**NEW PATIENT REGISTRATION FORM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **PATIENT NAME:** | | | **PREFERRED NAME:** | | |
| **HOME ADDRESS:** | | | **CITY:** | | |
| **STATE:** | | **ZIP CODE:** |
| **HOME TELEPHONE #:** | **WORK TELEPHONE #:** | | | **MOBILE TELEPHONE #:** | |
| **E-MAIL ADDRESS:** | | | | | |
| **SEX:**   |  |  | | --- | --- | | [ ] MALE | [ ] FEMALE | | **BIRTH DATE (MM/DD/YYYY):** | | | **SOCIAL SECURITY #:** | |
| **FAMILY STATUS:**   |  |  | | --- | --- | | [ ] SINGLE  [ ] MARRIED | [ ] DIVORCED  [ ] WIDOWED | | | | **SPOUSE’S NAME:** | | |
| **RACE:**   |  |  | | --- | --- | | [ ] WHITE  [ ] BLACK OR AFRICAN AMERICAN  [ ] AMERICAN INDIAN OR ALASKA NATIVE | [ ] ASIAN  [ ] PACIFIC ISLANDER OR NATIVE HAWAIIAN  [ ] OTHER RACE (PLEASE SPECIFY): | | | | **ETHNICITY:**  [ ] HISPANIC OR LATINO OR SPANISH ORIGIN  [ ] NOT HISPANIC OR LATINO OR SPANISH ORIGIN  [ ] OTHER / UNKNOWN (PLEASE SPECIFY): | | |
| **IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CONTACT?**   |  |  |  |  | | --- | --- | --- | --- | | **NAME:** | | **RELATIONSHIP:** | | | **HOME TELEPHONE #:** | **WORK TELEPHONE #:** | | **MOBILE TELEPHONE #:** | | | | | | |
| **LANGUAGE PREFERENCE (IF OTHER THAN ENGLISH):** | | **DO YOU HAVE AN ADVANCE CARE PLAN?** (e.g. ADVANCE DIRECTIVE, LIVING WILL, MEDICAL POWER OF ATTORNEY)  [ ] YES [ ] NO | | | |
| **DO YOU HAVE A HEARING OR VISION IMPAIRMENT THAT REQUIRES ASSISTANCE FOR EFFECTIVE COMMUNICATION?** IF YES, PLEASE CHECK APPROPRIATE ITEMS(S):  [ ] VISION [ ] HEARING | | | | | |

**REFERRING PHYSICIAN:**

|  |  |
| --- | --- |
|  | **REFERRING PHYSICIAN:** |
| **PREFERRED PHARMACY:**   |  |  | | --- | --- | | **NAME:** | | | **ADDRESS:** | **CITY: ZIP CODE:** | |

**PERSON RESPONSIBLE FOR ACCOUNT (GUARANTOR)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **NAME OF RESPONSIBLE PARTY:** | | **RELATIONSHIP TO PATIENT:**   |  |  | | --- | --- | | [ ] SELF | [ ] SPOUSE | | [ ] PARENT | [ ] OTHER (PLEASE SPECIFY): | | |
| **BIRTH DATE (MM/DD/YYYY):** | | **SOCIAL SECURITY #:** | |
| **HOME ADDRESS:** | | **CITY:**  **STATE:**  **ZIP CODE:** | |
| **HOME TELEPHONE #:** | **WORK TELEPHONE #:** | | **MOBILE TELEPHONE #:** |

**EMPLOYMENT INFORMATION**

|  |  |  |
| --- | --- | --- |
|  | **EMPLOYER NAME:** | |
| **ADDRESS:** | **TELEPHONE #:** |

**INSURANCE INFORMATION (PRIMARY)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **NAME OF INSURED:** | **RELATIONSHIP TO PATIENT:**   |  |  | | --- | --- | | [ ] SELF | [ ] SPOUSE | | [ ] PARENT | [ ] OTHER (PLEASE SPECIFY): | |
| **INSURED BIRTH DATE (MM/DD/YYYY):** |
| **INSURANCE PLAN NAME:** | **INSURANCE COMPANY TELEPHONE #:** |
| **GROUP #:** | **POLICY ID #:** |

**INSURANCE INFORMATION (SECONDARY)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **NAME OF INSURED:** | **RELATIONSHIP TO PATIENT:**   |  |  | | --- | --- | | [ ] SELF | [ ] SPOUSE | | [ ] PARENT | [ ] OTHER (PLEASE SPECIFY): | |
| **INSURED BIRTH DATE (MM/DD/YYYY):** |
| **INSURANCE PLAN NAME:** | **INSURANCE COMPANY TELEPHONE #:** |
| **GROUP #:** | **POLICY ID #:** |

**CHIEF COMPLAINT**

|  |  |
| --- | --- |
|  | **WHAT IS THE REASON FOR YOUR VISIT TODAY?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PERSONAL HEALTH HISTORY**

|  |  |
| --- | --- |
|  | **HISTORY OF PRESENT ILLNESS:** PLEASE DESCRIBE WHEN AND HOW YOUR SYMPTOMS BEGAN AND HOW THEY HAVE PROGRESSED.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PAST MEDICAL HISTORY:** PLEASE LIST ANY PREVIOUS OR CURRENT ILLNESSES AND TREATMENTS WITH APPOXIMATE DATES.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | [ ] DIABETES | [ ] HIGH BLOOD PRESSURE | [ ] STROKE | [ ] HEART DISEASE | [ ] HIGH CHOLESTEROL | |
| **SURGICAL, PREGNANCY, AND INJURIES:** PLEASE PROVIDE DESCRIPTION AND APPROXIMATE DATES.  **SURGERIES:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **INJURIES:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PREGNANCIES:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**FAMILY HEALTH HISTORY**

|  |  |
| --- | --- |
|  | **PLEASE LIST ANY ILLNESSES IN YOUR FAMILY ESPECIALLY THOSE THAT ARE RELEVANT TO YOUR CURRENT PROBLEMS:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**SOCIAL HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **DO YOU SMOKE CIGARETTES?**   |  |  |  | | --- | --- | --- | | [ ] YES | [ ] QUIT | [ ] NEVER |   HOW MANY PACKS / DAY? | **CAFFEINE?**   |  |  | | --- | --- | | [ ] YES | [ ] NO |   **ALCOHOL?**  [ ] YES [ ] NO [ ] NEVER [ ] DAILY |
| **WEIGHT:**  **HEIGHT:** | **DO YOU DO DRUGS?**   |  |  |  | | --- | --- | --- | | [ ] YES | [ ] QUIT | [ ] NEVER | | WHAT KIND (e.g. COCAINE, MARIJUANA, ETC…)?  **HAVE YOU BEEN EXPOSED TO HIV?**   |  |  | | --- | --- | | [ ] YES | [ ] NO | | | | |

**HAVE YOU HAD ANY OF THESE TESTS?**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  |  |  | | --- | --- | --- | | TEST | WHEN (MM/YYYY)? | WHERE | | [ ] MRI BRAIN |  |  | | [ ] MRI SPINE |  |  | | [ ] CT HEAD |  |  | | [ ] CT SPINE |  |  | | [ ] EEG |  |  | | [ ] EMG |  |  | | [ ] CAROTID ARTERY |  |  | | [ ] ECHOCARDIOGRAM |  |  | | [ ] LUMBAR PUNCTURE  (SPINAL TAP) |  |  | |

**REVIEW OF SYSTEMS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CURRENT MEDICATIONS:**   |  |  |  | | --- | --- | --- | | MEDICATION NAME | DOSAGE (MG) | FREQUENCY | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |
|  | **PLEASE CHECK EACH ITEM AS THEY RELATED TO YOUR HEALTH:**   |  |  |  | | --- | --- | --- | | **CONSTITUTIONAL** | **RESPIRATORY** | **HEMATOLOGY / LYMPH** | | [ ] Weight Loss | [ ] Cough | [ ] Easy Bruising | | [ ] Fatigue | [ ] Coughing Blood | [ ] Gums Bleed Easily | | [ ] Fever | [ ] Wheezing | [ ] Enlarged Glands | | **EYES** | [ ] Chills | **MUSCULOSKELETAL** | | [ ] Glasses / Contacts | **GASTROINTESTINAL** | [ ] Joint Pain/Swelling | | [ ] Eye Pain | [ ] Heartburn/Reflux | [ ] Stiffness | | [ ] Double Vision | [ ] Nausea/Vomiting | [ ] Muscle Pain | | [ ] Cataracts | [ ] Constipation | [ ] Back Pain | | **EAR, NOSE, THROAT** | [ ] Change in BMs | **SKIN** | | [ ] Difficulty Hearing | [ ] Diarrhea | [ ] Rash/Sores | | [ ] Ringing in Ears | [ ] Jaundice | [ ] Lesions | | [ ] Vertigo | [ ] Abdominal Pain | [ ] Itching/Burning | | [ ] Sinus Trouble | [ ] Black or Bloody BMs | **NEUROLOGICAL** | | [ ] Nasal Stuffiness | **GENITOURINARY** | [ ] Loss of Strength | | [ ] Frequent Sore Throat | [ ] Burning/Frequency: | [ ] Numbness | | **CARDIOVASCULAR** | [ ] Nighttime | [ ] Headaches | | [ ] Murmur | [ ] Blood in Urine | [ ] Tremors | | [ ] Chest Pain | [ ] Erectile Dysfunction | [ ] Memory Loss | | [ ] Palpitations | [ ] Abnormal Discharge | **FEMALES ONLY** | | [ ] Dizziness | [ ] Bladder Leakage | [ ] Are you pregnant? | | [ ] Fainting Spells | **ALLERGIC/IMMUNOLOGIC** |  | | [ ] Shortness of Breath | [ ] Hives/Eczema |  | | [ ] Difficulty lying flat | [ ] Hay Fever |  | | [ ] Swelling Ankles | **PSYCHIATRIC** |  | | **ENDOCRINE** | [ ] Anxiety/Depression |  | | [ ] Loss of hair | [ ] Mood Swings |  | | [ ] Heat/cold intolerance | [ ] Difficult Sleeping |  | |
| **ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**ANYTHING ELSE YOU WOULD LIKE TO TELL THE DOCTOR?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient / Guarantor Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Guarantor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT RELEASE FORM FOR PHI**

I understand that it is the policy of Northern Virginia Neurology to restrict access to my Protected Health Information in accordance with federal law. The following may have access to my healthcare information:

1. The caregiver(s) providing health services
2. My insurance company(-ies) for payment of my claim
3. The person(s) indicated below:

|  |  |  |
| --- | --- | --- |
| Name(s) (Please Print) | Date of Birth  (MM/DD/YYYY) | Information Access Preferences |
| 1. Myself (patient or legal guardian1) | N/A |  |
|  |  | **Clinical Information**  All or Restricted**\*** |
|  |  | **Clinical Information**  All or Restricted**\*** |
|  |  | **Clinical Information**  All or Restricted**\*** |

\* If you circle **Restricted** above, please specify what clinical information you do NOT wish to share with the person(s) in the above boxes:

|  |  |
| --- | --- |
| * Sexually Transmitted Disease(s) * Pregnancy * Terminal Illness | * Mental/Behavioral Health * Other |

**Communication preferences:**

* You may leave confidential clinical information on my answering machine

Patient Signature Date

Printed Patient Name

**FINANCIAL AGREEMENT & RELEASE OF INFORMATION**

1. **AUTHORIZATION FOR TREATMENT**

I hereby authorize treatment by Northern Virginia Neurology and/or affiliated medical staff member(s) on behalf of myself and my minor children, including stepchildren. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State law requires a sample of my blood to be tested for the presence of infectious diseases.

1. **RELEASE OF INFORMATION**

I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment in the payment of my treatment including but not limited to insurance payers, HMOs, workers compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become part of my medical record. I hereby authorize a query of medication history and/or formulary information within the Electronic Medical record in order for drug eligibility and coverage.

1. **PRESCRIPTION HISTORY CONSENT**

Northern Virginia Neurology uses an electronic medical record system (EMR) in which the physician is able to prescribe medications electronically. I give permission to Northern Virginia Neurology to send my prescription(s) electronically. Also, I agree that Northern Virginia Neurology may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

1. **PAST DUE BALANCES AND PROCEDURES FOR COLLECTION**

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that Northern Virginia Neurology may take action to collect its fees. I agree to pay all costs incurred by Northern Virginia Neurology for collecting its fees including an attorney’s fee of thirty-five percent (35%) of the unpaid bill.

1. **FINANCIAL POLICY**

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney’s fees, collection agency fees, costs and interest) due hereunder is to be made to Northern Virginia Neurology. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to Northern Virginia Neurology for any charges not covered by my insurance, including but not limited to copayments, deductibles and fees for non-covered services. The patient and undersigned guarantor are primarily liable for payment of the patient’s account and Northern Virginia Neurology will send all appointment reminders and billing information to the person responsible for payment of my bill. It is their sole responsibility to comply timely with all requirements and supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above. Some insurance plans (i.e. Medicare, Blue Cross, CHAMPUS) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.

We require 24 hours advance notice of a cancellation. Patients who do not provide 24 hour notice of a cancellation or who do not present for a scheduled appointment will be charged a $25.00 fee. Patients who fail to present for a second appointment will be charged an additional $25.00 fee and/or dismissed from the practice. You will be charged a $35.00 fee for any checks returned unpaid.

Northern Virginia Neurology will charge a Processing Fee between $25.00 and $50.00 to complete outside Paperwork. This includes Disability Forms and FMLA Paperwork. Payment is required in advance and paperwork will not be processed until payment is received. Please allow one week for paperwork to be completed.

**I HAVE READ AND UNDERSTAND AND AGREE TO THIS AGREEMENT.**

Patient Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Guarantor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE PARTICIPANTS ONLY**

I request that payment of authorized Medicare benefits be made on my behalf to Northern Virginia Neurology for any services furnished to me. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for payable related services. Regulations pertaining to Medicare assignment of benefits apply.

Patient/Guarantor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 12/01/2017 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our office. Information on contacting us can be found at the end of this notice.

**We will keep your health information confidential, using it only for the following purposes:**

**Treatment:** While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

**Disclosure:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

**Right to an Accounting of Disclosures:** You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $.50 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. Please contact our Office for an explanation of our fee structure.

**Right to Request Restriction of PHI:** If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider’s refusal of an individual’s request not to disclose PHI.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on December 01, 2017.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

**Fundraising:** We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

**Sale of PHI:** We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). “Sale of PHI” does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is “a reasonable cost-based fee” to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of “sale.”

**Appointment Reminders:** We may use your health records to remind you of recommended services, treatment or scheduled appointments.

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be a handling fee of $20.00 and an additional $.50 for each page copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Office for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Breach Notification Requirements:** It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

**QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**HOW TO CONTACT US:**

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Phone: 703-494-1111

Fax: 703-494-1141  
Email: [nvaneurology@gmail.com](mailto:nvaneurology@gmail.com)   
Address: 1910 Opitz Blvd. Woodbridge, VA 22191

PRINT PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_=