CAPITAL NEUROLOGY
4250 CRUMS MILL ROAD STE 102
HARRISBURG, PA 17112-2889
(717) 649-0211

PATIENT REGISTRATION FORM (PAGE 1 OF 2)

TODAY'S DATE: **PRIMARY CARE PHYSICIAN:**

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:
IS THIS YOUR LEGAL NAME? Y ☐ N ☐	MARITAL STATUS:	
IF N ABOVE, LEGAL NAME?	DATE OF BIRTH: ____/____/________	AGE:
	PRONOUNS:	SEX:
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE: ( ) ____ - ____	CELL PHONE: ( ) ____ - ____	SSN:
EMAIL:		
OCCUPATION:	EMPLOYER:	
EMPLOYER PHONE: ( ) ____ - ____	REFERRED BY:	
OTHER FAMILY MEMBERS SEEN HERE:		

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE? Y ☐ N ☐	RESPONSIBLE PARTY (RELATION):	
RESPONSIBLE PARTY (INSURED'S NAME):		
IS THIS PARTY A PATIENT HERE? Y ☐ N ☐	DATE OF BIRTH: ____/____/________	AGE:
OCCUPATION:	EMPLOYER:	
EMPLOYER PHONE: ( ) ____ - ____	EMPLOYER ADDRESS:	
GROUP #:	POLICY #:	SSN:
INSURER:	CLAIMS PHONE: ( ) ____ - ____	CO-PAY:
	Please give your insurance card to the receptionist.	

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PATIENT REGISTRATION FORM (PAGE 2 OF 2)

TODAY'S DATE: **PRIMARY CARE PHYSICIAN:**

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE? Y ☐ N ☐	**RESPONSIBLE PARTY (RELATION):**	
RESPONSIBLE PARTY (INSURED'S NAME):		
IS THIS PARTY A PATIENT HERE? Y ☐ N ☐	**DATE OF BIRTH:** ____/____/________	**AGE:**
OCCUPATION:	**EMPLOYER:**	
EMPLOYER PHONE: ( ) ____ - ____	**EMPLOYER ADDRESS:**	
GROUP #:	**POLICY #:**	**SSN:**
INSURER:	**CLAIMS PHONE:** ( ) ____ - ____	**CO-PAY:**
	Please give your insurance card to the receptionist.	

IN CASE OF EMERGENCY

NAME OF LOCAL CONTACT NOT AT SAME ADDRESS:		
RELATIONSHIP TO PATIENT:	**HOME PHONE:** ( ) ____ - ____	**EMAIL:**
	WORK PHONE: ( ) ____ - ____	
ADDRESS:		
CITY:	**STATE:**	**ZIP:**

The information completed on this form is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Capital Neurology to release any information required to properly process my claims.

Name of patient	MRN#	Date of birth
Signature of patient/responsible party	**Relationship (if applicable)**	**Today's date**

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CONSENT FOR TREATMENT AGREEMENT

I consent to the rendering of medical care, which may include diagnostic procedures and such medical treatment as my attending or consulting physician considers to be necessary. I also understand that, absent emergency circumstances, no invasive or experimental procedure will be performed upon me unless or until I have had an opportunity to discuss the procedure with my physician and give informed consent to the procedure. I understand that medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury or death. I acknowledge that no guarantee has been made to me regarding any examination or treatment in Capital Neurology.

1. **Assignment of insurance benefits**: I consent to the rendering of medical care, which may include diagnostic procedures and hereby authorize my Medicare and/or medical insurance benefits payable to me under the terms of my insurance policies to be paid directly to Capital Neurology entities. If my attending physician or other physician associated with them or whom they may designate accepts insurance assignment, then I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to those physicians. I assign any and all legal rights that I have to collect benefits to Capital Neurology. I understand that I am financially responsible for non-covered services, as well as any deductibles, coinsurance or amounts in excess of insurance benefits. I permit a copy of this consent to be used in place of the original.
2. **Grievance appeal consent**: I hereby authorize Capital Neurology to act on my behalf in requesting a reconsideration of a medical determination made by my managed care plan or utilization review entity regarding my medical care.
3. **Advance directives**: I understand that Capital Neurology will provide me with written information regarding my right to make healthcare treatment decisions in compliance with the Patient Self-Determination Act of 1990. This information will be provided.
4. **Telehealth (live video feed)**: I understand that certain specialty consultations may be conducted through Telehealth and the physician I see and talk to on the video screen will not be in the same room or at the same location as me and that there are risks with Telehealth, including but not limited to signal interruptions, unauthorized access, and technical difficulties.
5. **Use of telephone**: I understand that in order for Capital Neurology to service my account or collect any amounts I may owe, they may contact me by telephone or at any telephone number associated with my account, including wireless telephone numbers which could result in charges to me. I also understand that any telephone numbers associated with my account, including wireless telephone numbers which could result in charges to me. I also understand that methods used to contact me may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
6. **Use of electronic communication**: I understand that in order for Capital Neurology to communicate upcoming appointments, they may contact me by telephone, email, or text messaging. Wireless charges may apply. I also understand that methods used to contact me may include the use of an automatic dialing device, as applicable. I note that these methods are not inherently confidential means of communication.
7. **Medical records**: I hereby grant my Capital Neurology caregiver access to all my relevant medical and pharmaceutical records, which may include mental health, substance abuse, and HIV records.
8. **Personal valuables**: I understand that Capital Neurology is not responsible for personal items brought to the clinic. All personal items retained in the examination rooms are the sole responsibility of the patient.

SIGN: I have read and understand the consent for treatment policy. I agree to abide by its guidelines. Consent must be signed by the patient's legal representative in the case of a minor or when the patient is incapacitated.

____________________	____________________	____________________
Name of patient/legal representative	MRN#	Patient cannot sign because:
Signature of patient/legal representative	Relationship (if applicable)	Today's date

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PATIENT INSURANCE RESPONSIBILITY AGREEMENT

We welcome you as our patient and appreciate the opportunity to provide you with medical care. We are committed to providing you with timely and quality health care. Because many of our patients have questions regarding patient and insurance responsibility for the services rendered here, we have this policy available to assist you. Please read it, ask any questions you may have, and sign in the space provided. A copy can be provided to you, upon request.

1. **Insurance**: We participate in most plans, including Medicare. Knowing your insurance benefits is your responsibility. Please be sure to contact your insurance company with any questions you may have regarding your coverage. If you are not insured by a plan we do business with, be aware that you will be billed for all services provided.
2. **Proof of insurance and/or identity**: We must obtain a copy of your insurance card and photo ID. Each time you visit our office, you will be asked to show your business card and a photo ID.
3. **Non-covered**: Please be aware that some of the services received at our office may not be covered by your insurance. You are responsible for any balances not covered by your insurance plan. If you receive any durable medical equipment (including, but not limited to, casting and bracing) you may receive a bill for those non-covered items from the durable medical equipment provider.
4. **Coverage changes**: If your insurance changes, it is your responsibility to notify us prior to your visit, in order for us to make the appropriate changes so you can receive the maximum benefits.
5. **Co-payments and deductibles**: All co-payments and deductibles must be paid at time of service. We accept cash, check, credit card, as well as debit cards.
6. **Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid by the insurance company. Your insurance company may require you to provide certain information directly, before claims will be paid. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Your contract includes payment of co-pays and deductibles.
7. **Missed appointments and late arrivals**: Your may be charged a fee for a missed appointment that has not been canceled within 24 hours. The no-show charge for a regular appointment is $25.00. These charges will be your responsibility and billed directly to you. Please help us serve all patients by arriving on time. If you arrive 15 minutes late for a scheduled appointment, we may need to reschedule your appointment.
8. **Diagnostic services**: If the physician orders diagnostic services, such as an X-ray, this service can be [provided on site for your convenience. This service will be billed separately by Capital Neurology.
9. **Medication refills**: We require 24 hour notice for medication refills.
10. **Form completion**: There is a self-pay fee for completion of all forms due upon receipt.
11. **Litigation services**: Please note that our office does not provide litigation services.

Please let us know if you have any questions or concerns.
SIGN: I have read and understand the payment policy. I agree to abide by its guidelines.

Name of patient	MRN#	Date of birth
Signature of patient/responsible party	Relationship (if applicable)	Today's date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: ____

Date of Birth: ________________ SSN: ________________

I. My Authorization

I authorize the following using or disclosing party:

____

to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

____

☐ - My health information covering the period from _________ (date) to _________ (date)

☐ - Other: ____

The above party may disclose this health information to the following recipient:

Name (or title) and organization ____

Address ____

City ________________ State ________________ Zip ________________

Phone ________________ Fax ________________ Email ________________

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: ____

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

☐ - On (date)________________

☐ - When the following event occurs: ______________________________________

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ______________________________

Date: ________________

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: ____________ years of age

☐ - Patient is unable to sign because: ____

Signature of Authorized Representative: ____________________________________

Date: ________________

Print Name of Authorized Representative: _____________________________________

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ____________________

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion,** or **mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ______________________________

Date: ____________________ Time: ______________________

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ______________________________

Date: ____________________ Time: ______________________

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PATIENT CONFIDENTIALITY AND CONTACT INFORMATION FORM

It is the policy of Capital Neurology to release confidential information only with the authorization of the patient, unless otherwise permitted or required to by law.

I understand that I will receive correspondence through the U.S. Mail. I authorize Capital Neurology to provide or leave messages regarding scheduling or routine medical information pertaining to my care, such as a normal test with the following authorized individual(s):

Please list the names of, and your relationships with, the authorized person(s) (e.g. spouse, parent, child), with whom we may discuss your medical care.

NAME:	RELATIONSHIP:	TELEPHONE NUMBER:	MEDICAL INFO. TO BE SHARED:	METHOD:
			☐ All medical information ☐ Appointment information ☐ Info. restricted to (indicate): __________	☐ Telephone ☐ Voicemail ☐ In-person
			☐ All medical information ☐ Appointment information ☐ Info. restricted to (indicate): __________	☐ Telephone ☐ Voicemail ☐ In-person
			☐ All medical information ☐ Appointment information ☐ Info. restricted to (indicate): __________	☐ Telephone ☐ Voicemail ☐ In-person

PATIENT CONTACT INFORMATION: please indicate where we may attempt to call you.

Home ☐ YES ☐ NO Telephone: ( ) ___ - ___ Leave message? ☐ YES ☐ NO
Work ☐ YES ☐ NO Telephone: ( ) ___ - ___ Leave message? ☐ YES ☐ NO
Cell Phone ☐ YES ☐ NO Telephone: ( ) ___ - ___ Leave message? ☐ YES ☐ NO

SIGN: I understand that I am responsible for notifying Capital Neurology when any of this information changes.

________________ ________________ ________________
Signature of patient | Print name of patient | Date of birth

________________ ________________ ________________
Signature of parent/guardian | Print name of parent/guardian | Today's date