Neurology Clinic, Inc.
1333 Pine Street
Melbourne Florida 32901
321 984 9400 fax 321 984 0150

OUTSIDE PROVIDER REFERRAL TESTING

YOU HAVE TESTING SCHEDULED WITH OUR OFFICE ON:

_____at _____AM PM

*Please arrive 15 mins prior to appointment – *exception our office closes for lunch from 12-1pm

**** FOR GPS SYSTEM USE : PLEASE USE COMPLETE ADDRESS *INCLUDING ZIP CODE***

OTHERWISE, YOUR GPS WILL BRING YOU TO AN INCORRECT LOCATION**

Please note we single book our patients and therefore we have a strict scheduling policy. YOU MUST ARRIVE FOR YOUR APPOINTMENT WITH COMPLETED PAPERWORK.

Accepting an appointment is considered verbal consent to the information/policies as follows:

1. ARRIVING 10 MINUTES OR MORE AFTER SCHEDULED APPOINTMENT TIME or arriving at appointment time *without* completed paperwork WILL RESULT IN RESCHEDULING.
2. Missed (no show) appointments are subject to a $75.00 no show fee. Patients that miss, cancel, or reschedule 3 consecutive appointments will not be allowed to schedule any further appointments with out office.
3. **TEST RESULTS ARE DELIVERED TO YOUR ORDERING PROVIDER**. You will not receive results on the day of your appointment/test. You must contact or follow up with your ordering provider for your results.
4. Because insurance plans vary in billing for testing, we will submit the claim to your insurance first and send you a statement if there is a balance due. ***We recommend you contact your insurance company to determine what, if any, financial responsibility will be yours for the test to be done. Your insurance company will need the following CPT codes and ICD 10 code to estimate potential out of pocket cost to the patient. Timely payment is expected upon receipt of statement***.

   For NCV CODE:_____ along with EMG CODE 95886

   For EEG CODES 95816 AND 95819 ICD 10 (diagnosis) CODE _____.
5. **Authorization**, if required by insurance, is patient responsibility to confirm with their plan or the ordering provider. Ordering provider or patient's primary care provider is responsible for obtaining proper authorization to submit to the Neurology Clinic prior to test date.

Signing below acknowledges receipt of these policies. Failure to comply may result in discharge from practice.

Patient (or *Guardian) signature_____

Date_____ Witness_____

*If guardian signs : print patient name _____DOB:_____

David J. Packey, Ph.D., M.D. Jill W. Miller, M.D., Ph.D. Caitlin Featherston, APRN

Neurology Clinic, P.A.

PATIENT INFORMATION

Legal Name: (first)_____ (last) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Date of Birth _____ Gender _____ Marital Status _____

Last four digits of SS# _____ Occupation _____

Emergency Contact Name _____

Phone _____ Relationship _____

Spouse Name _____ Date of Birth _____

Check and date if appropriate: Injured on the Job ___ Auto Injury___ Date of Injury _____

If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. If our account is turned over to our collection agency an additional fee, 25% of your total bill, will be added to your balance.

Primary Insurance _____ ID# _____

Policyholder Name _____ Date of Birth _____ Relationship _____

Secondary Insurance _____ ID# _____

Policyholder Name _____ Date of Birth _____ Relationship _____

I hereby assign all medical benefits (money paid on my behalf for my medical care) to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private medical insurance , and any other health plans to Neurology Clinic, P.A. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize release to my insurance carrier, employer and / or referring health care provider any information needed, including diagnosis and records of any treatment or examination rendered to me to process the claim.

I authorize Neurology Clinic to obtain records from hospitals, health care providers, and pharmacies that will assist the health care providers at Neurology Clinic with my care.

Lifetime signature authorization: This authorization and assignment are to be continuing, remaining in force until revoked in writing by myself or legal representative.

Patient / Legal Representative _____

Witness _____ Date _____

If patient is a minor, provide parents name or legal representative and relationship.

Name _____ (circle) Parent Grandparent Guardian Other _____

Neurology Clinic, P.A.

1333 Pine Street - Melbourne, FL 32901

Name _____ Date _____

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that Neurology Clinic has a health information privacy policy. I can request the Neurology Clinic pamphlet 'Notice of Privacy Practices' should I want a copy.

I understand that I have the right to determine my preferred method of communication, and the right to restrict certain types of communication. I further understand that Neurology Clinic must honor this request as to the method of communication if reasonable. Neurology Clinic may not ask me why I want certain methods of communication.

I give Neurology Clinic permission to contact me as follows: (Check all that apply)

For APPOINTMENT information	Home phone ___	Cell phone ___	At work ___
For BILLING information	Home phone ___	Cell phone ___	At work ___
For MEDICAL information	Home phone ___	Cell phone ___	At work ___

Can messages be left on your machine or voice mail for the above numbers? Yes___ No___

Please fill in as appropriate for what you checked above:

Home phone: _____
Cell phone: _____
Work phone: _____

I give Neurology Clinic permission to speak to the person(s) named below:

Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____

I understand that I have the right to object to the use and/or disclosure of my individually identifiable personal health information to other physicians or family members.
I object to the use and/or disclosure of my health information as follows: _____
_____

I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that Neurology Clinic has already taken action in reliance on my earlier effective consent.

_____ _____
Signature of Patient or Legal Representative Signature of Witness

Date: _____