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	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 (May Receive HIPAA Information)	Mobile Telephone	Home Telephone	Work Telephone Ext

GUARANTOR

Complete this section if you are covered by someone else's insurance.

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 YOUR INSURANCE IS AN HMO, PPO, MCO, MEDICATE ADVANTAGE PLAN OR MANAGED CARE, PLEASE READ AND SIGN BELOW:

I understand that each insurance contract is personal to the insured and that ft 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 I 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.

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):

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):

____

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Please list any significant family medical history (how are they related and age):

____

____

____

____

____

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? ____

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 and 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: ______________

Authorization to treat.doc

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: ______________________________

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.

3. **Forms:** There is a $10 fee per page for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed. There is also a $5 fee for any forms that need to be faxed instead of mailed.

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.

   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

LIFESTYLE NEUROLOGY PC

Office Polices and Patient Agreement

Welcome to the office of LifeStyle Neurology PC. We are pleased you have chosen us to assist in your medical care.

Because we have a large number of recurring questions concerning our practice, we have prepared this "Patient Agreement" to help answer these questions. Please keep the front sheets of this agreement and provide our receptionist with the last sheet acknowledging that you have received these office policies.

Appointments

You may call 901-440-8482 to make an appointment or walk in to schedule an appointment. You may email at receptionist@lifestyleneuro.com to receive a phone call to make an appointment as well. In most cases, we will make your next appointment prior to your leaving.

Missed appointments cause a great deal of unnecessary burden to you, other patients and our office. Please be considerate and call at least 24 hours in advance to cancel and reschedule, OTHERWISE, YOU MAY BE ASSESSED A $50 FEE FOR A NO-SHOW!

We may call you in advance of your appointment to remind you. Unless you instruct us otherwise we may leave the message about your appointment with any adult member of your family or on your answering machine of telephone numbers you provide us as your home or personal answering machine.

Emergencies

If you are experiencing what you perceive as a true emergency and you may need assistance, call 911 so you may be evaluated and brought to the emergency room. Once in the emergency room, have their staff and/or your family member contact us.

Inclimate Weather

If the weather is such that the schools or other public offices are closed, please check with our office before keeping your appointment.

Lab/Other Tests

Within a reasonable time frame of our receiving your lab or test results, we will call you if the results are significantly abnormal. You may call but it is not necessary for you to call our office regarding lab/test results. Pursuant to the Notice of Privacy Practices for Protected Health Information provided with this form, we will leave these results directly with you, or with an adult member of your family at your home or cell phone telephone number or on your answering machine.

Medical records/forms

If you need medical records for any reason, we will be happy to copy them for you. Except in cases of true emergencies, we will need at least a two week advance notice. There will be a $20.00 fee for the first 45 pages of the records and an additional $0.25 per page thereafter to offset office time and costs. This fee must be paid in advance.
If you just need medical forms completed, there will be a $10.00 charge per page payable in advance.

Medicare Patients

We participate with Medicare. Therefore, you will only be responsible for the amounts allowed by Medicare unless you sign an Advance Beneficiary Notice stating that you know a service is not covered. It is important for us to know if Medicare is your primary insurance. If you or your spouse are still employed and a group health plan is available, that group health plan is primary. If you have been in an automobile wreck, if your retirement offers group insurance or if your visit is related to a worker's compensation claim, Medicare is not primary. Sometimes Medicare will deny a claim because it has information that it is not primary. If it is incorrect, you will need to call Medicare directly to clarify the mistake. We will inform you by letter if we receive information from Medicare that it is not primary. After you contact Medicare to resolve the matter, please call our billing office at **(901) 382-9786**. The office will be glad to assist you in rectifying the matter. Unless you have secondary insurance that covers coinsurance and deductibles, you will be expected to pay your annual deductible for physicians services and your 20% coinsurance amounts at each visit.

PLEASE NOTE THE MEDICARE ADVANTAGE PLANS ARE NOT TRADITIONAL MEDICARE PLANS AND HAVE RESTRICTIONS ON MEDICAL CARE. IF YOU ARE ON A MEDICARE ADVANTAGE PLAN, THE ABOVE DOES NOT APPLY TO YOU. YOU WILL NEED TO BE FAMILIAR WITH THE REFERRALS AND PRECERTIFICATIONS REQUIRED BY YOUR PLAN AND ABIDE BY THOSE RULES. IF YOU FAIL TO FOLLOW THE GUIDELINES OF YOUR PLAN, YOU M4Y BE RESPONSIBLE FOR ANY UNPAID BILLS.

Payment for services
Please bring your insurance cards each time you visit this office. We will ask to see your cards on each visit. Please also bring any co-pay, coinsurance and deductible amounts that are due. We will bill your insurance company as a courtesy to you. Any portion of your visit unpaid at the time of service or by your insurance company will be billed to you unless our agreement with your insurance company requires an adjustment.

If you have a change of insurance information, please call that change to **(901) 440-8482**. It's very important that you keep us apprised of any change in insurance. Frequently an insurance company will not change but a policy or group number will or there will be an update in where to file your insurance.

If your insurance does not pay your bill within 90 days, we will no longer bill the insurance company, but will bill you directly. You may call **(901) 382-9786**. We will be glad to refiled to new insurance for you. However, after 90 days, we will still look to you directly for payment.

Any amount billed to you is due upon receipt. If the bill is not paid or payment arrangements made within 60 days after billing you, your account may be turned over to a collection agency. The collection agency fee will also be billed to you.

Please note, if you have Medicare or Blue Cross, your insurance will be filed where services are rendered. This is the "interplan" system of these two carriers. Thus, if you have Blue Cross of Michigan, the claim SHOULD be filed to Blue Cross of Tennessee if the services were rendered in Tennessee. The only exceptions to this are Medicare Railroad and Blue Cross plans that specifically call for filing with the "home plan." Should you fall under either of these exceptions, please advise.

Prescriptions
Due to the large number of calls we receive for prescriptions daily, we are requesting that you ensure you have enough medication to last until your next visit. If not, please do not leave the office without a written prescription.
Please remember to call at least two business days before your medications run out. We will normally refill single prescriptions for chronic conditions for a maximum of three months before requiring a patient visit. Patients with multiple medications need to be seen more frequently.

Please remember to bring all your medications with you each time you visit the doctor.

Referrals
If you need a referral, please contact us at least 3 business days before it is needed. Of course, in cases of true emergency, we will rush the referral. If it is a referral for a new problem, you must be evaluated first before a referral is given.

Telephone Calls
When the office is busy, the nurse or physician may not be able to speak to you when you call. However, all telephone calls are returned by the end of the business day or the following morning of the next business day. If your call is urgent, please do not leave a recorded message. Indicate to the staff that you need to speak to a medical professional immediately. If the call is made outside of office hours, please follow the instructions on our recording or if you truly feel that you are experiencing an emergency, call 911 to bring you to the ER for immediate evaluation and necessary treatment if needed. Then have the ER staff or your adult family member call our office.

Notice of Privacy Practices For Protected Health Information

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.

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **LifeStyle Neurology PC**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Communications with you. Unless you indicate otherwise, if we call a home or personal cell phone number provided by you, we will leave messages concerning appointments and lab results with those who identify themselves as adult members of your family or on your answering machine. We will not leave messages at your work phone unless you specifically give us permission to do so. We may also text and/or email you appointment reminders.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of lnformation

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

lnformation about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Your Health Information Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information,
2. The right to receive confidential communications concerning your medical condition and treatment,
3. The right to inspect and copy your protected health information,
4. The right to amend or submit corrections to your protected health information,
5. The right to receive an accounting of how and to whom your protected health information has been disclosed,
6. The right to receive a printed copy of this notice.

LifeStyle Neurology PC and Staff's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.
Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting:

HIPAA Compliance Officer
Complaints:

(901)440-8482
Hope Wilbourn

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Secretary of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

If you believe that your privacy rights have been violated, you should call the matter to the attention of our privacy officer, Hope Wilbourn, by sending a confidential letter describing the cause of your concern to:

Lifestyle Neurology
Attn: Hope Wilbourn
2215 West Street
Suite 100
Germantown, TN 38138

You will not be penalized or otherwise retaliated against for filing a complaint.

This Notice is effective on 07/01/2019

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:

____

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