Henry Tellez, MD
Giridhar Chintalapudi, MD, FAASM
Board-Certified in Neurology, Vascular Neurology, Neuromuscular and Sleep Medicine

295 Olmsted Blvd, Ste 12
Pinehurst, NC 28374

101 Dennis Drive
Sanford, NC 27330

251 Keisler Dr., Ste 100
Cary, NC 27518

Phone: 910-235-0595 **Fax:** 910-235-0546

Patient Demographics

Name (Last, First, MI)	Today's Date		
Mailing Address	City	State	Zip

Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Social Security Number	Date of Birth	Gender ☐Male ☐Female	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Partner ☐Other

Preferred Language	Email Address
Race ☐White ☐Black ☐Hispanic ☐Asian ☐Other___________________	Ethnicity ☐Hispanic Origin ☐Not Hispanic Origin ☐Decline

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	Policy #	Group#

Patient's Relationship to Insured ☐Self ☐Spouse ☐Child ☐Other______________________	Name of Subscriber (If other than patient)

Subscriber's Social Security #	Gender ☐Male ☐Female	Date of Birth	Employer of Subscriber	Work Phone ( )

SECONDARY INSURANCE COMPANY	Policy #	Group#

Patient's Relationship to Insured ☐Self ☐Spouse ☐Child ☐Other______________________	Name of Subscriber (If other than patient)

Subscriber's Social Security #	Gender ☐Male ☐Female	Date of Birth	Employer of Subscriber	Work Phone ( )

FINANCIALLY RESPONSIBLE PARTY

Is patient responsible party/Guarantor? ☐Yes ☐ No (If No, fill out this section)

Name	Address	City/State/Zip	Relationship to Patient

Employer	Email Address	Date of Birth
Home Phone ( ) Preferred	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient	
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

REFERRAL INFORMATION

Referring Physician's Name	Physician Phone/Fax ( )
Address	

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name (☐ Check Here if same as referring physician)	Physician Ph#

By signing below, I acknowledge the information I provided is correct to the best of my ability

Signature:______________________________**Date:**____________

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Health History Questionnaire

PATIENT INFORMATION

Name (Last, First, MI)	Today's Date:
Referring Physician:	Primary Care Physician:

GENERAL HEALTH

1. Has your weight fluctuated much over the last year? ☐Weight loss of 10+ pounds ☐Weight gain of 10+ pounds
2. Do you smoke cigarettes? ☐Yes ☐No
   a) If yes, how many packs do you smoke per day?
   ☐Less than ½ pack ☐1/2 pack ☐1pack ☐2 packs or more
3. How many alcoholic beverages do you have each week on average?
   ☐None ☐1-7 drinks ☐8-14 drinks ☐15 or more drinks
4. How many days per week do you exercise 30 minutes or more?
   ☐0 days ☐1-2 days ☐3-4 days ☐5-7 days

Have you ever had any of the following conditions?

☐Brain Injury	☐High Cholesterol	☐Stroke	☐Emphysema/COPD	☐Congestive Heart Failure
☐Atrial Fibrillation	☐Migraine Headaches	☐Diabetes	☐Swallowing problems	☐Heart Valve Problems
☐Kidney Disease	☐Seizures/Epilepsy	☐Anxiety	☐Irregular Heart Beat	☐Allergies/Nasal Congestion/Sinusitis
☐Hyperthyroidism	☐Down's Syndrome	☐Arthritis	☐Kidney Disease	☐Heart Disease(Angina/Heart Attack)
☐Panic Disorder	☐High Blood Pressure	☐Asthma	☐Schizophrenia	☐Allergies/Nasal Congestion/Sinusitis
☐Hypothyroidism	☐Liver Disease	☐Depression	☐ Sleep Apnea	

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Please list all other medical conditions you currently have:______________________________

____

____

Please list all medications and the dose you are currently taking:

Medication	Strength	How often?	Comments

In addition to prescribed medications, it is also important to include such things as:

☐ Eye drops ☐ Inhalers/Nebulizers ☐ Creams/Ointments ☐ Oxygen @_____LPM ☐Contraceptives

☐Patches that contain medication ☐Over-the-counter medication (example: Aspirin, antacids, vitamins, laxatives, etc).

☐ Dietary and herbal supplements (example: include Gingko Biloba, St. John's Wort, Green Tea, etc.

Drug Allergies:____

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Office Policies & Fees

Financial Policy:

- Payments for services, including co- pays are **DUE AT THE TIME SERVICES ARE RENDERED.** As a courtesy, we contact your insurance company to find out information regarding your coverage and submit claims on your behalf**.** Because insurance policies vary greatly, we can estimate your coverage in good faith but cannot guarantee it. You are ultimately responsible for your payment of all fees incurred at our office if your insurance does not cover your treatment costs.
- Your insurance is a contract between you and/or your insurance company. YOU are responsible for providing us with current and accurate health insurance information. If you do not provide the correct insurance information at the time of billing, your insurance company may deny the claim and YOU may be responsible for payment in full.
- You agree to have Medicare or other insurance companies make payments on your behalf directly to Sandhills Neurologists.
- You acknowledge and accept final responsibility for payment of all charges if your insurance company does not pay.
- Tests sent to outside laboratories may result in additional charges billed to you by the laboratory.
- You authorize release of medical information to Medicare or other insurance companies pertaining to your history, services rendered, or treatment given to you or your dependents for purposes of claims review.
- You are aware that Sandhills Neurologists, PA does not file Medicaid as a third-party payor, if this condition applies to you.

Letters/Legal Paperwork:

- Letters, legal paperwork, disability forms and other miscellaneous forms will have applicable fees applied for their service preparation. Minimum charge is typically $25.00 per letter or one-page form. These fees depend on the quantity and depth of forms and documents that a patient requests us to prepare. Letters will be ready for pick up or for fax within 14 days of request. Payment may be required prior to pick-up, mailing, or faxing. If faxing or mailing to an address other than the patient's address of record, we must have a signed consent form. If mailing, additional mailing fees will apply.

Returned Checks:

- If a personal check is returned unpaid from the patient's bank, their account will be charged a returned check fee of $25 for each check and their account may be placed on a "cash only" basis for one year.

Same Day Cancellations and No-Show Fees:

- Much effort goes into staff scheduling and preparing for your visit. If you are unable to keep your appointment, please be considerate and notify us immediately. Failure to cancel within 24 hours of your scheduled appointment time deprives other patients from being seen in a timely manner.
- **"Physician Appointments"** - Missed appointments or appointments cancelled without 24-hour notice are subject to a $50 fee. This fee will be collected at the second offense and appointments will not be re-scheduled until the fee has been paid. More than 2 missed appointment (or less than 24-hour notice) within 1 year will be subject to being permanently released from our practice.
- **"Diagnostic Testing Appointments"**- Diagnostic Testing appointments (such as Sleep Studies, EEG's, VNG's, etc.) cancelled without giving **48-hour notice** are subject to a $75 fee. This fee will be collected at the second offense and appointments will not be re-scheduled until the fee has been paid. More than 2 missed appointment (or less than 24-hour notice) within 1 year will be subject to being permanently released from our practice.

By my signature below, I acknowledge that I have read, understand and agree to the above.

______________________________ ____________________
Patient Signature Date

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AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean ____.

"Physician" shall be understood to mean Henry Tellez, MD and/or Giridhar Chintalapudi, MD

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Board of Psychiatry and Neurology.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

______________________________	______________________________
Henry Tellez, MD	Giridhar Chintalapudi, MD

____
Effective from Date of Treatment

______________________________	______________________________
Patient/Guardian Signature	Date of Signature

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HIPAA Acknowledgement

Authorization to Disclose Information to Family Members/Friends

I, the undersigned, authorize Sandhills Neurologists to disclose all of my medical information to myself and the following people:

Name	Relationship	Phone Number

I understand that I have the right to revoke or terminate this authorization by submitting a written revocation to the office manager for Sandhills Neurologists. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. The privacy of this information may not be protected under federal privacy regulations.

HIPAA Message Authorization

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request that communications concerning your protected health information (PHI) be made by alternative means or at an alternative location(s). ***Unless I state otherwise, I give permission to leave messages at my home regarding appointments and account/billing information.***

I, ___________________________________hereby request the following changes be made in the way the office communicates with me regarding my personal health, treatment or payment for treatment:

(print name)

Description of special communication methods to be used (Please specify alternate telephone numbers, alternate mailing addresses, etc.)

Consent to review medication history

I hereby give consent to Sandhills Neurologists, PA to review my medication history.

Pharmacy Name	Address	Phone#

Advance Directives:

I have an advanced directive and can supply a copy for my medical history.

☐ Living Will

☐ Power of attorney given to____

☐ Do Not Resuscitate (DNR)

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received the Notice of Privacy Practices of Sandhills Neurologists.

By my signature below, I acknowledge that I have read, understand and agree to all of the above.

_____________________________________ _______________________________________ __________

Patient Name (Printed) Patient Signature Date

Office Staff: If unable to obtain written acknowledgement of receipt of the Notice of Privacy Practices, please list reason:_________________________________

____.