GREAT VALLEY NEUROLOGICAL ASSOCIATES, LLC

PAOLI POINTE MEDICAL OFFICE BUILDING

11 INDUSTRIAL BLVD., SUITE 204

PAOLI, PA 19301

CRAIG J. GARDNER, DO
LAUREN C. FLYNN, DO
KATHLEEN F. CANFIELD, PA-C
LELIAN HANNA, CRNP

TEL 610-644-6251
FAX 610-644-1440
www.greatvalleyneuro.com

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 09/2026

GREAT VALLEY NEUROLOGICAL ASSOCIATES

DATE COMPLETED_____PATIENT REGISTRATION FORM ACCT #_____

NAME_____DATE OF BIRTH_____MALE _____ FEMALE _____

SPOUSE'S NAME/DOMESTIC PARTNER_____

ADDRESS: _____

HOME PHONE: _____WORK PHONE_____CELL_____

FAX NUMBER: _____ IS THIS TURNED ON ALL THE TIME? YES_____ NO_____

EMAIL ADDRESS: _____

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 GVNA CONTINUED PAGE #2

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 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; $75..00 Missed appointment fee for office visits, **appointments must be cancelled or re-scheduled greater than 24 hours prior to your appointment,** $125.00 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: 10-2026

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?

o EASY BRUSING/BLEEDING	o WEAKNESS	o IMBALANCE
o PALPITATIONS	o HEADACHES	o FEVER
o SKIN RASHES	o ABDOMINAL PAIN	
o NUMBNESS	o MUSCLE CRAMPS	o URINARY FREQUENCY
o NAUSEA/VOMITTING	o NIGHT SWEATS	o CONSTIPATIONDIARRHEA
o FAINTING	o BLOOD CLOTS	o MEMORY LOSS
o FATIGUE	o TROUBLE BREATHING	o POOR ATTENTION
o VISION CHANGES	o SNORING	o DOUBLE VISION
o CHEST PAIN	o NIGHT SWEATS	o SPEAKING
o HEARING CHANGES	o WEIGHT CHANGE	o SWALLOWING
o PAIN IN EXTREMITIES	o NECK PAIN	o APPETITE CHANGES
o URINARY INCONTINENCE	o BACK PAIN	o ANXIETY
o HEARING CHANGES	o SEASONAL ALLERGIES	o INSOMNIA
o VERTIGO/DIZZINESS	o WORD FINDING	
o DEPRESSION	o PAIN WITH URINATION	OTHER:

GREAT VALLEY NEUROLOGICAL ASSOCIATES, LLC

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_____

Patient'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_____

Patient's Agent Representative/Guarantor Signature_____Date_____

rev: 11-2014