

Lawrenceville Neurology Center Patient Registration Form

DATE: _____

NAME: _____
First Middle Initial LastADDRESS: _____
Street/Box Apt # City State Zip

PHONE: (____) _____ WORK: (____) _____ CELL: (____) _____

EMAIL ADDRESS: _____ OCCUPATION: _____

SEX: MALE FEMALE AGE: _____ DATE OF BIRTH: _____ SOC. SEC. #: _____

LANGUAGE: _____ RACE/ ETNICITY: _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
 DOMESTIC PARTNER CIVIL UNION

SPOUSE'S / PARENT'S NAME: _____ CONTACT NUMBER: (____) _____

EMERGENCY CONTACT NAME: _____ CONTACT NUMBER: (____) _____

REFERRING DOCTOR: _____ PHONE NUMBER: (____) _____

ALLERGIES: Yes or No (please Circle and list, if any) _____**INSURANCE INFORMATION***PRIMARY INSURANCE & ID #:* _____
NAME OF INSURANCE IDENTIFICATION #NAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____
MANDATORY*SECONDARY INSURANCE:* _____
NAME OF INSURANCENAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____
MANDATORY**ACCIDENT INFORMATION – PLEASE NOTIFY THE FRONT DESK IF THIS IS ACCIDENT RELATED AS WE NO LONGER SEE PATIENTS FOR MVA/W. COMP RELATED INJURIES** AUTO WORKMEN'S COMPENSATION DATE OF ACCIDENT / INJURY: _____

CASE MANAGER NAME/PHONE NUMBER: _____

ADJUSTERS NAME/PHONE NUMBER: _____

POLICY NUMBER: _____ INSURANCE COMPANY'S NAME/ADDRESS: _____

RELEASE OF INFORMATION / PAYMENT AUTHORIZATION/ASSIGNMENT OF BENEFITS/NO SHOW POLICY

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I assign direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance and that any payments due not covered by insurance over 120 days old will be charged a 15% late fee. I certify that the information I have reported to be correct. In addition, I understand that I may be billed a \$25.00 no show fee for all missed appointments without prior notification.

SIGNATURE_____
DATE



LAWRENCEVILLE NEUROLOGY CENTER, P.A.

Neurology • Neurophysiology • Neuromuscular • Epilepsy • Stroke • Headache • Multiple Sclerosis

René Gómez, M.D., F.A.A.N. *▼•

Paul K. Kaiser, M.D. **♦

Aissa Alexeeva, M.D. **♦■

Kimberly Palangio, D.O. *♦■

Manuel Vergara, M.D. **♦#■

C. Rao, M.D., MRCP, (UK), DM *♦~#■▼

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 South • Suite 202
Princeton, NJ 08540
(609) 688-3492 • Fax (609) 688-3493

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.

The undersigned individual guarantees prompt payment of all charges. You agree to reimburse Lawrenceville Neurology Center, PA the fees of any collection agency, which are based on a percentage of the original debt, at a maximum of 35% of the debt, and all costs and expenses including reasonable attorney fees, we incur in such collection efforts. Accounts will be sent to collections if they remain unpaid for equal to or greater than 90 Days.

Patient Signature _____ Date _____

Responsible Party Name (please print) _____

Responsible Party Signature _____ Date _____



EMG/Nerve Conduction Studies



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, ♦ Board Certified in Clinical Neurophysiology

■ Board Certified in Epilepsy, ▼ Multiple Sclerosis Certified Specialist, • Added Qualification in Headache Medicine



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Neurology • Neurophysiology • Neuromuscular • Epilepsy • Stroke

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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



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~ Board Certified in Neuromuscular Medicine, ≠ Board Certified in Electrodiagnostic Medicine, ◇ 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 #** _____

Name of Medication	Strength	Frequency	Date Discontinued	Signature & Date

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

Health History

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: Yes No If yes, please list: _____

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

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

Do you have a caregiver/surrogate decision maker? Yes No If yes, who? _____

Do you have a living will? Yes No

Do you have a Power of Attorney? 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>General Health</p> <ul style="list-style-type: none"> <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>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ulcers <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Hives <input type="checkbox"/> Cancer <p>Ears, Nose, Mouth, Throat</p> <ul style="list-style-type: none"> <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>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> discharge <input type="checkbox"/> Redness <input type="checkbox"/> Loss of vision <input type="checkbox"/> Blurred vision <p>Respiratory</p> <ul style="list-style-type: none"> <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>Heart</p> <ul style="list-style-type: none"> <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>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal pains <input type="checkbox"/> Bloody stools <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Nausea <input type="checkbox"/> IBS <p>Genitourinary/Female</p> <ul style="list-style-type: none"> <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>Genitourinary/Male</p> <ul style="list-style-type: none"> <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>Endo</p> <ul style="list-style-type: none"> <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>Musculoskeletal</p> <ul style="list-style-type: none"> <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>Neurological</p> <ul style="list-style-type: none"> <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>Psychiatric</p> <ul style="list-style-type: none"> <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>Hematological/Lymph Nodes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bruising <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Swollen lymph nodes <p><input type="checkbox"/> None of Above</p> <p><input type="checkbox"/> Other</p> <hr/> <hr/> <hr/>
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*****If you are 65 years or older, please answer the following questions*****

- Tendency to falls? Yes or No
 How many falls? _____
 Falls with injury? Yes or No

NAME: _____ DATE: _____



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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing this authorization: I _____
SSN: _____, Date of Birth: _____, authorize
_____ to use and/ or disclose
the following individually identifiable information about me (specifically describe the
information to be used or disclosed, such as dates(s) of services, level of detail to be released,
origin of information, etc.):

TO: LAWRENCEVILLE NEUROLOGY CENTER, PA
3131 PRINCETON PIKE, BLDG 3C, SUITE 202
LAWRENCEVILLE, NJ 08648

The information will be disclosed for purpose of neurological evaluation, treatment, and/or neurological testing.

This authorization will expire (12) months from the signature date below.

I understand that I do not have to sign this authorization in order to receive treatment from Lawrenceville Neurology Center, PA. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon the authorization. My written revocation must be submitted to the Privacy Officer at:

Lawrenceville Neurology Center, PA
3131 Princeton Pike, Bldg 3c, Suite 202
Lawrenceville, NJ 08648

Signature of Patient or Legal Guardian

Relationship to Patient

Print Name of Patient or Legal Guardian

Date Signed



EMG/Nerve Conduction Studies



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~ Board Certified in Neuromuscular Medicine, # Board Certified in Electrodiagnostic Medicine, ♦ Board Certified in Clinical Neurophysiology
■ Board Certified in Epilepsy, ▼ Multiple Sclerosis Certified Specialist, • Added Qualification in Headache Medicine by the National Headache Foundation