**NEUROLOGIC ARTS ASSOCIATED, LLC**

**New Patient Information Forms**

**TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

 **(Last name) (First name)**

**Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did, symptoms start: (approx.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height: \_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_ Known Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications & Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**SMOKER: YES: \_\_\_\_\_\_\_NO \_\_\_\_\_\_\_\_ FORMER \_\_\_\_\_\_\_\_ how many years? \_\_\_\_**

**PERSONAL INFORMATION:**

**Gender: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Street Address/ Mailing Address)**

**State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred way to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*You will receive a Patient Portal invite if there is an email on file\*\***

**CREDIT CARD INFO TO KEEP ON FILE FOR ANY COPAYS DUE:**

**NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP:\_\_\_\_\_\_\_\_\_\_\_\_\_ CVC:\_\_\_\_\_**

**Circle the recent test you’ve had done:**

**MRI MRA Cat-Scan Pet-Scan Bone Scan EEG**

 **Carotid Doppler Stress Test Heart Angiogram Spec Scan Labs**

**Flu Vacc: (Inj.or nasal) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia Vaccine/Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COVID VACCINE DATE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BOOSTER DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mr. Mrs. Miss. Miss. Rev. Jr.Sr.**

**Single Married Divorced Separated Widowed Partner Child**

**American Indian Asian White African American/Black**

 **Native Hawaiian/ Other Pacific Islander**

**Highest Education Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Significant Family Health History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any Linguistic / Cultural Barriers: YES NO**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred form of Appointment confirmation: (please check) Email: \_\_\_\_\_\_\_\_\_Call: \_\_\_\_\_\_\_**

**Has the patient had any of the following: (Circle all that apply)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ASTHMA** | **SEIZURES** | **HIGH BLOOD PRESSURE** | **HEPATITIS HIV OR JAUNDICE** | **ARTHRITIS** | **DIABETES** |
| **HEAD INJURIES** | **VISION PROBLEMS** | **HEARING PROBLEMS** | **HEADACHES OR MIGRAINES** | **SHORTNESS OF BREATH** | **JOINT SWELLING** |
| **MUSCLE WEEKNESS** | **NUMBNESS** | **DEPRESSION** | **BACK PAIN** | **SPEECH PROBLEMS** | **NECK PAIN** |
| **INVOLUNTARY MOVEMENTS** | **STROKE SYMPTOMS** | **CONCENTRATION PROBLEMS** | **DAYTIME TIREDNESS** | **FACIAL PAIN** | **BIPOLAR DISORDER** |
| **ANXIETY** | **PHOBIAS** | **MEMORY LOSS** | **PHYCHOSIS** | **SCHIZOPHRENIA** | **PARANOIA** |

***I ALLOW NEUROLOGIC ARTS ASSOCIATED TO LEAVE ME A DETAILED MESSAGE & DEBIT MY CC ON FILE SHOULD I NEED TO BE CONTACTED FOR ANY REASON EITHER FOR MEDICAL OR BILLING PURPOSES.***

**PLEASE NOTE:**

1. **There is a $ 50.00 No Show fee for appointments NOT cancelled within 24 hours. There is a $ 100.00 fee for No Show of any testing NOT cancelled within 24 hours.**
2. **Patients are responsible for having their referral/ authorizations to see our physicians if their insurance requires. Patients will not be refused treatment if they do nothave a referral at the time of visit, however any bills not covered by insurance nor NON-REFERRAL will become the patients’ responsibility. It is the patient’s responsibility to know their plan benefits. *It is NOT the responsibility of Neurologic Arts to know if referrals or out of network authorizations are required.* All insurance plans are different; therefore, the patient assumes responsibility of benefit knowledge. While NAA is participating with most insurance companies, *it is the patient’s responsibility to know if our doctors are PAR and covered by their insurance plan*.**
3. **Patients are responsible for any balance that their insurance does not pay.**
4. **Patients are responsible for knowing & having their co-pay at the time of visit; it is NOT the office staff responsibility to remind the patient of co-pays. A $ 20.00 fee will apply if co-pay is not paid at the time of visit and no fees will be reversed.**
5. **This office is NON-PAR with Medicaid, therefore any balances not paid by primary insurance the patient is responsible. We will NOT send to Medicaid.**
6. **This office conducts urine screenings for all patients that are on controlled/pain medications. If the patient fails, this screening they will be discharged from the practice.**
7. **All prescription refills require a 72-hour notice. NO refill will be honored after 3 pm on Friday or over the weekends. It is the patient’s responsibility to know & monitor their refills.**
8. **Patients will be required to follow a treatment plan for all medications. If appointments are not kept, refills will not be honored, and patient will be discharged.**
9. **Any forms that need to be filled out or completed will have a PRE-PAY fee. See staff for fees.**

**PLEASE SIGN BELOW STATING YOU UNDERSTAND THESE POLICIES LISTED ABOVE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I the undersigned patient, give permission to DR. Yevgeniy I Khesin to evaluate & treat me.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\* ALL NEW PATIENT APPOINTMENTS MUST BE CONFIRMED 24 HOURS PRIOR TO APPOINTMENT OR THEY WILL BE CANCELLED \*\*\***

**NOTICE OF PRIVACY PRACTICE IN COMPLIANCE WITH HIPAA/HIPAA LAWS**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have been informed by staff, seen a copy of and accept the policy of Neurologic Arts Associated, LLC as far as the notice of privacy practice that are practiced at Neurologic Arts Associated, LLC. (Pamphlet at front desk)**

**I understand that I may ask for a copy of this policy at any time. I understand that I must inform NAA by certified letter stating that I wish NAA to no longer release any of my medical information. I authorize NAA to leave a detailed message either for medical or billing purposes.**

**I authorize NAA to obtain all and any of my medical records including medication records from Sure scripts and NJ/PA PMP aware or from any facility or doctor’s office to assist in my complete medical care. I also understand that if I have seen one of the physicians in the hospital, my records will obtain/ imported into my chart prior to my arrival.**

**I understand that if my insurance requires referral / authorizations or co-pays I will be held liable for any balance due or fees that apply on any bill unpaid by my insurance. I understand that if I see the doctor and they are out of network it is MY RESPONSIBILITY for bill payment. I understand if my insurance does not cover select testing or BOTOX injections or other injectable treatments the balances un-paid are my responsibility*. I understand that if NAA is NON-PAR with my insurance and I decide to be seen it is MY responsibility for all balances due within 3 months of service. It is my responsibility to know provider participation for my health care plan.***

**I understand any balances on my account must be paid in full within 3 months of my original date of service or my account defaults to a collection agency and all future appointments will be rescheduled until account is paid in full. I authorize NAA to leave a detailed message for billing purposes.**

**I understand I must allow 30 business days for medical records to be released to me. I also understand Neurologic Arts will not mail records they are to be picked up by me or an authorized representative. I also understand that Neurologic Arts will send my most recent consult & test to only an authorized requesting doctor, and it is my responsibly to obtain ALL my records.**

**I authorize Neurologic Arts to debit my credit card I have provided on file for any co-pays my insurance may require or balances past 60 days old.**

**PLEASE SIGN BELOW STATING YOU UNDERSTAND THESE POLICYS LISTED ABOVE.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA Authorization Form for Family Members/Friends**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to Neurologic Arts Associated, LLC providers to disclose and release my protected health information described below to:

**Name(s): Relationship:**

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

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

**Health Information to be disclosed (Check all that applies):**

**\_\_\_\_\_** My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) this may include phone calls to and from the physician.

\_\_\_\_\_ My complete health record, as above, with the exception of the following information:

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

**Other (please specify)**

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

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

 **This authorization shall be effective until (Check one):**

\_\_ All past, present, and future periods.

\_\_ OR until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ unless I revoke it.

 (You must revoke this authorization in writing.)

**X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(**Name of the Individual Giving this Authorization (please print)

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of the Individual Giving this Authorization