NEUROLOGY CLINIC, P.C.
8000 Centerview Parkway, Suite 300, Cordova, TN 38018
901-747-1111 fax 901-747-1137
www.neurologyclinic.org

WELCOME TO OUR PRACTICE

We appreciate your selection of this practice to provide the neurological services you desire. Please know that by choosing the Neurology Clinic, P.C. you have chosen quality.

Some insurance companies require a referral from the primary care physician before seeing a specialist. It is **YOUR** responsibility to contact your insurance carrier and provide us with a referral if it is required. If we do not have a referral at the time of service, your visit will be rescheduled.

If you are referred by another physician to our practice, please make sure that you have arranged for your medical records to be forwarded to our office, or bring them with you to your appointment. This includes films and/or discs of any type.

On the day of your appointment, please bring your referral (if required), your medical records, your insurance card(s), your driver's license, and the enclosed forms (completed). Any co-payment that you have **is due at time of service**.

CLINIC POLICIES

Clinic hours are from 8:00 a.m. to 4:30 p.m. Monday through Friday.

Non-emergent telephone calls after 3 p.m. will be returned by the next business day.

Prescription refill requests must be received by 3:00 p.m. Monday through Friday to be processed the same day.

Narcotic analgesics will not be available for pick up in after 4:30 p.m. weekdays or on the weekend.

The lab is open Monday through Friday from 8:30 a.m. until 4:00 p.m. and is closed for lunch between 12:00 p.m. and 1:00 p.m. You do **not** need an appointment to have labs drawn that have already been ordered.

Only persons listed in your chart may be given information regarding your health. This includes test results.

For all correspondence to include **medical records requests and all form completions to include but not limited to disability, time off, return to work, and letters of medical necessity**, please ask to speak with a secretary. Please **allow at least 5 (five) business** days for this information to be processed and returned to you.

For all billing inquires or account information, please ask to speak with the insurance department.

THE NEUROLOGY CLINIC PC DOES NOT TREAT PATIENTS WITH INJURIES OR SYMPTOMS DUE TO A WORK INJURY OR AUTO ACCIDENT.
We are sorry for any inconvenience this may cause you.

Please do not mail or fax this form to our office; bring the completed packet to your appointment. Only use black ink to complete these forms.

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PLEASE PRINT **TODAY'S DATE** _____

Have you previously been seen by one of our physicians? YES◯ NO◯ If yes, whom?_____

Patient Name:
Last: _____ First: _____ MI: ____

Address:
Street: _____
City:_____
State: _____
Zip Code: _____

Patient Information:
Home Phone: _____
Cell Phone: _____
Work Phone: _____
SS Number: _____
Date of Birth: _____
Marital Status: _____
Sex: _____

Spouse or Parent:
Name: _____
SS number: _____
Date of birth: _____
Phone: _____

Patient's Employer:
Name:_____
Street: _____
City: _____
State: _____
Occupation: _____
Phone: _____

Referring Physician:
(please supply **all** info for this doctor)
Name: _____
Street: _____
City: _____Zip Code: _____
Phone: _____

Primary Care Physician:
Name: _____
Street: _____
City: _____
Zip code: _____
Phone: _____

Primary Insurance:
Name: _____
Policy no: _____

Secondary Insurance:
Name: _____
Policy no: _____

Emergency Contact:
Name: _____
Phone: _____
Relationship to the Patient:_____

Is this visit related to a work injury? Y◯N◯
Is this visit related to an auto accident? Y◯N◯
Is this visit related to an injury with an attorney involved? Y◯ N◯

Are you enrolled in hospice/SNF? Y◯N◯
Location _____

AUTHORIZATION:

I hereby authorize the Neurology Clinic to treat my condition and to release any information concerning my treatment. I hereby assign them all insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered, including any co-pays, deductibles, and coinsurance. I understand that I am responsible for reasonable collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

Patient Signature X _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose it.

- We may use and disclose your medical records only for each of the following purposes:

  Treatment: means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example would include a physical examination.

  Payment: means such activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a claim to your insurance company.

  Healthcare Operations: include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.

- Any other uses and disclosures will be made only with your written authorization. You may revoke such an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on you authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information form us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective immediately and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

CONTACT PERSON: Chip Harris, Administrator, 8000 Centerview Parkway, Suite 300, Cordova, TN 38018 (901)747-1111

By signing here, I acknowledge that I have received a copy of Neurology Clinic's Notice of Privacy Practices.

Patient Signature X_____ **Date** _____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis, including treatment, payment, and health care operations.

Name _____ Phone # _____

Relationship to the Patient: _____

Name _____ Phone # _____

Relationship to the Patient: _____

Name _____ Phone # _____

Relationship to the Patient: _____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL".**

_____ YES _____ NO

Can confidential messages be left on your home answering machine and/or cellphone voicemail?

_____ YES _____ NO

How did you hear about the Neurology Clinic? Friend/Family Member___. Another Doctor___.

Website/Search Engine___. Radio Ad___. Neurology Clinic Employee___. other_____

Pharmacy Information:

Name: _____ is this a mail order pharmacy? ___YES ___NO

Address: _____
(At least street name and/or closest intersection)
Phone Number: _____Fax Number: _____

Effective January 1, 2013, TN State law requires that all physicians obtain a patient's prescription history before prescribing new medications. Please sign below acknowledging that you understand this new law.

Patient Signature: _____ Date: _____

Patient WebPortal:

Effective Spring 2009, we now offer a WebPortal for our patients. You may request appointments, medication refills, or ask our physicians general questions. You may also view your current and past billing statements. If you are interested in this service and have access to the internet, please request a login and password at the time of your appointment.

Would you like to participate? ___ YES ___ NO

Email address: _____

Chief complaint: What is the reason for your visit today? _____

_____

Past Medical History: (list any medical problems that other doctors have diagnosed)

☐ High blood pressure ☐ Alzheimer's/ Dementia ☐ Diabetes (sugar) ☐ Cancer ☐ Depression ☐ Anxiety ☐ Seizures/Epilepsy

☐ Stroke ☐ Migraine/Headache ☐ Heart disease ☐ Other _____

Have you had Blood work, MRI, CT Scan, EMG, EEG? ◯ Yes ◯ No If so, WHEN & WHERE: _____

_____

Surgeries/Operations: Year:

List your prescribed Medications and Over-the-Counter meds, such as vitamins & inhalers: (name, dosage, & directions/frequency)

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

Allergies to medications: (name of medication & reactions) _____

_____

Caffeine: ☐ none ☐ coffee ☐ tea ☐ soda # of cups/cans per day: _____

Illicit Drugs: Do you currently or have you ever used recreational or street drugs? ◯ yes ◯ no
Have you ever given yourself street drugs with a needle? ◯ yes ◯ no

Tobacco: Do you currently or have you ever used tobacco products? ◯ yes ◯ no # of years _____ or year quit _____
☐ Cigarettes - pks/day _____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____ ☐ Cigars - #/day _____

Alcohol: ☐ never ☐ occasional ☐ moderate ☐ heavy
How many drinks might you have in a typical week? _____ ☐ Beer ☐ Wine ☐ Liquor ☐ Other _____

Current weight: _____ lbs. **weight loss/gain in the last year:** + / - _____ lbs. **average # of meals/day:** _____

Height: _____ ft. _____ in.

Family History:	age	age at death	Significant health problems or cause of death			age at death	Significant health problems or cause of death
Father				Grand-Parents	Maternal		
Mother					Paternal		
Brother (s)				Children	Son (s)		
Sister (s)					Daughter (s)		

Has anyone in your immediate family had:

High Blood Pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Heart Disease	◯ Yes ◯ No	Depression/anxiety	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Migraine	◯ Yes ◯ No

Please fill in the appropriate circle for all current conditions:

General

Lethargy/weakness	Yes	No
Weight loss	Yes	No
Dizzy spells	Yes	No
Fainting spells	Yes	No
Fever	Yes	No
Poor appetite	Yes	No

Ophthalmology

Wears glasses	Yes	No
Blurring of vision	Yes	No
Diminished vision	Yes	No
Double vision	Yes	No
Eye pains	Yes	No

ENT/respiratory

Hearing loss	Yes	No
Ringing in ears	Yes	No
Sinus problems	Yes	No
Congestion/sneezing	Yes	No
Wheezing/coughing spells	Yes	No

Cardiology

Chest pain	Yes	No
Heart attack	Yes	No
Heart murmur	Yes	No
Leg swelling	Yes	No
Palpitations	Yes	No

Gastroenterology

Difficulty swallowing	Yes	No
Ulcers	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Recent changes in bowel habits	Yes	No
Diarrhea	Yes	No
Blood in stool	Yes	No

Sleep

Fatigue	Yes	No
Snoring	Yes	No
Daytime drowsiness	Yes	No
Leg movements	Yes	No
Frequent naps	Yes	No
Trouble sleeping	Yes	No

Neurology

Difficulty making decisions	Yes	No
Memory problems	Yes	No
Tingling numbness	Yes	No
Falling/poor balance	Yes	No
Tremors	Yes	No
Seizure	Yes	No
Headache	Yes	No

Psychology

Depression	Yes	No
Tension/stress	Yes	No
Attention deficit	Yes	No
Anxiety	Yes	No
Loss of energy	Yes	No
Thoughts of suicide	Yes	No

Hematology

Bleed/bruise easily	Yes	No
Anemia/low blood	Yes	No
Blood disease	Yes	No
Enlarged glands/nodes	Yes	No

Endocrinology

Fatigue	Yes	No
Excessive sweating	Yes	No
Diabetes	Yes	No

Dermatology

Rash	Yes	No
Sores	Yes	No
Itching	Yes	No

Genitourinary

Difficulty urinating	Yes	No
Lumps in breast	Yes	No
Menstrual irregularity (Female)	Yes	No
Difficulty starting urine	Yes	No

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HIPAA Release of Information
AUTHORIZATION FORM

I, _____ authorize Neurology Clinic, PC to:
(Print Patient's Name)

☐ Obtain/request copies of my health information from:

_____
(Name and Address) –Specify: Hospital, Doctor, etc.

This authorization for release of information covers the:

☐ Complete medical record of treatment including office notes, laboratory reports, radiology reports, physical/occupational/speech therapy notes, and any other ancillary/Doctor/Nurse notes.

☐ Description of specific records to be released:_____

I authorize the release of my complete health record **with the exception** of the following information:

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify):_____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that this authorization cannot be retroactively revoked for information that has already been sent.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. However, if I need records sent or received at a later date I understand this form must be signed by me at that time.

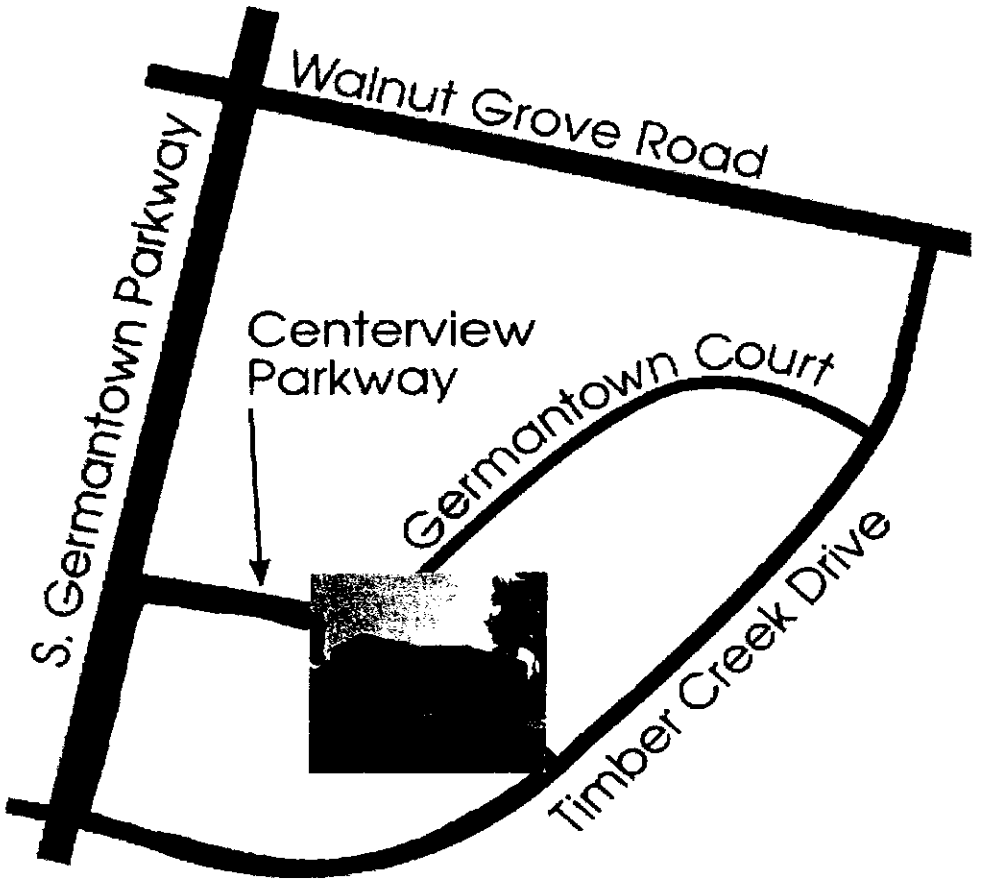
I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

I understand that even if I do not withdraw this authorization, it will expire **one (1) year** from the date below.

_____ _____
Signature of Patient/Parent/Legal Guardian/Representative | Patient's Date of Birth

_____ _____
Printed name of Parent/Legal Guardian/Representative | Relationship to patient

_____
Date



Neurology Clinic, PC

at the Germantown Park
8000 Centerview Parkway, Suite 300
Cordova, TN 38018
Southeast Corner of Walnut Grove and Germantown Parkway
Across from the Agricenter and Butcher Shop

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