HUNTERDON
NEUROLOGY
1322 NJ-31 Suite 2, Annandale, NJ 08801
Phone: (908) 894-7222 Fax: (908) 894-7128

Last Name:____ **First Name:**__________________ **MI:**___________

DOB: ____________________ **Age:** ______________ **Social Security Number:** ____-____-____

Marital Status: Single Married/Partnership Separated Divorced Widowed

Sex:_____________________ **Gender:** __________________

Street Address:____ **PO Box:** _____________________

City: ____________________________________ **State:** _______________________________ **Zip:**____________

Primary (preferred) phone: ____________________________ - Mobile Home Work

May we leave a detailed message on this line? YES / NO

Alternate phone: ___________________________ - Mobile Home Work

May we leave a detailed message on this line? YES / NO

Primary (preferred) email: ____

Emergency Contact: __________________________________ **Allowed to call on your behalf?** YES / NO

Emergency Contact Phone: ___________________________________

Primary Care Physician: ____ **Phone:** ____________________

Primary Care Physician Town/State: _____________________________________ **Fax:** ___________________

Referring Physician: ____ **Phone:** ____________________________

Primary pharmacy: _______________________________ **City/State:** _________________________________

Primary pharmacy phone: ____________________________ **Primary pharmacy Fax:** __________________

Alternate pharmacy: ____________________________ **City/State:** ____________________________________

Alternate pharmacy phone: ___________________________ **Alternate pharmacy Fax:** _________________

Responsible Party/Insurance Information:

Last Name: ___________________________________ **First Name:** ___________________________ **MI:** _____

DOB: ____________________ **Relationship to patient:** _____________________

Insurance Plan:_____________________________________ **ID Number:** ________________________

Group/Plan Number: ______________________ **Effective Date:** _____________________

Is Insurance plan in patient's name? YES / NO **If NO, please complete below:**

Subscriber Last Name, First Name, MI: ____

Subscriber DOB: _______________________ **Subscriber Relation to Patient:** _____________________

Secondary Insurance Plan:_____________________________________

ID Number: ________________________

Group/Plan Number: ______________________ **Effective Date:** _____________________

Is Insurance plan in patient's name? YES / NO **If NO, please complete below:**

Subscriber Last Name, First Name, MI: ____

Subscriber DOB: _______________________ **Subscriber Relation to Patient:** _____________________

Do you have a living will/health care proxy? YES / NO **(If yes, please provide a copy for your chart.)**

Preferred Language (if other than English): ________________________

Interpreter needed? YES / NO

Race: _______________________ **Ethnicity:**__________________________

Consent to Treat:

I, the undersigned, voluntarily consent to and authorize Hunterdon Neurology, through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my practice physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

I understand that I may revoke my consent at any time, in writing or typed, to the practice.

Patient Signature: ___________________________

Date:______________________________________

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Included is information to answer some frequently asked questions regarding insurance, billing, and patient responsibilities. Please read and sign in the space provided.

Co-payments, coinsurances, deductibles, and any other account balances are due at the time of service, unless payment arrangements have been requested and approved by the billing manager IN ADVANCE OF YOUR APPOINTMENT.

Insurance

We participate with most insurance plans *except* NJ Medicaid where Medicare is the primary insurance. We recommend you verify with your insurance provider that we are in-network with your specific policy, as not all providers are in-network with all insurances. We will bill your insurance company as a courtesy to you. Although every effort is made to provide accurate estimates of what insurance may cover, it is ultimately up to the insurance carrier to make the final determination of what is covered and what is not.

Claims Submission

We will submit your claims and assist you within reason to help get claims paid. Your insurance company may need you to supply certain information directly from you. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility *whether or not your insurance pays for the claim*. Your insurance benefit is a contract between your and your insurance company.

Referrals

If you have an insurance plan that requires referrals to see a specialist, **it is your responsibility to have a referral authorization sent to Hunterdon Neurology, or bring it with you to your appointment.** We can accept referrals from your doctor via fax or mail. If we have not received a referral prior to your arrival to the office, it will be YOUR responsibility to call your PCP to obtain the referral. If you are unable to obtain the referral at that time, you will be rescheduled to another time after the referral documentation has been received.

Proof of Insurance

We MUST obtain a copy of your current primary and secondary insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the claim's balance.

Coverage Changes

Should your insurance change in any manner (new card, new policy, new company, etc.), please notify us of this change so we can appropriately update your files to help you receive the maximum benefit to pay your claim.

Billing Statements

If you have questions regarding billing statements you have received, please contact our billing department. Please call our main number 908-894-7222 and press option 5.

No Call / No Show Fee

Please call the office ahead of time if you are going to be late, and call within 24 hours if you need to cancel. Should you not call ahead or cancel, there will be a **NO SHOW FEE of $50.00**. **Please note, after 3 no shows there is a possibility of being discharged from the practice.**

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This document is to notify you of our office's practices and requests for patients and care givers.

MEDICATION REQUESTS AND REFILLS:

- All refill requests **MUST** come from the patient or care giver – ***WE DO NOT ACCEPT REFILL REQUESTS FROM YOUR PHARMACY***. Please note that this includes faxed refill requests.
- Please allow **72 HOURS (3 days)** for refills to be sent. This means that if you may run out of medication over the weekend or a holiday, contact the office to be sure there is enough time to send the refill to your pharmacy.
- Please leave only **ONE (1)** voicemail regarding refills. We will notify you when the refill request has been completed. Leaving multiple voicemails on multiple lines causes confusion, and your request may be missed, and your call may not get returned.
- In the event you need an **URGENT REFILL REQUEST** – please contact the main number and request to speak to a clinical staff member. *Remember, an **urgent** request denotes that the patient is out of medication and is at **risk of having a medical complication** – this is **not** to be confused with a routine request.*
- Patients must be ***current on follow-up visits.*** If we have not seen you or the patient within the appropriate time frame, we may not be able to refill your medication until the physician sees you in the office.

PRIOR AUTHORIZATIONS FOR MEDICATIONS:

- If your medication needs a *Prior Authorization* from your insurance company, we will begin the necessary steps to complete this as soon as possible. Please note that this is not a guarantee of medication coverage.
- We will make every effort to appeal any denials on your behalf. Please do not leave repeated messages regarding prior authorizations. We will contact you regarding this process.
- **Please note that it can take several days to get a response. We will notify you with updates as we receive them.**

PAPERWORK/FORMS FOR COMPLETION:

- Please be sure to bring any paperwork that may need to be filled out by our office or the physician to your appointment. We DO NOT accept paperwork via email to be completed. Forms may be dropped off ahead of your appointment if needed.

- Please allow **<u>3 BUSINESS DAYS</u>** for regular documents to be filled out. We will notify you when the documents are completed.
- Please allow **<u>5 – 7 BUSINESS DAYS</u>** for any **disability/MVA/DMV/Worker's Comp** paperwork to be completed. These documents require more time to complete appropriately.
- If a different physician or provider has put you out of work or out on disability, our office **CAN NOT** fill out paperwork returning you to work or to come off disability. We may be able to provide supplemental information to your condition, but the **ORIGINAL** physician will need to complete any paperwork.

<u>MEDICAL RECORDS:</u>

- Please be sure to allow **<u>7 – 10 BUSINESS DAYS</u>** to compile medical record requests.
- If the records request needs to be sent to another physician, please be sure to have the name of the practice/facility, practice/facility address, physician's name, and fax number at the time of request.

<u>UNTOLERATED BEHAVIORS:</u>

- Hunterdon Neurology reserves the right to be able to ask patients to leave the office if necessary. Should you be asked to leave, we respectfully ask that you be compliant in an orderly and appropriate manner.
- *We do not tolerate any behaviors that may be harmful or threatening to others, yourself, staff, and visitors.* Examples of these are as follows:
    - Raising your voice / yelling aggressively
    - Using vulgar, profane, perverse, or unacceptable language
    - Becoming physically aggressive toward yourself, or others
    - Engaging in any unwanted physical contact (hitting, kicking, spitting)
    - Throwing objects
    - Harassing other patients
    - Harassing staff – this includes by phone, email, or text
- If you act in a manner unbecoming to the staff and/or other patients, and you refuse to leave the premises, the local authorities will be notified at that time.
- Incidents will be documented appropriately

<u>PLEASE NOTE THAT HUNTERDON NEUROLOGY RESERVES THE RIGHT TO DISCHARGE AND TERMINATE THE PROVIDER-PATIENT RELATIONSHIP AT ANY TIME.</u>

Please sign and date on the following page

I hereby acknowledge that I have read and understood the above office policies and procedures. I understand that if I do not follow these policies, I may cause delays in my care.

I have received a copy of the attached notices for my records.

Patient Name (print): ____

Patient/Authorized Party Signature: ____

Date Signed: _________________

HUNTERDON NEUROLOGY

Patient Medical History Form

PATIENT NAME	DATE OF BIRTH (MM/DD/YYYY)
	____ / ____ / ______
Age:	**Sex:** ☐ Male ☐ Female ☐ Other
Height:	**Weight:**

SOCIAL HISTORY

Do you smoke tobacco products? ☐ Yes ☐ No **If yes, pack(s) per day:**	**Please choose one of the following:** ☐ Current Smoker ☐ Never Smoked ☐ Former Smoker ☐ Vape User
Do you drink alcohol? ☐ Yes ☐ No **If yes, drink (s) per day:** __________ **per week:**____________	**Do you take recreational drugs?** ☐ Yes ☐ No **If yes, please specify:**

MEDICAL HISTORY

Please check if you currently have or have ever had any of the following conditions:

☐ AIDS/HIV ☐ Alzheimer's Disease ☐ Asthma ☐ Arthritis ☐ Bleeding disorder ☐ Cancer Type: __________ ☐ Dementia ☐ Diabetes (Type I/ Type II)	☐ Emphysema ☐ Gallbladder Disease ☐ Glaucoma ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmur/ Valve Problem ☐ Hepatitis Type: ________ ☐ High Blood Pressure ☐ High Cholesterol	☐ Hypothyroidism ☐ Intestinal Problems ☐ Acid Reflux ☐ Crohn's Disease ☐ Irritable Bowel Syndrome ☐ Kidney Disease ☐ Liver Disease ☐ Migraines ☐ Myasthenia Gravis	☐ Mental/Nervous Disorder ☐ ADHD ☐ Bipolar Disorder ☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Substance use disorder ☐ Multiple Sclerosis ☐ Osteoporosis/ Osteopenia	☐ Parkinson's Disease ☐ Seizures ☐ STD: ______________ ☐ Sleep Apnea ☐ Stroke ☐ Other medical issue: _____ ______________________ ______________________ ______________________

FAMILY HISTORY

Please check if any family members, such as parents, children, siblings or grandparents, had or currently have any of these conditions:

☐ AIDS/HIV ☐ Alzheimer's Disease ☐ Asthma ☐ Arthritis ☐ Bleeding disorder ☐ Cancer Type: __________ ☐ Dementia ☐ Diabetes (Type I/ Type II)	☐ Emphysema ☐ Gallbladder Disease ☐ Glaucoma ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmur/ Valve Problem ☐ Hepatitis Type: ________ ☐ High Blood Pressure ☐ High Cholesterol	☐ Hypothyroidism ☐ Intestinal Problems ☐ Acid Reflux ☐ Crohn's Disease ☐ Irritable Bowel Syndrome ☐ Kidney Disease ☐ Liver Disease ☐ Migraines ☐ Myasthenia Gravis	☐ Mental/Nervous Disorder ☐ ADHD ☐ Bipolar Disorder ☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Substance use disorder ☐ Multiple Sclerosis ☐ Osteoporosis/ Osteopenia	☐ Parkinson's Disease ☐ Seizures ☐ STD: ______________ ☐ Sleep Apnea ☐ Stroke ☐ Other: ______________ ______________________ ______________________ ______________________

SURGICAL HISTORY

Please list ANY surgeries that you have had:

Surgery:	Date (MM/YYYY):

REVIEW OF SYSTEMS

Please check any symptoms that you are CURRENTLY experiencing:

☐ Chest pain ☐ Dizziness ☐ Fluid Accumulation in the legs ☐ High Blood Pressure ☐ Back Pain ☐ Joint Stiffness ☐ Leg Cramps ☐ Muscle Spasms	☐ Neck Pain ☐ Sciatica ☐ Balance Difficulty ☐ Difficulty speaking ☐ Dizziness ☐ Fainting ☐ Gait abnormality ☐ Headache ☐ Irritability	☐ Loss of strength ☐ Loss of use of extremity ☐ Low back pain ☐ Memory Loss ☐ Pain ☐ Paralysis ☐ Seizures ☐ Stroke	☐ Tic ☐ Tingling/numbness ☐ Transient loss of vision ☐ Anxiety ☐ Hallucinations ☐ Delusions ☐ Depressed Mood ☐ Difficulty sleeping

I certify that the above information is accurate and completed to the best of my knowledge. Please provide your signature below.

Signature of patient/guardian: ____ **Date:**__________________

Patient Medication List

☐ I currently take no prescription medication, vitamins, supplements, or over-the-counter medications

Medication Name	Dose	Frequency

☐ I have provided my own medication list to my physician to be scanned into my chart

Please choose one of the following:

☐ I have no known drug allergies / ☐ Allergies: ____

I certify that the above information is accurate and completed to the best of my knowledge. Please provide your signature below.

Signature of patient/guardian: ____ Date:_______________________