Wayne Neurology, PLC

34815 W. Michigan Ave, Wayne, MI 48184, Tel (734) 721-4739, Fax (734) 725-3184

Dr. Matthew Holtzman, M.D
Joseph Sabra, PA

Patient Name: _____ Sex:_____

Date of Birth: _____ Social Security Number _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City: _____ Zip Code: _____

Email Address: _____

Marital Status: _____ Spouse Name: _____

Current Employment Status: _____ Occupation: _____

Description of Occupation: _____

Do you have Medical Directive or Advance Care Plan: Y N (Please circle one)

If Yes, Name:_____ Relation: _____ Phone: _____

Whom may we contact in case of emergency?

Name: _____ Relation: _____ Phone: _____

Primary Care or Referring Physician: _____Phone:_____

Do you have a Preferred Pharmacy? _____Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Do you have a: Chiropractor Y or N Physical Therapist Y or N
Pain Management Physician Y or N Any Spine Specialist Y or N

Did you sustain an injury at work? Y or N Are you covered under an employee or union policy? Y or N

Are your injuries accident related? Y or N Is your spouse or other family member employed? Y or N

Do you have a secondary insurance policy? Y or N

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Wayne Neurology of any changes in my status or the above information. I was given a chance to review the HIPAA Privacy and the Office Financial Policies. I agree that I will comply with the office financial policy.

Patient's Signature: _____Date:_____

Please print your name at the top of each page

Name: _____ Date: _____

INSURANCE INFORMATION

Please give the receptionist any insurance cards to copy.

Primary Insurance	*Secondary Insurance*
Insurance Co:_____	Insurance Co:_____
ID Number:_____	ID Number:_____
Group Number:_____	Group Number:_____
Subscriber Name:_____	Subscriber Name:_____
Subscriber DOB:_____	Subscriber DOB:_____
Subscriber Employer:_____	Subscriber Employer:_____

Other Insurance (*Workman's Compensation / Auto Accident*)

Insurance Company: _____ Claim Adjustor: _____
Phone Number:

_____

Address: _____ City: _____ State: _____ Zip:

_____

Claim Number: _____ Authorization:

_____

Were you injured in the job? ___ Yes ___ No

How did you find out about our office?
___ Newspaper ___Signage ___Medical Referral ___Personal Referral ___Phone Book ___Internet

AUTHORIZATION TO RELEASE RECORDS

I authorize any holder of medical information about me to release to any insurance company or to its intermediaries, any medical information needed for this or a related claim. Request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services and request that payments be made to Nilofer Nisar MD PLC and authorize them to submit a claim on my behalf. I fully understand that I am financially responsible for any balance not covered by my insurance company.

Patient Signature: _____ Date: _____

Please print your name at the top of each page:

Name: _____ Date: _____

MEDICAL INFORMATION

HISTORY:

Main Reason for Visit: _____

What Occurred? _____

Is this visit a result of Work Injury? ___Yes ___No Date of Injury: _____

Auto Accident? ___Yes ___No Date of Accident: _____

What treatment have you received? _____

Where? _____

Have you had: ___X-Rays ___Blood Tests ___MRI ___CT Scan ___EMG/NCS

PRESENT MEDICATION:

_____

Do you have any Medication Allergies?

_____

PAST HISTORY/FAMILY HISTORY:

Previous injuries, specify briefly how injury occurred: _____

	I have/had:	My relatives have/had:
Diabetes	____	____
Hypertension	____	____
Heart Disease	____	____
Lupus and related diseases	____	____
Cancer	____	____
Stroke	____	____
Arthritis	____	____
Seizure	____	____
Migraine	____	____
Surgeries	____	____

Have you been hospitalized recently? ___Yes ___No Name of Hospital: _____

CURRENT/PAST TREATMENT: Please List Name/Location

Physical Therapy: _____Phone:_____

Chiropractic Treatment: _____Phone:_____

SOCIAL HEALTH HISTORY:

Do you smoke?	___Yes	___No
If yes, please list No of pack per day:_____		
Do you drink alcoholic beverages?	___Yes	___No
If yes, please list amount/frequency:_____		
Do you have a history of illicit drug use?	___Yes	___No

Please print your name at the top of each page:

Name: _____ Date: _____

REVIEW OF SYSTEMS

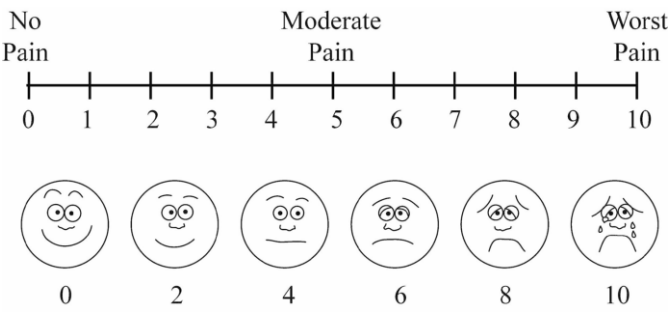
Do you have?

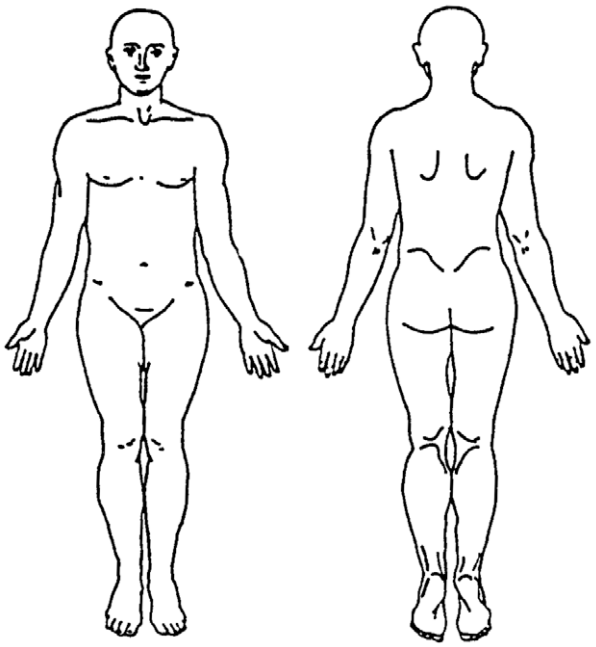
____	Fever	____	Loss of Bowel/Bladder
____	Weight Loss/Gain	____	HA
____	Skin/Hair Changes	____	Dizziness
____	Mood/Behavioral Changes	____	Blurred Visions
____	Abdominal Pain	____	Memory Problems
____	Chest pain/Cough	____	Balance Problems

Do you have limited range of motion?	___ Yes ___ No
Do you have muscle weakness?	___ Yes ___ No

PATIENT PAIN DRAWING

Using the symbols below, mark the areas on your body where you feel the described sensations. Include all affected areas. If whole areas are painful, please shade in the painful area.





Does your pain disturb your sleep? ___Y ___N

What makes your symptoms worse ___Sitting	___Sneezing	___Coughing	___Standing	___Bending	___Walking
			___Cold		___Heat
___ Lifting	___ Household chores	___Dampness	___Weather Changes	Other_____ _____ _	

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Health Information Release Authorization

I _____, authorize Wayne Neurology, to release my reports/records to the following Physicians/Case Managers/Attorney.

	Name	Phone Number
1.	_____	_____
2.	_____	_____

I also authorize to release my report/records or discuss & disclose my case, treatment, or medical condition with the following persons:

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____

Signature: _____ Date: _____

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PATIENT RESPONSIBILITY

Primary Insurance	***Secondary Insurance***
Ins. Name:_____	Ins. Name:_____
ID Number:_____	ID Number:_____

I understand that I am seeing the doctor on this date with/without authorization from my insurance company or a referral from my primary care physician. I understand I will be responsible for the cost of the visit if the insurance rejects payment for any reason for this visit.

Name (Print):_____ Date:_____

Signature: _____ Date: _____
(Patient or Person responsible)

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OFFICE FINANCIAL POLICY

1. There will be a charge for all services performed in our office and forms which require the physician or staff to fill out. These include, but are not limited to, FMLA and disability forms. By allowing the doctor to treat you, you agree to pay for all services rendered and are responsible for payment in full for any services not covered by your insurance. Payment must be made at the time of your office visit. We accept cash, check, Visa, and MasterCard. There will be a fee of $35 for all returned checks.

2. Co-pays and prior balances are required at the time of services unless prior arrangements are made.

3. Any procedures performed in our office will be billed to your insurance company.

4. If a procedure is not covered by your insurance, you will be responsible for payment in full. To avoid procedures not being covered, it is your responsibility to call your insurance company before the procedure.

5. We reserve the right to charge a fee for all patient records requested by the patient. There is no charge for transferring records to another physician.

6. Payments will be applied to the oldest outstanding balance. Any payment due for over 30 days will be considered delinquent and any remaining balance will be due immediately. It is your responsibility to keep up with your account; Failure to pay will result in your account being reported to a collection agency. Exceptions may be made for financial hardship and will be considered on a case-by-case basis.

7. This office also charges a No Call/No Show fee of $25. You must notify us at least 24 hours in advance from your scheduled appointment if you cannot make it. If your appointment is on a Monday, the appointment needs to be cancelled by the Friday before. Messages left over the weekend will not count as timely notification.

8. Our office may charge for telephone calls or services with physicians or other qualified health care professionals. However, if it's not covered by your insurance, you will be responsible for payment in full.

I have read the above policy and understand that I am responsible for paying balances on my account.

Signature: _____ Date:_____

Welcome to our Specialty Practice 12.2019

We are a part of your Patient-Centered Medical Home Neighborhood!

We are partnering with your Primary Care Physician as they build your Medical Home. We are sharing their commitment to co-manage your care over-time effectively and efficiently. As your Specialist, we will be sharing limited or long-term management (depending on the nature and impact) of your condition and provide advice, guidance and periodic follow-up until the crisis or treatment has been stabilized or completed.

You may notice that:

- We will be communicating with your Primary Care Physician (PCP) and will be providing timely written reports on our consultations with you to them.
- We will be notifying your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
- We will be providing future scheduled appointments and treatment plans.
- We will be notifying your PCP of referrals needed for other Specialties.

We trust you, our patient, to:

- Keep your appointments as scheduled, or call and let us know when you cannot.
- Learn about your insurance, so you know what it covers.
- Learn about wellness and how to prevent disease.
- Seek the advice of your PCP before you see other physicians.
- Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help or change the plan.
- Tell us what medications you are taking and ask for a refill at your office visit when you need one.
- See your PCP on an annual basis for all preventive services.

AVAILABLE COMMUNITY SERVICES

NEED HELP? DIAL 211 FROM ANY PHONE AND YOU WILL BE CONNECTED WITH A REFERRAL HOTLINE THAT CAN CONNECT YOU WITH NON-PROFIT AGENCIES IN THE AREA THAT CAN HELP WITH HUMAN, HEALTH, AND SOCIAL NEEDS (I.E., UTILITIES, HOUSING, HEALTH INSURANCE, FOOD, DIAPERS, ETC.)

PLEASE ASK OUR STAFF FOR INFORMATION PERTAINING TO YOUR SPECIFIC NEEDS.

Name: _____

Signature: _____

Date: _____

A Patient-Centered Medical Home (PCMH) is a system of care in which a team of health professionals' work together to provide all your health care needs. You, the patient, are the most important part of a patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

AFTER HOURS CARE

IF YOU HAVE NEUROLOGICAL CARE NEEDS AFTER-HOURS, PLEASE CALL (313) 396-052TU9 FOR ASSISTANCE. FOR NON-NEUROLOGICAL CARE CONTACT YOUR PRIMARY CARE/FAMILY PHYSICIAN TO GUIDE YOUR CARE TO THE NEAREST URGENT CARE CENTER OR FOR ADVICE PERTAINING TO YOUR HEALTH SITUATION.

TEST RESULTS

PLEASE TRY TO USE LABORATORIES AND OTHER TEST FACILITIES WE USE REGULARLY TO ENSURE BETTER COMMUNICATION. WE STRIVE TO GET TEST RESULTS TO PATIENTS. IF YOU HAVE NOT RECEIVED A CALL OR NOTIFICATION BY MAIL WITHIN 14 DAYS AND/OR DO NOT HAVE A FOLLOW-UP APPOINTMENT, PLEASE CALL THE OFFICE FOR YOUR RESULTS.

Comprehensive Quality of Care

PLEASE BE AWARE, IN THE COURSE OF PROVIDING YOUR CARE, YOUR HEALTH CARE INFORMATION MAY BE SHARED AMONG OTHER PROVIDERS INVOLVED IN YOUR CARE, AS APPROPRIATE.

PATIENT WEB-PORTAL

WE HAVE A PATIENT PORTAL THAT SUPPORTS TWO-WAY, SECURE & COMPLIANT COMMUNICATION. IF YOU WOULD LIKE TO ACCESS YOUR MEDICAL INFORMATION, PLEASE ASK US HOW TO DO SO.

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Administrative Hours

Monday – Thursday 9 – 4:00
Friday 9 – 3:00

Clinical Hours

Monday - 9:00 – 5:30 PM
Tuesday, Wednesday, Thursday 9:00 AM-4:00 PM
Friday - 9:00 – 2:00 PM

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LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 15 minutes late or more to your appointment you will be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time, and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise, if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

Signature: _____ Date: _____

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Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Entity Requested to Release Information: _____

Phone/Fax Number: _____

Who will be authorized to receive information - I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below:

Individual/Entity Name: **WAYNE NEUROLOGY, PLC**

Address: 34815 W Michigan Ave. Ste. C Wayne, MI 48184

Phone*: (734) 721-4739 Fax: (734) 725-3184

Email *: wayneneurology@gmail.com

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Check **only** those items of the record to be disclosed:

- ☐ office notes for last three visit only
- ☐ Neuro consult records.
- ☐ lab results, pathology reports
- ☐ record of HIV and communicable disease testing
- ☐ x-rays, MRI / CT Scans
- ☐ ER records/ Discharge Summary
- ☐ Other: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Treatment/ Continuing Medical Care
Other (please specify): _____

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

_____ _____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

ASSIGNMENT OF RIGHTS, BENEFITS AND CAUSES OF ACTION

Patient Name _____ ("Assignor", hereinafter referred to as Patient)

Medical Provider _____ ("Assignee", hereinafter referred to as Medical Provider)

Patient acknowledges that he/she has received treatment, products, services and/or accommodations (collectively the "Services") from Medical Provider and that Patient has incurred charges for such Services for which the rights, privileges, claims and remedies for payment on those Services are hereby assigned to Medical Provider as supported by *the Supreme Court decision in Covenant Medical Center v. State Farm Mutual, docket #152758 issued May 25, 2017.* Patient understands this Assignment is effective and irrevocable (subject to the termination provision below), and that they have received Services on or before the date signed below and in furtherance of the Assignment, Patient acknowledges the following:

This is an assignment of the right to enforce payment of charges incurred for Services for the date(s) detailed above, for which charges are payable by any Payer. Payer is any entity providing insurance coverage or benefits for my medical care by law or contract including, but not limited to, any employer-sponsored benefit plan, liability or health insurance carrier, worker's disability compensation insurance carrier, no-fault automobile insurance carrier, and the Michigan Automobile Insurance Placement Facility (MAIPF) or Michigan Assigned Claims Plan (MACP).

For all purposes of enforcement of this Assignment, Medical Provider or its agent is designated as my attorney in fact with respect to any action taken in pursuit of payment for Services provided by Medical Provider. In the event Medical Provider files suit to enforce payment of benefits due or past due for the Services, Patient consents that such suit may be pursued solely in Patient's name or by Medical Provider on behalf of Patient, at Medical Provider 's sole discretion. Patient further agrees to cooperate and assist Medical Provider to enforce the payment of benefits and authorizes Medical Provider to speak with Patient's attorneys and representatives regarding any and all aspects of such legal claims.

Patient and Medical Provider agree that in consideration for this assignment, Medical Provider assumes the burden, otherwise born by the Patient, to pursue payment for Services rendered by the Medical Provider, from the insurance company or entity responsible to pay for such Services.

By signing below, I agree to fully cooperate with Medical provider in pursuing payment of my Medical provider bills. I will not interfere with or compromise Medical provider's ability to recover my Medical provider bills. I waive any and all rights to settle, release or retain payment of my Medical provider bills. I understand that the right to payment of my Medical provider bills belongs only to Medical provider. I consent to the imposition of constructive trust over my insurance benefits in favor of the Medical provider. If the Medical provider has made a claim for my benefits or filed a lawsuit to recover payment of my Medical provider bills, this Assignment Of Rights, Benefits And Causes Of Action is retroactive to the date Medical provider filed the litigation or made the claim.

To the extent that Patient or his/her representatives receive any award by judgment, settlement, arbitration or otherwise, pertaining to or comprising any portion of the Services, Patient consents to assign such portion of such award to Medical Provider. Patient further acknowledges and agrees that this agreement shall, for all purposes, constitute a lien on any such award in favor of Patient and Medical Provider is authorized to provide notice of this assignment to any party involved in any such award in favor of Patient pertaining to or comprising any portion of the Services.

This assignment shall not reduce, diminish or impair Patient's obligation to pay Medical Provider for the Services, and Medical Provider acknowledges that, at any time hereto, Medical Provider may pursue Patient directly for payment for the Services, irrespective of this assignment.

This assignment shall be irrevocable unless terminated by mutual agreement of Medical Provider and Patient in writing.

Patient and Medical Provider agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

Patient Signature _____ ("Assignor")

Date ____/____/____