Notice to patients

Effective January 1, 2018
Self-Pay patients or high deductible plan patients will be required to pay a deposit
of $50.00 prior to seeing the neurologist.

Upon check-out, the remaining visit balance up to 70% will be due for self-pay patients.

Thank you for choosing Carolina Neurological Clinic
No Show Policy:

1. The patient will be considered late if they are 10 minutes over their scheduled appointment time.
2. After 10 minutes, the patient will be no-showed after double-checking the waiting area to ensure patient is not waiting or in the process of checking in with another staff member.
   - If a patient arrives after 10 min or more late – the front desk will ask the clinical team and/or the provider to see the patient. If provider agrees, the patient may be seen prior to the end of the morning or afternoon session depending upon the appointment. Patients are offered the choice to reschedule if they don’t wish to wait.
3. For established patients, after the 1st and 2nd no-show in a rolling 12 month period, the office will call the patient to verbalize the policy and the patient will receive a hard copy of the policy for their reference. After the 3rd no-show appointment in a rolling 12 month period, the provider will be consulted for approval and the patient will be dismissed from the practice. If the provider feels circumstances warrant providing the patient with another opportunity to become compliant, that may be noted and the patient will receive another chance.
4. For new patients, they will receive a termination letter immediately after missing their second consecutive new patient appointment.
5. Termination letters are sent by certified mail. The patient will be immediately terminated in the system to prevent future appointments from being made. All future appointment will be cancelled.

Late Cancellation Policy: Patient cancels appointment the same day the appointment is scheduled.

6. Clinical team will be notified (and note placed in comment section of appointment history) so that open visit may be filled.
7. Practice confers with patient to understand circumstances of excessive rescheduled appointments.
8. 2 late cancels in rolling 12 months equate to one “No Show”. (see No Show policy)
9. Termination letters are sent by certified mail. The patient will be immediately terminated in the system to prevent future appointments from being made. All future appointment will be cancelled.

Thank You,
CNC Management
CAROLINA NEUROLOGICAL CLINIC

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 (____)____________________

-OVER-
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
CAROLINA NEUROLOGICAL CLINIC
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 pregnancy: ____________
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).

- 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:

- 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

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

Anesthesia given: Yes No Type of anesthesia: Caesarian Breech Twins or more:

Birth was: Normal Caesarian Breech

Were forceps used? Yes No 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)
- Jaundice (yellow)
- Injury
- Convulsions
- Infection
- Feeding difficulty
- Skin rash
- Deformity
- 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
- 75 - 100 words
- 25 - 50 words
- over 100 words

Is your child's speech understandable by you? 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
- rolled over
- pulled to standing
- bladder trained
- undressed himself
- tied shoelaces
- followed with eyes
- sat without support
- stood without support
- bowel trained
- dressed himself
- rode tricycle

- reached for objects
- crawled
- walked alone
- went to bathroom alone
- buttoned clothes
- drew a circle

Emotional Growth:

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

- Difficult to discipline (age)
- 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
PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Carolinas HealthCare System Medical Group 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 HealthCare System Medical Group participate with Traditional Medicare (Part A & Part B) and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for-Service 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 and a limited number of PFFS, 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.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. 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 not be accepted by your provider. Please check with your provider’s office before making an appointment. If your provider does accept Medicaid, you will need to bring your current Medicaid Identification Card to each 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 insurance coverage. Self pay patients will be given a 30% discount off the charges for services provided and are expected to pay a minimum of $50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/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

**Directions to our Randolph Road location**

From the north
Depart I-77 South / US-21 South
At exit 9, take ramp right and follow signs for I-277 North / US-74 East / W John Belk Freeway
At exit 2A, take ramp right for Kenilworth Ave toward Third Street / Fourth Street
Keep straight into Charlottetown Avenue
Turn right onto E 4th Street
Road name changes to Randolph Road
Arrive at 3541 Randolph Road Ste 101
*(If you reach Meadowbrook Road, you have gone too far)*

From the south
Depart I-77 North / US-21 North
At exit 9, take ramp right and follow signs for I-277 North / US-74 East / W John Belk Freeway
At exit 2A, take ramp right for Kenilworth Ave toward Third Street / Fourth Street
Keep straight into Charlottetown Avenue
Turn right onto E 4th Street
Road name changes to Randolph Road
Arrive at 3541 Randolph Road Ste 101
*(If you reach Meadowbrook Road, you have gone too far)*

**Directions to our Ballantyne location**

From I-77
Take I-485 east traveling towards Pineville-Matthews area
Take exit 61, Johnston Road
Make a left onto Johnston Road
At 1st traffic light North Community House Rd., make a left into our business complex
Bear left at water fountain and we are the next building on you left. Circle to front of building for entrance.
Arrive at 12311 Copper Way, Suite 200  *(We are next door to the 3 story LA/Fitness gym)*

From I-85 East
Take I-485 to exit 61A, Johnston Road (this exit bears you off to the right onto Johnston Rd.)
Immediately merge into the far left turning lane
At the next stoplight North Community House Rd., make a left into our business complex
Bear left at water fountain and we are the next building on the left. Circle to front of building for entrance.
Arrive at 12311 Copper Way, Suite 200  *(We are next door to the 3 story LA/Fitness gym)*

**Telephone number** 704-377-9323

Fax number to our Randolph location ~ 704-331-4030
Fax number to our Ballantyne location ~ 704-541-1069