Carolinas HealthCare System

Carolina Neurological Clinic

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

Carolinas HealthCare System

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

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**

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 <u>to the child</u> (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	_____

Carolinas HealthCare System

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 _____

Carolinas HealthCare System

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