Piedmont Neurology, LLC
Stroke · Botox · Headache · Epilepsy · Neuropathy
Spine/Back Disorders · Alzheimer's/Parkinson's Disease
917 Bypass 225 South, Greenwood SC 29646
Phone: 864-227-5240 Fax: 864-227-5239

Consent for Treatment

I hereby give my permission for **Piedmont Neurology, LLC** (the Practice) to provide diagnostic services and medical treatment.

I permit the Practice to file for insurance benefits to pay for the care I receive.
I understand that:

- The Practice will be required to send my medical record information to my insurance company in order to receive benefits.
- I must pay my share of the costs.
- I am responsible for the cost of these services if my insurance does not pay or I do not have insurance.

I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____ _____

Patient Signature (or legal guardian) **Date**

_____

Printed Name

Piedmont Neurology, LLC

Financial Policy

This is an agreement between Piedmont Neurology, LLC, as creditor, and the Patient/Debtor named on this form.In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Piedmont Neurology, LLC.
By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement - If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payments - Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued. For your convenience, we accept cash, check, debit cards, Visa, MasterCard, Discover, and American Express.

Contracted Insurance - If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance - Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Required Payments - Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned Checks - There is a fee (currently $50) for any checks returned by the bank.

Missed appointment fee/ late cancellations - Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment. We reserve the right to charge (currently $35 for an office visit; $100 for an MRI) for missed, late, or canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Disability/FMLA Forms/Letters - There is a $35.00 fee for most forms and letters. Fees for documents that require extensive research of your medical record or multiple pages of documentation may be higher. This fee must be paid prior to completion of the form(s) or letter(s). Please allow a minimum of 7-14 business days for the completion of these forms.

Prescription Preauthorization - If pre-authorization forms have to be completed, there will be a $35.00 charge. This fee must be paid before changes to your prescriptions are authorized. (This fee will not be covered by your insurance).

Signature (patient,parent/guardian if minor):_____Date:_____

Past due accounts - If you have a balance that is past due, this balance must be paid in full prior to your next appointment. If your account becomes past due, we will take necessary steps to collect this debt. Collection of debts may be made by referring debts to a collection agency, an attorney or court. You agree to pay all charges that we incur in collection of this account. This includes court costs, and a charge of 30% of the balance owed on all accounts referred to a collection agency.

Waiver of Confidentiality - You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce - In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records - You will need to request in writing, and may pay a reasonable copy/digital transmission fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy/transmit. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation - We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury/Liability - If this is a liability claim, payment of the account is the responsibility of the individual who is receiving treatment, not the individual who is being sued or the attorney. Payment is expected at the time of service.

Effective Date - Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Non-Covered Services - You are financially responsible for any services provided by our offices that are not covered by your insurance plan.

I acknowledge that I have read and understand this policy, and agree to abide by its terms. Leniency in the enforcement of this policy for a patient does not nullify this agreement. By signing below, I authorize the release of medical or other information necessary to process health insurance claims. I permit a copy of this authorization to be used in place of the original. I authorize payment of medical benefits directly to Piedmont Neurology, LLC for services rendered. This authorization may be revoked by me or my insurance company at any time, in writing.

PLEASE READ: All payments are due at the time of services. The patient is responsible for furnishing accurate insurance information and notifying us of any changes. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is NOT a substitute for payment.

Signature (patient): _____ Date: _____

Signature (parent/guardian if minor): _____ Date: _____

Piedmont Neurology, LLC

Patient Consent for Use and Disclosure of Protected Health Information

I understand that as a part of my healthcare, PIEDMONT NEUROLOGY originates and maintains health records describing health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care or treatment. This information serves as a basis for planning care, diagnosis, and treatment. It also serves as a means of communication among health care professionals who may contribute to my healthcare; a source of information for submitting my diagnosis and surgical information to my bill; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby give my consent for PIEDMONT NEUROLOGY to use and disclose protected health information about me to carry out treatment, payment and health care operations. The notice of Privacy Practices provided by PIEDMONT NEUROLOGY describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PIEDMONT NEUROLOGY reserves the right to revise its Notice of Privacy Practices at any time. A copy of the current Notice of Privacy Practices may be obtained upon request to PIEDMONT NEUROLOGY, 917 Bypass 225 S, Greenwood, SC 29646; Phone number (864) 227-5240.

With this consent, PIEDMONT NEUROLOGY may call my home or other alternative locations and leave a message on voice mail, text message, or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, PIEDMONT NEUROLOGY may mail to my home or other alternative locations any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, PIEDMONT NEUROLOGY may e-mail to my home or other alternative locations any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements. I have the right to request that PIEDMONT NEUROLOGY restrict how it uses or discloses my protected health information to carry out treatment, payment and health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PIEDMONT NEUROLOGY to use and disclose my protected health information to carry out treatment, payment and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PIEDMONT NEUROLOGY may decline to provide treatment to me.

Ways In Which Piedmont Neurology May Reach You

Remember: We may need to be able to reach you promptly about issues concerning your health. We must have at least two phone numbers.

Home: _____ Work: _____ Mobile: _____ Text Message Yes ☐ No ☐

May leave message on answering machine: Yes ☐ No ☐ May leave message at phone number listed below: Yes ☐ No ☐
(We will not disclose specific medical information on an answering machine, but will only leave a message for you to call the office.)

Your mailing address (required): _____

_____

May we email you through our patient portal? Yes ☐ No ☐
_____

Individuals with whom we may discuss your health care and may contact in case of an emergency (include phone numbers):

_____

Family Members with whom we may **NOT** discuss your care: _____

I acknowledge that I have read this disclosure and may have a copy of the Privacy Policy for Piedmont Neurology, LLC:

_____ _____ _____
Signature of Patient (or legal guardian) Full Name (printed) Date

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Spine/Back Disorders · Alzheimer's/Parkinson's Disease

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Patient First Name: _____ **Middle Name:** _____ **Last Name:** _____

Preferred Name (AKA): _____ **Maiden Name:** _____ **Mother's Maiden Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Student:** ☐ Full ☐ Part

Employment: ☐ Full ☐ Part ☐ Retired ☐ Military ☐ Disabled

Date of Birth: _____ **Social Security #:** _____ **Sex:** ☐ Male ☐ Female

Email Address: _____ **(If your e-mail has changed since your last visit, please alert the staff)**

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Language: _____ **Race:** ☐ Black ☐ White ☐ Other _____. **Ethnicity: Hispanic/Latino** ☐ Yes ☐ No

Primary Care Provider: _____ **Phone:** _____

Referring Provider: _____ **Phone:** _____

Employer/School: _____ **Phone:** _____

Person responsible for payment if NOT patient: _____ **Relationship:** _____

Date of Birth: _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

List individuals with whom we may discuss your health care and may contact in case of emergency (include phone numbers):

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Insurance: _____ **Certificate/Policy Number:** _____

Group Number: _____ **Subscriber Name:** _____

Subscriber DOB: _____ **Relationship:** _____ **Place of Employment:** _____

Secondary Insurance: _____ **Certificate/Policy Number:** _____

Group Number: _____ **Subscriber Name:** _____

Subscriber DOB: _____ **Relationship:** _____ **Place of Employment:** _____

****Please bring all prescriptions and non-prescription medications to all office visits.**

Piedmont Neurology, LLC

Medical History Questionnaire

Full Name: _____ **Today's Date**: _____

Date of Birth: _____ **Age**:_____ **Social Security #**: _____

What doctor referred you today? _____

Are you currently seeing or being treated by any other medical provider? (If yes, please list) _____

_____

Chief Complaint (Why do you need to see a neurologist today)? _____

_____

Past Medical History

1. What medical problems do **you** have?

☐ High Blood Pressure ☐ Heart Attack ☐ Epilepsy (seizures)

☐ Stroke ☐ Heart Rhythm Problem ☐ Heart Failure

☐ Diabetes ☐ Cancer ☐ Other: _____

2. What studies have you had (circle studies that apply)?

MRI CT Scan EEG EMG

3. Have you ever been hospitalized? (Please give year and reason):

_____

_____

4. Have you had any surgeries? (Please give year and type of surgery):

_____

_____

Family History

	Heart Disease	Stroke	High Blood Pressure	Seizures	Cancer	Diabetes
Father	☐		☐	☐	☐	☐
Mother	☐		☐	☐	☐	☐
Brother	☐		☐	☐	☐	☐
Sister	☐		☐	☐	☐	☐

Does anyone in your family have an illness like yours? _____.

Social History

1. What is the highest level of education you completed? _____

2. Do you work? ☐ YES ☐ NO Type of work: _____

3. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

4. Have you ever smoked cigarettes? ☐ YES ☐ NO If yes, how many do you smoke per day? _____

☐Current ☐ Former ☐ Nonsmoker

Patient Name _____

5. Do you drink alcohol? ☐ YES ☐ NO If yes, how much per week? _____

6. Are you ☐ Left Handed ☐ Right Handed

7. Do you have any medication allergies? ☐ YES ☐ NO

If yes, list the medications: _____

Review of Systems Do you currently have or have you ever had?

General
- ☐ Weight Loss
- ☐ Fever, Chills, Night Sweats

Integ
- ☐ Skin Rash
- ☐ Birthmarks

Eyes
- ☐ Double Vision
- ☐ Loss of Vision in One Eye
- ☐ Glaucoma
- ☐ Cataracts

Ears
- ☐ Ringing in the ears
- ☐ Hearing Loss
- ☐ Dizziness/Vertigo
- ☐ Balance Difficulty

Nose
- ☐ Nosebleeds
- ☐ Sinus Infections
- ☐ Loss of Smell

Throat
- ☐ Hoarseness
- ☐ Change in Voice
- ☐ Trouble Swallowing

Heart
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ History of Heart Attack
- ☐ Swelling in the Legs/Feet

Resp
- ☐ Shortness of Breath
- ☐ Wheezing/Asthma
- ☐ Chronic Cough

GI
- ☐ Indigestion/Reflux
- ☐ Ulcers
- ☐ Blood in Stool
- ☐ Hepatitis

GU
- ☐ Urinary Frequency
- ☐ Loss of Urine Unexpectedly
- ☐ Difficulty Urinating
- ☐ Kidney Infections

Musc
- ☐ Joint Pain
- ☐ Swelling Joints
- ☐ Muscle Aches
- ☐ Fatigue Easily

Neuro
- ☐ Seizures/Epilepsy
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Stroke
- ☐ Headaches
- ☐ Meningitis/Encephalitis

Psych
- ☐ Depression
- ☐ Anxiety
- ☐ Mood Swings
- ☐ Hallucinations

Heme
- ☐ Free Bleeder
- ☐ Blood Clots
- ☐ Easy Bruising

Endo
- ☐ Heat/Cold Intolerance
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Menopause
- ☐ Pregnant

Allerg/Immuno:
- ☐ Medication that suppresses immune system
- ☐ HIV/AIDS
- ☐ Allergies

Comments about the above: _____

_____

UNIVERSAL MEDICATION FORM

Date form started:

Name:	**Address:**
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	
Please List All Current Pharmacies you use (Local-specify location and Mail Order):	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	**OTHER**

Allergic To /Describe Reaction:	**Allergic To /Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	**NAME OF MEDICATION / DOSE**	**DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)**	**DATE STOPPED**	**Notes: Reason for taking / Doctor Name**