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

___Dementia ___Seizures

___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 ____Hypertension ___Heart disease

___Diabetes ___Stroke ___Dementia ___Migraines

___Epilepsy ___Cancer (indicate type) _______________

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

Skin

__rash or itching

Eyes and ears

__visual loss

__double vision

__hearing loss

Respiratory

__cough

__shortness of breath

Sleeping

__snoring

__insomnia

__falling asleep during the day

Gastrointestinal

__abdominal pain

__nausea/vomiting

__diarrhea

Urinary

__frequent urination

__incontinence

Musculoskeletal

__joint pain or swelling

__muscle aches or cramps

Cardiac

__chest pain

__palpitations

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. If you do not have a referral, you will be considered as a "self pay" patient.

2. There is a $35.00 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.

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 workers compensation claims, nor do we file third party 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, this is your responsibility.

6. 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.

7. 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.

8. 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.

9. 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.

10. We will mail you two statements once your insurance has settled your claim if you owe a balance. After the second statement, if you have not paid the balance or made payment arrangements, the account will be turned over to collections.

11. 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 or cash, the account will be turned over to collections and an additional fee of $35.00 will be incurred for processing to the collection agency.

Updated 10/27/2020

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______________________