# Coastal Neurology, PA

## PATIENT INFORMATION

| | |
|---|---|
| Name: | Birth Date: Marital Status: S M Sep D W |
| Mailing Address: | Social Security #: |
| Address: | Sex: F M Race: Language: |
| City: | E Mail: |
| State: Zip: | Emergency Contact: |
| Home Phone#: | Emergency Phone#: |
| Cell Phone#: | Emergency Relationship: |
| May we leave Voice Mails? Yes No | Messages on Answering Machine? Yes No |
| Work Phone#: | Student: Yes No Part Time Full Time |
| Employer: | Work Status: FT PT RET SELF AD Mil OTHER |
| Employer Address: | Job Related?: Yes No |
| City: State: Zip: | Accident Related?: Yes No |
| Date of Injury/Accident:<br>Type of Injury/Accident: | Adjusters Name/Phone: |
| Referring Doctor: | Primary Care Doctor: |

## GUARANTOR INFORMATION

| | |
|---|---|
| Name: | Date of Birth: |
| Address: | Social Security#: |
| Address: | Relationship: |
| City: | Employer: |
| State: Zip: | Employer Address: |
| Home Phone#: | Employer City: |
| Cell Phone#: | Employer State: Zip: |
| | Employer Phone: |

## INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance: | Secondary Insurance: |
| ID#: | ID#: |
| Group #: | Group #: |
| Group Name: | Group Name: |
| Copay: | Copay: |
| Subscriber Name: | Subscriber Name: |

**Authorization To Pay Benefits To Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to Coastal Neurology when they accept assignment.

**Authorization To Release Medical Information.** I hereby authorize my Provider, Coastal Neurology, to release any information necessary for my course of treatment.

**Responsibility:** All professional services are the responsibility of the patient/guarantor. The patient/guarantor is responsible for any and all collection fees, attorney charges and court costs. A finance/billing fee may apply to delinquent balances. Coastal Neurology maintains the right to refuse treatment to any non-emergent patient.

_____ _____

Signature (patient or guarantor) Date

_____ _____

Name Relationship

COASTAL NEUROLOGY

# Coastal Neurology
## New Patient Questionnaire

**Patient Name:** _____
**Date of Birth:** _____ **Hand You Write With:** ☐ L / ☐ R

**Why are you being seen today?**

_____
_____
_____
_____

**Please List CURRENT Medications with Dosages and Frequency**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

**Please List Any Medication Allergies**

_____ _____ _____ _____

**Please List Current and Past Medical Problems and Prior Surgeries Including Dates and Side of Body Where Appropriate**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | Stroke | ☐ | Pacemaker | ☐ | Prostate Surgery | ☐ |
| Heart Bypass / Stent | ☐ | COPD | ☐ | Diabetes | ☐ | Knee Replacement | L / R |
| High Cholesterol | ☐ | Asthma | ☐ | Neck Surgery | ☐ | Hip Replacement | L / R |
| Low Back Surgery | ☐ | Cancer | ☐ | Heart Attack | ☐ | Other _____ | |
| Atrial Fibrillation | ☐ | Hysterectomy | ☐ | Reflux | ☐ | _____ | |

**What Medical Problems Run In Your Family?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High Blood Pressure | ☐ | Epilepsy | ☐ | Alzheimer's | ☐ | Heart Disease | ☐ |
| Diabetes | ☐ | Migraine | ☐ | Stroke | ☐ | Other _____ | |

**Have You Ever Smoked?** Yes ☐ No ☐

**If Yes, How Many Packs Per Day?** _____ **For How Long?** _____ **years**

**How Much Alcohol Do You Drink Per Week?** _____

**Where you ever a Heavy Drinker?** Yes ☐ No ☐

**If you've Quit, How Long Ago?** _____ **years**

**Marital Status:** Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

**What is the Highest Level of School that You Completed?** _____

**Occupation:** _____

**Please List ALL Medical Problems, Hospitalizations, or Surgeries**

_____ _____ _____ _____

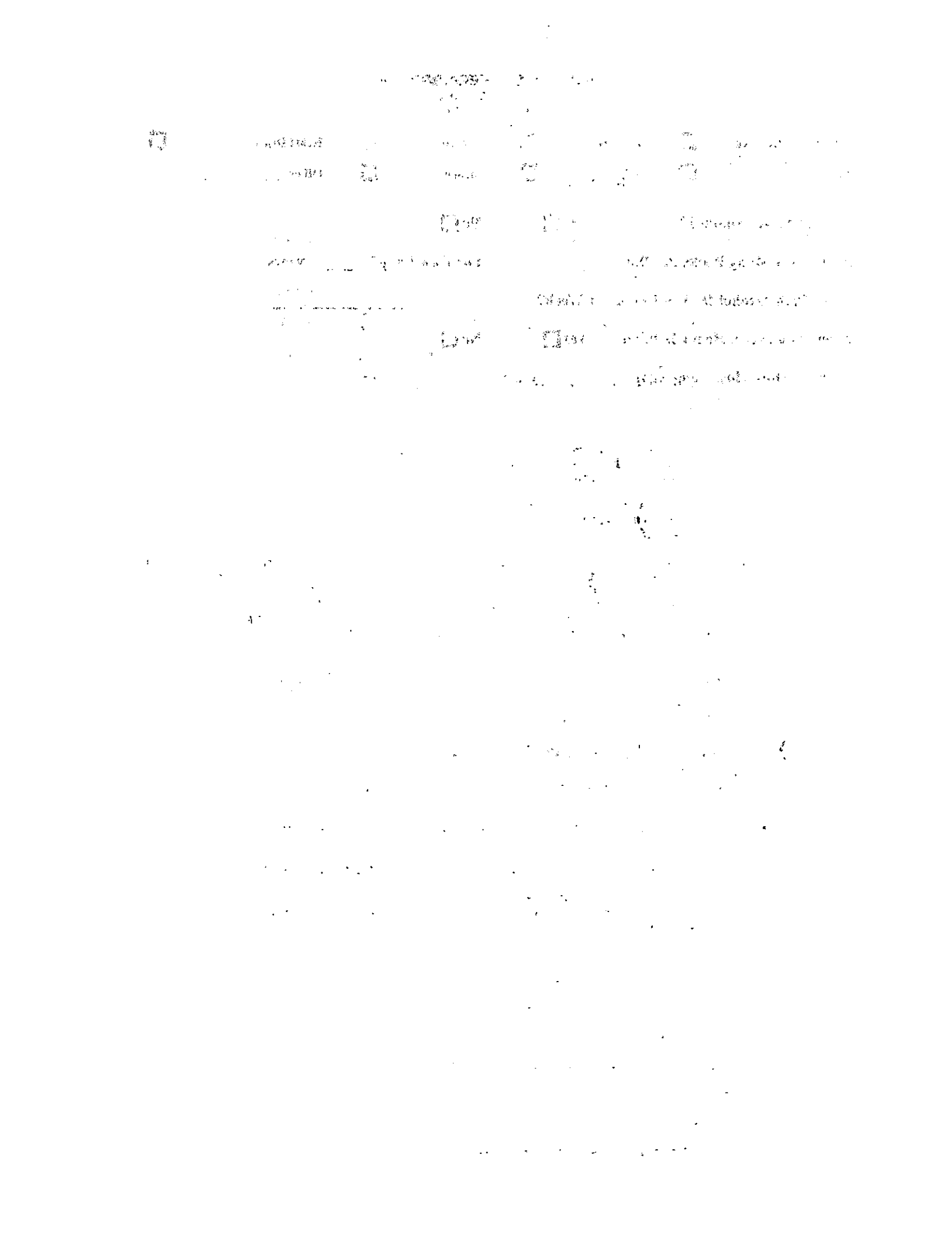
_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

**Are you <u>currently</u> experiencing any of the following problems? (Check where appropriate)**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Headaches** | ☐ | ☐ | **Visual Changes** | ☐ | ☐ |
| **Dizziness** | ☐ | ☐ | **Hearing Loss** | ☐ | ☐ |
| **Vertigo** | ☐ | ☐ | **Problems Swallowing** | ☐ | ☐ |
| **Balance Problems** | ☐ | ☐ | **Unexplained Weight Loss** | ☐ | ☐ |
| **Memory Loss** | ☐ | ☐ | **Fainting** | ☐ | ☐ |
| **Attention Problems** | ☐ | ☐ | **Liver Trouble** | ☐ | ☐ |
| **Sleep Problems** | ☐ | ☐ | **Kidney Trouble** | ☐ | ☐ |
| **Numbness In Hands or Feet** | ☐ | ☐ | **Bladder Incontinence** | ☐ | ☐ |
| **Neck Pain** | ☐ | ☐ | **Bowel Incontinence** | ☐ | ☐ |
| **Back Pain** | ☐ | ☐ | **Depression** | ☐ | ☐ |
| **Are you Pregnant?** | ☐ | ☐ | **Thoughts of Suicide** | ☐ | ☐ |



**COASTAL NEUROLOGY, P.A.**
1833 North Paris Avenue
Port Royal, SC 29935
(843) 522-1420 ~ Facsimile (843) 522-1460

## NOTICE OF PRIVACY PRACTICES (HIPAA)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Purpose of this Notice**
This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal and we are committed to protecting your privacy and ensuring that your health information is used appropriately.

**Our Responsibilities**
We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We have also appointed a Privacy Officer who is responsible for ensuring that we protect your health information and that we abide by the terms of this Notice.

**How We May Use or Disclose Your Health Information**
The following categories describe examples of the way we use and disclose health information:

***For Treatment:*** We may use your health information to provide you with medical treatment or services. An example of this would include a physical examination. We may also disclose your health information to another physician or other healthcare providers to be sure those parties have all the information necessary to diagnose and/or treat you.

***For Payment:*** We may use and disclose your health information to others so they will reimburse either party for your treatment. For example a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information tat identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

***For Health Care Operations:*** We may ask you to sign your name to a sign-in sheet, or we may call your name in the waiting room; we may use your name in conversations within the scope of the practice; we may contact you for appointment reminders; we may leave a recorded message for you citing who we are and the purpose in which we are calling. We may disclose your health information to a third party that performs services, such as billing and collections. In these cases we will enter into a written agreement with the third party to ensure they protect the privacy of your health information. We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of students, necessary credentialing and for other essential activities.

***Treatment Alternatives and Health-Related Benefits and Services:*** We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

***Other Individuals Involved in Your Care or Payment for Your Care:*** We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify our Privacy Officer or other staff member.** We may also disclose your health information to disaster-relief organizations so that your family or friends can be notified about your condition, status and location.

***We are also allowed to use and disclose your health information without your authorization as required to do so by Federal, State or local law(s).***

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosure of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.*

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print: Name: X _____ Signature: X _____

Date: X _____ If not the patient, your relationship: _____

**Please circle and initial:** Would you like a copy of this signed notice? **Yes** **No** _____

Direct inquiries to: The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20202
(877) 696-6775

**YOU MAY SPEAK WITH:** X _____

**For additional questions or concerns, contact Annette Kelley, Office Manager, at 843/522-1420.**

## ***Coastal Neurology* No Shows / Late Arrival Expectations**

Our goal at Coastal Neurology is to provide quality individualized medical care in a timely manner. No shows, late arrivals and cancellations inconvenience those individuals who need access to medical care. It also hinders our ability to provide you with the quality of care you deserve.

As a courtesy, and to help patients remember their scheduled appointments, our receptionists will call you to confirm your appointment the day prior to when you are scheduled.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice..

Our Policy is as follows:

1. Patients are considered a No show if they do not arrive for a scheduled appointment.
2. If you arrive after your scheduled visit time we will have to reschedule your appointment for some other day.
3. If you arrive more than 15 minutes past your appointed time, your appointment will have to be rescheduled.
4. If you fail to bring your insurance cards and picture ID / Driver's License, our staff is required to reschedule your appointment.
5. If you fail 3 or more appointments ( No show's, late arrival ) within a three months time frame you will be discharged from the practice.

*Your signature below indicates acceptance and understanding of the policy above.*

_____ _____

Printed Name Signature

_____

Date


# Coastal Neurology
## Follow-up Visit Questionnaire

Patient Name: _____

Why are you being seen today?

_____

_____

Please List CURRENT Medications with Dosages and Frequency

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please List NEW Medical Problems, Hospitalizations, or Surgeries Since Your Last Visit

_____ _____ _____ _____

_____ _____ _____ _____

Are you currently experiencing any of the following problems? (Check where appropriate)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Headaches | ☐ | ☐ | Visual Changes | ☐ | ☐ |
| Dizziness | ☐ | ☐ | Hearing Loss | ☐ | ☐ |
| Vertigo | ☐ | ☐ | Problems Swallowing | ☐ | ☐ |
| Balance Problems | ☐ | ☐ | Unexplained Weight Loss | ☐ | ☐ |
| Memory Loss | ☐ | ☐ | Fainting | ☐ | ☐ |
| Attention Problems | ☐ | ☐ | Liver Trouble | ☐ | ☐ |
| Sleep Problems | ☐ | ☐ | Kidney Trouble | ☐ | ☐ |
| Numbness In Hands or Feet | ☐ | ☐ | Bladder Incontinence | ☐ | ☐ |
| Neck Pain | ☐ | ☐ | Bowel Incontinence | ☐ | ☐ |
| Back Pain | ☐ | ☐ | Depression | ☐ | ☐ |
| Are you Pregnant? | ☐ | ☐ | Thoughts of Suicide | ☐ | ☐ |