PATIENT REGISTRATION FORM

NOVA Neurology Center

PATIENT INFORMATION

Last Name	First Name	MI	Gender □ M □ F
Social Security Number	Date of Birth	Marital Status □ M □ S □ W □ D □ SEP	
Race	Ethnicity □ Hispanic □ Non-Hispanic	Language if other than English	
Home Address	E-Mail Address	Pharmacy Name and Address	
	Home Phone		
City / State / Zip	Cell Phone	Pharmacy Phone	
Employer Name and Address	Preferred Method of Communication □ Home Phone □ Cell Phone □ E-Mail	Emergency Contact Name	
	Work Phone	Emergency Contact Phone	
	Primary Physician Name	Referring Physician Name	

Primary Insurance Name	Secondary Insurance Name
Insurance ID #	Insurance ID #
Subscriber's Name & SSN	Subscriber's Name & SSN
Relationship to Patient □ Self □ Spouse □ Child □ Other	Relationship to Patient □ Self □ Spouse □ Child □ Other

RESPONSIBLE PARTY/GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

Last Name	First Name	MI	Gender □ M □ F
Social Security Number	Date of Birth	Relationship to Patient	
Address		Phone Number	

DISCLOSURE TO FAMILY MEMBERS AND FRIENDS

Please list any person that you would like to grant permission to your provider to discuss your Medical Record and/or Plan of Care

Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone

Patient's Signature _____ Date _____

NOVA Neurology Center

FINANCIAL AGREEMENT & RELEASE OF INFORMATION

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by NOVA Neurology center and/or affiliated medical staff member(s) on behalf of myself and/or my minor children, including stepchildren.
The possibility exists (during treatment) for the 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.

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 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 formulary information within the Electronic Medical record in order for drug eligibility and coverage.

PRESCRIPTION HISTORY CONSENT

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

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, judgements 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 fee's costs and interest) due hereunder is to be made to NOVA Neurology Center. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible for any charges not covered by my insurance, including but not limited to co-payments, deductibles and fees for non-covered services.
The patient and/or undersigned guarantor are primarily liable for payment of the patient's account and NOVA Neurology Center will send all appointment reminders and billing information to the person responsible for the payment of my bill.
It is the patient and/or undersigned guarantor's 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 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.
I understand that co-pays, co-insurances and deductibles are due at the time of service. Patients who do not have insurance must pay the self-pay fee at the time of service.
Failure to notify the office 24 hours prior to the appointment time to cancel or re-schedule it will result in a $50.00 charge. The returned check fee is $35.00

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 collateral or contingent promise to answer for the debt of another. If payment is not made, I understand that NOVA Neurology Center may take action to collect its fees. I agree to pay all costs incurred by NOVA Neurology Center for collecting its fees equal to the thirty percent (30%) of the unpaid bill and if applicable, all attorneys' fees.

MEDICARE PARTICIPANTS ONLY

I request that the payment of authorized Medicare benefits be made on my behalf to NOVA Neurology Center 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.

ACKNOWLEDGMENTS

I acknowledge that I have received, have previously received or have been offered but declined to receive the NOVA Neurology Center Notice of Privacy Practices.
By providing my E-mail address, I authorize NOVA Neurology Center to use the address for the purpose of communicating health-related information or services. I acknowledge that I may opt-out of such communication at any time by providing a written notice.
By providing my Cell phone number, I authorize NOVA Neurology center to send appointment reminders and other communications via text message to my cell phone number. I understand that standard text messaging rates from my mobile carrier may apply. I acknowledge that I may opt-out of such communication at any time by providing a written notice.
It is the patient's responsibility to know their insurance carrier's patient responsibilities and procedures. If proper procedures are not followed, the patient may be liable for full payment of the bill. If the insurance carrier requires a referral and/or prior authorization, contact your primary care physician prior to your appointment. The patient is responsible to verify the referral is valid for the initial visit and all the follow-up visits.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND AND AGREE TO THE NOVA NEUROLOGY CENTER FINANCIAL AGREEMENT & RELEASE OF INFORMATION POLICIES IN ITS ENTIRETY.

_____ _____

Patient's Name (please print) **Date**

_____ _____

Signature of Patient/Guarantor **Name of Guarantor and Relationship to Patient** (if not signed by patient)

NOVA Neurology Center

Office Policies

USE OF AI TECHNOLOGY

Our office uses a HIPAA compliant AI-powered scribe to enhance documentation efficiency and accuracy. While every effort is made to ensure that the information is complete and correct, there may be unintentional errors or omissions. All medical decisions are based on the physician's professional judgment.

APPOINTMENTS

Patients are asked to arrive on time for their appointments. If you are more than 15 minutes late, we reserve the right to re-schedule the appointment.

REPEATED MISSED APPOINTMENTS

Although circumstances sometimes prevent timely notice of cancellation, we reserve the right to refuse an appointment to a patient who has an established pattern of missing appointments without providing us with appropriate notice.

PRESCRIPTION REFILLS

We try to prescribe enough medication refills so that you have enough to last until your next scheduled visit. Most medications taken on regular basis require lab tests and/or a follow up visit for safe monitoring. If you do need a refill, we require at least 72 hours notice. Please contact your pharmacy first and they will contact our office for this request.

LABS, IMAGING AND OTHER TEST RESULTS

We ask that you make a follow up appointment to discuss the results of all the tests ordered by our physician.

FORMS AND LETTERS

The following charges will apply to all forms and letter requests:

FMLA ---------- $50.00
Disability ---------- $50.00 and up (depending on complexity)
Letters ---------- $15.00 and up (depending on complexity)
Other forms ---------- $20.00 and up (depending on complexity)

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

By signing below, I acknowledge that I have read and fully understand and agree to the NOVA Neurology Center's office policies in its entirety.

_____
Patient's Name

_____ _____
Signature Date

If signing on behalf of patient please print your name and relationship to patient below:

_____ _____
Authorized Person's Name Relationship to Patient

NOVA Neurology Center

Email Consent Form

1- RISKS OF USING EMAIL

Transmitting patient information by email has a number of risks that the patients should consider before using email. These risks include, but are not limited to, the following risks:

- Emails sent from NOVA Neurology Center ("the practice") are not encrypted, so emails may not be secure. Therefore, it is possible that the confidentiality of such communications may be breached by a third party.
- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email can be received by many intended and unintended recipients.
- Email senders can easily send an email to the wrong address.
- Email is easier to falsify than handwritten or signed documents.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.
- Backup copies of email may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.

2- CONDITIONS FOR THE USE OF EMAIL

The practice cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. The practice and physician are not liable for improper disclosure of confidential information that is not caused by the practice's or physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- **Email will not be used for urgent or emergency situations.**
- The practice cannot guarantee that any particular email will be read and responded to within any particular period of time. Therefore, should you need immediate assistance, please call our office directly.
- If you send an email to the practice that requires a response and one is not given within a reasonable time frame, it is your responsibility to follow up with the practice.
- You should NOT use email in order to make disclosures about sensitive medical information such as: Substance Abuse, Mental Health and AIDS/HIV.
- Office staff may receive and read your messages.
- All emails to/from the practice concerning diagnosis or treatment will be made part of patient's medical record. Therefore, other individuals authorized to access the medical records, such as staff and administrative personnel, will have access to those emails.
- It is patient's responsibility to follow up and/or schedule an appointment if warranted.
- This consent will remain in effect until terminated in writing by either the patient or the practice.

3- INSTRUCTIONS

To communicate by email, the patient shall:

- Take precautions to preserve the confidentiality of email and protect his/her password or other means of access to email.
- Avoid use of his/her employer's computer.
- Inform the practice of changes in his/her email address in writing.

4- PATIENT ACKNOWLEDGEMENT AND AGREEMENT

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the practice, physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the practice may impose to communicate with the patient by email. I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge NOVA Neurology Center and its affiliates, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such email. Any questions I may have had are answered.

_____ _____

Patient's Name Email address

_____ _____

Signature Date

If signing on behalf of patient please print your name and relationship to patient below:

_____ _____

Authorized Person's Name Relationship to Patient

PATIENT REGISTRATION FORM

NOVA Neurology Center

HEALTH HISTORY QUESTIONARE

Name (Last, First ,MI) □ M □ F	DOB
Previous/Referring Doctor	Reason for Today's Visit

List your prescribed drugs and over-the-counter drugs such as vitamins and inhalers

Name of the Drug	Strength of Medication	Frequency taken

List any medical problems that other doctors have diagnosed

Allergies to medications

Name of the Drug	Reaction you had

Surgeries

Year	Type of Surgery and Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

PATIENT REGISTRATION FORM

NOVA Neurology Center

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	□ M □ F	
Mother				□ M □ F	
Sibling	□ M □ F			□ M □ F	
	□ M □ F			□ M □ F	
	□ M □ F		Grandfather Paternal		
	□ M □ F		Grandmother Paternal		
	□ M □ F		Grandfather Maternal		
	□ M □ F		Grandmother Maternal		

HEALTH HABITS AND PERSONAL SAFETY

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed

Alcohol	Do you drink alcohol?	□ Yes □ No	Tobacco	Do you use tobacco?	□ Yes □ No
	If yes, what kind?			□ Cigarettes pks/day	□ Chew #/day
	How many drinks per week?			□ Cigars #/day	□ Pipe #/day
				□ # of years	□ year quit
Drugs	Do you currently use recreational or street drugs?			□ Yes □ No	
	Have you ever given yourself street drugs with a needle?			□ Yes □ No	

WOMEN ONLY

Are you pregnant or breastfeeding?	□ Yes □ No	Number of Pregnancies	Number of live births

SYMPTOMS EXPERIENCED IN THE PAST 6 MONTHS (CHECK ALL THAT APPLY)

Neurological
- □ Headache
- □ Double Vision
- □ Slurred Speech
- □ Imbalance/Unsteady gait
- □ Falls
- □ Abnormal movements
- □ Tremor
- □ Memory loss
- □ Numbness/Tingling
- □ weakness
- □ Seizure
- □ Cramps/Spasms

General
- □ Fevers
- □ Chills
- □ Night sweats
- □ Excessive fatigue
- □ Weight gain/loss
- □ Trouble sleeping
- □ Trouble staying asleep
- □ vivid dreams

Throat/Sinus
- □ Nasal congestion
- □ Sinus pain
- □ Nose bleeds

Eyes/Ears
- □ Visual loss
- □ Blurred vision
- □ Eye pain
- □ Double vision
- □ Hearing loss
- □ Ringing in ears

Psychiatric
- □ Depression
- □ Anxiety
- □ High levels of stress
- □ Hallucinations
- □ Uncontrollable laughter/crying

Cardiac
- □ Chest pain
- □ Palpitation
- □ Syncope/Passing out
- □ Heart murmur

Urinary
- □ Frequency
- □ Incontinence
- □ Urgency
- □ Incomplete bladder emptying

Neck
- □ Neck stiffness
- □ Swollen lymph nodes

Vascular
- □ Swollen leg(s)
- □ Easy bruising or bleeding
- □ Recent Transfusions

GI
- □ Swallowing difficulty
- □ Constipation
- □ Diarrhea

Pulmonary
- □ Shortness of breath
- □ Dry cough
- □ productive cough

Musculoskeletal
- □ Joint pain
- □ Muscle aches

Patient Name: _____ **Date of Birth:** _____

Sleep Schedule

What time do you turn off the lights intending to bed? _____

How long does it take you to fall asleep? _____

How many times do you wake up during night? _____

How long are you awake at night? _____

What time do you wake up in the morning? _____

How long after waking up do you get out of bed? _____

How many hours do you sleep at night in total? _____

Do you feel refreshed in the morning? _____

Depression Screening

Do you feel sad? _____

Do you cry often? _____

Do you feel guilty about the past? _____

Do you have low energy or feel tired? _____

Have you lost interest and pleasure in doing daily activities and hobbies? _____