NEUROLOGY SERVICES, INC.
www.neuro-doc.com

P.G. Bernad, MD, MPH, FACP
Medical Director

NEW PATIENT FORM

Today Date:_____

PT:LAST_____**FIRST**_____**MI**_____

PT'S SSN #: _____**PT'S DOB**: _____**AGE**: _____ **SEX**: M or F **STATUS**: S M D W

HOME ADDRESS: _____
(# Street) (City) (State) (Zip)
PT'S (H) PHONE: ( )_____ **PT'S (W) PHONE**: ( ) _____ EXT_____
PT'S CELL PHONE ( )_____ **PT'S EMPLOYER:** _____
LOCAL PHARMACY NAME/PHONE NUMBER:_____

PT EMAIL:_____ REFER BY_____
EMERGENCY CONTACT W/CELL #:_____

Guarantor Information (Responsible Party)

LAST NAME: _____ **FIRST NAME**: _____ **MI** ____

HOME ADDRESS: _____
(# Street) (City) (State) (Zip)
HOME PHONE: ( )_____ **WORK PHONE**: ( ) _____ EXT_____
CELL PHONE: ( )_____RELATIONSHIP TO PATIENT: _____
DOB:_____**SOCIAL SECURITY NO.** _____

INSURANCE INFORMATION (FOR PLANS WE PARTICIPATE WITH ONLY)

PRIMARY INSURANCE: _____

POLICYHOLDER'S NAME: _____ **DOB:**_____ **SSN:**_____

POLICYHOLDER'S ADDRESS: _____
(if different from patient/guarantor – required by ins co)
POLICY NUMBER: _____ **GROUP NUMBER**:_____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER_____

SECONDARY INSURANCE (ONLY IF WE PARTICIPATE):_____

POLICYHOLDER'S NAME: _____ **DOB:**_____ **SSN:**_____

POLICYHOLDER'S ADDRESS: _____
(if different from patient/guarantor – required by ins co)
POLICY NUMBER: _____ **GROUP NUMBER**:_____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER_____

Authorization for Assignment of Benefits / Release of Information/ Financial Agreement

I authorize Neurology Services, Inc to apply for benefits from my insurance carrier and further authorize payment directly to Neurology Services, Inc. for the medical and/or mental health benefits, if any, otherwise payable to me for services rendered by Neurology Services, Inc. I understand that this service is available for health plans that Neurology Services, Inc. participates and will only be submitted for the primary insurance plan unless my primary plan is Medicare. I further authorize the release of medical/mental health information required by my insurance carrier or its designated review agent, required for payment, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of Neurology Services, Inc. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by the insurance carrier at any time in writing. **I hereby assume financial responsibility for and agree to make payment in full to Neurology Services, Inc**. **for all charges for services provided to the above-named patient not otherwise authorized or paid by my insurance carrier**. Payment is to be made within fourteen (14) days as statements are presented with settlement in full, or payment arrangements to be made with Neurology Services, Inc. I certify that the information given is true, accurate, and complete to the best of my knowledge, and further authorize Neurology Services, Inc. to investigate any and all information given concerning this or related claims

Policies and Procedures

LATE CANCELLATIONS/ MISSED APPOINTMENTS POLICY:

If you cancel your appointment without 24 (twenty-four) hour notice, or do not show for a scheduled appointment, you will be charged $50 for office visit, All TESTS require 48hrs notice the fee will be for: EEG , NCV/EMG, DOPPLER, TM FLOW, SUDOSCAN, you will be charged $150 for tests scheduled. SLEEP STUDY REQUIRE 48 HR NOTICE OR FEE IS $300. To avoid this charge, you must leave a message on our voicemail which is time stamped

FEES:

At the time of your visit, we will be glad to discuss our fee structure for specific diagnostic/treatment procedures. You will be expected to pay your deductible and/or co-payment at the time of each visit. We will bill your primary insurance carrier if you have signed the authorization section below and if we participate with health plan.

INSURANCE COVERAGE:

We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. If we have submitted a claim to your carrier, we will receive an Explanation of Benefits (EOB) from the plan. Neurology Services, Inc. will use this information to determine your responsibility for full payment. You should review the EOB that is sent to you by the plan carefully. If you feel that they have made in error in administering your benefits, please call them directly to have it corrected. We will use the EOB as a final determination of benefits available. **HMO PATIENTS ARE RESPONSIBLE TO OBTAIN THE REQUIRED REFERRAL FROM YOUR PCP PRIOR TO EACH VISIT.**

PRIVACY NOTICE: My signature below confirmed that I am aware of Neurology Services, Inc. Notice of Privacy Practices.

NOTIFICATION OF CHANGES:

We expect that you will notify our office immediately of changes in the following information:

- Name, address, or phone number changes
- Change in Insurance Carrier
- Change in Primary Care Physician
- Change in marital status

RETURNED CHECKS:

There is a $25 (Twenty-five) charge for any returned check from your bank.

I understand and agree to abide by the above policies and procedures:

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

PLEASE REMEMBER TO SIGN

MEDICAL INFORMATION

1. Current Medications (name, dosage, start date) :

_____

_____

2. List Allergies:

_____

3. List past and present medical problems:

_____

_____

_____

_____

4. List previous hospitalizations:

_____

_____

_____

5. Do you smoke? _____ If yes, how many packs per day? ___ Years? _____

6. Do you drink alcohol/use drugs? ____ If yes, how often _____times per week
Number of beers per week __ Cocktails __ Wine glasses __ Other(what)_____

7. Do you exercise? ____ If yes, how often? _____times per week
What kind of exercise? _____

8. Does anyone in your family have the following? If yes, please describe:

Heart disease	Anxiety
Hypertension	Headaches
Strokes	Gynecological problems
Muscle problems	Urology problems
Joint problems	Thyroid problems
Gastrointestinal problems	Diabetes
Weight problems	Blood problems
Alcohol/ Drug Abuse	Cancer

9. Describe your present concerns. Be specific.

_____

_____

10. How did you learn about our center?

PATIENTS' RIGHTS AND RESPONSIBILITIES STATEMENT:

Statement of Patient Rights:

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other member information kept private.
- Only in an emergency, or if required by law, can records be released without member permission.
- Patients have the right to information from staff/providers in a language they can understand.
- Patients have the right to have an easy-to-understand explanation of their condition and treatment.
- Patients have the right to know all about their treatment options, regardless of cost and whether those options are covered by insurance or not.
- Patients have the right to get information about Neurology Services, Inc. Services and role in the treatment process.
- Patients have the right to relevant information about providers.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide input on Neurology Services, Inc.policies and services.
- Patients have the right to know about the complaint, grievance and appeal process.
- Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process.
- Patients have the right to share in the formation of their plan of care.

Statement of Patients' Responsibilities:

- Patients have the responsibility to give providers information they need. This is so they can deliver the best possible care.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients should not take actions that could harm the lives of Neurology Services, Inc.employees, providers, or other Patients.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Patients have the responsibility to let their provider know about problems with paying fees.
- Patients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.

Signature Name Date

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NOTICE REGARDING OUR YOUNG MD'S OBSERVING/ASSISTING

To our honored patients:

Dr Peter Bernad is a clinical professor of Neurology at George Washington University and as a preceptor for American International Quality Training (AMIQT).
It has been his great pleasure to give back to the next wave of young doctors providing them with an opportunity at his practice to observe and assist with his patients. This allows our young doctors to gain the necessary knowledge so that they may in turn provide the same level of excellence in care to their future patients.

Please know that your experience and privacy is paramount to us here at Neurology Services, Inc. While we would love to have every patient give our young students an opportunity to participate in their care, we certainly understand that some patients may want to see the doctor privately. Please, if for any reason you would be uncomfortable with the young doctors observing/assisting in your care let us know. Please indicate at the bottom of this form if you would like to participate with the young doctors.

Respectfully,

Peter Bernad, MD

I, _____ DOB:_____
Print first and last name

Please X one of the following answers:

_____ Yes, I would like to participate.

_____No, I would NOT like to participate

Signature:_____Date: _____

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COVID 19 SCREENING QUESTIONS

Dear Patient:

You have presented to the office today for medical treatment. While our office complies with the State Health Department and the Centers for Disease Control and Prevention Infection control guidelines to prevent the spread of the Covid-19 virus, we cannot make guarantees.

Our staff members are symptom-free and, to the best of their knowledge have not been exposed to the virus. However, since we are a place of public accommodations, other person's (include other patients) maybe infected with or without their or our knowledge. Be advised, all exam rooms are sanitized with CDC-approval cleaning solutions between patients. All patients, providers, and staff should wear masks during the visit. Frequent handwashing, glove changes and wearing of gloves during examinations are practiced by our providers. We make effort to minimize your time spent in our reception area; if you with, you may wait for your appointment in your vehicle if you advise our receptionist.

In order to reduce the risk of spreading Covid-19, we asked you several screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers. If you are not feeling well today, we as that you reschedule your appointment without penalty.

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Do you have a Fever? _____YES _____NO

Do you have any shortness of breath _____YES _____NO

Do you have a sore throat _____YES _____NO

Do you have chills, heartaches, or muscle pain _____YES _____NO

Do you have any other flu like symptoms _____YES _____NO

Have you recently experienced loss of taste or smell? _____YES _____NO

Covid19 or someone with symptoms of Covid-19 I the past 2 weeks? _____YES_____NO

Within the last 2 weeks have you traveled to a foreign country or outside the Washington DC Area?
If so When and Where? _____ _____YES _____NO

Patient Name and Date of Birth: _____DATE_____

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TEXT MESSAGE-BASED APPOINTMENT REMINDER OPT IN OR OUT

DATE:_____

PATIENT NAME:_____

DATE OF BIRTH:_____

CELL PHONE#_____

_____YES, I OPTIN FOR TEXT MESSAGE-BASED APPOINTMENT REMINDERS

_____NO, I DO NOT WISH TO OPT IN FOR TEXT MESSAGE-BASED APPOINTMENT REMINDERS.

_____
PATIENT SIGNATURE