ENCLOSED PLEASE FIND PATIENT REGISTRATION AND HEALTH HISTORY FORMS THAT EVERY NEW PATIENT IS REQUIRED TO COMPLETE PRIOR TO THE FIRST VISIT TO OUR OFFICE. SINCE OUR OFFICE HAS IMPLEMENTED ELECTRONIC MEDICAL RECORDS, ALL FORMS FOR ALL ESTABLISHED PATIENTS MUST BE UPDATED AND COMPLETION OF THESE FORMS IS ALSO REQUIRED.

COMPLETE ALL FORMS, ALL SECTIONS, PROVIDE ALL SIGNATURES AND:

1. BRING TO YOUR FIRST APPOINTMENT OR
2. MAIL TO OUR OFFICE AHEAD OF YOUR APPOINTMENT OR
3. FAX AHEAD TO OUR OFFICE TO 610-644-1440 ATTENTION CHECK IN STAFF
4. KEEP THIS COVER LETTER AS A REMINDER OF YOUR APPOINTMENT

ARRIVAL AT OUR OFFICE:

NEW PATIENTS TO OUR OFFICE ARE TO ARRIVE 30 MINUTES PRIOR TO THE APPOINTMENT FOR INITIAL CHART PREPARATION.

ESTABLISHED PATIENTS IN OUR PRACTICE WHO HAVE BEEN ASKED TO COMPLETE THESE FORMS ARE ASKED TO ARRIVE 20 MINUTES PRIOR TO THE APPOINTMENT FOR UPDATING THE ELECTRONIC CHART.

IN ADDITION TO THE COMPLETED FORMS EVERYONE SHOULD BRING THE FOLLOWING TO THE APPOINTMENT:

1. YOUR INSURANCE CARDS; ORDER A REFERRAL FROM YOUR PRIMARY PHYSICIAN IF YOUR INS REQUIRES
2. PHOTO ID
3. COPAY IN CASH, CHECK OR CREDIT CARD.
4. COPIES OF PERTINENT MEDICAL RECORDS AND MRI FILMS AND DISKS

PATIENT NAME____________________________________________

YOUR APPOINTMENT IS _________________________________ AT __________________

YOU SHOULD ARRIVE AT OUR OFFICE BY _________________________________

KEEP THIS COVER LETTER AS YOUR APPT REMINDER!

REV 11-2014
GREAT VALLEY NEUROLOGICAL OFFICE POLICIES

- **PLEASE REFRAIN FROM USING YOUR CELL PHONE IN OUR OFFICE OR EXAM ROOMS. IF YOU NEED TO MAKE OR RECEIVE A CALL, PLEASE GO INTO THE HALLWAY.**

- If your insurance requires a REFERRAL, it is your responsibility to obtain the referral; if you do not have one your appointment may need to be rescheduled.

- COPAYMENTS are due at time of service. Our office can process your copay as a CREDIT card transaction, CASH and / or CHECK. You will be assessed a $5.00 billing fee if this office has to bill you for the copay.

- **Do not contact our office for prescription refill requests.** Contact your pharmacy first and they will fax us your request. Allow 48 hours to process a routine PRESCRIPTION request.

- It is expected that you will call by 12 noon the business day prior to your appointment to cancel or reschedule the appointment or you will be assessed a CANCELLATION FEE as described above.

- If you fail to show up for an APPOINTMENT or fail to give acceptable notice you will be billed for the appointment in the amount of $50.00 for an office visit and $100.00 for a visit involving a procedure.

- If your home phone is BLOCKED TO CALLER ID you may not receive a timely call back from this office since our phones are blocked to caller ID.

- There may be a fee for your record request or to have a form completed. This fee will need to be paid prior to the service being rendered.

- Always provide a stamped, self-addressed envelope with anything you wish return mailed to you such as a payment receipt, or completed form.

- If your insurance requires a PRECERT FOR AN IMAGING TEST ask the office staff for details regarding our process so we have all the information needed to obtain this pre-cert for you. DO NOT make your imaging appointment until you have your pre-cert.

- Please take your MRI films home with you today, unless the doctor specifically requests that you leave them.

- **Have you requested all the prescriptions you need today?**

Revised 11-2016
DATE COMPLETED__________________ PATIENT REGISTRATION FORM ACCT #_________________

NAME________________________________________________________ DATE OF BIRTH__________________ MALE _____ FEMALE _____

SOCIAL SECURITY__________________ SPOUSE’S NAME/DOMESTIC PARTNER_____________________________________________

ADDRESS: ____________________________________________________________

HOME PHONE: __________________________ WORK PHONE: ______________________ CELL: __________________________

FAX NUMBER: __________________________________________ IS THIS TURNED ON ALL THE TIME? YES_______ NO______

WHAT IS YOUR PREFERRED PHARMACY? LOCAL____ MAIL ORDER____

NAME & ADDRESS OF LOCAL PHARMACY: __________________________________ TEL: __________________________

DO YOU USE A MAIL ORDER PHARMACY? NO____ YES____ IF YES, COMPLETE NAME: __________________________________

ADDRESS: __________________________________________ TEL: __________________________ FAX ＃________________

MARITAL STATUS: ANNULLED____ DIVORCED____ DOMESTIC PARTNER_____ LEGALLY SEPARATED____ MARRIED____

NEVER MARRIED____ WIDOWED____

STUDENT STATUS: NOT A STUDENT_____ YES, I AM A STUDENT_____ FULL TIME____ PART TIME____

FOR REPORTING PURPOSES ONLY, NOT MANDATORY

RACE: WHITE____ BLACK/AFRICAN AMERICAN______ ASIAN____

NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER____ OTHER____________________ PATIENT DECLINED/UNKNOWN____

ETHNICITY: SPANISH/HISPANIC ORIGIN____ NOT OF SPANISH/HISPANIC ORIGIN____ PATIENT DECLINED/UNKNOWN____

PRIMARY LANGUAGE: __________________________________________ COUNTRY: __________________________

SECONDARY LANGUAGE, IF APPLICABLE: ____________________________ COUNTRY: __________________________

OCCUPATION________________________________________________________

EMPLOYMENT STATUS: FULL TIME____ PART TIME_____ RETIRED____ IF YES, DATE: __________________________

NOT EMPLOYED_____ SELF-EMPLOYED_____ ACTIVE MILITARY_____ UNKNOWN: __________________________

DISABLED: NO____ YES____ IF YES, DATE: __________________________

REPORTS OF YOUR VISIT TODAY WILL BE SENT TO THE FOLLOWING UNLESS OTHERWISE NOTIFIED:

PRIMARY CARE PHYSICIAN: __________________________ ADDRESS: __________________________

REFERRING PHYSICIAN: __________________________ ADDRESS: __________________________

CONTINUE TO PAGE #2
PATIENT REGISTRATION FORM

PATIENT NAME: ___________________________________________ DATE OF BIRTH: ________________________________

EMERGENCY CONTACT: LIST NUMBERS OTHER THAN PATIENT’S HOME, WORK OR CELL

NAME__________________________________________ RELATIONSHIP_________ HOME #________________________

WORK#_________________________ CELL#________________________

NAME__________________________________________ RELATIONSHIP_________ HOME #________________________

WORK#_________________________ CELL#________________________

GUARANTOR: PLEASE COMPLETE IF THE PERSON RESPONSIBLE FOR THE PATIENT’S BILL IS OTHER THAN SELF:

GUARANTOR: ___________________________________________ RELATIONSHIP_________ SOCIAL SECURITY__________

ADDRESS: _____________________________________________

DATE OF BIRTH _________ HOME #_________________________ WORK #_________________________ CELL #________________________

INSURANCE INFORMATION TO INSURE PROPER BILLING / A SEPARATE FORM IS REQUIRED FOR WORKER’S COMP, AUTO LIABILITY OR LEGAL SERVICES

PRIMARY CARRIER: ___________________________________________ ID NUMBER________________________

SUBSCRIBER: SELF YES____ NO____ IF NOT SELF, COMPLETE THE FOLLOWING

SUBSCRIBER NAME_________________________________________ DOB_________________________ SOCIAL SECURITY________________________

EFFECTIVE DATE: ___________________ GROUP NUMBER/PLAN NAME_________________________ REQUIRES A REFERRAL: yes_____no____

SECONDARY CARRIER: ___________________________________________ ID NUMBER________________________

SUBSCRIBER: SELF YES____ NO____ IF NOT SELF, COMPLETE THE FOLLOWING:

SUBSCRIBER NAME_________________________________________ DOB_________________________ SOCIAL SECURITY________________________

EFFECTIVE DATE: ___________________ GROUP NUMBER/PLAN NAME________________________

I CONFIRM THAT THE ABOVE INSURANCE INFORMATION IS ACCURATE AND UNDERSTAND IT IS MY RESPONSIBILITY TO KEEP MY PROVIDER INFORMED OF CHANGES IN MY INSURANCE COVERAGE.

PATIENT SIGNATURE: ___________________________________________ DATE: __________________________

PATIENT GUARANTOR PRINTED NAME, IF DIFFERENT THAN SELF: ___________________________________________

PATIENT GUARANTOR SIGNATURE: ___________________________________________ DATE: __________________________

DO YOU HAVE ANY DRUG ALLERGIES? NO______ YES________

IF YES, LIST__________________________________________________________________________________________

UPON COMPLETION OF THIS FORM, PLEASE RETURN IT TO CHECK- IN DESK PERSONNEL
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Patient Name__________________________________________________________Date of Birth________________________

******************************************************************************

I authorize the release of any medical information necessary to process claims with my insurance company or companies, or, in the case of Workers Compensation claims, to my past and present employer(s) for the purposes of satisfying charges billed by GVNA and the release of information back to my physician.

I authorize Great Valley Neurological Associates to release medical information regarding my visit to my referring and/or family physicians.

Patient Signature__________________________________________________________Date________________________

Payment's Agent Representative/Guarantor Signature________________________________________Date________________

******************************************************************************

I acknowledge that I have received the Notice of Privacy Practices (v.1) available in the office. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice’s use and disclosure of my communications between the Practice and myself or others.

Patient Signature__________________________________________________________Date________________________

Payment’s Agent Representative/Guarantor Signature________________________________________Date________________

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rev: 11-2014
GREAT VALLEY NEUROLOGICAL ASSOCIATES
PATIENT CONSULTATION HISTORY TO BE COMPLETED BY PATIENT

TODAY’S DATE: ______________________

PATIENT NAME_________________________________________________

DATE OF BIRTH______________AGE_______

PRIMARY CARE PHYSICIAN: ______________________________

REFERRING PHYSICIAN: ____________________________

OCCUPATION: __________________________________________

DOMINATE HAND: RIGHT / LEFT/ AMBIDEXTROUS

MARITAL STATUS: S / M / W / D / CO-HABITATE

SMOKER: Y / N HOW MUCH PER DAY? _____________ DID YOU EVER SMOKE? YES / NO

ALCOHOL: Y / N HOW MUCH? ________________

HAVE YOU FALLEN IN THE LAST YEAR? YES NO IF YES, HOW MANY TIMES? ________ ANY INJURIES? ____________

REASON FOR TODAY’S VISIT:

CURRENT MEDICATIONS AND DOSAGES, INCLUDING VITAMINS AND SUPPLEMENTS (use reverse side if needed)

DRUG ALLERGIES: Y/ N IF YES, LIST:

PAST MEDICAL HISTORY:

ANEMIA Y/N OTHER EYE PROB Y/N

ARTHRITIS Y/N HEAD INJURY Y/N PEPTIC ULCER Y/N

ASTHMA Y/N HEART DISEASE Y/N SEIZURE Y/N

BACK INJURY Y/N HEPATITIS Y/N STROKE Y/N

BOWEL DISEASE Y/N HIGH B. P. Y/N THYROID DISEASE Y/N

DEPRESSION Y/N MIGRAINE Y/N CANCER Y/N

DIABETES Y/N MUSCLE DISEASE Y/N TYPE______

GLAUCOMA Y/N NECK INJURY Y/N

OTHER, PLEASE LIST:

MAJOR SURGERY HISTORY:

CABG Y/N CAROTID SURGERY Y/N HEART SURGERY Y/N

JOINT SURGERY Y/N HEART STENTS Y/N PACEMAKER Y/N

BRAIN SURGERY Y/N Type________ NECK SURGERY Y/N OTHER, LIST:

CANCER SURGERY Y/N BACK SURGERY Y/N

FAMILY HISTORY: LIST RELATIONSHIP OF AFFECTED FAMILY MEMBER

HEART DISEASE Y/N_______ MENTAL ILLNESS Y/N_______ PARKINSON’S DISEASE Y/N_______

MIGRAINE Y/N_______ SEIZURES Y/N_______ MULTIPLE SCLEROSIS Y/N_______

CANCER Y/N_______ TREMOR Y/N_______ NEUROPATHY Y/N_______

SENSIBILITY/DEMENTIA Y/N_______ STROKE Y/N_______

OTHER CONDITIONS THAT RUN IN YOUR FAMILY AND FAMILY MEMBER AFFECTED:

REVIEW OF SYSTEMS: DO YOU HAVE SIGNIFICANT PROBLEMS WITH ANY OF THE FOLLOWING?

- EASY BRUISING/BLEEDING
- PALPITATIONS
- SKIN RASHES
- NUMBNESS
- NAUSEA/VOMITTING
- FAINTING
- FATIGUE
- VISION CHANGES
- CHEST PAIN
- HEARING CHANGES
- PAIN IN EXTREMITIES
- URINARY INCONTINENCE
- HEARING CHANGES
- VERTIGO/DIZZINESS
- DEPRESSION

- WEAKNESS
- HEADACHES
- ABDOMINAL PAIN
- MUSCLE CRAMPS
- NIGHT SWEATS
- BLOOD CLOTS
- TROUBLE BREATHING
- SNORING
- CHEST PAIN
- WEIGHT CHANGE
- NECK PAIN
- BACK PAIN
- SEASONAL ALLERGIES
- WORD FINDING
- PAIN WITH URINATION

OTHER:

rev: 11-2014
GREAT VALLEY NEUROLOGICAL ASSOCIATES LLC
FINANCIAL POLICY

Great Valley Neurological Associates is dedicated to providing our patients with the best possible care and services. We ask your help by understanding and cooperating with our financial policy.

INSURANCES: We participate with several insurance companies. It is, however, the patient’s responsibility to inquire with their insurance company to determine if Great Valley Neurological Associates is an in-network provider with his insurance company. Your health insurance coverage is an agreement between you and your insurance company and your doctor’s bill for the services provided to you is an agreement between you and your doctor.

If we DO participate with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. All co-payments and deductibles are the patient’s responsibility. All copayments are due at the time services are rendered or a $5.00 billing fee will be added to your account.

If we DO NOT participate with your insurance company, we will submit a claim to your insurance company for you, but will not accept payment from them as payment in full for the services provided. All insurance carriers have a schedule of fees from which they pay, however, the doctor’s fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient.

HMO INSURANCES may require a referral for services. It is the patient’s responsibility to obtain the referral prior to the appointment or the patient will be responsible for payments in full for that service at the time of service.

PAYMENT FOR SERVICES RENDERED: Our office accepts CASH, CREDIT and PERSONAL CHECKS for payment. A $25.00 transaction fee will be added to your account for any personal check returned by the bank for any reason. All payments are expected at the time of service as stated above and any outstanding balances are due within 30 days unless prior arrangements have been made with our Billing Dept. All balances that reach 90 days past due will be sent to a Collection Agency. Should your account be sent to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

ADMINISTRATIVE FEES including but not limited to the following will be the patient’s responsibility; $50.00 Missed appointment fee for office visits, $100.00 for Missed office visits with a scheduled procedure $25.00 returned check fee, $5.00 copay billing fee, $25.00 fee to repeat a precertification for imaging if the patient fails to obtain the imaging before the precert expires or changes the site. Fees for record retrieval and copying, completion of forms and legal services may apply and are available on request.

I request that payment of Medicare and/or insurer benefits be made to me or on my behalf to Great Valley Neurological Associates for the services furnished to me by Great Valley Neurological Associates. I understand that if, under Medicare and/or insurer guidelines, a necessary service is determined to be non-covered, I will personally be responsible for any amounts denied or partially paid by the third payer.

I confirm that the personal billing & insurance information I have provided to Great Valley Neurological Associates is accurate and I agree to inform the office of changes. I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY GREAT VALLEY NEUROLOGICAL ASSOCIATES, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Patient Name Printed:_________________________________________Date of Birth____________________________

Patient Signature:_________________________________________Date:________________

Printed Name of Patient’s Agent/ Guarantor:_____________________________________________________________

Signature of Patient’s Agent/ Guarantor:_____________________________________________________________Date:________________

REV: 11-2016
GREAT VALLEY NEUROLOGICAL ASSOCIATES ENCOURAGES YOUR USE OF THE PATIENT PORTAL

This is the most efficient and easy way for you to communicate with the office.

What is the Patient Portal?

The Patient Portal provides you with secure, online access to portions of your medical records, as well as an easy and convenient way to communicate with the practice through a secure internet connection. Think of it as an online account for your doctor’s office, similar to online banking or credit card accounts you may currently have.

With the Patient Portal you will be able to:

- Send and receive non-urgent messages and information from your doctor’s office, including test results and educational material
- Easily notify the practice of changes to your personal information, including phone number, address and insurance changes
- Request a refill for a medication prescribed by a provider at the practice
- View upcoming and previous appointments, including the doctor and location of those appointments
- View and or print your current medication and allergies list

How is the Patient Portal secure?

We take great care to make sure your health information is kept private and secure. The Patient Portal uses HTTPS to provide encrypted communication between you and your doctor’s office. Access to your portal account is controlled through secure access codes, personal ID’s, and passwords. Only you will have access to the login information needed to view your account.

What are the benefits of the Patient Portal?

The Patient Portal helps you take a more active role in your healthcare. Having a patient portal account helps the practice create a more accurate record of your medical history as well as educate you on certain aspects of your health. It provides you and the practice with a more efficient means of communication, eliminating sources of frustration such as phone tag. You will also be able to print or download portions of your chart to take with you to other providers participating in your care, thus reducing the amount of paperwork you may need to fill out. Having a patient portal account also helps to eliminate the amount of paper waste a practice produces. Documents, letters, and orders that might otherwise be mailed to you can be sent quickly and conveniently to your portal account. You will continue to have access to these documents until you choose to delete them from your inbox, so you won’t have to worry about important medical papers or letters getting damaged or lost.

What do I need to use the Patient Portal?

You will need access to a computer connected to the internet and an up-to-date browser (such as Internet Explorer or Safari). You will also need an email address. The email address you provide is only used to notify you when you have a new message in your portal account. It is treated with the same privacy and care as your health records and will never be sold or leased. It is recommended that you use an email address only you have access to.

How do I sign up?

In order to have a patient portal account you will need to already be a patient at this practice or have a new patient appointment scheduled. To activate your account, you will need to receive an activation code from us. Once you have received the code, you will be able to create your own username, password, and other login information used to verify your identity. If you would like to activate your portal account, please contact the office to receive your activation code.
GREAT VALLEY NEUROLOGICAL ASSOCIATES, LLC

11 INDUSTRIAL BLVD., SUITE 204
PAOLI POINTE MEDICAL OFFICE BUILDING
PAOLI, PA 19301

THOMAS H. GRAHAM MD FAAN  
CRAIG J. GARDNER DO  
JOYCE D. LIPORACE MD  
RUTH A BROBST CRNP MSN

TEL 610-644-6251  
FAX 610-644-1440

DIRECTIONS

From the PA turnpike traveling East or West

Take the Valley Forge exit / exit Route 202

After the tollbooth, follow signs for 202 South / West Chester

From 202, exit at Malvern / Route 29 South

Follow signs to Route 29 South

Take Route 29 South to Route 30

At the traffic light, bear left following Route 30 East

Travel about 1 ½ miles to Paoli Hospital entrance on the left

*** Drive into the entrance of the hospital, pass the parking garage on the left. Do not follow signs for the Medical Office Buildings to the left.

You will come to a dead-end stop sign where you should turn right.

Paoli Pointe Medical Office Building is immediately on your left; it is not attached to the hospital.

The parking lot is on your right, across the driveway from the Paoli Pointe Building.

Our office is on the second floor, in Suite 204. Elevators are available; public wheelchairs are not available.

IF YOU CHOOSE TO MAPQUEST THE DIRECTIONS, THEN MAPQUEST FOR PAOLI HOSPITAL, 255 WEST LANCASTER AVENUE, PAOLI, PA  19301 AND THEN FOLLOW THE DIRECTIONS ABOVE FROM THE *** TO LOCATE OUR OFFICE.
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual’s health information as described below.

Patient Name __________________________________________ Date of Birth ________________________  
Complete Address _________________________________________________________________  
Home Phone Number __________________________ Work Phone Number __________________________  
The following individual or organization is authorized to make the disclosure:  
_______ GREAT VALLEY NEUROLOGICAL ASSOCIATES LLC  
_______ OTHER, PLEASE SPECIFY ____________________________________________________________  
This information may be disclosed / sent TO and used by the following individual or organization:  
Practice Name/Address: ________________________________________________________________  
City/State/Zip: __________________________ Phone: __________________________ Fax: ____________  
_______ OTHER, PLEASE SPECIFY ____________________________________________________________  
Treatment dates to be released: ____________________________________________________________  
Purpose of Request:  
The following information is to be disclosed: Please circle YES or NO for each item  
YES NO Physician Notes YES NO Lab results  
YES NO Imaging reports YES NO Neurodiagnostic reports (EMG, EEG, EP)  
(CT scans, MRI/MRA, x-rays)  
YES NO Complete Record  
YES NO Other: ____________________________________________________________  
SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency syndrome (AIDS) or infection with the immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.  
RE-DISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.  
RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.  
OTHER RIGHTS:  
a. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study my enrollment in the research study may be denied.  
b. I understand that I may inspect or obtain a copy of the information to be used or disclosed.  
EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I do not specify an expiration date, event, or condition, this authorization will expire in six (6) months.  
Signature of Patient or legal representative __________________________________________ Date ________________  
If signed by legal representative, relationship to patient __________________________________________