Last Name: _____ ***First Name:*** _____ ***MI*** ____ ***Date of Birth:*** _____

Social Security: _____ ***Marital Status:*** _ *Married* _ *Divorced* _ *Single* _ *Widowed* _ *Unknown*

Sex: _ *Male* _ *Female* ***Home Phone:*** _____ ***Cell Phone:*** _____

Best Number for Reminders: __ ***Home*** __ ***Cell*** __ ***Other (Specify):*** _____

Address: _____

Email Address: _____ ***Language:*** _____

Race: __ *American Indian or Alaska Native* __ *Asian* __ *Black or African American*

__ *White* __ *Native Hawaiian or Other Pacific Islander* __ *Hispanic* __ *Refused*

Ethnicity: __ *Hispanic* __ *Not Hispanic or Latino* __ *Refused*

Pharmacy Name and Number _____ ***Referring Physician:*** _____

Emergency Contact Information:

Name: _____ ***Relationship:*** _____ ***Phone #:*** _____

Address: _____

Do you have an advance directive plan? __ Yes __ No

If yes, is it a __ living will __ power of attorney __ Organ donor __ Other, Specify _____

Primary Insurance: _____ ***ID Number:*** _____ ***Group #:*** _____

Name of insured: _____ ***DOB:*** _____ ***Relationship:*** _____

Secondary Insurance: _____ ***ID Number:*** _____ ***Group #:*** _____

Name of insured: _____ ***DOB:*** _____ ***Relationship:*** _____

I certify that the above information is correct to the best of my knowledge and authorize NeurocarePlus to submit claims to the above insurance companies, and authorize NeurocarePlus to act as an agent on my behalf to appeal any claim denial. I understand that I am responsible for all charges whether or not covered by my insurance. I also understand that a $25 no show fee will be applied for all missed office visits($50 for procedures), not cancelled or rescheduled 24 hrs prior to the scheduled time, and that this charge is not covered by insurance. I also understand that if my insurance requires referral from my PCP, I am responsible to obtain and to send it to NeurocarePlus prior to my appointment. If not obtained, my appointment will have to be rescheduled. By signing this form, I voluntarily give consent to such medical care, treatment and diagnostic tests that Dr. Nammour and his designated staff believe are necessary.

Signature:_____ Date:_____

Consent to treat

To the patient: You have the right, as a patient to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing or treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.
I voluntarily request Dr. Nammour and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.
I also allow Dr. Nammour and his staff to request a copy of any previous or current prescribed medications to be included in my chart.
I certify that I have read and fully understand the above statements and consents fully and voluntarily to its content.

_____ _____
Signature of Patient or Legal Guardian *Date*

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Legal Guardian *Date*

_____
Print Name of Patient or Legal Guardian

Policies and Procedures Effective January 1st, 2018

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following policies. If you have any questions about these policies please discuss them with the office manager or staff. We are dedicated to providing the best possible care and service to you and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Missed or Cancelled Appointments/ Late Arrivals

It is the responsibility of the patient to arrive for appointments on time. Cancellations MUST be received 24 hours in advance. We reserve the right to charge a $25 fee for missed, cancelled, or no show appointments. If you are more than 15 minutes late, we reserve the right to ask you to reschedule. If you are late we recommend that you call our office to verify that your appointment will still be honored.

***Initial*_____**

Patient Appointment Responsibility

When you do not keep your agreed upon appointment, three people are affected. Firstly, you do not receive the needed treatment prescribed by your physician. Secondly, another patient could have benefitted by utilizing your appointment time. Finally, the physician now has a gap in his schedule due to time reserved for you. Note that any missed, cancelled, or no show fees are not covered by your insurance.

Initial_____

Insurance Coverage

Please understand that as your health care provider and healthcare facility, our relationship is primarily with you and not your insurance company. As a courtesy and convenience to you, we will file insurance claims for all of our patients. We cannot bill your insurance company unless you give us current and accurate insurance information.

Initial_____

Patients without Insurance

Occasionally, our patients may find themselves without health insurance coverage. Our policy states that 100% of all anticipated charges must be paid at the time of service.

Initial_____

Forms/Copies of Records

Please be aware as becoming an establish patient per HIPPA guidelines we are required to have you sign and fill out yearly forms and to make copies of your picture ID/TDL and Insurance cards.

Completion of any forms that require your provider's input can be very time consuming for both you and your provider. We require an appointment be made to review the requested information. We reserve the right to charge for a follow up visit. We also reserve the rights to charge for the first 20 pages $ 25.00 and any additional page 0.50 cents per page for copying medical records and $ 30 for any forms or documents to be filled out. Please allow 1week for forms and copies to be completed.

Initial_____

Pre-Certification

Pre- Certification (prior approval) may be required by your insurance plan before certain procedures or diagnostic testing. Please allow 48-72 hours for this process to be complete. Please make sure that pre-certification has been given before proceeding with any procedure or diagnostic testing. Scheduling is done through the facility. Our office does not coordinate any scheduling for any outgoing diagnostic studies. Once approval from your insurance is obtained, the facility will contact you to schedule.

Initial_____

Outgoing Referrals

All referrals given by the physician will be faxed to the facility. We will provide you with a copy of the referral order. The referred physician's office will contact you to schedule your appointment. Please allow 72 hours for them to contact you, pending office procedure. If the physician is out of network with your insurance please contact your insurance for a list in network providers.

Initial_____

Benefit Verification Disclaimer

Quote of benefits are not a guarantee of payment. Final payment determination will be made upon processing of claims. All claims will be subject to the provisions and exclusions of each individual policy. As a courtesy, our office verifies coverage details prior to services; however this does not suffice as the sole verification of benefits as it is patient responsibility to know their benefit details according to the patient benefit booklet received from insurance upon initial coverage.

_____ _____

Patient Signature **Date**

Patient History Form

Name:_____Today's Date:_____ What is the

Are your symptoms related to the following?

- Work injury: **Y** or **N** Date of Injury: _____
- Motor vehicle: **Y** or **N** Date of injury:_____
- Other: _____ Explain: _____

Medication(s): (Please list all medications you are taking including over-the-counter/vitamins)

Name of Medication:	Dose/Directions:

Drug Allergies: _____

Medical History· (Please check all that apply)

Tension/Migraine Headache	☐	Myocardial Infarction	☐	Thyroid Disease	☐
Epilepsy/Seizures	☐	Heart Murmur	☐	Liver Disease/Hepatitis	☐
Cerebral Vascular	☐	Hypertension	☐	Renal Disease	☐
Head Injury	☐	COPD	☐	Arthritis	☐
Depression/ Anxiety	☐	Asthma	☐	Cancer	☐
Coronary Artery Disease	☐	Anemia	☐	Tuberculosis	☐
Arrhythmias	☐	Diabetes	☐	HIV	☐
Congestive Heart Failure	☐	Peripheral Vascular Disease	☐	Other:	☐

Surgical History: _____

Hospitalizations not requiring surgery:

_____

Family History:

	Mother, Father, or Grandparents
Diabetes	
Hypertension	
Heart Disease	
Mental Illness	
Cancer	
Seizures	
Epilepsy	
Parkinson's	
Alzheimer's	
Multiple Sclerosis (MS)	
Neuropathy	
Amyotrophic lateral Sclerosis (ALS)	
Other	

Social History:

Are you a current smoker? ☐ Former smoker? ☐ Non-Smoker? ☐

If so, how many cigarettes a day? _____

Have you considered quitting? **Y or N Thinking about it**

If former, how long has it been since you last smoked? _____ **Day(s) / month(s) / year(s)**

Do you use any other type of tobacco? **Y or N** what type? _____

Do you use any recreational drugs? **Y or N** If so, which drugs? _____

How often do you have a drink containing alcohol?

Monthly or less **2-4 times a month** **2-3 times a week** **4+ times a week**

How many drinks do you have on a typical day?

1-2 drinks **3-4 drinks** **5-6 drinks** **7-9 drinks** **10 or more drinks**

How often do you have 6 or more drinks on one occasion?

Never **Less than monthly** **Monthly** **Weekly** **Daily or almost daily**

Do you drink any beverages containing caffeine? **Y or N**

Coffee **Tea** **Soda** **Other: _____**

If yes, how many cups per day?

1-2 cups **2-3 cups** **3-4 cups** **more than 4**

Last Name: _____ First Name: _____M.I: ____DOB:_____

Thinking Ability Changes

1. I have noticed a recent decline in my memory Y ☐ N ☐
2. Others (my family and friends) tell me that I am forgetting things they tell me Y ☐ N ☐
3. My ability to concentrate seems to have declined recently. Y ☐ N ☐
4. I have suffered recent losses that might hurt some of my thinking abilities. Y ☐ N ☐
5. I get confused or easily distracted more than I am used to. Y ☐ N ☐

Family Observations:

_____

_____

_____

PROVIDER AND OFFICE STAFF USE ONLY

Patient Acct#: _____

Healthcare Provider Notes:

_____

_____

Staff Instructions to patient:

_____

_____

_____

Staff Initials: _____

Test Time In: _____ Test time Out: _____

First Name: _____

Last Name: _____

Please provide the best phone number and email address for our office to contact you

Phone Number: _____

Email Address: _____

I, _____, hereby give consent to the following persons to discuss my medical/billing records, and or test results with Dr. Nicolas Nammour and his staff, as needed.

1- *Name:* _____ *Relationship:* _____
2- *Name:* _____ *Relationship:* _____
3- *Name:* _____ *Relationship:* _____

I understand that I have the right to revoke this authorization, in writing, at any time and this may apply to one or more of the above persons.

_____ _____

Patient Printed Name *Date*

_____

Patient/ Guardian Signature