2570 Village Professional Drive
Opelika, Alabama 36801
Phone: 334-203-1917
Fax: 334-203-1918

Thank you for choosing Neurology Center of East Alabama. We look forward to seeing you at your first appointment!

Please arrive **20 minutes early** so that we may enter your information into our system. If you are unable to keep your appointment, notify us as soon as possible.

Complete the documents on the following pages and bring to your appointment. In addition, please bring the items listed below:

- Photo ID
- Insurance Card

Directions

From Tiger Town and exit 58, go west on Highway 280. After crossing Pepperell Parkway, take the first right onto Dunlop Drive. Go over the bridge and take the first left onto Village Professional Drive. Turn right into our parking area and our office is on the left.

Sincerely,

The Staff of Neurology Center of East Alabama

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**AUTHORIZED PATIENT
NOTIFICATION LIST**

(Required of HIPPA) Health Insurance Portability and Accountability

I authorize Neurology Center of East Alabama and/or whomever he/she may designate as his/her professional representative/assistant to discuss any aspect of my primary care, to include: appointments, test, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people (i.e. Spouse, child, friend, etc.):

Please list:

Name	Relationship

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have added or removed to the Authorized Notification List.

Patient/Other Person Authorized to Sign: ____

Date: _________________________________

Relation to Above Signature: _______________________________

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Patient's Name:____

Please List ALL MEDICATIONS you are currently taking: (Prescription and Over the Counter)

Medication Name	Dosage	Frequency

Please list ALL allergies

Allergy	Type of Reaction

☐ By checking this box, I am stating that I do not currently take ANY prescription or over the counter medications.

Patient Signature:_______________________________________Date:____________________

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AUTHORIZED PATIENT
NOTIFICATION LIST

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I authorize Neurology Center of East Alabama and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my care, to include appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people (i.e. spouse, child, friend):

Please list name and relationship to patient.

____

____

____

____

This document will be a part of your permanent medical record. Should any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

______________________________ ______________

PATIENT/OTHER PERSON AUTHORIZED TO SIGN DATE

______________________________ ______________

RELATION TO ABOVE SIGNATURE DATE

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AUTHORIZATION FOR MEDICAL AND DIAGNOSTIC TREATMENTS

(1) I wish to receive treatment at Neurology Center of East Alabama (NCEA). While I am at NCEA, I permit my doctor and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. (2) NCEA sometimes serves as a training center for students in a variety of different health care professions. Students will sometimes be allowed to observe procedures which would benefit their educational experience. I do not object to students observing my care, treatment or procedures performed upon me. (3) I understand that medical equipment/supply company representatives will sometimes be present during a procedure to instruct medical personnel on new equipment or supplies. I do not object to these representatives being present during my care, treatment, or procedures performed upon me. (4) I understand that photographs or films may be taken during the course of my treatment to be made a part of my medical record. I do not object to the taking of these photographs or films

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient or his/her authorized representative, authorize NCEA and any other professionals who provided care, treatment, or services to release to my insurance company (ies) or their authorized representative or other appropriate agency (ies) that information which is necessary to validate this claim for payment purposes. This includes my employer if workers' compensation is claimed. NCEA is also authorized to release to my physician(s), or the persons authorized to bill for them, such information as necessary for billing purposes, including, without limitation, all records and information pertaining to my medical treatment (including that for drug & alcohol abuse), laboratory & other diagnostic test results, x-rays, therapy, diagnoses, and prognosis. In the event that I am transferred to another healthcare facility, I authorize NCEA to make a copy of my medical records for the receiving healthcare facility.

RELEASE OF RESPONSIBILITY FOR LOSS OF VALUABLES

I understand that NCEA will not be responsible for valuables, including jewelry, watches, money, etc., not specifically placed in the care of NCEA through proper procedures. I also understand that NCEA cannot be responsible for personal items such as clothing, glasses, dentures, etc., inadvertently damaged or misplaced during my course of treatment. I accept full responsibility for those valuables or personal items which I choose to keep in my possession.

MEDICARE AND/OR MEDICAID PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release such information to the Social Security Administration of the State of Alabama or any of their intermediaries or carriers for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made to NCEA and/or other physicians involved in my care on my behalf.

Patient's Signature: ____ Date: _______________________ or the
Authorized Representative: Relationship: ____
If the patient or their authorized representative is unable to sign, state the reason why here: ________________________________

Assignment of Insurance and Financial Responsibility

I authorize payment of all insurance benefits, basic and major medical, for this period of medical, emergency and/or diagnostic treatments, to be made directly to NCEA. I understand that I am financially responsible for all charges not covered by my insurance plan, including but not limited to co-pays, deductibles, non-covered charges, professional fees and nurse practitioner professional fees. All efforts for collection of the benefits are for my convenience and do not represent a guarantee for collection or a credit to my account until such time as payment is received by NCEA. I also assign the benefits payable for physicians' services to the physicians(s) furnishing the services, or authorize such physicians or physician group to submit a claim to my insurance company (ies), Medicare and/or Medicaid. I will be responsible for any collection fees, court cost and/or attorney fees incurred by NCEA or any physician participating in my care while collecting on my account(s). Photocopies of this authorization are as valid as the original. I authorize NCEA, its employees and agents to contact me at any/all phone numbers (including cell phone numbers) for the purpose of treatment, insurance and payment. I acknowledge that I may be contacted by telephone at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. I also may be contacted by text messages or emails, using any email address that is provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices. By my admission to NCEA, I acknowledge that I am entering into a credit transaction as defined under The Fair Credit Reporting Act 15 U.S.C.§ 1681and that NCEA may, with or without my knowledge, obtain a consumer credit report for all permissible purposes, including, but not limited to, debt collection activities and use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status.

Patient's Signature: ____ Date: ___________________________ or the
Authorized Representative: Relationship ____
If the patient or their authorized representative is unable to sign, state the reason why here: ________________________________

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MEDICAL HISTORY QUESTIONNAIRE

Patient Name ____ Date of Birth: ______________________________

Past Medical History: Do you have, or have you had, any of the following: (PLEASE CIRCLE)
Diabetes High blood pressure Heart condition Seizure Sleep apnea Ulcer Cancer Blood or bleeding disorder
Phlebitis or blood clots Stroke Asthma Emphysema Complication of anesthesia Kidney stones
List other medical conditions and/or illnesses not mentioned above:

____________________________________ _________________________________ ______________________________

List reasons for hospitalizations and/or surgeries with dates and any complications:

____________________________________ _________________________________ ______________________________

List any significant injuries you have sustained:
(Please include if the patient has ever lost consciousness or history of head trauma)

____________________________________ ___________________________________ ______________________________

List current medications:

____________________________________ ___________________________________ ______________________________

____________________________________ ___________________________________ ______________________________

List any Drug Allergies:

____

Latex Allergy: ▯ Yes or ▯ No
Family History (if deceased, please provide age and cause)
Age(s) and overall health of parents

____

Age(s) and overall health of sibling(s)

____

List any significant family health problems

____

Social History
Alcohol use (type/amount) ______________________________Tobacco use (amount/years used)
____

Review of Systems (Circle positive symptoms and describe and/or add others, if needed.)
Constitutional: Fever, weight gain/loss, loss of appetite Digestive: Abdominal pain, constipation, diarrhea, bleeding, nausea, Vomiting

Eyes: Double vision, blurring, difficulty seeing Urologic: Pain when urinating, hesitancy, bleeding, incontinence, dysuria

ENT: Deafness, sinusitis, hoarseness, vertigo Skin: Rashes, lesions that do not heal, changes in moles

Cardiovascular: Chest pain, murmur palpitations, Gynecologic: Breast masses, pain, discharge, problems irregular/rapid heartbeat

Respiratory: Shortness of breath, wheezing, spitting blood, Neurologic: Headache, seizures, loss of balance/coordination, paralysis,
chronic cough weakness, loss of memory, numbness, paresthesia, changes in vision
Psychiatric: Depression, anxiety, hallucinations, sleep disturbances Other:
____

____ _________________________ ________________________
PATIENT SIGNATURE (Or Other Authorized Person) RELATIONSHIP DATE

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BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

____ ______________________
Printed Name of Patient Date

____
Signature of Patient or Patient's Representative

____
Printed Name of Patient's Representative (*if applicable*)

____
Representative's Relationship to Patient (*if applicable*)
==
To be completed by Neurology Center of East Alabama:
After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) ______________________________
____
____

____ ______________________________
Signature of Facility Representative Date