The Neurology Center of South Delaware, P.A.

24488 Sussex Highway, Suite 6
Seaford, DE 19973
Phone (302)628.7730
Fax (302)628.7791

21635 Biden Ave, Suite 203
Georgetown, DE 19947
Phone (302)858.4524
Fax (302)858.4766

PATIENT REGISTRATION

PATIENT				
Name (Last, First, MI)	Sex M F	Birthdate	Social Security Number	Marital Status- M S W
Mailing Address	City	State	Zip Code	
Employer	City	State	Zip Code	
Home Phone	Cell Phone	Work Phone		
Email Address	How did you hear about us? Circle one Newspaper/Magazine Online Friend/Family Other Physician			
Reason for Visit	Referring Physician	Primary Care Physician		

EMERGENCY CONTACT- For emergency purposes only. Not a HIPAA consent.		
Name	Relationship	**Phone (Circle one - Work, Home, Cell)**

(Emergency contact is not authorized to obtain any medical information unless they are added to the HIPAA paperwork.)

AUTOMOBILE ACCIDENT ï Is this visit the result of an automobile accident? **YES** or **NO**
WORKMAN'S COMPENSATION ï Is this visit the result of injury on the job? **YES** or **NO**

INSURANCE INFORMATION	
Primary Insurance Company Name	**Please provide insurance card with this form.**
Second Insurance Company Name	**Please provide insurance card with this form.**

If you are not the policy holder complete policy holder information below.

POLICY HOLDER INFORMATION OR RESPONSIBLE PARTY IF OTHER THAN SELF OR MINOR				
Name (Last, First, MI)	Social Security Number	Birthdate	Sex M F	Marital Status
Mailing Address	City	State	Zip Code	Home Phone ( )
Employer	City	State	Zip Code	Work Phone ( )

I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies including the Health Care Financing Administration, for the purpose of filing and payment of all medical claims. I authorize payment of medical benefits to The Neurology Center of South Delaware. I recognize and accept personal responsibility for my balance on my account where applicable.

This authorization applies to all occasions of services for all insurance companies until revoked in writing. I permit a copy of this release to be used in place of an original for insurance purposes.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

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Permission to Release and Obtain Medical Information

With your consent and with respect to your privacy, The Neurology Center of South Delaware will obtain and disclose medical information/records from prior healthcare providers, healthcare facilities and physicians we refer you to, as well as your insurance companies for authorization, payment processing, and contractual obligations.

Please list additionally individuals/family members you authorize us to inform/discuss your medical condition/diagnosis, treatment and insurance & payment information to. Please add your emergency contact if you would like that that person to be authorized.

Name of Persons, Employers, Organizations	Phone Number	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you do NOT wish for our office to release any information to family members /additional individuals please initial here: _____

Continuity of Care: The Neurology Center of South Delaware, P.A. requires that you are under the current care and designate a primary care provider in the event that our neurologists are unavailable.

Please list your current primary care/family physician: _____

To assure continuity of care, please observe the following: Our office is open Monday through Friday 8:30-5:00 PM. You may call between the hours of 9:00-12:00 and 1:00-4:30 PM Monday-Thursday, and Friday 9:00-2:00 PM (the office is open until 5:00).

For urgent questions after hours, please contact your primary care physician or call Nanticoke Memorial Hospital for an on-call physician.

EMERGENCIES-CALL 911 OR REPORT TO NEAREST EMERGENCY ROOM.

Prescription Refills/ Requests

To prevent exhausting a supply of medication, please contact us 2 weeks prior to running out. Be prepared when calling to leave the name of the medication, dosage, and pharmacy or mail order information you want the medication request sent to. ALLOW 72 BUSINESS HOURS FOR US TO COMPLETE YOUR REQUEST.

Thank you.

Print Patient Name_____

Patient Signature_____ **Date**_____/_____/_____

Turn Over to Complete Other Side of Form

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Patient Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. The following is a statement of our financial policy. This financial policy applies to all services provided by The Neurology Center of South Delaware, PA.

Insurance Coverage: We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Referrals: If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician. A referral should be requested from your primary care physician's office at least 48-72 hours prior to your appointment, and is required for you to be seen at your scheduled appointment.

Copays: We have a contractual obligation (with your insurance company) to collect your copay and will collect it at the time of service. **Our office does not bill copays. Copays are the patient's responsibility and are due at the time of service**. We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service. We **cannot** waive copays, deductibles, or coinsurance or non-covered services defined as patient responsibility under the terms of our contract with various health plans.

For our patients with no Medical Insurance Benefits: If you do not have group or individual medical insurance, payment for all services is expected at the time of your visit. Please let us know if you are having difficulty paying your account. The Neurology Center of South Delaware, PA may be able to help by setting up a payment plan based on your financial needs. Our billing office is available Monday – Friday from 9:00am to 4:00 pm to assist you in satisfying your financial obligation. Please contact our billing department directly at **(302) 628- 7730** to discuss payment plans.

Unpaid Accounts: In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

Collections: Past due accounts are placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for a partial payment made on the past due account.

Other Possible Fees:

Missed Appointment Fee - A missed appointment is a scheduled appointment that you miss without notifying us in advance. A $10 fee will be billed for patients who do not show for a scheduled appointment, or who cancel within 24 hours. Our practice requests that you provide us with at least a 24 hour notice to cancel your appointment to avoid this charge. Insurance companies do not cover this charge.

Returned Check Fee - It is the policy of The Neurology Center of South Delaware, PA to charge $25.00 to patients whose checks are returned by our bank for non-sufficient funds.

I have read and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

_____	_____	_____
Patient Name	**Signature of Patient or Legally Authorized Representative**	**Date**

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Signature indicates you read, understand and authorize as stated in this form.

Do you have regular access to Internet? Please check one: Yes ☐ No ☐

Have you signed up for Patient Portal?

This online tool gives you the flexibility to access your health information and other resources at your leisure – any time of day and from any location! Since the ChartMaker® PatientPortal is available over the Internet, you can use it from virtually anywhere. You can also use the ChartMaker® PatientPortal to access information for family members and individuals for whom you provide care, if given permission.

As a patient of The Neurology Center of South Delaware, PA, enrolling in the **ChartMaker® PatientPortal** is free and will allow you to:

- Securely Message with Your Physician's Office
- Request Appointments
- Review Your Lab Results
- Update Personal Information
- Request Prescription Renewals
- Pre-register for Your Visit
- View Visit History via Clinical Summaries

Also, the ChartMaker® PatientPortal is completely secure, so you can be confident that your private information is protected. Only you – or an authorized representative – can access your ChartMaker® PatientPortal. Remember: treat your health information like your banking information and use caution when sharing with others!

If you would like to register for Patient Portal, please submit your name and email address. We will update your information and send you an email to notify you that your Patient Portal is active.

(Please Print Clearly)

Patient Name: _____ Date: _____

Email: _____

Turn Over to Complete Other Side of Form

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Medical Health History

Patient Name: _____ DOB: _____

Allergies

List all allergies including medications, latex, etc.

Allergy	Reaction

Medications

Please list all medications including over-the-counter:

Medication	Dose

Do you take your medications as prescribed: Yes / No

Name of Pharmacy: _____ City, State: _____

Medical History

Please check if you have/had any of the following:

- ○ Headaches
- ○ Stroke
- ○ Diabetes
- ○ Heart Disease
- ○ Fevers
- ○ Arthritis
- ○ Back Pain
- ○ Dizziness/Lightheadedness
- ○ Neck Pain
- ○ Kidney Disease
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Shortness of Breath
- ○ Sleep Apnea

Turn Over to Complete Back of Form

Family History

*** Please specify, brother, sister, grandmother, grandfather (paternal/maternal).*

	Mother	Father	Siblings **	Children **	Other **
High Blood Pressure					
High Cholesterol					
Heart Disease					
Diabetes					
Heart Attack					
Stroke					
Cancer					
Multiple Sclerosis					
Parkinson's disease					
Other					

Personal Medical History Questionnaire

Have you smoked at least 100 cigarettes in your entire life: Yes / No
Do you currently smoke cigarettes: Yes / No
Do you use smokeless tobacco: Yes / No
Are you at risk for secondhand smoke: Yes / No
Do you drink alcohol: Yes / No

Surgical History

Please list the procedure and date:

- ☐ Appendectomy _____
- ☐ Heart Surgery _____
- ☐ Cholecystectomy _____
- ☐ Hysterectomy _____
- ☐ Kidney Transplant _____
- ☐ Hernia Repair _____
- ☐ Colonoscopy _____
- ☐ Laparoscopy _____

Others (please list)

Procedure/Operation	Date

Do you have a Pacemaker / Loop Recorder: Yes / No
Do you have any Metal in your body: Yes / No If so, what?: _____
Do you have Claustrophobia (fear of small places): Yes / No

Current Height: _____ Current Weight: _____

Please explain problems/symptoms you are experiencing today:

_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____

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Patient Authorization to Release Medical Information

_____ _____ _____/_____/_____
Patient Name (Print) SS or Health Record Number Patient DOB

_____ I authorize (practice/physician's name) to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):_____
  _____
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
  _____
- ☐ Consultation reports (please supply doctors' names): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose:

☐ My personal records
☐ Release of medical information to (specific destination): _____
☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____/_____/_____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ _____/_____/_____
Witness Signature Date