Neurological Associates of Augusta, P.C.

1210 Roy Road
Augusta, GA 30909
Ph: (706) 860-6515 Fax: (706) 860-1225

Last Name: _____ **First Name:** _____ **MI:** _____

Soc. Sec. #: _____ **Date of Birth:** _____ **Age:** _____

Marital Status: Married / Single / Divorced / Widowed / Separated **Sex:** Male / Female

Race: American Indian / Asian /Asian Indian / African American / Caucasian / Hispanic / Other: _____

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

Email Address: _____

Street Address: _____ Apt/Lot #: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____

Work Status: Employed / Self-Employed / Active-Duty Military / Student / Retired / Disabled / Not Employed

Employer: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ **Primary Care Physician:** _____

Other Physician(s): _____ _____ _____

Reason for Visit: _____ **Date of First Symptom(s):** _____

Were You Injured: No / Yes If Yes, please specify: On the Job / Auto Accident / Other: _____

Spouse/Parent/Guardian Name (if applicable): _____

Soc. Sec. #: _____ Date of Birth: _____ Relationship: _____

In case of emergency, please notify (other than spouse):

Name: _____ Phone #: _____ Relationship: _____

CONSENT FOR EXAMINATION/TREATMENT: I HEREBY AUTHORIZE AND CONSENT TO SUCH EXAMINATIONS AND TREATMENTS BY NEUROLOGICAL ASSOCIATES OF AUGUSTA, PC AS MAY BE ORDERED BY THE DOCTOR IN CHARGE OF THIS CASE.

_____ _____ _____

Signature of Patient or Legal Representative **Printed Name of Patient or Legal Representative** **Date**

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I understand that as part of my healthcare, Neurological Associates of Augusta, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care and treatment.

I am aware that I may review and/or ask for a copy of the current privacy practices in accordance with Neurological Associates of Augusta, PC's access policies. I further understand that Neurological Associates of Augusta, PC reserves any right to make periodic changes to these practices and I may obtain a copy at any time at the front desk of the office.

I acknowledge that it is my right to request that Neurological Associates of Augusta, PC restrict how my personal health information is used or disclosed. However, I recognize that the information released to the person(s)/organization(s) of my authorization may be re-disclosed by those parties and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Neurological Associates of Augusta, PC in writing. If I do choose to revoke this authorization, it will not have an effect on any actions taken before the office received the revocation.

Neurological Associates of Augusta, PC does not limit its right to the disclosure of your information in the event that the disclosure is required to avoid a serious threat to the health or safety to the public, or in the event that the information is required by law.

Please list below the name, relationship, and phone number of individuals that we may communicate with regarding your personal health information.

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. NEUROLOGICAL ASSOCIATES OF AUGUSTA, PC WILL NOT CONDITION THE TREATMENT OF PATIENT ON THE PROVISION OF THIS AUTHORIZATION.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient Patient's Date of Birth

_____ _____
Printed Name of Patient's Legal Representative (if applicable) Relationship of Representative

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FINANCIAL POLICIES

INSURANCE INFORMATION

Patient Name: _____ Patient DOB: _____

Primary Insurance: _____ ID# _____ Group # _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____ ID# _____ Group # _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Worker's Compensation Company: _____ Claim #: _____

CANCELLATION & NO SHOW POLICY

Our office strives to make patient care a top priority and thus does not double/over book appointment times. An integral part of providing our patients with the best care possible is patient compliance with appointments. If you must cancel or reschedule your appointment, we ask that you please contact our office ***at least 24 hours prior to your appointment time or on Friday at 11AM for any Monday appointments***. A no-show fee will be assessed to the patient's account if 24 hours (or on Friday as above for a Monday appointment) is not provided for cancellation or if an appointment is missed with no notification. Multiple no shows or same-day cancellations will result in higher no show charges for each missed appointment and may result in dismissal from the practice.

- There is a $50 charge for a missed/same day cancelled Initial visit to establish care. If a second initial visit is missed or same day cancelled the appointment will not be rescheduled.

- There is a $75 charge for a missed/same day cancelled EMG appointment.

- There is a $25 charge for the first missed/same day cancelled Return appointment.
- There is a $50 charge for the second missed/same day cancelled Return appointment.

- If a third appointment is missed/same day cancelled, the patient may be considered noncompliant with follow-up, which may result in dismissal from the practice.

No show fees are considered the responsibility of the patient and will not be billed to insurance companies or other medical billing agencies. All no show fees must be paid in full before another appointment can be scheduled. Payments can be made in the office, over the phone with a credit/debit card, or mailed to the office. Once payment is received we are happy to reschedule an appointment for the first available time with your physician. We appreciate your understanding and cooperation with this policy.

Please initial and date: _____ (_____/_____/_____)

PAYMENT POLICY

We file your insurance claims as a courtesy to you. Your insurance is a method of reimbursement for physician services. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, co-payment, non-covered services, and any other balance not paid by your insurance. Our office asks that the amount left to patient responsibility be paid at the time services are rendered. Any additional balances not paid by the insurance company are ultimately the responsibility of the patient. Any balances left to patient responsibility are expected to be paid within 30 days of receipt of the first account statement for that balance. ***After the first statement a rebill fee of $5 will apply to each statement sent.***

After 60 days past due this new balance as well as any no-show fees will be forwarded to an outside collection agency. All additional costs incurred due to the delinquency of the account are the patient's responsibility. These costs may include billing fees and collection agency cost which may exceed 50 percent of the balance, and/or attorney fees if applicable. The patient must then contact the agency rather than the office for any further payment arrangements. Patients who provide checks with insufficient funds will incur a fee of $35 and will no longer be permitted to pay by personal check.

Please initial and date: _____ (_____/_____/_____)

FORMS AND DOCUMENTATION

We understand that your place of employment or other agency may require that you provide documentation outside of the clinical office note. We are happy to complete these for you but please understand that we do charge a fee starting at $25 based on the length of the form and the time anticipated to complete it. Please allow at least 7 days for this process. There are some forms we will be unable to complete. Please direct all forms to the front desk rather than the physician. Thank you for your understanding.

Please initial and date: _____ (_____/_____/_____)

Please sign below to verify that you have read and understand our financial and no show policies.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient Patient's Date of Birth

_____ _____

Printed Name of Patient's Legal Representative (if applicable) Relationship of Representative