Newton-Wellesley Neurology Associates, P.C.
www.nwneurology.com / www.patientgateway.org
2000 Washington St. Suite 567 (Green Bldg)
Newton Lower Falls, MA 02462
Phone 617-928-1500 * Fax 617-630-0860

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

GENERAL INFORMATION (Please Print)

First Name _____ M____ Last Name _____

Address: Street_____

City/State/Zip_____

Home Phone(___)_____ Preferred# Y / N Cell Phone(____)_____ Preferred# Y / N

E-Mail Address_____

Social Security Number _____-_____-_____Date of Birth_____/_____/_____

Marital Status M___ S___ W___ D___ Partner___ Gender (Sex) M [ ] F [ ]

Do you require American Sign Language Interpretation? **(Y / N)**

Do you require Spoken Language Interpretation? **(Y / N)** If Yes, please specify language_____

Please note: For ASL or other translation, we require advanced notification.

Employment Status: Full-Time Part-Time Retired Other_____

Primary Care MD Name_____

Address (City, State)_____

Reason for your Current Visit (signs / symptoms / diagnosis?)_____
_____

Is TODAY's VISIT related to any of the following?

a) Motor Vehicle Accident **(Y / N)** Work Related Accident **(Y / N)** Other Liability **(Y / N)** _____

Is someone other than your health insurance carrier responsible for today's charges? (Y / N)

b) Has any organization (i.e. work, adoption agency, humanitarian agency) requested that you get medical clearance **AND** you currently have no related neurological signs/symptoms/diagnosis? **(Y / N)**_____

c) Are you seeing the doctor strictly to assess for neurological risk, based on a family history of a specific diagnosis (i.e. aneurysm, stroke, multiple sclerosis) but have no past/current related symptoms/diagnosis ? **(Y / N)** _____

Diagnosis/Disease?

PLEASE CONTINUE ON OTHER SIDE

CREDIT/DEBIT CARD POLICY

Effective January 1, 2018 –for ALL patients, a valid Credit/Debit card on file will be required.

Your credit/debit card information will reside in a secure/protected/encrypted electronic system through Instamed.Com.

By signing below:

- I understand and agree that payment in full, for all patient related charges and service fees within 365 days of date immediately below (cancellation/no-show/forms/procedures/inpatient or outpatient visits, etc), is expected within **60 days of billing**. I further understand and agree that if I fail to make payment in full, fail to make other approved payment arrangements with the Practice **within 60 days of billing** or fail to dispute the bill within **30 days of billing**, my CREDIT/ DEBIT CARD on file will be charged for payment in full.

Signature: _____Date_____

Signature of Patient or Guardian / Card Holder

FINANCIAL

By signing below:

- I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations.
- I understand and agree that I am responsible for payment in full of all patient related charges as directed by my health insurance carrier or per a policy of the Practice that has been explained to me.
- **I understand and agree that it is MY RESPONSIBILITY to ensure that today's visit is a COVERED SERVICE by my INSURANCE CARRIER. I understand that IF my INSURANCE CARRIER denies payment as a NON-COVERED service, I will be responsible for payment in full of all charges.**
- I understand and agree that if I fail to pay any charges owed by me, my financial account may be turned over to a collection agency and ultimately may be filed against my credit report.
- I request that payment of authorized Medicare and other insurance benefits be paid directly to Newton-Wellesley Neurology Associates, PC. I also authorize Newton-Wellesley Neurology Associates, PC to release all information necessary for the processing of insurance claims to CMS, its agents or any other insurance company to determine the benefits payable for related services.
- **I understand and agree that if I <u>fail to show up for an appointment</u> without prior notification or <u>cancel an appointment with less than 24 BUSINESS hours' notice</u> I will be subject to a Service Fee.**
- **I understand and agree that all co-payments are due in full at time of appointment check-in, unless arrangements have been previously made and approved by the Practice.**

Signature_____ Date_____

Signature of Patient or Guardian

RELEASE of MEDICAL RECORDS

If verbally requested, I authorize release of my medical records directly to me:_____

Signature of Patient or Guardian

ELECTRONIC COMMUNICATION

- NWNA participates with Partners Gateway; a secure communication system.
- To access this system, please register at **patientgateway.org**
- This system will allow you to communicate electronically and securely with our office and physicians.
- <u>For an in depth or complex discussion</u> with your physician, *please call the office to schedule an appointment*.
- Our physicians e-mail accounts are not secure and should not be used for patient communication.

INSURANCE INFORMATION

Please have your insurance card(s) and a photo ID ready when you visit the office. We will make a photocopy.