MEDICAL SERVICES OF SYRACUSE PLLC

NEUROLOGY | NEW PATIENT REGISTRATION PACKET

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Please print clearly. Complete only the sections that apply to you.

1. PATIENT INFORMATION

Legal name (First, Middle, Last):	Preferred name:
Date of birth:	Sex:
Street address:	Apartment/Unit:
City:	State: ZIP:
Cell phone:	Home phone:
Email address:	Preferred contact: ☐ Cell ☐ Home
Social Security number:	Marital status:
Employer:	Occupation:
Race (optional):	Ethnicity (optional):

2. CONTACTS & CARE TEAM

Emergency contact name:	Relationship:
Emergency contact phone:	May we discuss care in an emergency? ☐ Yes ☐ No
Primary care clinician:	Phone:
Preferred pharmacy and address:	Phone:

Please bring your current insurance card(s) and photo identification.

3. FINANCIAL GUARANTOR

Complete only if someone other than the patient is financially responsible.

Guarantor name:	Relationship to patient:
Date of birth:	Phone:
Address (if different):	

☐ I confirm that the information on this page is complete and accurate to the best of my knowledge.

Patient/guarantor initials: _____

1. REASON FOR TODAY'S VISIT

Main reason for your visit / symptoms: *When did the problem begin? What makes it better or worse?*

_____

_____

_____

Have you previously seen a neurologist? ☐ No ☐ Yes If yes, clinician and approximate date: _____

Tests, imaging, or treatments already completed *Examples: MRI, CT, EEG, EMG, physical therapy*

_____

_____

2. MEDICAL HISTORY

Current and past medical conditions: *Include neurological and other significant conditions (Hypertension, Diabetes, High Cholesterol, Stroke, Asthma, Hypothyroidism etc.)*

_____

_____

_____

_____

_____

3. SURGERIES & PROCEDURES

Surgery / procedure	Approximate date	Hospital / surgeon (optional)

4. HOSPITALIZATIONS & EMERGENCY VISITS

Reason	Approximate date	Hospital

5. ADDITIONAL INFORMATION

Anything else you would like the neurology team to know?

_____

_____

6. SOCIAL & FUNCTIONAL HISTORY

Tobacco / vaping / marijuana: ☐ Never ☐ Former ☐ Current Type, amount, and duration: _____

Alcohol: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily Approximate amount: _____

Caffeine: ☐ None ☐ 1-2 cups/day ☐ 3-5 cups/day ☐ More than 5 cups/day

Exercise: ☐ 0-1 days/week ☐ 2-5 days/week ☐ 6-7 days/week Dominant hand: ☐ Left ☐ Right ☐ Both

Highest education completed: ☐ Elementary ☐ Middle school ☐ High school/GED ☐ College/graduate school

1. CURRENT MEDICATIONS

Include prescriptions, over-the-counter medicines, vitamins, and supplements.

☐ I do not currently take any medications

Need more room? Please attach a copy of your complete medication list. ☐ Medication list attached

Medication	Dose / strength	How often / when taken	Reason

2. ALLERGIES

☐ No known allergies ☐ Latex allergy: ☐ No ☐ Yes

Medication / substance / food	Reaction

3. FAMILY HISTORY

List serious conditions in immediate family members (for example: seizures, migraine, tremor, stroke, dementia, or neuromuscular disease).

Condition	Relationship

1. PEOPLE WE MAY SPEAK WITH

I authorize the practice to discuss information related to my care, appointments, billing, and claims with the people listed below. I understand that I may change or revoke this authorization in writing at any time, except to the extent the practice has already relied on it.

Name	Relationship	Phone	Information permitted

☐ Do not release information to anyone other than me, except as permitted or required by law.

2. PHONE & MESSAGE PREFERENCES

Preferred number: ☐ Cell _____ ☐ Home _____ ☐ Work _____

If I cannot be reached: ☐ Leave a detailed message ☐ Leave callback information only ☐ Do not leave a message

4. AUTHORIZATION & ACCURACY

I certify that the information in this packet is accurate and complete to the best of my knowledge. I authorize the practice and its clinicians to provide medically appropriate evaluation and treatment. I understand that this communication authorization remains in effect until I revoke or replace it in writing, subject to applicable law.

Patient name:	Date of birth:
Patient/authorized representative signature:	Date:
If representative, print name:	Relationship / authority:

Our goal is to provide excellent care while keeping billing and scheduling expectations clear. Please review this policy and sign the acknowledgment on the final page.

Download TalkPHR 360 today and keep your health information at your fingertips!

Scan the QR code to conveniently:

- **Access your health information and test results**
- **Update your demographic information**
- **View upcoming appointments**
- **Check outstanding balances**
- **Upload your insurance cards and photo ID and other documents!**

TalkPHR 360

Before your first appointment: Bring current insurance card(s), photo identification, any required referral, and relevant medical records. Missing required information may require us to reschedule your appointment.

Payment at check-in: Copayments and other amounts due are payable at the time of service. We accept cash, checks, money orders, and major credit cards. Returned checks are subject to a $35 processing fee.

Insurance coverage: You are responsible for confirming that the practice participates with your specific plan and whether a referral or authorization is required. Insurance benefits vary. You are responsible for charges your plan does not cover.

Referrals: If your plan requires a referral, the patient or guarantor must obtain it from the primary care clinician before the visit. Without a valid referral, the visit may be treated as self-pay with payment due at the visit, or it may be rescheduled.

Participating insurance: When we participate with your plan and have complete billing information, we will submit claims to the insurer. Required copayments remain due at the time of service.

Self-pay: Self-pay patients must make payment at the time of service. A payment arrangement may be required for a remaining balance after the initial payment.

Minor patients: Patients under age 18 must be accompanied by a parent or legal guardian. The accompanying responsible adult must provide current insurance information and pay amounts due. The practice does not determine financial responsibility under custody or divorce agreements.

Liability cases: Injuries attributed to another person's negligence are considered liability cases. The practice does not bill liability carriers; these visits are self-pay, with payment due at the appointment. **Insurance questionnaires:** Your insurer may require an injury questionnaire before paying a claim. Complete requested forms promptly. You are responsible for charges the insurer rejects because required information was not provided.

Statements and collections: After insurance processes a claim, we will send a statement for any patient balance. Payment arrangements may be available. If two payments are missed, the account may be referred to collections. A $25 collection fee may be added.

Disability and other forms: Most forms require a $25 fee, payable when the form is submitted. Please allow 10 days for completion and provide forms as early as possible.

Medical records: A signed and dated authorization is required before records are released to you or a third party, as required by privacy law. Physical copies are charged at $0.25 per page.

Changes to your information: Please promptly notify us of changes to your address, phone number, email, or insurance so we can contact you and bill accurately.

APPOINTMENT CANCELLATION / NO-SHOW POLICY

Please provide at least 24 hours' notice if you need to cancel or reschedule an appointment. A $50 fee may be charged for a cancellation, rescheduling, or missed appointment without proper notice. We understand that emergencies can occur. Two missed appointments without notice may result in discharge from the practice. Consecutive no-shows may also lead to dismissal.

Timely notice allows us to offer the appointment to another patient and helps improve access to care. Appointment reminder calls are a courtesy and do not replace the patient's responsibility to remember scheduled appointments.

ACKNOWLEDGMENT & FINANCIAL RESPONSIBILITY

By signing below, I acknowledge that I have received, reviewed, and agree to the Office Financial & Appointment Policy. I understand that I am financially responsible for charges not paid by insurance and for applicable fees described above. If I am the guarantor, I authorize medically appropriate care for the patient and accept financial responsibility for amounts due.

Patient name:	Date of birth:
Patient/guarantor signature:	Date:
Print guarantor name (if different):	Relationship to patient:

Thank you!