GREAT VALLEY NEUROLOGICAL ASSOCIATES, LLC

PAOLI POINTE MEDICAL OFFICE BUILDING

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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. <u>KEEP THIS COVER LETTER AS A REMINDER OF YOUR APPOINTMENT</u>

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. <u>YOUR</u> 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________________________________

<u>KEEP THIS COVER LETTER AS YOUR APPT REMINDER!</u>

REV 09/2019

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

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: ____ MARITAL STATUS: S / M / W / D / CO-HABITATE
DOMINATE HAND: RIGHT / LEFT/ AMBIDEXTROUS
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_________
SENILITY/DEMENTIA	Y/N_______	STROKE	Y/N______		

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

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

- EASY BRUSING/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
- NIGHT SWEATS
- WEIGHT CHANGE
- NECK PAIN
- BACK PAIN
- SEASONAL ALLERGIES
- WORD FINDING
- PAIN WITH URINATION
- IMBALANCE
- FEVER
- URINARY FREQUENCY
- CONSTIPATIONDIARRHEA
- MEMORY LOSS
- POOR ATTENTION
- DOUBLE VISION
- SPEAKING
- SWALLOWING
- APPETITE CHANGES
- ANXIETY
- INSOMNIA

OTHER:

rev: 11-2014

GREAT VALLEY NEUROLOGICAL ASSOCIATES

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: ___________________________

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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 GVNA CONTINUED PAGE #2

PATIENT NAME: ____DATE OF BIRTH____

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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 SELFl____

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

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, LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Patient Name____Date of Birth______________________

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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___________________________

Patient's Agent Representative/ Guarantor Signature____Date____________

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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___________________________

Patient's Agent Representative/Guarantor Signature____Date____________