GARDENS NEUROLOGY – NEW PATIENT INFORMATION PACKET (PLEASE PRINT CLEARLY)

First name:________________________ Last name:_________________________________ Date of Birth:____________

Email (in all caps please):____

Gender: M F X Race:____________ Ethnicity:_______________ Language: English Other:____________________

Occupation:__________________________________ Social Security #:____

Home Address:______________________________ City:____________________________ State:______ Zip:________

Primary phone #:________________________ Cell phone #:_________________________ Alt. phone #:_____________

Primary care physician:___________________________ Primary care physician's phone #:_________________________

Referring physician:_____________________________ Referring physician's phone #:____________________________

Spouse/Other name:_____________________________ Phone #:_____________________ Email:_________________

Emergency contact person name:___________________________ Phone #:_____________________________________

Pharmacy Name:___________________ Address:______________________________ Phone #:_____________________

Is this visit due to an auto accident/work related injury/worker's comp case? Y N

Is there any current litigation, or potential litigation involved? Y N

Have you seen a neurologist before? If so, who and when:____

By signing below, I certify that the information in this packet is correct. I understand that Gardens Neurology only accepts traditional Medicare, therefore any other policy requires me to be a self-pay patient. I authorize the release of any medical information to any insurance for the purpose of filing my claim and billing (courtesy or Medicare). Any physician that I list as my primary care provider and/or referring physician can provide my records and will receive a copy of the office visit note.

Please note that new patient visits are set up for 50 minutes face-to-face time with the providers while follow ups are set up as 25 minutes face-to-face appointments. One personal chief complaint should be discussed per appointment.

I hereby consent to medical treatment for myself. For any claims filed by the office, I authorize payment to be made directly to Gardens Neurology. I understand that I am financially responsible for any services deemed not covered or denied by my insurance. Any payments (self-pay, deductibles, co-insurance, copays) are due at time of service while membership fees are annual. If I fail to make payments for services rendered, I am financially responsible for any and all costs and fees relating to the collection of my debt. For out of network claims, I will be responsible for the payment up front and will submit and collect on my own unless Gardens Neurology offers the courtesy of submitting such claims on my behalf where the payer might reimburse the providers directly. I understand that I am NOT guaranteed reimbursement upon submission of an our of network claim and I will cover all balances due. Payment plans are not available. In case of my records changing to a different EMR, I give Gardens Neurology permission to transfer my records over. Any EMR that Gardens Neurology chooses, will be where my records will be kept in accordance with HIPAA regulations unless instructed differently by me in a written request. By signing below, I agree to all of the above.

Signature:____ Date:_______________________

If needed, Guardian name:_________________________ Signature:__________________________Date:____________

GARDENS NEUROLOGY – CONTACTING DOCTORS OUTSIDE OF REGULAR BUSINES HOURS

Our providers and staff are here to assist you during business hours. During the regular workweek the office is staffed from 9 am – 4 pm on Mondays through Thursdays, and 9 am – 2 pm on Fridays, however doctor's hours may vary. Patients are encouraged to contact the office staff at any time, during business hours, with any questions and/or concerns that they may have. We recommend that all patients monitor their medications to ensure that they do not run out over the weekend and require refills when the office is not staffed. You may use your portal to reach out to us during the weekend or leave a message on our voicemail. A link to your portal should have already been sent. Using your portal for any information and/or communication is encouraged. All messages will be handled the next business day.

FOR EMERGENCIES CALL 9-1-1 FIRST AND FAST!!

If you have an urgent medical concern that arises outside of our business hours, you may either 1) contact your primary care doctor, 2) go to the nearest urgent care center or 3) go to the nearest hospital/emergency room. Do not hesitate to seek immediate medical care. You should follow up with us upon your discharge if it was recommended that you see a neurologist. If you visited the ER or were admitted to the hospital, you must notify us within 48 hours of your discharge!

IMPORTANT NOTICE TO ALL!

As you get ready to establish a relationship with us, it is crucial that you understand the guidelines we have implemented regarding behavioral expectations. Any negative behavior exhibited by you, or anyone representing you, will not be tolerated and will result in the patient being discharged from our practice. Any verbal abuse, threat, inappropriate language, blatant complaints of dissatisfaction, aggressive manners, and outrageous demands are unacceptable.

YOU ARE INVITED!

You may join our patient portal at any time. It is another way for you to communicate with our office 24/7. This may be a more convenient option to get in touch with us online. Once your chart was created and an appointment was made, a message will be sent to your email on file asking you to sign in to the portal. We recommend that you use this portal as a last resort for communications and encourage you to always call our office first with any questions, issues, comments or concerns. The portal may be used if and when you need a copy of the office visit note for your records or for reimbursement purposes.

I, the undersigned, read this notice and verify that I will respond as explained above.

Signature:_________________________ Print name:____________________________ Date:_________________________

Gardens Neurology - Patient Questionnaire Form

Patient Name:___________________________ Chief Complaint:_____________________ Date:_______

Past Medical History: (please check all that apply)

☐ Diabetes mellitus ☐ Glucose intolerance ☐ Hypertension ☐ Hyperlipidemia
☐ Atrial fibrillation ☐ Coronary artery disease ☐ Coronary angioplasty ☐ Stenting
☐ Coronary bypass surgery ☐ Cardiac valve disease ☐ Pacemaker
☐ CHF ☐ Other cardiac ____
☐ HIV/AIDS ☐ COPD ☐ Asthma ☐ Kidney stones
☐ Hyperthyroidism ☐ Hypothyroidism ☐ Multiple sclerosis ☐ Epilepsy
☐ Stroke(s) ☐ Pulmonary emboli ☐ DVT
☐ Other clotting condition____
☐ Obstructive sleep apnea: using CPAP Y N ☐ Migraine without aura ☐ Migraine with aura
☐ Parkinson disease ☐ Other movement disorder(s) ____
☐ Brain tumor ☐ Peripheral neuropathy ☐ Other neuromuscular condition_____________________
☐ Mild cognitive impairment ☐ Alzheimer disease ☐ Other cognitive disorder___________________________
☐ RLS ☐ Depression ☐ Anxiety ☐ Other neurological/psychiatric condition______________
☐ Cancer (Type[s])_________________________ ☐ Treatments: (circle) radiation / chemotherapy
☐ Other major medical conditions____

Medication List; attach or write below – (Include Medical Marijuana, Supplements, Dosage and Instructions):

____
____
____

Allergies:____

Past Surgeries____

Social History: (please circle)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Alcohol Use:	Never	Rarely	Moderate	Daily	
Tobacco Use:	Never	Previously, but quit		Current packs/day _____	
Recreational Drug Use:	Never	Type/Frequency:_________________________________			

Patient Family History: (please check all that apply)

	Father	Mother	Siblings	Children
Stroke	☐	☐	☐	☐
Migraine	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Dementia	☐	☐	☐	☐
Parkinson’s/Movement disorders	☐	☐	☐	☐
Neuromuscular condition	☐	☐	☐	☐
If deceased, cause of death	__________	______________	__________	______________

Gardens Neurology - Review of Systems

DOB:____________ Date: ____________

Patient Name:____

Weight:__________ Height:___________

Hypertension	Y N
Smoking	Y N
Any falls in the last 12 months?	Y N
↳ If yes to falls, how many falls?	______
were the falls with injury?	Y N

Cardiovascular

Lightheaded or dizziness	Yes
Chest pain or angina	Yes
Palpitations	Yes
Anemia	Yes
Bleeding tendencies	Yes
Shortness of breath	Yes

Constitutional Symptoms

Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Rash or itching	Yes
Thyroid disease	Yes
Change in libido	Yes

Gastrointestinal/Urinary

Rectal bleeding/blood in stool	Yes
Abdominal pain/heartburn	Yes
Painful urination	Yes
Frequent urination	Yes
Incontinence	Yes

Musculoskeletal

Joint pain or swelling	Yes
Muscle weakness	Yes
Muscle pain or cramps	Yes
Low back pain	Yes
Neck pain	Yes

Neurological

Frequent headaches	Yes
Convulsions/seizures	Yes
Numbness or tingling	Yes
Tremors	Yes
Weakness and paralysis	Yes
Stroke	Yes
Traumatic brain injury	Yes
Difficulty walking	Yes
Memory loss	Yes
Daytime sleepiness	Yes
Anxious	Yes

Eyes/ENT

Visual loss	Yes
Double vision	Yes
Hearing loss/ringing in the ears	Yes

Other

____

____

____

Psychiatric

Depression Y N

↳ **If yes, answer questions below**

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself, being a failure, let yourself/your family down	☐	☐	☐	☐
7. Trouble concentrating on things such as reading or watching TV	☐	☐	☐	☐
8. Moving/speaking slowly or being fidgety/restless moving more than usual	☐	☐	☐	☐
9. Thoughts of being better off dead or hurting yourself in some way	☐	☐	☐	☐

GARDENS NEUROLOGY – CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I authorize Gardens Neurology, the use and disclosure, in accordance with HIPAA, of all individual, identifiable, personal health, financial and demographic information (known as Protected Health Information or PHI) for the purpose of: Providing medical treatment, obtaining payment and reimbursement, obtaining authorization for tests, requesting medical information from other providers, cooperating with other providers in my medical care, fulfilling request for information when specifically authorized by me, as well as all else related to providing healthcare to me. Any doctors I list as my Primary Care Provider and/or referring physician will automatically receive a copy of the office visit note.

The purpose and all other uses are known as collectively Treatment, Payment and Other healthcare options. (TPO). I authorize any physician or healthcare facility to provide upon request any PHI to Gardens Neurology for the TPO. I consent to Gardens Neurology discussing any or all of my medical care, including evaluation, treatment, diagnosis, even if related to psychiatric or psychosocial impairments, substance abuse, AIDS, HIV related infections or pregnancy with:

Name:______________________________ Relationship:_______________________ Phone #:____________________

Name:______________________________ Relationship:_______________________ Phone #:____________________

Name:______________________________ Relationship:_______________________ Phone #:____________________

The persons above are allowed to have conversations with the office and are not automatically provided with records.

I have been given the opportunity to review Gardens Neurology's Privacy Notice posted in the waiting room.

By signing below, I consent to Gardens Neurology leaving messages on my answering machine and sending me emails.

I understand my rights to restrict the use and discloser of PHI and may revoke this consent in writing at any time.

I understand that should I choose not to consent to the terms & conditions of Garden Neurology's privacy notice, I will provide a written request and the practice has the right to withhold treatment except where required by law.

A note to **NEW Medicare patients** regarding potential membership enrollment, (**NOT** applicable to self-pay patients):

Since all new patients fill out this form, it is impossible for us to predict whether your medical needs and neurological issues will be resolved in the next appointment or within the next few weeks, months or even years. Our dedication is such that we will provide you with the best medical services regardless of whether you are a "one timer" or become a life-long patient. Once you have been established for 4 months, and your plan of care has been determined and presented to you by your provider, you will be given the opportunity to remain a patient in our practice, therefore continue to receive care, for an annual membership fee, or choose to go elsewhere for your follow-up neurological care. This membership provides patients access to our office staff and providers along with other enhanced benefits. If you choose to remain in our practice, an annual membership fee will apply and an agreement will be reviewed and signed by you in a few months. If you choose to go and seek treatment elsewhere, your chart will be sent to the doctor of your choice upon receiving a written request from you. This transfer of records by fax to your new provider will be at no additional cost to you. Membership dues are not extended to self-pay patients since their self-pay rate includes the membership cost.

Patient's name (please print):________________________ Signature:________________________ Date:___________

Guardian's name and signature (if needed):____ Date:___________

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 prohibits the use and discloser of protective health information for the treatments, payments and other healthcare operations without a signed consent and prohibits the use and discloser of protective health information for non-healthcare related activities without specific and explicit authorization. The signature above allows Gardens Neurology, with your permission, to use this information for the sole purpose of medical treatment in our facility. In the case of an EMR migration, this signature will authorize the transfer of information from one carrier to another.

GARDENS NEUROLOGY – STATEMENT OF PATIENT'S FINANCIAL RESPONSIBILITY

Patient name:____ DOB:__________________________

The staff at Gardens Neurology will verify your coverage, but we are only contracted with the traditional, government issued Part B Medicare plan. Due to this credentialing setup, you are in charge of confirming whether this visit, or visit type, is covered. You are ultimately the one who should verify benefits (in and out-of-network) and you will be responsible for payment in full if services are denied for any reason whatsoever. If you have a Medicare advantage plan, you will be a self-pay patient for all your new and follow-up visits with our providers, and then you may submit for reimbursement. We cannot guarantee that you will be reimbursed, but we will do our best to assist you with documentation. Direct billing for testing performed by our nurse practitioner will be done as a courtesy to you, but following any denials, full payment is your responsibility. Due to this uncertainty, your credit card number may be kept on file to bill for any denied services after an attempt has been made to collect. You must pay in full any balance due after payment has been made, or denied, by your insurance. The same applies to secondary coverage: Any balances due from denials by secondary insurances, become the patient's responsibility for payment. If your balance due is over 90 days, we may cancel your next appointment and send your account to collections. Agency fees may be added to your account if the balance was successfully collected by the agency. Medicare patients' membership fees are NOT covered by any insurance. Signing this form authorizes Medicare to pay any in-network benefits directly to Gardens Neurology. At this time, we cannot offer any payment plans.

Deductibles, Co-pays and Co-insurance Policies

Some policies, including Medicare, require a deductible payment, a co-pay or co-insurance. It is expected, and appreciated, that those payments will be made upon arrival in our office. Because we are specialists, some diagnostic procedures are not considered part of your office visit co-pay and may be applied towards your deductible and/or co-insurance. Please check with your payer ahead of time to ensure you understand your coverage. Since we can not predict a patient's deductible responsibility, your credit card number will be kept for payment in the beginning of each calendar year.

Cancellation and/or No-Show Policy

You must notify the office **MORE THAN 2 BUSINESS DAYS** in advance of any changes to your appointment date and time (reschedule or cancel). Failure to do so will result in a $100 fee for new patient appointments and testing, and a $75 fee for follow ups. We always attempt to confirm with you by phone, email and text (charges may apply), therefore we ask that you contact us IN-PERSON to let us know if you are coming or rescheduling. In the event that we were unable to reach you to confirm your appointment for the next day, we will assume you are not coming and will assign your time slot to the next waitlisted patient. In that case, you will be bumped to the next available opening. Such changes by the office will not be subject to a fee. Remember, the appointment was YOUR choice of date and time. If you no-showed after confirming an appointment, this fee must be paid in order to reschedule any future appointments and continue care.

Self-Pay

By signing below, you understand that we DO NOT participate with any insurances other than Government issued Medicare part B (NO Medicare advantage plans either). The self-pay rate is collected prior to each and every visit (it includes the membership fee) and the prices are posted for your review. You agree to pay the full amount for each visit and treatment at the time of your visit. Forms for self-pay patients will be provided at each visit per state and federal laws. You should also know that any reimbursements to you from your out-of-network payers will not cover the entire cost of the visit.

I understand that as a self-pay patient some imaging, bloodwork, therapies and/or medications may not be covered. I understand that Gardens Neurology will do their best to provide information for coverage, however any unpaid portions of such medications and tests are the patient's responsibility to pay. I have read the above policy regarding my financial responsibility to Gardens Neurology. This financial responsibility form supersedes any prior signed documents which are now null and void and are no longer in effect.

Patient/Guarantor Signature:____ Date:___________________

Patient Name:___________________________ Chief Complaint:___________________ Date:_______

You may use this sheet for any additional information such as medications or other issues you would like to bring to our attention:

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