Carolina Neurological Clinic, PA

CAROLINA NEUROLOGICAL CLINIC, PA
PEDIATRIC NEUROLOGY

Dear Parents:

Pediatric Neurology new patient evaluations are quite detailed and require information from other related professionals. It is essential that prior evaluations from Neurosurgery, Ophthalmology, Psychology, school educational testing, and other Neurologists be PRESENT at the time of your new patient visit.

Although you may have signed a release for such information to be mailed to our office, there is often a lag between your scheduled new patient visit and the time that this information arrives. This significantly reduces the accuracy and value of your first visit with our Pediatric Neurologists or Pediatric Nurse Practitioner.

Parents, therefore, must take responsibility to have this information present.

Many families have waited long periods for new patient evaluations, but if the proper information is not PRESENT at the time of your first visit, your provider may choose to have you reschedule your appointment until the appropriate information is available.

Thank you for your cooperation.

Yours truly,

Teresita Y. Nelson, MD

Usha Dayal, MD

Rev 3/07

Mailing Address: Carolina Neurological Clinic, PA / PO Box 221009 / Charlotte, North Carolina 28222
☐ 3541 Randolph Road / Suite 101 / Charlotte, North Carolina 28211 / 704-377-9323 / Fax 704-331-4030
☒ 12311 Copper Way / Suite 200 / Charlotte, North Carolina 28277 / 704-541-8788 / Fax 704-541-1069
☐ 10320 Mallard Creek Road / Suite 230 / Charlotte, North Carolina 28262 / (704) 373-5216 / Fax (704) 595-9501

Carolina
Neurological
Clinic, PA

Adult Neurology
Steven F. Putman, M.D.
Steven F. Kamer, M.D.
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William B. Dawson, M.D.
Andrea Diedrich, M.D.
Emeritus
Fred H. Allen, Jr., M.D.
Philip S. Lesser, M.D.

Pediatric Neurology
Teresita Y. Nelson, M.D.
Mandy Bost, CPNP
Usha Dayal, M.D.
Sleep Disorder Medicine
Mark Letica, M.D.
Mary Susan Esther, M.D.
Administrator
David Handy, MBA

Dear Parents of Patients:

Please send all forms completely filled out, back to the clinic for review by the doctor before an appointment will be scheduled.

If available, include.....School report cards
Reports from teachers
IEP'S
Psychoeducational evaluations

Thank you for your cooperation!
Pediatric staff.

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Carolinas Physicians Network

Carolinas HealthCare System

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Carolinas Physicians Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Carolinas HealthCare System and Carolinas Physicians Network participate with **Traditional Medicare (Part A & Part B)** only. We do not accept any Medicare Advantage managed care plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

COMMERCIAL INSURANCES are those plans we do not participate in. You will be responsible for payment in full at the time of service. Since we are non-participants in the plan, we do not accept the Usual & Customary fee. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

MEDICAID may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Indentification Card to each visit. These cards are valid for only one month at a time, so it is very important to bring the current month card to your visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have any insurance coverage**. Self pay patients will be given a 20% discount off the charges for services provided, if the patient pays their bill in full at the time of service. The discount does not apply to billed services. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name _____

Patient/Guardian
Signature _____ Date _____

CAROLINA NEUROLOGICAL CLINIC, P.A.
CONFIDENTIAL MEDICAL HISTORY - PARENTS

CHILD'S FULL NAME: _____ DATE: _____

AGE (Years & Months): _____ BIRTHDATE: _____

REFERRED BY:(name & address) _____

FAMILY DOCTOR or PEDIATRICIAN: _____

HOME TELEPHONE: _____ BUSINESS PHONE: _____

DESCRIBE NATURE OF PROBLEM: _____

_____

_____

MEDICATIONS AND DOSAGE CHILD RECEIVING: _____

_____

REVIEW OF SYSTEMS

Does patient complain of, or indicate presence of:

Headaches: Frequent Severe Yes No (circle)

a. How often? Daily Weekly Monthly Other: _____
b. How long does it last? _____
c. Major pain: Front Back One side All over Other: _____
d. When did they first ever begin? _____
e. How have they changed? _____
f. Do they wake child from sleep? Never Sometimes Often
g. With headache does child have: Nausea Vomiting Blurred Vision
Lost Vision Spots before eyes
h. Have headaches caused school absences? Yes No How many days? _____

If the patient has spells or seizures, is there: (circle)

a warning or aura dizziness numbness a stare
look to one side a fall walk around dazed
jerk or twitch, where _____

Has child recently:

lost weight been nervous been depressed
had fever had crying spells had night sweats

Learning or school problems? Yes No

Repeated grades _____ Clumsiness
Short attention span Difficulty making friends
Can't sit still Difficulty with reading, writing, math
Fights with schoolmates Expelled (when) _____

School grade: _____ School name: _____

Address of school: _____

Teachers: _____

Principal: _____

Previous learning evaluations (with whom, address, dates, telephone): _____

_____

FAMILY HISTORY

Father's name:_____ Age:_____
Highest academic level reached:_____
Mother's name:_____ Age at time of pregnamcy:_____
Highest academic level reached:_____
Number of pregnancies:_____ Number of living children:_____
With whom does child live:_____

If any of the child's relatives have had any of the following conditions, please check the condition and write next to it the relationship to the child (brother, sister, parents, grandparent, uncle, aunt, cousin).

	(relationship to child)
_____ convulsions, spells, seizures	_____
_____ cerebral palsy	_____
_____ hearing loss	_____
_____ mental retardation	_____
_____ speech problems	_____
_____ school difficulties	_____
_____ muscular weakness	_____
_____ deformities	_____
_____ severe visual impairment	_____
_____ alcoholism	_____
_____ emotional problems	_____
_____ headaches	_____

Has either parent had a serious illness? Yes No Specify:_____

PREGNANCY HISTORY

Do you plan to have other children? Yes No
During the pregnancy with this child, did the mother:

	Yes	No	When	Complications and/or Medications
have excessive nausea & vomiting	_____	_____	_____	_____
gain more than 25 pounds or less than 10 pounds	_____	_____	_____	
have RH incompatibility	_____	_____	_____	_____
drink alcoholic beverages (indicate how much)	_____	_____	_____	_____
take medications or drugs other than vitamins and iron	_____	_____	_____	_____
have high blood pressure	_____	_____	_____	_____
have toxemia	_____	_____	_____	_____
have severe headaches	_____	_____	_____	_____
have spotting or bleeding	_____	_____	_____	_____
have any sever accidents	_____	_____	_____	_____
have German measles	_____	_____	_____	_____
have any x-rays taken	_____	_____	_____	_____
have false labor	_____	_____	_____	_____
have a special diet	_____	_____	_____	_____
have unusual physical strain	_____	_____	_____	_____
have unusual emotional strain	_____	_____	_____	_____
have other illnesses or medical problems	_____	_____	_____	_____

If yes, specify:_____

BIRTH HISTORY

Hospital & city where baby was born (Complete address):_____

_____

Length of pregnancy:_____ How long was labor?_____ Was labor induced?_____

Anesthesia given: Yes No Type of anesthesia:_____

Birth was: Normal_____ Caesarian_____ Breech_____ Twins or more:_____

Were forceps used?_____ Did mother have complications? Yes No If yes, specify below:

_____

_____

NEWBORN HISTORY

Birth weight:_____ Was baby in incubator? Yes No If so, how long?_____

Check any of the following which baby had in the first month of life: (circle)

Cyanosis (blue)	Convulsions	Skin rash
Jaundice (yellow)	Infection	Deformity
Injury	Feeding difficulty	Excessive crying

DEVELOPMENT

Language:

Do you feel your child hears: well_____ poorly_____ not at all_____

inconsistently_____ uncertain_____

Does your child communicate mostly by: gestures_____ words_____ crying_____

Specify age child (use "not yet" where appropriate):

made single sounds_____ used words_____ combined words in short sentences_____

Estimate present vocabulary size (circle)

0 words	1 - 15 words	25 - 50 words
50 - 75 words	75 - 100 words	over 100 words

Is your child's speech understandable by you? Yes No Others? Yes No

Did your child begin to use words and then stop? Yes No

Motor Skills:

Specify age at which child (use "not yet" where appropriate):

smiled_____	followed with eyes_____	reached for objects_____
rolled over_____	sat without support_____	crawled_____
pulled to standing_____	stood without support_____	walked alone_____
bladder trained_____	bowel trained_____	went to bathroom alone_____
undressed himself_____	dressed himself_____	buttoned clothes_____
tied shoelaces_____	rode tricycle_____	drew a circle_____

Emotional Growth:

Check any of the following which have been or are problems with this child and indicate age:

	(age)
_____ Difficult to discipline	_____
_____ Gets upset easily	_____
_____ Difficulty paying attention in school	_____
_____ Temper tantrums	_____
_____ Thumb sucking	_____
_____ Difficulty sleeping	_____
_____ Nightmares	_____
_____ Bed wetting	_____
_____ Destructiveness	_____
_____ Preferring to be alone	_____
_____ Unusually active	_____
_____ Unusually inactive	_____
_____ Unusual difficulty in getting along with other children	_____

MEDICAL HISTORY

Check any of the following pertaining to child with age and any complications:

_____ Convulsions	_____	_____
_____ Meningitis	_____	_____
_____ Encephalitis	_____	_____
_____ Injury to head	_____	_____
_____ Fainting spells	_____	_____
_____ Measles	_____	_____
_____ Ear infections	_____	_____
_____ Other infections	_____	_____
_____ Allergies	_____	_____
_____ Heart disorders	_____	_____
_____ Hospitalizations (give details)	_____	_____

_____ Reactions to immunizations (specify)_____

Has the child ever been hospitalized? Yes No If yes, give the names of hospitals and dates of hospitalization:

If there is any specific information which has not been requested on this form but which you think would help us in understanding your child's problem, please add below:

NICHQ Vanderbilt Teacher Assessment Scale

Teacher's Name: _____ Teacher's Phone #: _____ Today's Date: _____

Child's Name: _____ Grade: _____

Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____. Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure.

SYMPTOMS

	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through on instructions and fails to finish school-work (not due to oppositional behavior or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by extraneous stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected.	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor."	0	1	2	3
15. Talks excessively.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting in line.	0	1	2	3
18. Interrupts or intrudes on others (e.g., butts into conversations or games).	0	1	2	3
19. Loses temper.	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules.	0	1	2	3
21. Is angry or resentful.	0	1	2	3
22. Is spiteful and vindictive.	0	1	2	3
23. Bullies, threatens, or intimidates others.	0	1	2	3
24. Initiates physical fights.	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others)	0	1	2	3
26. Is physically cruel to people.	0	1	2	3

NICHQ

-Please Turn Over-

NICHQ Vanderbilt Teacher Assessment Scale

Teacher's Name: _____ Teacher's Phone #: _____ Today's Date: _____

Child's Name: _____ Grade: _____

	Never	Occasionally	Often	Very Often
27. Has stolen items of nontrivial value.	0	1	2	3
28. Deliberately destroys others' property.	0	1	2	3
29. Is fearful, anxious, or worried.	0	1	2	3
30. Is self-conscious or easily embarrassed.	0	1	2	3
31. Is afraid to try new things for fear of making mistakes.	0	1	2	3
32. Feels worthless or inferior.	0	1	2	3
33. Blames self for problems, feels guilty.	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her."	0	1	2	3
35. Is sad, unhappy, or depressed.	0	1	2	3

PERFORMANCE

Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written Expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

SEVERITY OF IMPAIRMENT:

Considering your total experience with this child, how severely impaired is he/she at this time? Compare this child to average normal children you are familiar with from your totality of experience. Please circle the number that best describes this child.

NORMAL, NO IMPAIRMENT 1	Symptoms are not present any more than expected (of a typical child of the same age and gender in the same situations) and do not produce impairment of normal functioning at home or at school.
SLIGHT IMPAIRMENT 2	Symptoms are present a little more frequently or intensely than expected (of a typical child of the same age and gender in the same situations) and only rarely produce impairment of normal functioning at home or school.
MILD IMPAIRMENT 3	Symptoms are present somewhat more frequently or intensely than expected (of a child of the same age and gender in the same situations) and only sometimes produce impairment of normal functioning at home or school.
MODERATE IMPAIRMENT 4	Symptoms are present a lot more frequently or intensely than expected (of a child of the same age and gender in the same situations) and usually produce impairment of normal functioning at home or school.
SEVERE IMPAIRMENT 5	Symptoms are present a great deal more frequently or intensely than expected (of a child of the same age and gender in the same situations) and most of the time produce impairment of normal functioning at home or school.
VERY SEVERE IMPAIRMENT 6	Symptoms are present so much more frequently or intensely than expected (of a child of the same age and gender in the same situations) that they almost always produce impairment of normal functioning at home or school.
MAXIMAL, PROFOUND IMPAIRMENT 7	Symptoms are present so frequently or intensely that they produce significant and pervasive impairment, which creates a crisis requiring immediate action to prevent serious deterioration, to avoid danger, or to prevent harm.

NICHQ Vanderbilt Parent Assessment Scale

Today's Date: _____ Child's Name: _____ Date of Birth: _____ Parent's Name: _____

Each rating should be considered in the context of what is appropriate for the age of your child.
Is this evaluation based on a time when the child _____ was on medication _____ was not on medication.

SYMPTOMS

		Never	Occasionally	Often	Very Often
1	Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2	Has difficulty keeping attention to what needs to be done	0	1	2	3
3	Does not seem to listen when spoken to directly	0	1	2	3
4	Does not follow through when given directions and fails to finish activities (not due to refusal or misunderstand)	0	1	2	3
5	Has difficulty organizing tasks and activities	0	1	2	3
6	Avoids, dislikes, or does not want to start tasks that require ongiong mental effort	0	1	2	3
7	Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8	Is easily distracted by noises or other stimuli	0	1	2	3
9	Is forgetful in daily activities	0	1	2	3
10	Fidgets with hands or feet or squirms in seat	0	1	2	3
11	Leaves seat when remaining seated is expected	0	1	2	3
12	Runs about or climbs too much when remaining seated is expected	0	1	2	3
13	Has difficulty playing or beginning quiet play activities	0	1	2	3
14	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15	Talks too much	0	1	2	3
16	Blurts out answers before questions have been completed	0	1	2	3
17	Has difficulty waiting his/her turn	0	1	2	3
18	Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19	Argues with adults	0	1	2	3
20	Loses temper	0	1	2	3
21	Actively defines or refuses to go along with adults' requests or rules	0	1	2	3
22	Deliberately annoys people	0	1	2	3
23	Blames others for his or her mistakes or misbehaviors	0	1	2	3
24	Is touchy or easily annoyed by others	0	1	2	3
25	Is angry or resentful	0	1	2	3
26	Is spiteful and wants to get even	0	1	2	3
27	Bullies, threatens, or intimidates others	0	1	2	3
28	Starts physical fights	0	1	2	3
29	Lies to get out of trouble or to avoid obligations (i.e., "cons" others)	0	1	2	3
30	Is truant from school (skips school) without permission	0	1	2	3

- Please Turn Over -

Today's Date: _____ Child's Name: _____ Date of Birth: _____ Parent's Name: _____

		Never	Occasionally	Often	Very Often
31	Is physically cruel to people	0	1	2	3
32	Has stolen things that have value	0	1	2	3
33	Deliberately destroys others' property	0	1	2	3
34	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35	Is physically cruel to animals	0	1	2	3
36	Has deliberately set fires to cause damage	0	1	2	3
37	Has broken into someone else's home, business, or car	0	1	2	3
38	Has stayed out at night without permission	0	1	2	3
39	Has run away from home overnight	0	1	2	3
40	Has forced someone into sexual activity	0	1	2	3
41	Is fearful, anxious, or worried	0	1	2	3
42	Is afraid to try new things for fear of making mistakes	0	1	2	3
43	Feels worthless or inferior	0	1	2	3
44	Blames self for problems, feels guilty	0	1	2	3
45	Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46	Is sad, unhappy, or depressed	0	1	2	3
47	Is self-conscious or easily embarrassed	0	1	2	3

PERFORMANCE

		Excellent	Above Average	Average	Somewhat of a Problem	Problematic		
48	Overall School Performance	1	2	3	4	5		
49	Reading	1	2	3	4	5		
50	Writing	1	2	3	4	5		
51	Mathematics	1	2	3	4	5		
52	Relationship with parents	1	2	3	4	5		
53	Relationship with siblings	1	2	3	4	5		
54	Relationship with peers	1	2	3	4	5		
55	Participation in organized activities (e.g., teams)	1	2	3	4	5		

SEVERITY OF IMPAIRMENT:

Considering your total experience with this child, how severely impaired is he/she at this time? Compare this child to average normal children you are familiar with from your totality of experience. Please circle the number that best describes this child.

NORMAL NO IMPAIRMENT 1	Symptoms are not present any more than expected (of a typical child of the same age and gender in the same situations) and do not produce impairment of normal functioning at home or at school.
SLIGHT IMPAIRMENT 2	Symptoms are present a little more frequently or intensely than expected (of a typical child of the same age and gender in the same situations) and only rarely produce impairment of normal functioning at home or school.
MILD IMPAIRMENT 3	Symptoms are present somewhat more frequently or intensely than expected (of a child of the same age and gender in the same situations) and only sometimes produce impairment of normal functioning at home or school.
MODERATE IMPAIRMENT 4	Symptoms are present a lot more frequently or intensely than expected (of a child of the same age and gender in the same situations) and usually produce impairment of normal functioning at home or school.
SEVERE IMPAIRMENT 5	Symptoms are present a great deal more frequently or intensely than expected (of a child of the same age and gender in the same situations) and most of the time produce impairment of normal functioning at home or school.
VERY SEVERE IMPAIRMENT 6	Symptoms are present so much more frequently or intensely than expected (of a child of the same age and gender in the same situations) that they almost always produce impairment of normal functioning at home or school.
MAXIMAL PROFOUND IMPAIRMENT 7	Symptoms are present so frequently or intensely that they produce significant and pervasive impairment, which creates a crisis requiring immediate action to prevent serious deterioration, to avoid danger, or to prevent harm.

CAROLINA NEUROLOGICAL CLINIC, P.A.

NEW_____ UPDATE_____

CHART#_____ **CNC DOCTOR**_____ **DATE**_____

PATIENT LAST NAME_____ FIRST NAME_____ MI.___

ADDRESS_____ CITY_____STATE_____ ZIP_____

SOC. SEC.#__ __ __ - __ __ - __ __ __ __ MARITAL STATUS: S M W D BIRTHDATE _____ _____ _____
MONTH DAY YEAR

SEX: M F HOME PHONE (_____)_____ WORK PHONE (_____)_____

EMERGENCY CONTACT_____ PHONE (_____)_____

PRIMARY CARE PHYSICIAN_____ **REFERRING PHYSICIAN**_____

PARENT/LEGAL GUARDIAN

LAST NAME_____ FIRST NAME_____ MI.___

HOME ADDRESS_____ CITY_____STATE_____ ZIP_____

RELATIONSHIP TO PATIENT_____ HOME PHONE (_____)_____

IS THIS VISIT THE RESULT OF AN ACCIDENT OR INJURY? ☐ YES ☐ NO

ARE YOU CONSIDERING LITIGATION REGARDING THIS ACCIDENT OR INJURY? ☐ YES ☐ NO

INSURANCE (PRIMARY)_____(IF APPLICABLE) CO-PAYS $_____

CLAIMS ADDRESS_____CITY_____STATE_____ ZIP_____

POLICY ID#_____ GROUP ID#_____

PHONE (_____)_____ SUBSCRIBER'S SOC. SEC.#___ ___ ___ - __ __ - ___ ___ ___ ___

SUBSCRIBER'S LAST NAME_____ FIRST NAME_____ MI.___

ADDRESS_____ CITY_____STATE_____ ZIP_____

SUBSCRIBER'S HOME PHONE (_____)_____ RELATIONSHIP TO PATIENT_____

DATE OF BIRTH _____ _____ _____ SUBSCRIBER'S PLACE OF EMPLOYMENT_____
MONTH DAY YEAR

WORK ADDRESS_____ WORK PHONE (_____)_____

INSURANCE (SECONDARY)_____ (IF APPLICABLE) CO-PAYS $_____

CLAIMS ADDRESS_____CITY_____STATE_____ ZIP_____

POLICY ID#_____ GROUP ID#_____

PHONE (_____)_____ SUBSCRIBER'S SOC. SEC.#___ ___ ___ - __ __ - ___ ___ ___ ___

SUBSCRIBER'S LAST NAME_____ FIRST NAME_____ MI.___

ADDRESS_____ CITY_____STATE_____ ZIP_____

DATE OF BIRTH _____ _____ _____ SUBSCRIBER'S PLACE OF EMPLOYMENT_____
MONTH DAY YEAR

WORK ADDRESS_____ WORK PHONE (_____)_____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Carolina Neurological Clinic to release any information acquired in the course of my examination or treatment to insurance carriers, attorneys or agencies involved in the payment of my account. We will file for all hospital related charges and diagnostic testing. Office visits will be filed for patients covered by HMO, PPO, NC Blue Cross/Blue Shield, and Medicare insurance claims only.

PERMISSION TO TREAT A MINOR (UNDER AGE OF 18): In the event of an emergency, and I cannot be contacted, I give my permission to the doctors, or the persons under their instruction, to treat my child in their office or hospital as required by the events of that emergency situation.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Carolina Neurological Clinic for medical benefits.

✓ _____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

One Patient Per Authorization Form

Carolinas HealthCare System - CPN Ongoing Communications Authorization for Release of Health Information Form

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations once it is disclosed.

PURPOSE OF RELEASE: ☒ Ongoing Communication regarding your healthcare.

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:
Facility/Practice Name: _____ **Telephone #:** _____

DATES OF SERVICE, RANGE OF TIME OR EVENT(S): The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s):
From: (MM/DD/YY) Beginning of treatment To: (MM/DD/YY) End of Treatment
This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details** ❑ **Other (Please Specify)** _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ (First) _____ (Middle/Maiden) _____ (Last)

Patient Address: _____ (Street Address/PO Box, City, State, Zip)

Social Security #: _____ **Date of Birth:** _____ **Medical Record/Chart #** _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

RELEASE TO: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

NAME OF MINOR: _____ **SIGNATURE OF MINOR:** _____ **DATE:** _____

Un Paciente Por Formulario de Autorización

Carolinas HealthCare System – CPN Ongoing Communications

Formulario de Autorizacion de CPN para dar a conocer la informacion de salud para comunicacion en curso. Por medio del presente, autorizo el uso o la revelación de mi información de salud identificable como es descrito abajo. Entiendo que si la organización autorizada a recibir la información no es una compañía de seguro o un proveedor de salud, la información entregada podría ya no ser protegida por las regulaciones federales de privacidad una vez sea entregada.

PROPÓSITO DE LA ENTREGA: ☒ Comunicación en curso en cuanto a sus cuidados de salud.

ENTREGA POR PARTE DE: La instalación/consultorio/individuo anotado abajo está autorizado a entregar la información de salud solicitada:

Nombre de la instalación/consultorio: _____ **Número Telefónico** _____

FECHAS DE SERVICIO, MÁRGEN DE TIEMPO, O EVENTOS (S): La instalación/consultorio/individuo anotado arriba está autorizado a entregar la información de salud solicitada anotada abajo para las siguientes: fecha (s) de servicio, márgen de tiempo, o evento (s):

Desde (mes/día/año) Principio del Tratamiento _____ **Hasta (mes/día/año) Final del Tratatmiento** _____

Esta autorización expirará cuando la información de salud solicitada (como está descrito abajo), para la fecha (s) de servicio solicitada, márgen de tiempo, o evento (s) (como está descrito arriba), sea entregada al recipiente nombrado en este documento y el propósito de la entrega sea satisfecho.

MARQUE LA INFORMACIÓN ESPECÍFICA A SER ENTREGADA:

☐ Todos los historiales y detalles ☐ Otros (por favor especifique) _____

Entiendo que la información en mi historial médico puede incluir información relacionada a tratamiento de abuso de droga o alcohol, anemia de células falciformes, insuficiencia psicológica o psiquiátrica, enfermedades por transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA), complejo relacionado al SIDA y/o otros virus de la inmunodeficiencia humana (VIH).

NOMBRE DEL PACIENTE CUYA INFORMACIÓN SERÁ ENTREGADA:

Nombre del Paciente: _____ _____ _____
Primer Segundo/De Soltera Apellido

Dirección del Paciente: _____
(Dirección de Calle-Apdo. Postal, Ciudad, Estado, Código Postal)

Número de Seguro Social: _____ **Fecha de Nacimiento** _____ **Número de Historial/Hoja Médica**_____

Por favor, provea los números telefónicos donde usted está autorizando a CHS a dejar la información del paciente descrita arriba:

Casa: _____ **Trabajo:** _____ **Celular:** _____

ENTREGAR A: Esta información puede ser entregada a y usada por los siguientes individuos/organizaciones. Una autorización aparte debe ser completada si la información entregada o el propósito difieren entre los individuos/organizaciones anotados abajo:

Nombre	Dirección	Número Telefónico/Fax	Parentesco/Relación

DERECHOS Y FIRMA DEL PACIENTE:

- Entiendo que tengo el derecho de revocar esta autorización en cualquier momento al notificar por escrito al Departamento de Registros Médicos ("Medical Record Department") de la organización mencionada arriba. Entiendo que la revocación no se aplicará a la información que ya ha sido entregada en respuesta a esta autorización.
- Entiendo que autorizar la revelación de esta información de salud privada es voluntario y puedo rehusarme a firmar esta autorización.
- Entiendo, según el Anuncio de Cómo Manejamos la Privacidad de CHS, que puedo solicitar para inspeccionar u obtener una copia de la información a ser usada o revelada.
- Entiendo que mi tratamiento no puese ser condicionado por firmar esta autorización a menos que esté siendo tratado para que una tercera entidad pueda recibir mi información de salud, tal como un empleador con una evaluación para regresar al trabajo, una compañía de seguros para eligibilidad, ó un projecto de investigación en el cuál esté participando.

Si el paciente es menor de edad o es incapaz clínicamente de firmar, un representante autorizado puede firmar esta autorización.

NOMBRE EN LETRA DE IMPRENTA (Paciente/Representante Autorizado): _____

FIRMA: _____ FECHA: _____

Si la firma es de un Representante Autorizado, por favor, indique su parentesco/relacion: ☐ Esposo/a ☐ Padre/Madre ☐ Guardián ☐ Testamentario ☐ Apoderado

FIRMA DEL MENOR DE EDAD: Por favor note, si el menor consiente (no hay guardian presente para consentir) para su propio tratamiento por embarazo, enfermedad venérea, o trastorno emocional, el menor debe firmar esta autorización. Cuando el paciente es un menor siendo tratado por abuso de drogas o alcohol, el menor debe firmar esta autorización, sin importar quien consintió para el tratamiento.

NOMBRE DEL MENOR: _____ **FIRMA DEL MENOR:** _____ **FECHA:** _____

Carolinas Physicians Network

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

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

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar:_____