NEUROLOGY ASSOCIATES, LLP
673 Pine Street
Macon, Georgia 31201
478-743-9123 (phone) / 478-742-9809 (fax)

LAST NAME:__________________ FIRST:________________________ MIDDLE:______________________
STREET:____________________________ CITY:____________ STATE:___________ ZIP:______________
MAILING ADDRESS (If Different):____ ZIP: ______________
EMAIL ADDRESS:__________________________ SOCIAL SECURITY NUMBER: ____________________
HOME #: ____ CELL #: __________________________________
ARE YOU A FULL TIME STUDENT? _________ YES _______ NO
MALE: ___ FEMALE: ___ BIRTHDATE: _______________ AGE: ___ MARITAL STATUS: ____________
RACE: ______ HISPANIC ___ NON-HISPANIC ___ PREFERRED LANGUAGE:______________________
PATIENT'S EMPLOYER: ____
EMPLOYER'S ADDRESS: ____ PHONE: ________________

SPOUSE'S INFORMATION: NAME: __________________________________ DOB: ____________
EMPLOYER:______________________________ WORK #: ______________ CELL #: ________________

CONTACT OTHER THAN SPOUSE AND/OR GUARDIAN – NOT IN YOUR HOUSEHOLD:
NAME: ____ RELATIONSHIP: ____________________
ADDRESS: ____ CELL #: ______________________

GUARDIAN'S NAME (IF PATIENT IS UNDER AGE 21): ______________________________________
GUARDIAN'S ADDRESS: ____ PHONE #: ______________
GUARDIAN'S EMPLOYER: ____ PHONE #: ______________

REFFERING PHYSICIAN: ____ PHONE #: ______________
PRIMARY CARE PHYSICIAN: ____ PHONE #: ______________

IS THIS VISIT DUE TO ANY TYPE OF ACCIDENT? IF SO, PLEASE COMPLETE THIS INFORMATION.

ACCIDENT IS DUE TO: (PLEASE CIRCLE) AUTO JOB RELATED THIRD PARTY

DATE OF ACCIDENT/INJURY: _______________ SYMPTOMS: ______________________________
REASON FOR VISIT: ____

IT IS VERY IMPORTANT THAT YOU LIST THE ORDER OF YOUR INSURANCE CORRECTLY.

PRIMARY INSURANCE: ____ PPO:___ HMO: ___
INSURED (POLICY HOLDER'S NAME): _____________________________ DATE OF BIRTH: ______________
SECONDARY INSURANCE: ____ PPO: __ HMO: ___
INSURED (POLICY HOLDER'S NAME): _____________________________ DATE OF BIRTH: ______________

******** PAYMENT IS EXPECTED AT THE TIME OF SERVICE********
BE PREPARED TO PAY YOUR INSURANCE CO-PAY AT CHECK-IN

CHART #: _______________ DATE: ____________________ DOCTOR/TEST: ______________

NEUROLOGY ASSOCIATES, LLP

HAVE YOU EVER BEEN SEEN IN THIS OFFICE? ______ YES ______ NO
HAVE YOU EVER SEEN A NEUROLOGIST? ______ YES ______ NO
ARE YOU UNDER THE CARE OF HOSPICE? ______ YES ______ NO
DO YOU RESIDE IN A NURSING HOME? ______ YES ______ NO

I hereby authorize the release of any medical information necessary for payment, treatment, and healthcare operations, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information. I hereby assign and authorize payment to Neurology Associates, LLP, of all medical and/or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insured program or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I herby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Neurology Associates, LLP, by an insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

I UNDERSTAND THAT UNLESS INDICATED BELOW, NEUROLOGY ASSOCIATES, LLP, IS ALLOWED TO CONVEY PAYMENT, TREATMENT, AND HEALTHCARE OPERATIONS TO MY IMMEDIATE FAMILY - TO INCLUDE PARENTS, SPOUSE, SIBLINGS, CHILDREN (16 AND OLDER). PLEASE LIST BELOW ANY ADDITIONAL PEOPLE YOU WOULD LIKE LISTED ON YOUR ACCOUNT AS HAVING AUTHORITY TO DISCUSS YOUR PERSONAL INFORMATION IN REGARD TO TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

_______ Home Answering Machine: ___________________________ (or) Cell Phone #: ____________________
_______ Significant Other/Friend: ____
_______ Other: ____

Also, list anyone you want EXCLUDED from the above:

_______ Immediate Family (to include parents, spouse, sibling, children (16 and older)
_______ Home Answering Machine: ____
_______ Other: ____

****** CONSENT TO TREATMENT AND DIAGNOSTIC PROCEDURES******

IF A PRE-CERT OR PRE-AUTHORIZATION IS REQUIRED BY MY INSURANCE COMPANY, I UNDERSTAND THAT I AM RESPONSIBLE FOR MAKING SURE THIS PRE-AUTHORIZATION IS OBTAINED. IF I AM A MEMBER OF AN HMO PLAN THAT REQUIRES NOTIFICATION OF A PRIMARY PHYSICIAN (PCP) PRIOR TO RECEIVING TREATMENT, I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING THIS PRE-AUTHORIZATION AND FAILURE TO CONTACT MY PCP MAY RESULT IN REDUCED BENEFITS OR NON-PAYMENT.

****** PPO AND HMO******

PLEASE BE ADVISED THAT IT IS THE PATIENT'S RESPONSIBILITY TO MAKE SURE EVALUATIONS, LABS, TESTS AND REFERRALS ARE DONE WITHIN YOUR PARTICULAR NETWORK.

YOU ARE NOT OBLIGATED TO HAVE TESTING DONE AT THIS OFFICE. IF YOUR DOCTOR ORDERS A TEST AND YOU WISH TO HAVE IT DONE ELSEWHERE, PLEASE DISCUSS THIS WITH THE DOCTOR OR NURSE.

I UNDERSTAND THE ABOVE INFORMATION, AUTHORIZATION AND CONSENT TO TREATMENT BY THIS OFFICE. I UNDERSTAND THE NEUROLOGY ASSOCIATES, LLP, NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR REVIEW.

******** PLEASE COMPLETE BOTH SIDES OF THIS FORM. GIVE THIS COMPLETED FORM, YOUR INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST. BE PREPARED TO PAY YOUR INSURANCE CO-PAY AT CHECK-IN. ********

SIGNATURE: ____ DATE: ______________________
REALATIONSHIP TO PATIENT (IF NOT PATIENT): ____
PATIENT UNABLE TO SIGN DUE TO: ____

This form has been reviewed by: ____ Time: ____________

Neurology Associates, LLP
673 Pine Street
Macon, Georgia 31201
478 – 743 – 9123 (phone)
478 – 742 – 9809 (fax)

Patient's Name: ____________________ **Date:** ____________________

Height: ____________________ **Weight:** ________________________

Current Medications *(Please list doses and frequency)*

____

____

____

____

____

____

____

____

Allergies / Intolerances *(Please describe reaction)*

____

____

____

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____

Have you had any falls in the past year? Yes [ ] No [ ]

Do you smoke? Yes, currently [ ] No, ex-smoker [ ] No, never-smoker [ ]

Do you drink alcohol? Yes [ ] (about how many drinks/week?) _____ No[ ]

Any recent hospitalizations? If so, where? _____________________________

Any MRIs or CTs of the brain or spine? If so, where? _____________________

Please list your current pharmacy, including address. __________________

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