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**

NEUROLOGICAL ASSOCIATES OF AUGUSTA, P. C.
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Name: _____ DOB: _____ Right / Left Handed

Pharmacy Name: _____ Location: _____ Phone: _____

Medication Allergies: _____ or ☐ No Known Allergies

Occupation: _____ Highest Level of Education: _____

MEDICAL HISTORY: (PLEASE CIRCLE THOSE THAT APPLY TO *YOU*) or ☐ None Apply

Anxiety	Colitis/Crohn's	Heart Attack	Lupus	Sleep Apnea
Arthritis	Depression	Hepatitis	Multiple Sclerosis	Stroke
Asthma	Diabetes	High Blood Pressure	Neck Injury	Thyroid Disease
Atrial Fibrillation	Emphysema/COPD	High Cholesterol	Neuropathy	TIA
Back Injury	Fainting Spells	HIV/AIDS	Pacemaker	Tuberculosis
Blood Clot	Glaucoma	Kidney Disease	Pneumonia	Ulcers
Blood Transfusion	Head Injury	Kidney Stones	Polio	
Cancer (Type: _____)	Headaches	Liver Disease	Seizures	
Cataracts	Heart Disease	Loss of Bowel/Bladder Control	Sickle Cell Disease/Trait	

Other: _____

Have you ever had surgery? ☐ Yes ☐ No (Circle all that apply and give date)

Appendix _____ Back _____ Cataract _____ Gallbladder _____ Gastric Bypass _____

Hernia _____ Heart Surgery _____ Hysterectomy _____ Neck _____ Tonsils _____

Tubal Ligation _____ Other: _____

Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

HEALTH HABITS: (PLEASE CIRCLE THOSE THAT APPLY TO *YOU*)

Cigarette/Cigar Use: ☐ No
☐ Yes: What year did you start & how many packs per day: _____
☐ Past: What year did you stop & how many packs per day: _____

Alcohol Use: ☐ No
☐ Yes: ☐ Rare ☐ Socially ☐ Moderate ☐ Daily

Smokeless Tobacco Products: ☐ No ☐ Yes Quantity: _____ Frequency: _____

Illegal Drug Use: ☐ No ☐ Yes **Caffeine Use:** ☐ No ☐ Yes

HEALTH HISTORY: (PLEASE CIRCLE THOSE THAT APPLY TO *YOUR FAMILY*) or ☐ None ☐ Unknown ☐ Adopted
(M=MOTHER, F=FATHER, S=SISTER, B=BROTHER)

Alzheimer's/Dementia: M F S B other _____

Cancer: M F S B other _____

Diabetes: M F S B other _____

Heart Attack/Disease: M F S B other _____

High Blood Pressure: M F S B other _____

High Cholesterol: M F S B other _____

Migraine: M F S B other _____

Multiple Sclerosis: M F S B other _____

Neuropathy: M F S B other _____

Stroke/TIA: M F S B other _____

Tremor: M F S B other _____

Seizures: M F S B other _____

Mother: ☐ Living ☐ Deceased
Age at Death: _____ Cause: _____

Father: ☐ Living ☐ Deceased
Age at Death: _____ Cause: _____

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NAME: _____ **DOB:** _____

CONSITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight gain	No	Yes
Recent weight loss	No	Yes
Fever, chills, or sweats (circle one)	No	Yes
Fatigue	No	Yes

INTEGUMENTARY (skin/breast)

Rash or itching	No	Yes
Change in skin texture	No	Yes
Change in hair or nails	No	Yes
Varicose Veins	No	Yes
Breast discharge	No	Yes
Dry skin	No	Yes

ALLERGIC/IMMUNOLOGIC

Reaction to foods	No	Yes
Season Allergies	No	Yes
Reaction to drugs	No	Yes
Immune Dificiency	No	Yes
Reaction to Latex	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems	No	Yes
Nose Bleeds	No	Yes
Mouth Sores	No	Yes
Sore throat or voice change	No	Yes
Dentures	No	Yes
Neck stiffness, pain, or tenderness	No	Yes

HEAD/EYES

Frequent headaches	No	Yes
Head Injury	No	Yes
Eye Disease of injury	No	Yes
Cataract …	No	Yes
Vertigo	No	Yes
Vision Change	No	Yes
Blurred Vision	No	Yes
Double Vision	No	Yes
Wear glasses/contacts	No	Yes
Lightheadedness	No	Yes
Glaucoma	No	Yes
Eye pain	No	Yes
Blind spots	No	Yes

CARDIOVASCULAR

Chest pain	No	Yes
Palpitations (heart "fluttering")	No	Yes
Shortness of breath with walking	No	Yes
Swelling of feet/ankles/hands	No	Yes
Heart murmur	No	Yes
High blood pressure	No	Yes
Syncope (passing out)	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Dry Cough	No	Yes
Productive Cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
Snoring	No	Yes
Tuberculosis	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Difficulty swallowing or choking	No	Yes
Abdominal pain	No	Yes
Heartburn	No	Yes
Rectal bleeding/blood in stool	No	Yes
Constipation	No	Yes
Peptic Ulcer	No	Yes

GENITOURINARY

Change in frequency of urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of urine stream	No	Yes
Kidney Stones	No	Yes
Sexual difficulty	No	Yes
Urinary incontinence	No	Yes
Male—testicle pain	No	Yes
Female—painful/irregular periods	No	Yes

Pregnancies _____ # Miscarriages _____ # Children _____

ENDOCRINE

Excess thirst	No	Yes
Heat intolerance	No	Yes
Cold intolerance	No	Yes
Glandular or hormone problem	No	Yes
Diabetes	No	Yes
Change in hat or glove size	No	Yes

MUSCULOSKELETAL

Pain	No	Yes
Weakness	No	Yes
Muscle pain/cramps	No	Yes
Joint pain/stiffness	No	Yes
Back pain	No	Yes
Difficulty in walking	No	Yes
Cold extremities	No	Yes

NEUROLOGIC

Seizures	No	Yes
Stroke	No	Yes
Numbness/tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Loss of memory	No	Yes
Difficulty with speech	No	Yes

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NAME: _____ DOB: _____

PSYCHIATRIC

Depression	No	Yes
Memory loss/confusion	No	Yes
Visual hallucinations	No	Yes
Audio hallucinations	No	Yes
Insomnia	No	Yes
Suicidal thoughts	No	Yes
Previous psychiatric care	No	Yes
Anxiety	No	Yes
Bipolar	No	Yes
Anorexia nervosa	No	Yes
Bulimia	No	Yes

HEME/LYMPHATIC

Easy bruising	No	Yes
History of swollen glands	No	Yes
History of blood clots	No	Yes
Blood transfusions	No	Yes
Slow to heal after cuts	No	Yes
Bleeding tendency	No	Yes
Anemia	No	Yes
HIV	No	Yes
Syphilis	No	Yes

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706-860-6515

Current Medications

Patient Name: _____ DOB:_____

Medication	Dosage	Frequency

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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