Patient Registration Form

Advanced Neurodiagnostics LLC

Please complete this form to the best of your ability.

Patient Information:

Last Name:_____ **First Name: :**_____

Middle Name:_____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Cell Phone:**_____

Work Phone:_____ **Social Security Number:**_____

Email:_____

Required by Government Mandate (but you may refuse):

Language:_____ **Marital Status:**_____

Race:_____ **Ethnicity:**_____

Guarantor Information:

Name (if not Self):_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Relationship to Patient:_____ **Date of Birth:**_____

Phone Number:_____ **Social Security Number:**_____

Emergency Contact Information:

Name:_____ **Relationship:**_____

Phone Number:_____

Primary Insurance Information:

Insurance Plan Name:_____

Policy Holder Name (if not Self):_____

Member ID#:_____ **Policy/Group #:**_____

Policy Holder Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Policy Holder Date of Birth:_____ **Relationship to Patient:**_____

Secondary Insurance Information:

Name:_____

Policy Holder Name (if not Self):_____

Member ID#_____ **Policy/Group #:**_____

Policy Holder Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Policy Holder Date of Birth:_____ **Relationship to Patient:**_____

Contact Preferences (Circle all that apply):

Home Phone / Cell Phone / Work Phone / Email / Patient Portal

To the best of my knowledge the above information is complete and accurate.

Signed:_____ **Date:**_____

Acknowledgement and Authorization

I authorize Advanced Neurodiagnostics LLC to obtain/ have access to my medication history (Check one): _____ **Yes** _____ **No**

Signed:_____ **Date:**_____

Past Medical History Form

Advanced Neurodiagnostics LLC

Please complete this form to the best of your ability.

Patient ID#_____

Patient Name:_____ **Date of Birth:**_____/_____/_____ **Age:**_____

Sex Assigned at Birth (circle): Male / Female Gender Identify if Different:_____

If female, are you currently pregnant (circle): Yes No

Present Occupation:_____

Allergies (list):_____

_____

Current Medications: If none, please circle: NONE

Medication Name	Dose and Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Social History (circle):

History of Smoking? Yes No
If yes, please explain (How many cigarettes/day, how long):_____
_____

History of Alcohol Consumption? Yes No
If yes, please explain (Average drinks/day):_____

History of Substance Use? Yes No
If yes, please explain (Types of substances/time period):_____
_____

Medical History (circle):

Diabetes/Prediabetes: Yes No If yes, do you use Insulin and for how long? Do you know your most recent A1C level?_____

Kidney Disease/Failure: Yes No If yes, do you require dialysis? Do you know your current kidney function percentage?_____

Known exposure to heavy metals, toxic agents (ie. Lead, Mercury, Agent Orange.): Yes No
If yes, please explain:_____

Thyroid Disease? Yes No
If yes, is it hypothyroid or hyperthyroid and the year diagnosed:_____

History of Chemotherapy or Radiation? Yes No
If yes, please explain:_____

History of tick bites or Lyme Disease? Yes No
If yes, please explain:_____

Do you have a pacemaker, defibrillator, deep brain or spinal cord stimulator? Yes No
If yes, please provide details (type and year implanted):_____
_____

Please list any previous surgeries:_____
_____

Do you have any family members with known hereditary nerve and/or muscle disorders (ie. Multiple Sclerosis, muscular distrophy, ALS): Yes No If yes, please explain:_____
_____

Have you been told by a physician that you are unable to have needles/bloodwork in an extremity?
Yes No If yes, please explain:_____

Do you have any blood clotting disorders? Yes No If yes, please explain:_____
_____

Please describe your current complaints that have brought you in for electrodiagnostic testing:
_____
_____

Patient Name (Printed): _____
Patient Signature:_____ **Date:**_____

Parent/Legal Guardian Signature (If patient is under 18 years of age):
_____ **Date:**_____

Notice of Privacy Practices Acknowledgement Form

Advanced Neurodiagnostics LLC

Patient Name:_____

Date of Birth:_____ Patient ID Number:_____

☐ I have received a copy of Advanced Neurodiagnostics LLC Notice of Privacy Practices.

☐ I refuse to sign the Advanced Neurodiagnostics LLC Notice of Privacy Practices.

Reason:_____
_____
_____
_____

☐ Patient was given the Advanced Neurodiagnostics LLC Notice of Privacy Practices but unable to sign.

Reason:_____
_____
_____
_____

☐ Notice given to patient representative.

Name:_____ Relationship:_____

☐ Advanced Neurodiagnostics LLC Notice of Privacy Practices was sent to patient on_____ by _____

Method of Communication (paper/electronic/etc.):_____

_____ _____ _____

Patient Signature Print Name Date

Assignment of Benefits

Advanced Neurodiagnostics LLC

Fiscal Responsibility:

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made with our office prior to services being rendered. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, auto or any other health/medical plan, to issue payment directly to Advanced Neurodiagnostics, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

I hereby authorize Advanced Neurodiagnostics LLC, to (1) release any information necessary to insurance carriers regarding my treatments and condition; (2) process insurance claims generated during the course of my care; (3) allow a photocopy of my signature to be used in the process of insurance claims for the period lifetime. This order will remain in effect until revoked by me in writing.

I have requested care from Advanced Neurodiagnostics LLC, on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges not covered by insurance.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

Date:

_____ _____

Patient/Responsible Party Signature: Date

_____ _____

Witness Date

Patient Financial Policy

Advanced Neurodiagnostics LLC

1. **Payment for Services:** Payment is expected at the time of service unless other arrangements have been made in advance. We accept the following forms of payment:
   - Cash
   - Personal checks
   - Credit cards
   - Debit cards

   For patients with insurance, copayments, and deductibles are due at the time of service. It is the patient's responsibility to ensure that their insurance information is up-to-date and accurate. Any balance not covered by insurance is the patient's responsibility and is due upon reciept of the statement.

2. **Cancellations and No-Shows:** We require a 24 hour notice for appointment cancellations. If you cancel your appointment with less thant 24 hours notice or fail to show up for your scheduled appointment, you will be charged a cancellation fee of $100. Repeated no-show or late cancellations may result in being discharged from the practice.

3. **Late Arrivals:** If you arrive more than 15 minutes late for your appointment, the appointment will need to be rescheduled and you will be charged a no-show fee of $100.

4. **Testing Refusal:** If you present to the appointment and durin the informed consent process refust to move forward with testing you will be charged a cancellation fee of $100.

5. **Returned Check Fees:** A fee of $50 will be charged for any checks returned by your ban k for insufficient funds. This fee covers the cost incurred by our practice due to the returned check.
   Payment for the original amount, plus the returned check fee, must be made promptly.

I acknowledge that I have reviewed and understand the Patient Financial Policy of Advanced Neurodiagnostics LLC.

Signed:_____ **Date:**_____