

# 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: \_\_\_\_\_

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### **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: \_\_\_\_\_

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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: \_\_\_\_\_

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***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:*** \_\_\_\_\_



1322 Route 31 North, Suite 2

Annandale, NJ 08801

Phone: 908-894-7222, Fax: 908-894-7128

### **PATIENT FINANCIAL RESPONSIBILITY STATEMENT**

Thank you for choosing Hunterdon Neurology as your healthcare provider. The medical services you seek imply financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or receiving medical services from Hunterdon Neurology, you agree:

1. You acknowledge and agree to the established policies and procedures of Hunterdon Neurology, including but not limited to this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, in effect from time-to-time ("Policies"). The financial policies may be changed from time to time by Hunterdon Neurology, without notice. If there is any conflict between another policy or procedure of Hunterdon Neurology and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, this Statement shall be controlled.
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our Policies, which are not otherwise covered by supplemental insurance.
3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Hunterdon Neurology, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Hunterdon Neurology are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Hunterdon Neurology; or (v) you have chosen not to use your health plan coverage. If you are not familiar with

your plan coverage, we recommend you contact your carrier or plan provider directly.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-paying patient. As a self-paying patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by Hunterdon Neurology.

5. By signing below, you authorize Hunterdon Neurology to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to Hunterdon Neurology, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Hunterdon Neurology and associated physicians, and staff to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Hunterdon Neurology does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit the same to Hunterdon Neurology until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Hunterdon Neurology to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

7. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a claim submitted. You must notify us of any errors or objections to the billing statement within thirty (30) days, or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.

8. Whether or not you have insurance or are self-pay, payment of any account balance is due at our Patients Account Offices in Annandale, NJ within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to by a collection agency. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower. For small balances, between \$4.01 to \$25.00, we may stop sending billing statements any time after the initial statement, but you understand that the amount shall remain due and owing until paid in full.

9. We accept payment by check, cash, debit cards, or credit cards.

a. **Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of \$30.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize Hunterdon Neurology, if your check is dishonored or returned for any reason, to electronically debit your account for the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). PLEASE NOTE: The above language authorizes an electronic debit to your account for the check plus the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, this authorization is to remain in effect until Medical Associates has received written notice of termination in such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that Hunterdon Neurology cannot collect a return fee by other methods.

b. **Payment by Credit Card/Debit Card.** You may pay with a credit card or debit card, including Visa, Mastercard, and Discover ("credit card"). Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement. All regular credit card rules will apply. Once authorization of the submitted information is received, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment. While processing your credit card payment, only the last 4 digits of your credit card are viewable by Hunterdon Neurology personnel. We do not otherwise store your sensitive credit card information.

10. **Managed Care (HMO, PPO, etc.).** All managed care co-payment amounts are due at the time of service. If your insurance plan requires referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all the charges. You acknowledge that it is your responsibility to be aware of what services are covered, and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

11. **Medicare Hunterdon Neurology** is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, co-payment, and any non-covered services specified by Medicare. By signing below, you request that payment of authorized Medicare benefits be made on your behalf to Hunterdon Neurology for any services furnished to you by Hunterdon Neurology.

**12. Workers' Compensation Cases.** Charges for services incurred because of a verified work-related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

**13. Third Party Liability Injuries.** If you receive treatment because of a third-party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because Hunterdon Neurology does not protect charges incurred relating to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments. Hunterdon Neurology cannot act as administrator to resolve financial arrangements. We may agree to bill a third-party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us with all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

**14. Ancillary Services.** You may receive ancillary medical services while a patient of Hunterdon Neurology such as interpretation of tests, neuropsychological testing, and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence but are actively involved during diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges because of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

**15. Additional Charges.** Patients may incur and are responsible for the payment of additional charges at the discretion of Hunterdon Neurology including but not limited to: charges for returned checks; charges for a missed appointment without 24 hours advance notice; charges for copying and distribution of patient medical records; charges for extensive forms preparation or completion; or any costs associated with collection of patient balances, all as allowed by law.

**16. Non-payment on Account.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Hunterdon Neurology has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: late fees and charges and interest due as a result of such delinquency; all court costs and fees (but only to the extent allowed by law); and a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third-party collection agency. You acknowledge that any such interest assessed on the account will be a late fee because of default or delinquency on your account and is not deemed interest as part

of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care. By signing below, you agree, on behalf of yourself, your legal representatives and next of kin, that the jurisdiction, venue, and choice of law of any dispute or state court action related to the health care services or the billing provided by Medical Associates shall, at the option of Medical Associates, be subject to the exclusive jurisdiction of (i) the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered or (ii) where you reside.

**17. Minor Patients.** The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility of judgment must be determined between the individuals involved, without the inclusion of Medical Associates.

**18. Authorization to Contact.** You authorize Hunterdon Neurology personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Hunterdon Neurology, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Hunterdon Neurology to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contract.

**19. Financial Responsibility Party.** If this or a separate Hunterdon Neurology Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective on the date after receipt and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Hunterdon Neurology of all indebtedness of Patient to Hunterdon Neurology, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by Hunterdon Neurology in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until all said Indebtedness shall be fully paid. There shall be no obligation on the part of Medical Associates at any time to first exhaust its remedies against patients, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

**Acknowledgement**

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the HUNTERDON NEUROLOGY PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Hunterdon Neurology for the below Patient’s care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys’ fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

**ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (“.PDF”) SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.**

\_\_\_\_\_  
Patient/Responsibility Party/Guardian Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient/Responsibility Party/Guardian Date of Birth

\_\_\_\_\_  
Witness

**Waiver of Patient Authorizations**

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

\_\_\_\_\_  
Signature of Patient or Guardian Date

# HUNTERDON NEUROLOGY

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

**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 you 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.**

# HUNTERDON NEUROLOGY

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Phone: (908) 894-7222 Fax: (908) 894-7128

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 **3 BUSINESS DAYS** for regular documents to be filled out. We will notify you when the documents are completed.
- Please allow **5 – 7 BUSINESS DAYS** 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.

**MEDICAL RECORDS:**

- Please be sure to allow **7 – 10 BUSINESS DAYS** 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.

**UNTOLERATED BEHAVIORS:**

- 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

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

**\*\*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: \_\_\_\_\_

## Patient Medical History Form

<b>PATIENT NAME</b>	<b>DATE OF BIRTH (MM/DD/YYYY)</b> ____/____/____
<b>Age:</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<b>Height:</b>	<b>Weight:</b>

### SOCIAL HISTORY

<b>Do you smoke tobacco products?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, pack(s) per day: _____	<b>Please choose one of the following:</b> <input type="checkbox"/> Current Smoker <input type="checkbox"/> Never Smoked <input type="checkbox"/> Former Smoker <input type="checkbox"/> Vape User
<b>Do you drink alcohol?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, drink (s) per day: _____ per week: _____	<b>Do you take recreational drugs?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____

### MEDICAL HISTORY

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

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

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

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

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

