PATIENT REGISTRATION

LIFESTYLE NEUROLOGY

(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

What pharmacy do you use? Name, address, phone number

_____

Do you give permission to run prescription history reports? This will help us reconcile your medications. _____

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

Medical Information Questionnaire

Patient Name: _____ Date of Birth: _____

Why are you here today?

Drug Allergies:

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Tobacco, alcohol, and illicit drug use history:

Past medical history and surgeries:

Current ongoing medical issues:

Family History: only 1st degree relatives (mother, father, siblings, children):

Are you currently pregnant or trying to get pregnant?

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: _____

221 S WEST STREET • GERMANTOWN, TN • 38138
PHONE: 901-440-8482 • FAX: 901-440-8582

#1098 6119

PATIENT FINANCIAL AGREEMENT

Thank you for choosing Lifestyle Neurology PC to assist with your healthcare needs. Please review and sign this policy, asking questions as necessary. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. **Patient payment:** All copayments are to be paid at the time of service. This arrangement is part of your contract with your insurance company. If your insurance company requires a cost share before deductibles are met, you are responsible for the amount requested by Lifestyle Neurology. Any unpaid balances will be collected at your next appointment. It is your responsibility to view all of your insurance EOB's (explanation of benefits) to know your portion of what you will owe. Statements will be mailed out by Lifestyle Neurology as well

3. **Forms:** FMLA, sick leave, AFLAC, disability insurance forms, and any other forms required to be filled out by Lifestyle Neurology will require a form appointment. Insurance does not cover these appointments. A form appointment will be $125.00. Forms will be completed and given to you at the time of appointment or within 7 days after.

4. **Registration:** All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time fling restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

5. **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

6. **Uninsured patients:** We offer a 30-percent discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.

7. **Credit and collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at that time be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period our physicians will be able to treat you only on an emergency basis.

8. **Missed appointments:** Our policy is to charge $50 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

9. **Outside Testing/Labs:** We will refer you to a place that accepts your insurance. This DOES NOT mean your testing/labs will be covered by your insurance It is your responsibility to provide the outside facility your insurance. It is also your responsibility to discuss any out of pocket costs with the facility.

10. **Prescriptions:** Your prescriptions will go to the pharmacy on file. If you want these to go elsewhere, you must notify front desk at check in.

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:

_____

_____

_____

_____