Neuro Medical Clinic of Cenla, LLC
3311 Prescott Rd Ste 216 Alexandria, LA 71301

Patient Name___________________________________

Patient Forms

BASIC INFORMATION

Full Name ____
First Middle Last

Sex ____ Male ____ Female ____Unknown **Date of Birth** _______/_______/_______

Mobile Phone Number_____________________________ **Alternate Phone Number**_______________________

Email____ **Social Security Number**_____________________
(We do not share. We use for appt notifications.)

Address____

City ____ **State**____________ **Zip** ____________________

Marital Status ________________________________ **Maiden Name** ______________________________

Driver's License State__________________________ **Driver's License #**____________________________

Race____ **Language** ______________________________________

Emergency Contact____

Relationship to Contact____

Full Name____
First Middle Last

Phone_______________________________________ **Email**____

Address____

City_______________________________________ **State**___________ **Zip**____________________________

ADDITIONAL INFORMATION

Please list your preferred pharmacies in order of preference.

Pharmacy Name	Pharmacy Address

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FINANCIAL INFORMATION

Who will be financially responsible for you? _______ Myself _______ Someone else

If you chose someone else, please fill out the following:

Relationship_____________________ **Name**____

Method of Payment

What will be your method of payment? _____ Insurance _______ Self-Pay

If you chose Insurance please fill out the following:

Please provide us a copy of each of your insurance cards and a copy of your Driver's License or State ID.

PRIMARY INSURANCE POLICY

Insurance Company ___________________________________ **Policy Number**_______________________

Insurance Plan_____________________________ **Insurance Phone Number**__________________________

Group Number___________________________________

Insurance Company Address____

City____ **State**______________ **Zip**__________________________

Relationship to Primary Policy Holder____

If not primary policy holder, please fill out the following:

Full Name____

First Middle Last

Sex _____Male _____Female ____ Unknown **Date of Birth**_________/_________/_________

Policy ID Number _____________________________ **Social Security Number**______________________

City______________________________________ **State** _______________ **Zip**__________________________

Patient Name________________________________

FINANCIAL INFORMATION (CONTINUED)

SECONDARY INSURANCE POLICY
If you do not have Secondary policy, you may leave this blank.

Insurance Company____________________________ **Policy Number**____________________________

Insurance Plan__________________________ **Insurance Phone Number**_________________________

Group Number__________________________

Insurance Company Address____

City_______________________________ **State** ______________ **Zip**_________________________

Relationship to Secondary Policy Holder____
If not policy holder, please fill out the following:

Full Name____
First Middle Last

Sex _____Male _____Female ____ Unknown **Date of Birth**_________/_________/_________

Policy ID Number ___________________________ **Social Security Number**____________________

City____________________________________ **State** ______________ **Zip**________________________

Patient Acknowledgment of Office Policy

- **Narcotic medication will not be written unless all other pain relief options are unsuccessful and then only for TEN days.**
- **Prescriptions cannot be refilled if you have cancelled and/or not been seen in the clinic for six months.**
- **Phone calls and Prescriptions will be returned and called in the afternoon when clinic is finished. Multiple messages can delay call back.**
- **No excuses (work or school) will be given unless you were seen in the clinic on that day.**
- **Discharge from out clinic may occur if you fail to be compliant, no show, or repeatedly cancel scheduled appointments. This is at the physician's discretion.**
- **If your account has been placed with collections, it must be paid in full before you can see the doctor.**

_______________________________________ _____________________
Signature of Patient or Responsible Party **Date**

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Patient Name___________________________________

Patients Medical History

Name: ____ Age:_______________________

Referring Physician:____

Medical Reason for Referral:____

Have you been treated for the following problems or conditions?

	Yes	No		Yes	No		Yes	No
Head			**Gastrointestinal**			**Neurological**		
Trauma			Cirrhosis			Epilepsy		
			GERD			Seizures		
Eyes			Gallbladder Disease			Severe Headaches/ Migraine		
Blindness			Heartburn			Stroke		
Cataracts			Hemorrhoids			TIA		
Glaucoma			Hepatitis			Brain Aneurysm		
Glasses/Contacts			Hiatal Hernia			Brain Tumor		
			Jaundice			Parkinson's Disease		
Ears/Noes/Throat			Ulcer			Alzheimer's/Dementia		
Allergic Rhinitis			Irritable Bowel Disease			Multiple Sclerosis		
Sinus Infections			Diverticulitis			Myasthenia Gravis		
Chronic Sinusitis			GI Bleeding			Neuropathy		
Sleep Apnea			Colon/Rectal Cancer			Essential Tremors		
Vertigo								
Diziness			**Genitourinary**			**Psychiatric**		
Meniere’s Disease			Hernia			Bipolar Disorder		
			Incontinence			Depression		
Cardiovascular			Kidney Stone/ Nephrolithiasis			Hallucinations / Delusions		
Aneurysm			Kidney Infections			Suicidal Ideation		
Chest Pain / Angina			Chronic Kidney Failure			Suicide Attempts		
Blood Clot			Urinary Tract infection					
Dysrhythmia			STD's			**Endocrine**		
High Blood Pressure						Goiter		
Heart Murmur			**Musculoskeletal**			Hyperlipidemia		
Myocardial Infraction			Arthritis			Hypothyroidism		
Other			Gout			Thyroid Disease		
			Musculoskeletal Injury					
Respiratory			Fibromyalgla			**Thyroiditis**		
Asthma			Degenerative Joint			Type 1 Diabetes		
Bronchitis			Rheumatoid Arthritis			Type 2 Diabetes		
COPD			Osteoarthritis					
Pleuritis						**Heme/Oncology**		
Pneumonia						Anemia		
						Cancer		
						Infectious		
						HIV		
						STD's		
						Tuberculosis		

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Patients Medical History

List past surgeries:____
____
____

Family Medical History

	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents
Living (Check if relative is living)					
Check all below that apply					
Stroke					
Parkinson's Disease					
Dementia (Alzheimer's)					
Tremors					
Migraine Headaches					
Epilepsy					
Brain Tumor					
Multiple Sclerosis					
Aneurysms					
Heart Disease					
Hypertension					
Diabetes					
Cancer (type)					
Other (Please List)					

Social History

(Please check all that apply)

Tobacco Use:

_____Current every day smoker
_____Former Smoker
_____Light tobacco Smoker
______Current some day smoker
______Heavy tobacco smoker
______Never smoker

Alcohol Use:

______Do not drink
______Frequently drink
______Occasionally drink
______Drink daily
______History of Alcoholism

Drug Abuse:

______Current use
______Past use

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Patients Medical History

List
Allergies:____
____
____

List Current Medications and Dose:

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

_____ See Attached Medication List (Check if you brought a list of medication with you)

Alternative Communication Methods

The undersigned does hereby authorize and direct NeuroMedical Clinic of Cenla, LLC to speak to the following representatives on my behalf concerning my medical history, treatment, appointments and billing information.

___________________________________ ___________________________________
Name Relationship

___________________________________ ___________________________________
Name Relationship

_____ Appointment dates or medical information may be left on my voicemail or answering machine.
____ Do not leave appointment dates or medical information on my voicemail or answering machine.

Patient Acknowledgment of Privacy Rights

I have received the Notice of Privacy Practices Policies which complies with tip guidelines and understand that NeuroMedical Clinic of Cenla, LLC is using these to protect my privacy.

___________________________________ ___________________________________
Name Date

___________________________________ ___________________________________
Witness Date

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Authorization for the Release of Medical information

The undersigned does hereby authorize and direct ____

____
(Insert name and address of individual or company to provide information)

____

to give to the NeuroMedical Clinic of Cenla, LLC, Dr. Gonzalo Hidalgo, M.D. or Dr. Ariel Antezana, M.D., any information which he may require regarding medical history, diagnosis, and/or treatment which the provider has acquired while attending ____ in a professional capacity.

__________________________________	__________________________________
Signed	Date
__________________________________	__________________________________
Address	Date of Birth
__________________________________	__________________________________
	Social Security Number

Insurance Signature on File
Assignment Benefits

I authorize payments of medical benefits to be paid to NeuroMedical Clinic of Cenla, LLC for services rendered at this clinic and authorize release of any medical information necessary to process this claim. Payment of co-insurance or co-pay should be made at time of service.

Insurer's or Authorized Person's Signature:_____________________________ Date:____________

All services rendered are the responsibility of the patient. Insurance will be filed as a courtesy to you. Please follow up with your insurance company if there is a denial.

In the event of a collection action, the patient is responsible for all collection costs.

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Patient Name________________________________

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, Mastercard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. These can be paid in advance by payment plan.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and submit the claim for you on an assigned basis. You will be responsible for your portion and also any payments your insurance may deny.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Testing

- Prepayment of co-payments, deductibles or co-insurance amounts may be required by the facility for any testing, prior to scheduling. If you cannot pay this in full, payment plans are offered.
- Prepayment may be kept by practice if patient is a "No Show" and patient has not cancelled prior to day of appointment.
- Missed appointments due to "No Show" will be charged a $100 fee.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms, I also understand and agree that the practice may amend such terms from time to time.

____
Printed Name of the Patient

____ ______________________
Signature of Patient or Responsible Party if a Minor Date

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Non-Compliance Form

Patient non-compliance is a significant and contributory factor to poor treatment outcomes which can lead to more costly health care as well as potential malpractice claims. Accordingly, it is the policy of this office to document non-compliance to treatment recommendations including but not limi ed to the frequency of treatment recommended in the patient's treatment plan.

Additionally, it is the policy of this office that services provided to patients who do not comply with this office's treatment plans/treatment recommendations will not be billed to their health care plans as such services are not consistent with "medically necessary care" and therefore, not covered by their health care plan. This includes, but is not limited to, patients who do not keep scheduled appointments and/or choose to seek care at their discretion and/or at their convenience.) These charges would be the patient's responsibility.

We reserve the right to discharge a patient from our services at any time due to non-compliance at the physician's discretion.

Patient Sign:_______________________________________ **Date**:____________________

Summary of Non-Compliance Issues

- Failed to adhere to treatment recommendations
- Failed to adhere to treatment schedule; repeatedly failed to keep appointments as outlined in treatment plan.
- Stopped care before treatment plan complete
- Other:____

Follow-Up Actions Taken:

- Patient contacted and reminded of importance of complying with treatment recommendations and/or treatment/appt. schedule.

Method of Contact:

- Telephone
- Email
- Text
- Letter
- Fax

1. Initial Contact Attempt:_____________
2. Subsequent Contact Attempts:___________________

Final Action:

- Patient will be counseled on need for full compliance at next appt.
- Discharged patient (sent discharge letter). Date sent:_________________________