

Patient Demographics

PATIENT INFORMATION

Name (Last, First, MI)			Today's Date		
Mailing Address		City	State	Zip	
Home Phone () Preferred <input type="checkbox"/>		Work Phone () Preferred <input type="checkbox"/>		Cell Phone () Preferred <input type="checkbox"/>	
Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Other		
Preferred Language		Email Address			
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other		Ethnicity <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not Hispanic Origin <input type="checkbox"/> Decline			

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		Policy #	Group#		
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Name of Subscriber (If other than patient)		
Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber	Work Phone ()	
SECONDARY INSURANCE COMPANY		Policy #	Group#		
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Name of Subscriber (If other than patient)		
Subscriber's Social Security #	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber	Work Phone ()	

FINANCIALLY RESPONSIBLE PARTY

Is patient responsible party/Guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>	Cell Phone () Preferred <input type="checkbox"/>		

EMERGENCY CONTACT INFORMATION

Name		Relationship to Patient		
Home Phone () Preferred <input type="checkbox"/>	Work Phone () Preferred <input type="checkbox"/>	Cell Phone () Preferred <input type="checkbox"/>		

REFERRAL INFORMATION

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

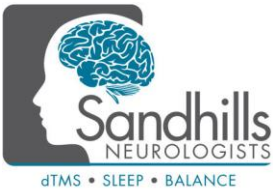
PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician Name (<input type="checkbox"/> Check Here if same as referring physician)	Physician Ph#
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By signing below, I acknowledge the information I provided is correct to the best of my ability

Signature _____

DATE: _____



Henry Tellez, MD
Giridhar Chintalapudi, MD, FAASM
Greg L. Clary, MD

Board Certified in Neurology , Vascular Neurology, Neuromuscular, Sleep Medicine, Psychiatry and Internal Medicine

Office Policies & Fees

Financial Policy:

- Payments for services, including co- pays, are **DUE AT THE TIME SERVICES ARE RENDERED.**
- 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

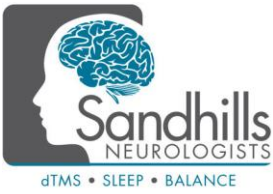
Date

Cary - 251 Keisler Drive Suite 100 • Cary, NC 27518
Sanford - 101 Dennis Drive • Sanford, NC 27330
Pinehurst - 295 Olmsted Boulevard, Suite 12 • Pinehurst, NC 28374

(910) 235-0595

(888) 688-5254

SandhillsNeurologists.com



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Authorization to Disclose Information to Family Members/Friends

I, the undersigned, authorize Sandhills Neurologists to disclose all of my medical information to 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 (HIPPA), 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.

I, _____ hereby request the following changes be made in the way the office communicates with me regarding my (print name) personal health, treatment or payment for treatment:

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 record:

- Living Will
- Power of Attorney, given to _____
- Do not Resuscitate order (DNR)

Acknowledgement of Notice of Privacy Practices

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

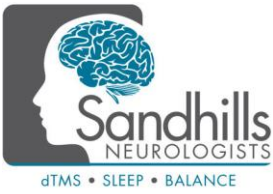
By my signature below, I acknowledge that I have read, understand and agree to all of the above.

Patient Name (Printed)

Patient Signature

Date

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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?	<input type="checkbox"/> Weight loss of 10+ pounds	<input type="checkbox"/> Weight gain of 10+ pounds
2. Do you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	a) If yes, how many packs do you smoke per day?	
	<input type="checkbox"/> Less than 1/2 pack	<input type="checkbox"/> 1/2 pack <input type="checkbox"/> 1 pack <input type="checkbox"/> 2 packs or more
3. How many alcoholic beverages do you have each week on average?	<input type="checkbox"/> None	<input type="checkbox"/> 1-7 drinks <input type="checkbox"/> 8-14 drinks <input type="checkbox"/> 15 or more drinks
4. How many days per week do you exercise 30 minutes or more?	<input type="checkbox"/> 0 days	<input type="checkbox"/> 1-2 days <input type="checkbox"/> 3-4 days <input type="checkbox"/> 5-7 days

Have you ever had any of the following conditions?

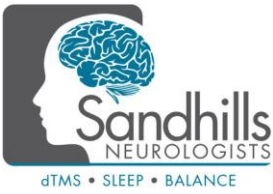
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/>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

<u>Medication</u>			<u>Comments</u>

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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