PATIENT REGISTRATION

(This information is needed to file your insurance.
Please print neatly on front and back of form.)

PATIENT INFORMATION

Preferred Prefix	PATIENT NAME First	Middle	Last	Suffix
Mr. Mrs. Ms. Miss Other:				

Sex/Race/Ethnicity/Language	Birthdate	Patient Social Security #

Mobile Telephone	E-mail Address	Home Telephone	Work Telephone Ext

Street Address

City	State	Zip Code

Preferred means of Communication	May we text your mobile?	Email you?	Voice message you?

Emergency Contact & Relationship (May Receive HIPAA Information)	Mobile Telephone	Home Telephone	Work Telephone Ext

GUARANTOR

Complete this section if you are covered by someone else's insurance.
If your insurance card has another name as subscriber.

IS THIS GUARANTOR RESPONSIBLE FOR ____ PRIMARY INSURANCE ____ SECONDARY INSURANCE ____ BOTH

Preferred Prefix	GUARANTOR NAME First	Middle	Surname (or company name)	Suffix
Mr. Mrs. Ms. Miss Other:				

Sex	Birthdate	Social Security #

Mobile Telephone	E-mail Address	Home Telephone	Work Telephone Ext

Street Address

City	State	Zip Code

INSURANCE INFORMATION

Please provide our front desk with your insurance card so that it may be copied. Thank you

PRIMARY INSURANCE

Insurance Company	Insured	Policy #	Group #	Deductible	Co-Pay

Street Address for Claims	City	State	Zip	Telephone Number

Please specify your insurance company's preferred lab (N/A for Medicare)	Referrals and/or precerts are required for (N/A for Medicare)

SECONDARY INSURANCE

Insurance Company	Insured	Policy #	Group #	Deductible	Co-Pay

Address for Claims	City	State	Zip	Telephone Number

IF YOU ARE BEING SEEN UNDER HEALTH INSURANCE, YOU MUST SIGN BELOW:

I understand that each insurance contract is personal to the insured and that it is my responsibility to know the terms of my plan. I have checked with my insurance company and verified that I am authorized to see the providers in this office; and that my insurance company will cover services rendered. If a referral from another provider is required, I agree that it is my responsibility to obtain such a referral. I also agree to advise the office when a precertification is needed according to the terms of my plan. If my insurance company limits the use of office-based labs and testing and requires the use of outside facilities, I have listed them below. If any charges remain unpaid because I have not provided the proper information, because I do not keep such information updated with this office or because my plan does not cover the kinds of services rendered, I agree to be personally liable for said charges. The above language does not apply to contractual adjustments of allowed charges under the plan. This statement remains in effect until I specifically revoke it in writing or until all charges on my account are paid in full and I am no longer a patient.

_____ Date

_____ Patient/Responsible Party

MEDICAL RECORDS CONFIDENTIALITY

My signature below indicates that I have been offered a copy of the office's Notice of Privacy Practices for Protected Health Information (Confidentiality Policy). Unless I specifically indicate disagreement below, I agree that my protected health information may be used according to the policies itemized in the Confidentiality Policy. Without limiting the Confidentiality Policy in any way, I agree that the office may release my records to other health care providers involved with my care, prescriptions may be faxed or emailed securely to pharmacies, records may be released to any company who is expected to pay or collect for services rendered to me. Messages may be left on my home or personal cell phone concerning appointments and test results provided the individual answering the phone identifies himself as an adult member of my family such as a spouse or parent. Appointment reminders may be texted or emailed to me. This statement remains in effect until I specifically revoke it in writing or until all charges on my account are paid in full and I am no longer a patient.

_____ Date

_____ Patient/Responsible Party

My records may not be used according to the practice's privacy policies in the following ways:

How did you find out about us?

Is there any additional information we need to properly file your insurance?

Who is your primary care provider? Please also list other members of your medical care team. If you want records sent to other providers, you must list fax numbers as well.

Medical Information Questionnaire

Patient Name: _____ **Date of Birth:** _____

Briefly describe why you are coming to see the doctor today:

_____

_____

_____

What drug allergies do you have?

_____

_____

_____

I have no drug allergies: _____

Please list all prescription medications and over the counter medications you are currently taking (include dosage and times each are taken):

_____

_____

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What is your preferred pharmacy (please include address and phone number):

_____

_____

_____

SMOKING STATUS

Current Smoker: _____ If yes, how many packs per day: _____ How many years: _____

Former Smoker: _____ When did you quit: _____ How long did you smoke: _____

Other forms of tobacco: _____

I have never smoked: _____

PRIOR MEDICAL HISTORY

Please list any major medical events in your life (including surgeries):

_____

_____

_____

What are your current ongoing medical problems (include all diagnoses you are treated for):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any significant family medical history. Please specify living or deceased and ages.

Mother:

Father:

Siblings:

Children:

Do you currently drink alcohol? YES/ NO If yes, how much and how often? _____

Are you a former drinker? YES/ NO If yes, for how many years and when did you stop _____

Do you currently use any illicit drugs? YES / NO If yes, what substance and how often? _____

Former drug use? YES/ NO If yes, please describe _____

Are you currently pregnant? _____

Are you trying to get pregnant? _____

Marital Status: _____

REVIEW OF SYSTEMS

Please circle any symptoms you are CURRENTLY experiencing:

Weight change, Fever, Chills, Fatigue, Pain

Headaches, Head injury

Visual blurring, Double vision, Tearing, Scotomata, Eye pain

Change in hearing, Ringing of the ears, Ear bleeding, Vertigo

Nose bleeds, Nasal obstruction, Nasal discharge

Dental difficulties, Gum bleeding

Neck stiffness, Neck pain, Neck tenderness, Neck masses

Skin rash, Itching, Swelling

Shortness of breath, Wheezing, Coughing, Coughing blood

Chest pains, Heart palpitations, Passing out, Orthopnea

Change in appetite, Difficulty swallowing, Abdominal pains, Bowel habit changes, Nausea, Vomiting, Dark stool

Urinary urgency, Painful urination, Change in nature of urine

Change in menses, Dysmenorrheal, Vaginal discharge, Pelvic pain

Pain in muscles or joints, Limitation of range of motion

Weakness, Tingling, Numbness, Tremor, Seizures, Changes in mentation, Ataxia, Dizziness

Depression, Anxiety, Hallucinations, Change in concentration, Changes in sleep habits, Changes in thought content

Patient Signature: _____ Date: _____

Reviewed: _____ Date: _____

Patient Name: _____ Chart #: _____

Lifestyle Neurology PC

AUTHORIZATION TO PROVIDE TREAMENT
INSURANCE ASSIGNMENT AND RELEASE

I hereby authorize the providers of Lifestyle Neurology PC or any other medical provider authorized by it, to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interests (or the best interests of my dependent if I am signing as a parent or guardian).

Further, I hereby assign, transfer and set over to Lifestyle Neurology PC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the insurance policy(ies) listed below or any other third-party payor that may be responsible for paying me for these services. Should payment be made directly to me, I agree to immediately endorse such payment to Lifestyle Neurology PC.

In those cases where payment is not collected at the time of service, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within ninety (90) days from the date billed unless there are other agreements between me or my insurance company and Lifestyle Neurology PC. I agree to pay all collection costs including, but not limited to bad check charges, court costs, witness expenses and reasonable attorney's fees if it becomes necessary to turn this account over to an outside party for collection. I further agree to pay an interest charge of 1 % (one percent) per month on any balance remaining on this account beginning ninety (90) days from the date of service. If at any time a single visit is overpaid and amounts from other visits remain unpaid, I agree that Lifestyle Neurology PC may apply the overpayment from one visit to outstanding balances from other visits. I understand that a refund will not be issued to me until all visits are paid in full and my account retains a credit balance.

I understand that it is my responsibility to know the requirements of my insurance policy and comply with them. If the providers of Lifestyle Neurology PC do not participate in my plan, I agree to be responsible for any costs not paid by my insurance company. Further, if my plan requires a referral, I agree it is my responsibility to obtain the referral. If I do not obtain such a referral and my plan does not pay because of my failure to do so, I agree to be responsible for the costs of my treatment. If my plan requires precertification for certain services, I agree to inform Lifestyle Neurology PC of these requirements and to be responsible for any bill if I did not inform them of the precertification requirements.

I specifically give Lifestyle Neurology PC the authority to release my medical records to any medical provider who needs access to them to provide appropriate medical care. Further my medical records may be released to those who perform Lifestyle Neurology PC billing services and to any third-party payors who are responsible for my bill. I have been given a copy of Lifestyle Neurology PC's privacy guidelines and been given the opportunity to object to other listed reasons for release.

These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to Lifestyle Neurology PC.

Patient/Responsible party: _____ Date: _____

Insurance company(ies): _____

_____ and any insurance companies that I may use in the future.

Medicare patients with Medigap Insurance: I request that payment of authorized Medigap benefits be made on my behalf to Lifestyle Neurology PC for any services furnished to me by that supplier.

Patient/Responsible party: _____ Date: _____

LIFESTYLE NEUROLOGY

RANCE WILBOURN, M.D.

MEDICAL RELEASE FORM FOR THE PRACTICE OF RANCE WILBOURN, M.D.

I, _____ do hereby authorize the release of all my medical records, laboratory test results, medical test results, and physicians' office records and notes to Lifestyle Neurology, office of Rance Wilbourn, M.D. Please send these records as soon as possible via fax. The fax number is (901) 440-8582. If you need to send the records via mail, you may mail them to 2215 West Street, Germantown, TN 38138. The phone number is (901) 440-8482.

_____ _____

Patient Signature Date

Patient's Social Security Number: _____

Patient's Date of Birth: _____

2215 West St. • GERMANTOWN, TN • 38138
PHONE: 901-440-8482 • FAX: 901-440-8582

#1098 6119

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____ Date: _____

Signature of patient or responsible party

Acknowledgement of Receipt

I acknowledge that I have received a copy of LifeStyle Neurology PC Patient Agreement including the Notice of Privacy Practices For Protected Health Information. I have been given an opportunity to ask questions about this agreement and the privacy practices described therein.

I agree to be bound by the terms of this agreement except for those areas listed below.

I understand that I may revoke this agreement at any time in writing. Such revocation will be effective when received by the practice and will not be effective for any privacy disclosure previously made under the terms of this agreement or for any payment obligations for services already rendered.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____

Restrictions on the use of my protected health information:

_____

_____

_____

_____