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**

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

FULL NAME: ______________________ DATE: ______________________
AGE: __________ BIRTHDATE: ______________ OCCUPATION: ______________________
REFERRED BY:(name & address) ______________________
FAMILY DOCTOR:(name & address) ______________________
MARITAL STATUS: Single Married Separated Divorced Widowed HANDEDNESS: Right Left
WRITE A BRIEF DESCRIPTION OF THE PROBLEM FOR WHICH YOU ARE BEING SEEN: ______________________

____

____

Leave Blank Chief Complaint:

MEDICATIONS

Are you presently taking: (circle)

Dilantin	Birth control pills	Insulin, diabetic pills	Thyroid
Barbiturates	Blood pressure pills	Iron, poor blood meds	Water pills
Sleeping pills	Aspirin, Bufferin	Weight reducing pills	Shots
Phenobarbital	Cortisone	Blood thinning pills	Antibiotics
Tranquilizers	Digitalis	Hormones	Laxatives

List any other medications: ______________________
List any drugs to which you are allergic, or other allergies: ______________________

____

PERSONAL HABITS

YES	NO	Do you smoke?	Cigarettes Pipe Cigars (please circle)		
			Daily Amount: __________ How Long: __________		
YES	NO	Do you drink:	Alcohol	Daily Amount: __________	How Long: __________
YES	NO	Do you drink:	Beer	Daily Amount: __________	How Long: __________
YES	NO	Do you drink:	Coffee	Daily Amount: __________	How Long: __________
YES	NO	Do you drink:	Tea	Daily Amount: __________	How Long: __________
YES	NO	Do you drink:	Soft Drinks	Daily Amount: __________	How Long: __________

PAST MEDICAL HISTORY

List any operations you have had including dates: ______________________

____

List any other hospital admissions, dates, diagnoses: ______________________

____

Other serious illnesses (not requiring hospitalization) with dates: ______________________

____

Serious injuries or accidents with dates: ______________________

____

Circle if you have had: Diabetes Anemia Thyroid trouble Stroke None
Other Medical History: ______________________

____

FAMILY HISTORY

FAMILY	AGE	AGE AT DEATH	CAUSE OF DEATH	HAS ANY BLOOD RELATIVE HAD:	
Father				Diabetes	______
Mother				Heart trouble	______
Brothers				High Blood Pressure	______
# living		■		Stroke	______
# dead				Cancer	______
				Epilepsy	______
Sisters				Migraine headaches	______
# living		■		Sick headaches	______
# dead				Nervous breakdown	______
				Asthma	______
Husband/Wife				Bleeding tendency	______
# sons				Stomach ulcers	______
# daughters				Kidney disease	______
				Your same problem	

REVIEW OF SYSTEMS

INSTRUCTIONS: Circle YES or NO for each section and indicate when the problem first began.

DO YOU NOW OR DID YOU IN THE PAST HAVE TROUBLE WITH:

HEADACHES? - Frequent of Severe NO YES

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 you from sleep? Never Sometimes Often
g. With headache do you have? Nausea Blurred Vision Lost Vision
Vomiting Spots before Eyes Numbness

PASSING OUT - FAINTING - CONVULSIONS - SEIZURES? NO YES

a. How often? Daily Weekly Monthly Other:______
b. When in the day do spells usually occur?______
c. With spells do you: Fall Get Stiff Bite Tongue Shake
Jerk Turn Blue Make Noise Lose Control of Kidneys

TROUBLE WITH EYES? NO YES

a. Loss of vision: One eye Both eyes Painful Only Blurred
b. Double vision: Objects are separated - Up Down Sideways
c. Lid droops: Right Left Both
d. Do you wear glasses: NO YES

TROUBLE WITH HEARING? NO YES

a. Noises or ringing in ear: How long______ Right Left Both
b. Loss of hearing: How long______ Right Left Both

DIFFICULTY WITH?

Eating Drinking Tasting Hoarseness Swallowing
Chewing Smelling Choking No of These

DIZZY SPELLS? NO YES

a. How often? Daily Weekly Monthly Other:______
b. With dizzy spells are you: Nauseated Sweating Numb
Pale Short of Breath Anxious
c. With dizzy spells do you: Lose hearing Hear roaring Feel faint
See double Have slurred speech
d. What makes you dizzy: Standing up Lying down Turning over

HAVE YOU EVER HAD THESE PROBLEMS? NO YES

a. Lost the use of: Arm Leg (Right / Left)
b. Been numb in: Arm Leg (Right / Left)
c. Had trouble with talking: Lost ability to talk - Express self
d. Had trouble: Saying words Thinking of words Concentrating Thinking Memory Pronouncing words
e. Had trouble with: Walking Writing Tremors Coordination

TROUBLE WITH HEART OR LUNGS? NO YES

Heart trouble
High blood pressure
Swollen ankles
Palpitations
Heart skipping
Chest pain
Chronic cough
Spitting up blood
Shortness of breath
Leg cramps with walking

STOMACH TROUBLE? NO YES

Poor appetite
Stomach pain
Ulcers
Liver trouble
Nausea
Vomiting
Diarrhea
Vomiting blood
Blood in stools
Hemorrhoids
Change in bowel habits
Black bowel movements
Ribbon-like stools
Constipation

TROUBLE WITH KIDNEYS AND GENITAL ORGANS? NO YES

Prostrate trouble
Pus in urine
Dribbling
Burning
Impotence
Voiding frequently
Loss of kidney control
Trouble starting kidneys
Blood in urine
Kidney stones

TROUBLE WITH BONES AND JOINTS? NO YES

Back pain: Worse with cough Sneeze Going into legs Right / Left
Neck pain: Going into arms Going into fingers Right / Left
How long?____________________
Swollen or tender joints?____________________ Which?____________________

TROUBLE WITH SKIN? NO YES

Rash Lumps Birthmarks None Other:____________________

HAVE YOU RECENTLY? Lost weight Been depressed Had fever Been nervous Had crying spells Had night sweats None

TO BE ANSWERED BY WOMEN ONLY:

How many pregnancies?__________ Date of last PAP Test?____________________
How many children born alive?__________ Any breast or nipple discharge?__________
Any complications of pregnancy?____________________
Have you ever had bleeding between periods? NO YES When?__________

PE	Possible Diagnosis	Plan

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 ______________

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: ______________________________