SAVANNAH NEUROLOGY SPECIALISTS

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Savannah, Georgia 31406
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Welcome!

You have been scheduled for an appointment with_____. In this packet you will find all of the necessary information you will need to complete for your appointment. **If you are unable to keep your appointment, please give us 48-hour notice.**

Save time! Please go online to our secure web portal at www.savannahneurologyspecialists.com and register to complete your New Patient paperwork. With our web portal, you will also be able to request follow-up appointments, request Rx refills, pay bills online, and ask questions of our staff! After registering, make sure you complete the **New Patient Medical History**. You may also call our office and provide us with your email. Two days prior to your appointment, you will receive a link to complete all your paperwork online and pre-check in for your appointment! This will significantly decrease your wait time in the lobby.

If you have not completed this paperwork, or registered online, you are required to arrive 45 minutes prior to your scheduled appointment to complete our electronic check-in process. Late arrivals may cause a delay or the rescheduling of your appointment.

Please be sure to bring ALL of the following to your appointment. Failure to do so may result in the rescheduling of your appointment:

- Insurance cards and Picture ID
- All current medications
- Copy of any diagnostic imaging studies (x-ray, MRI, CT-scan, etc...) **DISK AND REPORT.**
- Any referrals and/or authorizations required to process insurance. *You are responsible for obtaining any authorizations your insurance may require for your visit. If an authorization is required by your insurance company and there is no authorization on file, your appointment will be rescheduled.*
- Co-pays, co-insurance, and unmet deductibles due at your visit. This includes Medicare deductibles.

Please bring, or have your referring or primary care physician send all medical records to our office including diagnostic testing, EEG reports and laboratory findings.

If you have any questions, please do not hesitate to call us at (912) 354-7676 or visit our website at www.savannahneurologyspecialists.com

We look forward to having you as a patient!

Savannah Neurology Specialists Physicians and Staff

Insurance and Injury Questionnaire

All patients are <u>required</u> to answer the following questions.

We file insurance as a courtesy to our patients, however, the following must be filled out in order to process your claim.

Patient Name: _____ Date of Birth:_____

Primary Insurance (A copy of your insurance card is required)
If Workers' Compensation, please skip this section
Insurance Carrier: _____ ID#: _____
Group #: _____ Policy Holder (if other than patient): _____
Date of Birth: _____/_____/_____ SSN: _____ Relationship to Patient: _____

Secondary Insurance (A copy of your insurance card is required)
Insurance Carrier: _____ ID#: _____
Group #: _____ Policy Holder (if other than patient): _____
Date of Birth: _____/_____/_____ SSN: _____ Relationship to Patient: _____

Are you receiving Black Lung Benefits? YES NO

Are you receiving Worker's Compensation Benefits? YES NO

Are you receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? YES NO

Will this claim be filed with any other insurance such as homeowners or business liability, etc?
YES NO

Signature: _____Date:_____

☑*<u>Only if you answered YES</u> to any of the above questions, please complete the following:*

Name of Workers Compensation, Black Lung, Auto Insurance, Homeowners or Business Liability Insurance Co:

Claim/Policy #: _____ Date of Injury: _____
Adjustor Name: _____ Adjustor Phone: _____
Adjustor Fax: _____

Do you have any other insurance other than what you have listed above that you would like to be filed on this claim? YES NO

If yes, please list information below:
Name of Insurance Company: _____
Address: _____
Insured: _____
Policy #: _____ Group #: _____

Savannah Neurology Specialists, P.C.
Financial and Treatment Policy

Thank you for choosing Savannah Neurology Specialists, P.C. In order to keep your costs as low as possible, we have the following financial policy in place. All patients are required to read and sign this document prior to their first visit.

Before your appointment, please verify that we are a participating provider in your insurance plan and obtain any necessary authorizations. Our contracts with insurance plans require that we collect any co-payment, co-insurance, or deductible due before you are seen for your appointment, unless other arrangements have been made prior to your appointment. Failure to pay a fee due prior to your appointment may result in the rescheduling of your appointment. You will be financially responsible for any services provided that are not covered by your insurance. For patients without insurance coverage, all professional services rendered are charged to the patient and are due at the time of service, unless prior arrangements are made.

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit, while others pay only a percentage of the costs. Radiology, labs, and other outpatient procedures may have a higher co-payment or apply to the annual deductible. It is the patient's responsibility to understand their insurance coverage and to notify us of any changes in insurance coverage.

When you receive a statement from Savannah Neurology Specialists, you are required to pay the balance due upon receipt of the statement. Those accounts not paid in full within 90 days with no acceptable payment arrangement will be referred to an outside collection agency. Accounts turned over to outside collection agencies are subject to an administrative fee of 25% of the account balance.

Acceptable forms of payment are cash, check, and all major credit cards. Please note, if you pay with a check and it is returned unpaid by your bank, your account will be charged a service fee of $30.00. We will bill you for the amount of the returned check plus the service fee according to the policy stated above.

If you do not show up or if you do not cancel your appointment more than 24 hours prior to your scheduled appointment, a $50.00 No Show fee will be added to your account balance. This includes all procedure, radiology, and new patient visits.

If the patient is a minor, the adult accompanying the patient and the parents or guardians of the patient are responsible for full payment.

I have read and understand the financial policy of the practice and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice. I authorize the release of any medical information necessary to process my insurance claim.

Patient Name (PLEASE PRINT)

Signature of Patient or Responsible Party Date

Savannah Neurology Specialists, PC
6602 Waters Avenue, Building C
Savannah, Georgia 31406
(912) 354-7676 Phone
(912) 354-7181 Fax

HIPAA DISCLOSURE FORM

Authorization for release of information for specific purposes.

I hereby authorize Savannah Neurology Specialists to release the following information from the health records of:

Patient Name:_____Date of Birth:_____

To be released to:

Name: _____Relationship: _____ DOB:_____Phone:_____

Name: _____Relationship: _____ DOB:_____Phone:_____

INFORMATION TO BE RELEASED: (Check All That Apply)

o **Entire record**	o Lab results	o Demographics
o Radiology results	o Medication records	o Office notes

FOR THE PURPOSE OF:

o **Anything on behalf of patient**	o Creating/changing appointments	o Picking up prescriptions, forms, medications
o Speaking to SNS Staff regarding my PHI	o Billing Purposes	o Other:_____

I understand that Savannah Neurology Specialists will refuse to discuss my information with anyone not listed above, except in an emergency. I understand that I can revoke this authorization by providing written notice to Savannah Neurology Specialists at the address listed above. I understand that if information has been released by relying upon this authorization, that revocation will not be valid. I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or dependency, psychiatric or psychological illness, mental illness or retardation and acquired immune deficiency (AIDS) syndrome. I understand that I am waiving my rights to privacy by releasing my medical information to the above listed parties and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above. I also understand that this consent does not apply to medical providers in the treatment of my care.
In addition to granting permission to the above named individuals, I have received a copy of the Savannah Neurology Specialists "Notice of Privacy Practices" which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understand the contents of the notice. ***This form can be amended at any time if the patient/responsible party completes and signs a new form.***

_____ _____

Print Patient's Name **Date**

_____ _____

Signature of Patient or Responsible Party **Witness**

NOTICE OF PRIVACY POLICIES
Savannah Neurology Specialists, P.C.

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction
At Savannah Neurology Specialists, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit Savannah Neurology Specialists, P.C. a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Savannah Neurology Specialists, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record.
- Request that your record be amended.
- Obtain an accounting of disclosures of your health information: To do this, please contact Savannah Neurology Specialists, P.C.'s Privacy Officer. This information will be provided to you within 30 days.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose your health information.
- You may request that we not submit your information to your health insurance carrier if you have paid for the service.
- You may request an electronic copy of your health record.

Our Responsibilities
Savannah Neurology Specialists, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice about our privacy practices,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We must notify you of a breach of unsecured health information.

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please put your request in writing to Savannah Neurology Specialists, P.C.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer at (912)354-7676.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physicians or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives of other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Savannah Neurology Specialists, P.C.
6602 Waters Avenue - Bldg. C
Savannah, GA 31406
Tel: (912) 354-7676

PATIENT REGISTRATION (Please print clearly in BLACK or BLUE ink only.)

Name: _____ Date of Birth: _____/_____/_____ SSN: _____

Please circle all that apply: (These questions are required by the Federal Government to meet Meaningful Use Guidelines-you may decline to answer by circling DECLINED in each column.)

Marital Status:
Married
Single
Divorced
Separated
Widowed
Declined

Race:
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Pacific Islander
White
Other: _____
Declined

Ethnicity:
Hispanic/Latino
Not Hispanic/Latino
Declined

***Sexual Orientation**
Straight/Heterosexual
Lesbian/Gay/Homosexual
Bisexual
Don't Know
Choose not to disclose

Sex:
Male
Female

***Gender Identity:**
Male/Female
Transgender Male
Transgender Female
Genderqueer
Other
Choose not to disclose

Religion:
Buddhist
Catholic
Hindu
Islam
Jehovah's Witness
Jewish
Mormon
Protestant
Other: _____
Declined

Primary Language: _____

*State Regulations require us to include these questions, you do not have to answer *

Mailing Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Preferred Phone: □ home □ work □ cell Ok to leave message at home? □ yes □ no/ at work? □ yes □ no/ on cell? □ yes □ no

Email: _____ Employer: _____

Referring Physician: _____ Primary Care Physician: _____

Some insurances have a required pharmacy, hospital and/or lab. Please fill out your required or preferred location for:
Pharmacy: _____ Hospital: _____ Lab: _____

If Patient is a minor or dependent, please complete the following information:
Responsible Party: _____ Date of Birth: _____
SSN:_____Relationship to Patient: _____
Home #: _____ Cell #: _____ Work#: _____
Address: _____City: _____ State: _____ Zip: _____

EMERGENCY CONTACT (other than Responsible Party):

Name: _____ Relationship to Patient: _____

Home #: _____ Work #: _____ Cell #: _____

Patient Acknowledgment

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmission of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Savannah Neurology Specialists, PC.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to Savannah Neurology Specialists should they elect to receive such payment.
I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by written withdrawal.

Patient or Responsible Party Signature: _____ **Date:** _____