YES
Excessive Thirst st or Urination	NO	YES
Heat or Cold Intolerance	NO	YES
Skin Becoming Dryer	NO	YES
Change in Hat or Glove Size	NO	YES
HEMATOLOGIC/ LYMPHATIC		
Phlebitis	NO	YES
Past Transfusion	NO	YES
Enlarged Glands	NO	YES
RESPIRATORY		
Spitting up Blood	NO	YES
Shortness of Breath	NO	YES

Please list prior surgeries and hospitalizations, including dates: ❑ NONE

Surgery/Hospitalization	**Dates**

Please list Medications (include birth control, aspirin, and all over-the-counter medications) : ❑ NONE

Name of Drug	**Dosage**	**How Often**	**Date Started**

Please list any Drug Allergies: ❑ NONE

Medication Allergy	**Reaction**	**Date Occurred**

Physician Initials:_____

Have you ever had, please give dates:

❑ CT Head	_____	❑ EMG	_____	❑ TCD	_____
❑ MRI Brain	_____	❑ EEG	_____	❑ Other	_____
❑ MRI Spine	_____	❑ Carotid US	_____	❑ Other	_____
❑ MRA	_____	❑ VNG	_____	❑ Other	_____

Family Medical History: Please list below: ❑ Unknown-Adopted

Member	Age	Diseases	If Deceased, Cause of Death and Age
Mother			
Father			
Sister			
Brother			
Children			

Social History:

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner ❑ Widowed ❑ Legally Separated ❑ Divorced

Occupation:_____

Education: _____

Alcohol Consumption: ❑ Never ❑ Yes: Per Day:_____Per Week:_____Per Month:_____

Tobacco Use: ❑ Never ❑ Previously, but quit_____ago ❑ Current, _____packs per day

Recreational Drug Use: ❑ Never ❑ Yes: Type:_____

Date of last Mammogram:_____

Date of last Colonoscopy:_____

Is there any other important medical information we should know?_____

Office Staff Only – Please DO NOT write in Section Below:

VITALS:

HT:	**WT:**	**P:**	**R:**	**BP:**

Physician Initials:_____

CARING NEUROLOGY, LLC

Financial Agreement

Patients with insurance that *Caring Neurology, LLC* does not participate with or have no insurance coverage are responsible for payment at time of service.

Patients with insurance that *Caring Neurology, LLC* participates with will be responsible for providing necessary referrals at the time of service, as well as paying the co-pay/ deductible that are due at time of service.

Medicare patients will be responsible for their deductible as well as the 20% that is not covered by Medicare or your secondary insurance.

MVA patients will be responsible for deductibles/ co-insurance at time of service.

Caring Neurology, LLC requires 24 hours' notice of cancellations; we reserve the right to charge for missed appointments.

TO ALL PATIENTS: WHENEVER CARING NEUROLOGY, LLC IS NOT PAID AT THE TIME OF SERVICE AND SUBMITS FOR PAYMENT OF PROFESSIONAL FEES TO AN INSURANCE CARRIER FOR THIS SERVICE, THE PATIENT IS AUTHORIZING PAYMENT DIRECTLY TO CARING NEUROLOGY, LLC. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PROFESSIONAL FEES IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER ACCORDING TO AGREEMENT. SHOULD THE ACCOUNT BECOME DELIQUENT IN WHOLE OR PART, CARING NEUROLOGY, LLC MAY REFER TO OUR ATTORNEY AS ALLOWED BY LAW FOR COLLECTIONS.

Financial Policy

Thank you for choosing *Caring Neurology, LLC* as the provider of your neurologic care.

We strongly urge you to become familiar with the benefits and exclusions in your insurance policy and to have all of the necessary information and/ or paperwork, including referrals at the time of your visit. Because of the many different insurance plans made available by each insurance company *Caring Neurology, LLC* cannot be responsible for knowing the plan requirement for each patient. If the required referral or authorizations have not been obtained and presented before your appointment, your appointment will be canceled. You do have the option of paying for the appointment and seeing the doctor rather than canceling.

Referrals are the responsibility of the patient. Please remember to contact your Primary Care Physician to obtain your referral prior to your appointment if your insurance company requires a referral.

There will be a $25 charge for returned checks. This office reserves the right to deny future check payments and may ask that you pay cash for future visits. If in fact you do not pay the returned check fee and the original charge within 30 days of notice and we have your credit card information we reserve the right to charge the fees to your credit card.

You will be sent two statements. Any unpaid balance for 90 days (from the first statement) will be sent to collections. You will be required to pay any open balance prior to future appointments.

Caring Neurology, LLC reserves the right to charge $50 for missed follow up appointments and $100 for missed consult appointments that have been canceled less than 24 hours in advance.

In signing this agreement you are consenting that you understand and agree to the above financial agreement and policies of *Caring Neurology, LLC*

Signature: _____ **Print Name**: _____

Relationship to Patient:_____ **Date**:_____

ATTENTION:

IF YOU HAVE ANY CHANGES IN YOUR INSURANCE COVERAGE, PLEASE PROVIDE US WITH THIS INFORMATION SO WE MAY UPDATE OUR RECORDS.

IF COVERAGE HAS CHANGED AND WE ARE NOT AWARE OF THIS CHANGE, YOU ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES.

Signature of Responsible Party:_____ **Date**:_____

CARING NEUROLOGY, LLC

Patient Agreements and Notice of Privacy Practices

Patient Name:_____**DOB**:_____**Today's Date:**_____
(please print)

Please read the following statements and indicate your acknowledgement and/or authorization by initialing and signing and below.

Medical Information Agreement & Consent to Treatment

I, _____am authorized and hereby give consent for the medical staff of Caring Neurology, LLC
(Patient/Guardian)
to examine and render care to_____.
(Name of Patient/Self)

_____I authorize release of medical information that may be required to process my insurance claim to the proper insurance company or government agency for payment of medical bills.

_____I authorize release of appropriate medical information to other doctors, hospitals, or medical facilities participating in my care.

_____I authorized release of appropriate medical information including test results from other doctors, hospitals or medical facilities to *Caring Neurology, LLC*, in order to aid in my care and/ or treatment.

Acknowledgment of Receipt of Privacy Practices

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's Protected Health Information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

Your privacy is of utmost concern to us at *Caring Neurology, LLC* and we strictly adhere to HIPAA regulations. These regulations do allow us to call you at a phone number provided by you for specific purposes. We can call you to remind you of upcoming appointments and to leave either a voice mail message or a message with the person who answers the phone asking you to call us back. We do not leave Personal Health Information (PHI) unless authorized by you.

_____I acknowledge that I have received a copy of the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

_____I authorize staff of *Caring Neurology, LLC* to call me on the phone number provided regarding an appointment or test results. Caring Neurology, LLC will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours.

_____I authorize the staff of *Caring Neurology, LLC* to leave a message to call back the office during regular business hours containing with any person answering the phone number provided.

Patient Permission to Share Protected Health Information

_____I hereby authorize the staff of *Caring Neurology, LLC* to use or disclose my health information (referred to as "Protected Health Information") to any healthcare provider and/or employee of *Caring Neurology, LLC*. The Protected Health Information (PHI) I am authorizing for use of disclosure is the standard release of information (includes typed diction and therapy notes) and specific information from my chart which includes: _____.

_____I hereby authorize and request *Caring Neurology, LLC* to disclose my PHI to the person(s) or institution(s) listed below. I understand that this authorization will expire 180 days from signing, unless an earlier date is indicated:

Authorized Name(s)	**Relationship**	**Phone Number**	**Discuss PHI**
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

_____ I understand that *Caring Neurology, LLC* has the right to bill me $1.00 per page for each copy of my PHI.

Caring Neurology, LLC collects information including your email address or mobile phone number to deliver patient statements, alerts, and/or e-newsletters. You can opt out of these communications at any time. We will never sell, rent, or give away our email list for 3rd party marketing.

Revoking Rights for Patient Agreement

_____ I understand that I have the right to revoke this Authorization above, if the revocation is in writing, except if *Caring Neurology, LLC* has taken action in reliance upon this Authorization or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that I may revoke this Authorization by sending a written request to:

Caring Neurology, LLC
66 West Gilbert Street
Red Bank, NJ 07701

This consent shall remain in effect until revoked in writing.

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____
Name Printed Relationship of Authorized Representative to Patient

_____ _____
Patient's Telephone # Patient's Date of Birth

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclosure your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3. **For health care operations.** We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds: or when ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medicalresearch.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions**. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure Where You Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

D. **Incidental Uses and Disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.

However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would bepermitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your requires, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care Operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACYPRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATIN ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Caring Neurology, LLC, Attn: Carole Penzynski; 66 West Gilbert Street, Suite 100; Red Bank, New Jersey 07701-4918; (732) 212-0051 ext. 275; e-mail: cpenzynski@libertymedmanagement.com.

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on January 1, 2015.