



**FINANCIAL RESPONSIBILITY AGREEMENT**

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any medical service visit, EMG, EEG, Sleep Deprived/Video/Ambulatory EEG's, Evoked potentials, Transcranial Doppler, Carotid Duplex and Neuropsych testing ordered by my physician or the physician's staff.

I understand and agree it is my sole responsibility and not the responsibility of the provider of services or technicians to know if my insurance will pay for my medical service, testing or visit ordered by my physician or the physician's staff.

I understand and agree it is my sole responsibility to know if my insurance has any deductibles, referral requirement, co-payment, co-insurance, out-of-network amount and usual and customary limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.

I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied, or a higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment promptly.

By signing below, I agree to accept full financial responsibility as a patient who is receiving any medical services, that may include EMG, EEG, Sleep Deprived/Video/Ambulatory EEG's, Evoked potentials, Transcranial Doppler, Carotid Duplex and Neuropsych testing or as the responsible party for minor patients. My signature verifies that I have read the above disclosure statement, understand my responsibilities and agree to these terms.

Patient

Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Name (please print) \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_



# LAWRENCEVILLE NEUROLOGY CENTER, P.A.

Neurology • Neurophysiology • Neuromuscular • Epilepsy • Stroke

**Rene Gomez, M.D., F.A.A.N.\***

**Paul K. Kaiser, M.D. \*\*<sup>◇</sup>**  
**Aissa Alexeeva, M.D. \*\*<sup>◇</sup>**  
**Kimberly Palangio, D.O.\*<sup>◇</sup>**

**Manuel Vergara, M.D. \*\*<sup>◇</sup>≠**  
**C. Rao, M.D., MRCP, (UK), DM \*<sup>◇</sup>~≠**  
**Nidhi S. Modi, M.D. \***

3131 Princeton Pike  
Building 3 • Suite 202  
Lawrenceville, NJ 08648  
(609) 896-1701 • Fax (609) 896-3735

2 Centre Drive  
Suite 200  
Monroe Twp., NJ 08831  
(609) 896-1701 • Fax (609) 896-3735

10 Forrestal Road  
Suite 202  
Princeton, NJ 08540  
(609) 688-3492 • Fax (609) 688-3493

I \_\_\_\_\_ have informed Lawrenceville Neurology Center that the treatment/services I am receiving starting \_\_\_\_\_ are not the result of an automobile accident or work-related. The problem/condition for which I am seeking treatment/services do not arise from an auto/work related accident.

I \_\_\_\_\_ understand that by my notifying Lawrenceville Neurology Center that this is not motor vehicle/work related, that any bills incurred but not covered by my personal health insurance will be my personal responsibility and obligation to pay.

We at Lawrenceville Neurology Center ask that you sign this document only after any questions you may have concerning its content have been answered to your satisfaction and you understand your obligation to pay for any unpaid services by your insurance carriers.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Thank you,  
Lawrenceville Neurology Center



F.A.A.N. - Fellow of American Academy of Neurology, \* Board Certified in Neurology, + Board Certified in Vascular Neurology  
~ Board Certified in Neuromuscular Medicine, ≠ Board Certified in Electrodiagnostic Medicine, <sup>◇</sup> Board Certified in Clinical Neurophysiology

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

With my consent, Lawrenceville Neurology Center, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lawrenceville Neurology Center's P.A. Notice of privacy practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lawrenceville Neurology Center, P.A. reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office at 3131 Princeton Pike Bldg. 3C Suite 202, Lawrenceville, NJ 08648.

With my consent, Lawrenceville Neurology Center, P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

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

- Home Telephone** \_\_\_\_\_
  - O.K. to leave a message with detailed information
  - Leave a message with name of practice and call back number only.
  
- Work Telephone** \_\_\_\_\_
  - O.K. to leave a message with detailed information.
  - Leave message with name of practice and a call back number only.
  
- Email address:** \_\_\_\_\_
  - O.K. to communicate via email address provided above.
  
- Cell Phone/Text Messaging** \_\_\_\_\_
  - O.K. to leave a message/text with detailed information
  - Leave a message/text with name of practice and call back number only.

**I grant permission for you to discuss my care with the following person(s)**

Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____

By signing this form, I am consenting to Lawrenceville Neurology Center's, P.A. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lawrenceville Neurology Center, P.A. may decline to provide treatment to me.

*\*Each dated signature is valid for one (1) year\*\**

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

## MEDICATIONS

Please list all medications you are currently taking, including non-prescription medications

**Patient Name** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Phone #** \_\_\_\_\_

**Pharmacy  
Name & Phone #** \_\_\_\_\_

<b>Name of Medication</b>	<b>Strength</b>	<b>Frequency</b>	<b>Date Discontinued</b>	<b>Signature &amp; Date</b>

**DRUG ALLERGIES:** (Please circle and list, if any)

\_\_\_\_\_

\_\_\_\_\_

# Health History

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

**Past Medical History:** Please check all that apply to you

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Heart problems : Type _____ | <input type="checkbox"/> Ulcer/GERD       |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Blackouts        |
| <input type="checkbox"/> Cancer, Type: _____    | <input type="checkbox"/> Defibrillator               | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Other:           |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Blood Pressure         |   |
| <input type="checkbox"/> Epilepsy/Seizures      | <input type="checkbox"/> Psychiatric disease         |   |
| <input type="checkbox"/> Head Trauma/Concussion | <input type="checkbox"/> Stroke                      |   |
| <input type="checkbox"/> Headaches/Migraines    | <input type="checkbox"/> Thyroid                     |   |

**Allergies to medications:** \_\_\_\_\_

**Previous Surgeries and/or Hospitalizations:** Please list past surgeries with approximate date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Serious Injury:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much/week? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many cigarettes/day? \_\_\_\_\_  
 Former Smoker  Never Smoker

Do you consume caffeine?  Yes  No If yes, how many cups/day? \_\_\_\_\_  coffee  tea  soda

Do you use recreational drugs?  Yes  No If yes, what type and frequency? \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, please describe? \_\_\_\_\_

Do you exercise regularly?  Yes  No

**Family History:** Do you know of any blood relative who has or had:

<u>Condition</u>	<u>Relation</u>	<u>Condition</u>	<u>Relation</u>
<input type="checkbox"/> Arthritis _____		<input type="checkbox"/> Kidney disease _____	
<input type="checkbox"/> Asthma _____		<input type="checkbox"/> Lung disease _____	
<input type="checkbox"/> Aneurysm, Type: _____		<input type="checkbox"/> Migraine _____	
<input type="checkbox"/> Brain tumor _____		<input type="checkbox"/> Multiple Sclerosis _____	
<input type="checkbox"/> Cancer, Type: _____		<input type="checkbox"/> Parkinson's _____	
<input type="checkbox"/> Dementia/Alzheimer's _____		<input type="checkbox"/> Peripheral Neuropathy _____	
<input type="checkbox"/> Diabetes _____		<input type="checkbox"/> Psychiatric disease _____	
<input type="checkbox"/> Epilepsy/Seizures _____		<input type="checkbox"/> Stroke _____	
<input type="checkbox"/> Headaches _____		<input type="checkbox"/> Thyroid _____	
<input type="checkbox"/> Heart Problems _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> High Blood Pressure _____			

**Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**General Health History**

**Review of Systems**

As you review the following list, please select any problems that you are experiencing at present.

<p><b>General Health</b>  <input type="checkbox"/> General good health  <input type="checkbox"/> Fatigue  <input type="checkbox"/> Fever/Chills  <input type="checkbox"/> Insomnia  <input type="checkbox"/> Change in appetite  <input type="checkbox"/> Weight change</p> <p><b>Skin</b>  <input type="checkbox"/> Ulcers  <input type="checkbox"/> Rash  <input type="checkbox"/> Itching  <input type="checkbox"/> Hives  <input type="checkbox"/> Cancer</p> <p><b>Ears/Nose/Throat/Mouth</b>  <input type="checkbox"/> Ringing of the ears  <input type="checkbox"/> Loss of hearing/Deafness  <input type="checkbox"/> Earache  <input type="checkbox"/> Nasal congestion  <input type="checkbox"/> Nose bleeds  <input type="checkbox"/> Loss of smell  <input type="checkbox"/> Difficulty swallowing</p> <p><b>Eyes</b>  <input type="checkbox"/> Pain  <input type="checkbox"/> Discharge  <input type="checkbox"/> Redness  <input type="checkbox"/> Loss of vision  <input type="checkbox"/> Blurred vision</p> <p><b>Respiratory</b>  <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Wheezing  <input type="checkbox"/> Dry cough  <input type="checkbox"/> Productive cough  <input type="checkbox"/> Coughing up blood</p> <p><b>Name:</b></p>	<p><b>Heart</b>  <input type="checkbox"/> Chest pain  <input type="checkbox"/> Palpitations  <input type="checkbox"/> Swelling in legs/feet/ankles  <input type="checkbox"/> Shortness of breath when lying down (orthopnea)  <input type="checkbox"/> Loss of consciousness  <input type="checkbox"/> PND (awake from sleep unable to breath)  <input type="checkbox"/> MI ( heart attack)</p> <p><b>Gastrointestinal</b>  <input type="checkbox"/> Heartburn  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Bloating  <input type="checkbox"/> Abdominal pain  <input type="checkbox"/> Bloody stools  <input type="checkbox"/> Peptic ulcer disease  <input type="checkbox"/> Nausea  <input type="checkbox"/> IBS</p> <p><b>Genitourinary/Female</b>  <input type="checkbox"/> Blood in Urine  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Urgency in urination  <input type="checkbox"/> Nocturnal urination  <input type="checkbox"/> Irregular periods  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> Pelvic pain  <input type="checkbox"/> Heavy periods  <input type="checkbox"/> Flank pain (between upper and lower back)  <input type="checkbox"/> Dysmenorrhea (painful periods)</p>	<p><b>Genitourinary/Male</b>  <input type="checkbox"/> Blood in urine  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Urgency in urination  <input type="checkbox"/> Nocturnal urination  <input type="checkbox"/> Penile discharge  <input type="checkbox"/> Testicular pain  <input type="checkbox"/> Dysuria (painful urination)  <input type="checkbox"/> Impotence  <input type="checkbox"/> Rash  <input type="checkbox"/> Flank pain (between upper and lower back)</p> <p><b>Endo</b>  <input type="checkbox"/> Breast enlargement  <input type="checkbox"/> Low blood sugar  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Abnormal hair growth  <input type="checkbox"/> Steroid use  <input type="checkbox"/> Excessive thirst  <input type="checkbox"/> Weight gain  <input type="checkbox"/> Urinate frequently</p> <p><b>Musculoskeletal</b>  <input type="checkbox"/> Joint pain/stiffness  <input type="checkbox"/> Back pain  <input type="checkbox"/> Neck pain  <input type="checkbox"/> Difficulty walking  <input type="checkbox"/> Muscle pain  <input type="checkbox"/> Swelling</p> <p><b>Date:</b></p>	<p><b>Neurological</b>  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Loss of consciousness  <input type="checkbox"/> Weakness  <input type="checkbox"/> Headaches  <input type="checkbox"/> Numbness/tingling  <input type="checkbox"/> Altered mentation  <input type="checkbox"/> Seizures  <input type="checkbox"/> Memory loss  <input type="checkbox"/> Loss of coordination  <input type="checkbox"/> CVA</p> <p><b>Psychiatric</b>  <input type="checkbox"/> Anxiety  <input type="checkbox"/> Depression  <input type="checkbox"/> Stress  <input type="checkbox"/> Mood swings  <input type="checkbox"/> Hallucinations  <input type="checkbox"/> Delusions</p> <p><b>Hematological/Lymph Nodes</b>  <input type="checkbox"/> Anemia  <input type="checkbox"/> Easy bruising  <input type="checkbox"/> Abnormal bleeding  <input type="checkbox"/> Swollen lymph nodes</p> <p><input type="checkbox"/> None of Above</p> <p><input type="checkbox"/> Other</p> <hr/> <hr/> <hr/>
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