

PATIENT REGISTRATION (Please Print Legibly)

Patient's Last Name _____ First: _____ Middle Init: _____

Address: _____

City: _____ ST: _____ Zip: _____ Home Phone: _____

Email address: _____ Preferred Contact: Home ___ Cell ___ Work ___

Cell Phone: _____ Work Phone: _____ Ext: _____

Birth Date: M ___ / D ___ / Y ___ Soc Sec No: ___ - ___ - ___ Sex: M ___ F ___

Preferred Language _____ Ethnicity _____ Race _____

Emergency contact: _____ Phone _____ Relationship: _____

Spouse's Name: _____ Spouse's Birth Date: ___ / ___ / ___

Primary Care Physician: _____ Phone: _____

Insurance: _____ Policy Holder's Name: _____

Address (for claims): _____ City: _____ ST ___ Zip _____

Policy ID#: _____ Group #: _____ Policy Holder's Birth Date ___ / ___ / ___

Secondary Insurance: _____ Policy Holder's Name: _____

Address (for claims): _____ City: _____ ST ___ Zip _____

Policy ID#: _____ Group #: _____ Policy Holder's Birth Date ___ / ___ / ___

I ACKNOWLEDGE THAT THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

DATE: ___ / ___ / ___ X _____

(Signature) (revised 02/2021)

Lakeside Neurology P.C.

Name: _____ Referring physician: _____

Preferred Pharmacy: _____ Pharmacy number: _____

Past medical history: check all that apply

- Hypertension Heart disease Atrial fibrillation High cholesterol
- Diabetes Stroke Parkinson's Head injury
- Neuropathy Brain tumor Spine disease Migraines
- Asthma/COPD Kidney disease Liver disease HIV

Cancer (indicate type) _____ Other: _____

Past surgical history:

Social history: Occupation _____ Marital status/# of children: _____

Tobacco use: current, former, never? (circle)/if current, how many packs per day? _____

Alcohol use: _____ Recreational drug use: _____

Family history: check all that apply

- Diabetes Stroke Hypertension Heart disease
- Epilepsy Cancer (indicate type) _____ Dementia Migraines

Other: _____

Current medications: list doses and how often taken, including as needed medications, do not complete this section if written/typed list available (please provide to front desk staff)

Medication allergies: _____

Lakeside Neurology, P.C.

Review of Systems

Name: _____

Date: _____

Please check all symptoms that you have had in the last month

General

__fever

__weight loss

__fatigue

Gastrointestinal

__abdominal pain

__nausea/vomiting

__diarrhea

Skin

__rash or itching

Urinary

__frequent urination

__incontinence

Eyes and ears

__visual loss

__double vision

__hearing loss

Musculoskeletal

__joint pain or swelling

__muscle aches or cramps

Respiratory

__cough

__shortness of breath

Cardiac

__chest pain

__palpitations

Sleeping

__snoring

__insomnia

__falling asleep during the day

Miscellaneous

__depression

__anxiety

__loss of appetite

__other _____

In the event our physician needs to prescribe "controlled substance" medications for your condition, we have the following policy.

CONTROLLED SUBSTANCE MEDICINE POLICY

(Please read carefully and sign at the bottom. A copy will be provided to you.)

1. I agree to take controlled substance medication exactly as instructed. I am **NOT** allowed to change dosage amounts or alter the time schedule of taking the medication without first talking to my prescribing physician.
2. Controlled substance medications **WILL NOT** be phoned in after business hours or on weekends.
3. Only **ONE** pharmacy will be used for filling controlled substance prescriptions.
4. The following are conditions for **IMMEDIATE TERMINATION** from the practice:
 - a. Obtaining controlled substance medications from **ANY** other physician while under our care without our knowledge.
 - b. Altering or forging of a prescription is a **felony** and will be reported.
5. Patients may be terminated from the practice with 30 days notice for noncompliance in the taking of their medication.
6. We will **NOT** refill prescriptions that have been lost or misplaced. Please be responsible for keeping up with your controlled substance prescription.
7. Stolen medications will be replaced **ONCE** and **ONLY** if you have a valid police report.
8. In the case of intolerance or ineffective controlled substance medications, a different prescription could be given, provided the unused portion of the previously prescribed medication is returned.
9. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend **AGAINST** the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a **DUI**.
10. I will **NOT** combine any controlled substance medications with the consumption of alcohol.
11. I will **NOT** give, trade or sell controlled substance medications.
12. I will allow 24 hours for prescription refills to be authorized. I also understand that requests received after 4:00PM are handled on the next business day.

I have read and understand the above policy and agree to abide by its terms.

Patient Signature

Date

Lakeside Neurology PC Office Protocol and Policies

We would like to thank you for making an appointment with our office. We are aware that each medical practice has different procedures. Becoming familiar with our policies will help us in our working relationship with you. We do our best to see patients in a timely manner, please arrive on time for your appointment. Arriving late can result in not being seen and we may ask you to reschedule your appointment.

1. If your insurance company requires a referral for specialist office visits, you are responsible for obtaining this referral from your primary care physician and making sure that your referral is valid for every office visit.
2. There is a \$50.00 fee for missed appointments if we are not given at least a 24-hour notice. This fee is not covered by insurances and will be due prior to your next appointment being scheduled.
3. If your insurance turns down a claim because it is not a covered service under your plan, or because it is a preexisting condition, etc., you are responsible for payment of these services.
4. We do not file third party claims. This would include motor vehicle (MedPay) claims.
5. At the time of your visit you will be responsible for paying the portion of the bill not covered by your insurance. This includes co-pays for each visit. Please become familiar with your insurance requirements.
6. Patients being seen as a scheduled "work-in" will see the Doctor as quickly as possible after patients with regularly scheduled appointments.
7. At least 24 hours notice is needed to call in any prescription/refill. Please choose Option 3 (prescription line) to leave messages for prescriptions/refills. Check with your pharmacy after 5:00PM to see if your prescription has been called in. If you use a mail order pharmacy, it is the patient's responsibility to mail the written prescription to the pharmacy. We are not able to call in mail order prescriptions.
8. Prescription/refill calls received on Friday may not be filled until Monday. No additional requests for prescriptions/refills are taken after 4:30 Monday-Friday or on weekends. If you are in severe pain, go to the Emergency Room. Prescriptions are written to last until your next scheduled office visit. No narcotic medications will be prescribed over the phone after office hours. If narcotic medications are needed after office hours, they will be dispensed through the emergency room.
9. If you would like to know routine test results, please call one week after the testing to allow time for us to receive the information.
10. If you have insurance that we are in network with and choose not to use your insurance for any reason, you will be billed the full rate of our services.
11. We will mail you two statements once your insurance has settled your claim if you owe abalance. After the second statement, if you have not paid the balance or made payment arrangements, the account will be turned over to collections.
12. Any returned check written to our practice will incur a charge of \$35.00. This will be added to your account for collections. If the returned check is not taken care of immediately by credit card orcash, the account will be turned over to collections and an additional fee of \$35.00 will be incurred for the processing to a collection agency,

Patient Signature _____ Date: _____

**Patient Authorization for Practice to Release
Protected Health Information to Third Parties**

By signing this authorization, I authorize Lakeside Neurology, PC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

I give my permission to Lakeside Neurology PC to leave detailed messages on my home phone.

Patient Signature: _____ Date: _____

I give my permission to Lakeside Neurology PC to leave detailed messages on my cell phone.

Patient Signature: _____ Date: _____

I give my permission to Lakeside Neurology PC to email me.

Patient Signature: _____ Date: _____

I give my permission to Lakeside Neurology PC to discuss my medical information with my (ie relative/friend) _____ whose name is _____

Patient Signature: _____ Date: _____

I give my permission to Lakeside Neurology, PC to discuss my financial information with my (ie relative/friend) _____ whose name is _____

Patient Signature: _____ Date: _____

When my information is used for disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Medical Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Lakeside Neurology, PC has acted in reliance upon this authorization. My written revocation must be submitted to Lakeside Neurology, PC Privacy Officer at 1100 Northside Forsyth Dr Ste 440 Cumming, GA 30041-6015.

Signature of patient or legal guardian: _____ Relationship to patient: _____

Patient's Name: _____ Date: _____

Print Name of Patient or Legal Guardian: _____

Health Insurance Portability and Accountability Act (HIPAA) Privacy Compliance

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy at our office or by requesting a copy via email.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name _____

Date _____

Patient / Responsible Party Signature _____