Patient Registration Form

Neuropathy Relief Centers
Brentwood and Springfield
Office: 615-382-8144 • Fax: 615-382-8145

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home: ( ) _____ **Work:** ( ) _____ **Cell:** ( ) _____

S.S.N.: _____ **Date of Birth:** _____ **Age:** _____

Gender: Male ☐ Female ☐ **Email Address:** _____

Marital Status: Married ☐ Divorced ☐ Single ☐ Widowed ☐

Reason for your visit? _____

Referring Physician: _____ Phone: ( ) _____

Address: _____
Street City State Zip Code

Employer or School: _____ **Address:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** ( ) _____

Spouse's Name: _____ S.S.N.: _____

Spouse's Date of Birth: _____ **Employer:** _____

Spouse's Phone: ( ) _____ ***Are you insured under their policy?*** Yes ☐ No ☐

PATIENT INSURANCE INFORMATION COMPLETED ON PATIENT INSURANCE FORM ATTACHED

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

Signature: _____ **Date:** _____

Patient's Name: _____ Date: _____

Primary **Insurance Information:**

Insurance Name: _____ Effective Date: _____

Subscriber/ID#: _____ Group # _____

Claims Address: _____

Phone Number: _____ Copay: _____

Primary Insured: (***circle one***) Self Spouse

Employer: _____

Date of Birth: _____ Social Security Number: _____

Secondary **Insurance Information:**

Insurance Name: _____ Effective Date: _____

Subscriber/ID#: _____ Group # _____

Claims Address: _____

Phone Number: _____ Copay: _____

Primary Insured: (circle one) Self Spouse

Employer: _____

Date of Birth: _____ Social Security Number: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request the payment of the authorized Medicare/other Insurance Company benefits be made to me or on my behalf to Neuropathy Relief Centers for any services furnished to me by that party who accepts assignments/medical professional. Regulations pertaining to Medicare assignment benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act & 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Neuropathy Relief Centers
Insurance & Financial Policy

Welcome to our practice. We are committed to providing you with the best possible care by offering you treatment options that may or may not be covered by your insurance. We are open to discussing these options with you at any time.

Currently we are participating with many major insurance companies. Insurance is a contract between you and your insurance company. It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits. Certain services may or may not be covered by Medicare or Medicaid and it is the patient's responsibility to inquire as to the eligibility of a treatment for Medicare or Medicaid coverage.

This office bills your insurance for services performed by our providers. The laboratory will bill you or your insurance company of all labs performed. If you have question regarding your lab bill, please contact the laboratory directly or your insurance carrier.

Please bring your insurance card to each appointment. If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment. If you do not, you will be responsible for the bill.

All insurance information, including referrals, and claim forms when necessary must be provided at the time of services. Please be sure to check that referral from your primary care physician has been received two (2) days prior to your appointment. We cannot see you without a valid referral if a referral is required by your insurance company. It is your responsibility to ensure that a referral has been created through your Primary Care Physician's office when required by your insurance. Balances for any reason, co-pay, deductible, coinsurance and denials for any reason are the responsibility of the patient or guarantor.

All co-pays, deductibles, and payments are due at the time of service, with co-pays being collected prior to you seeing the doctor. When receiving a statement after your visit, payment is due immediately upon receipt. To better accommodate your needs, we accept cash, personal checks, debit cards, Visa and Mastercard as forms of payment. We do not bill secondary insurances or copays.

Any personal checks returned to us from you bank will be subject to a fee of $40.00.

We will assign all accounts thirty (30) days or more past due to an outside collection agency for assistance. This may be an automatic assignment unless prior arrangements have been approved by management. Should this step be necessary, we may add a $45.00 service charge to your balance. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/payments will need to be made directly to the collection agency. In addition, once an account has been turned over to the collection agency, the patient will receive a letter of discharge from our practice.

We understand that situations may arise that require you to cancel your appointment; however we do request a 24 business hour notice of such cancellation. We may charge a $50.00 fee for any appointments that have not been cancelled within this timeframe.

An administrative fee of $75.00 per form will be charged for any forms (relating to disability, auto injury, life insurance applications, motor vehicle division, employment matter, etc.) that need to be reviewed and/or filled out by our medical professionals. All administrative fees must be prepaid.

Please keep all copies of all patient receipts. Should you need an end of year statement for tax purposes, an administrative fee of $25.00 will apply.

Any patient who commits any of the following offenses, including but not limited to: abusive behavior, non-compliance with treatment, Rx misuse, multiple missed office visits, or failure to pay account shall be grounds for immediate dismissal from the practice.

Thank you for understanding our financial and insurance policies. If you have questions about the above information, please do not hesitate to ask us. We are here to assist you.

I have read the above Insurance & Financial Policy, and understand and agree to these terms.

Printed Signature: _____

Patient's Name: _____ Date: _____

Neuropathy Relief Centers

Protected Health Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ HOME TELEPHONE ( ) _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ O.K. to fax to: ( ) _____

☐ WORK TELEPHONE ( ) _____

- ☐ O.K. to leave message with detailed information ☐ Use other:
- ☐ Leave message with call-back number only

☐ WRITTEN COMMUNICATION

- ☐ O.K. to mail to my home address on file ☐ Use other:
- ☐ O.K. to mail to my work address

☐ Email

O.K. to email detailed information to the following email address:

_____

_____ _____

Patient Signature Date

_____ _____

Print Name S.S.N.

The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum information necessary to accomplish the intended purpose. These provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

Disclosure of treatment records, payment information, and healthcare operations may be permitted without prior written consent in an emergency.

Patient's Name: _____ Date: _____

Neuropathy Relief Centers

Authorization for Release of Information

Patient Name: _____ **DOB**:____/____/____ **SSN**: ____-____-____

Address: _____

Home Phone: ( ) _____ **Cell Phone**: ( ) _____

I authorize: _____
Physician Name Facility Phone

_____
Facility Name/Address Facility Fax

To send/release photocopies of medical records concerning the above named person to:

Neuropathy Relief Centers
2308D Memorial Blvd
Springfield, TN 37172

For the purpose of treatment for _____. I authorize the release of photocopies of the following medical records and information in their possession including all confidential HIV related information, confidential alcohol or drug abuse related information and confidential mental health diagnosis and treatment information. I agree that these provisions will remain in effect until I provide written revocation to Neuropathy Relief Centers.

☐ Medical Record ☐ Hospital Records ☐ Procedure Records ☐ Laboratory Records ☐ Other

_____ _____ _____
Signature of Patient/Legal Guardian Relationship to Patient Date

Patient's Name: _____ Date: _____

Neuropathy Relief Centers

Patient Consent Form

I, _____, understand that as part of my health care, that Neuropathy Relief Centers creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I acknowledge that I have been provided with a *Notice of Privacy* which provides a more completes description of information uses and disclosures.

I understand that Neuropathy Relief Centers is not required to agree to the restrictions requested and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Federal and State Regulations.

I further understand that Neuropathy Relief Centers reserves the right to change their notice and practices and prior to implementation, in accordance with Federal and State Regulations.

Neuropathy Relief Centers has my consent to give out my private health information, including my identity, diagnoses and treatments, whether in writing or verbally, to the following persons or entities (e.g. spouse, child or other representative):

_____
Name Relationship to Patient

_____
Name Relationship to Patient

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable disease) requested by my health insurance carrier, Medicare or any other third-party payers, and I authorize Neuropathy Relief Centers to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Neuropathy Relief Centers.

I agree that these provisions will remain in effect until I provide written revocation to NRC:

_____ _____
Patient or Guardian Witness

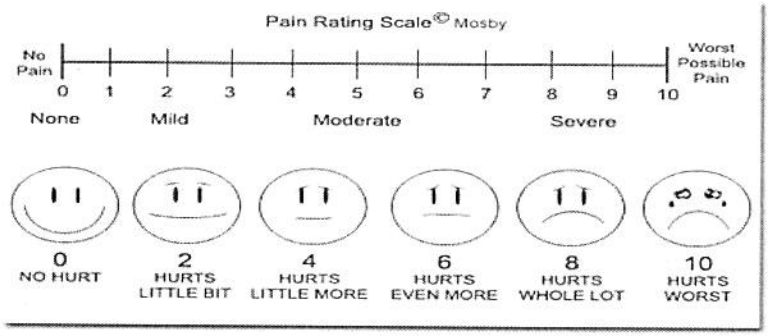
_____ _____
Date Date

Patient's Name: _____ Date: _____

Neuropathy Symptom Questionnaire

Circle Areas affected: Feet Hands Legs

Rate your pain: using a scale of 0 to 10: _____



Circle ***Yes*** or ***No*** to each question that describes your symptoms

Numbness	Yes	No
Tingling	Yes	No
Burning	Yes	No
Coldness	Yes	No
Pins & Needles	Yes	No
Crawling sensations	Yes	No
Walking on rocks	Yes	No
Cannot stand sheets	Yes	No
Have to wear socks	Yes	No
Balance problems	Yes	No
Discoloration of your legs	Yes	No

Patient's Name: _____ Date: _____

Neuropathy Medical History

1. Do you use a pacemaker _____ Yes No
2. Do you use a defibrillator _____ Yes No
3. Do you have a mechanical heart valve _____ Yes No
4. Do you have Diabetes _____ Yes No
5. Has your physician diagnosed "Neuropathy" _____ Yes No
6. Have you ever had an EMG or Nerve Conduction Test _____ Yes No
7. Have you had back surgery _____ Yes No
8. Have you ever had an MRI of your back _____ Yes No
9. Are you on Anticoagulant Therapy _____ Yes No
10. Have you had any amputations _____ Yes No
11. Do you suffer from palpitations _____ Yes No
12. Do you suffer from arrhythmias of your heart beat _____ Yes No
13. Are you on dialysis _____ Yes No
14. Do you suffer from epilepsy or convulsions _____ Yes No
15. Is there any metal in your body _____ Yes No
16. Have you had knee replacement surgery _____ Yes No
17. Have you had hip replacement surgery _____ Yes No
18. Have you had any transplants _____ Yes No
19. Have you had cancer _____ Yes No
20. Have you had chemotherapy _____ Yes No
21. Have you had radiation treatments _____ Yes No
22. Do you have arthritis _____ Yes No
23. Do you have gout _____ Yes No
24. Have you had back problems _____ Yes No
25. Have you had problems with your feet _____ Yes No

(fractures, deformities, ingrown toenails, fungal infections, bunions, hammertoe, amputations)

26. Do you have chronic swelling of your legs _____ Yes No
27. Have you experienced leg/foot ulcers? _____ Yes No

Patient's Name: _____ Date: _____

Neuropathy Medication Questionnaire

Please answer ***Yes*** or ***No*** to each question by marking a circle

Are you taking:

Gabapentin (Neurontin)_____ Yes No

Cymbalta_____ Yes No

Lyrica_____ Yes No

Lortab/Percocet_____ Yes No

NSAIDS(Aleve, Motrin, Ibuprofen)_____ Yes No

List other medications you are taking:

Medication Name	**Dose**	**How Often**

Please list any known **ALLERGIES** to medications or foods

Medication	**Reaction**

Patient's Name: _____ Date: _____

Please **circle** **Yes** or **No** appropriately if you have or have not had any of the following:

Scarlet Fever	Y	N	Heart Murmur	Y	N	Cancer, Tumor, Cysts	Y	N
Measles	Y	N	Atrial Fibrillation	Y	N	Recurrent Headaches	Y	N
Mumps	Y	N	Skin Disorders	Y	N	Recurrent colds/coughs	Y	N
Chicken Pox	Y	N	Sciatica	Y	N	High Blood Pressure	Y	N
Shingles	Y	N	Back Problems	Y	N	Gallbladder disease	Y	N
Rheumatic Fever	Y	N	Shortness of Breath	Y	N	Bloody Stools	Y	N
Malaria	Y	N	Asthma	Y	N	Recurrent Diarrhea	Y	N
Emphysema	Y	N	Hay Fever/Allergies	Y	N	Jaundice/Hepatitis	Y	N
Neck Pain	Y	N	Head Injury	Y	N	Stomach Ulcers	Y	N
Chest Pain	Y	N	Sinus Issues	Y	N	Recent Weight changes	Y	N
Diabetes	Y	N	Cataracts,	Y	N	Joint Disease	Y	N
Tuberculosis	Y	N	Glaucoma	Y	N	Anxiety/Depression	Y	N
Insomnia	Y	N	High Cholesterol	Y	N	Weakness/Paralysis	Y	N
Hepatitis	Y	N	HIV/AIDS	Y	N	Dizziness/Fainting	Y	N
History Stroke	Y	N	Gum/Tooth Problems	Y	N	Urination Problem	Y	N
Alcoholism	Y	N	Vascular Problems	Y	N	Multiple Sclerosis	Y	N

Patient's Name: _____ Date: _____

Hospitalization, Accidents, Surgeries

Hospitalizations: (Do not include surgeries)

Date of Accidents:

Date of Surgeries or Procedures:

Patient's Name: _____ Date: _____