

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 xxx - xx - last 4 Date of Birth _____ / _____ / _____

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

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?

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

c) Are you seeing the doctor to be assessed for risk based solely on a family history of a neurological disorder (i.e. aneurysm, stroke, multiple sclerosis)? (If you have a history or current symptoms, please answer NO) (Y / N) _____
Family Diagnosis/Disease?

We encourage you to check with your insurance carrier to clarify what charges will be covered at this and all visits. It is the responsibility of the patient to know what visits, procedures, labs, and medications will be covered. Only your insurance carrier can give you the coverage information for your specific plan. We urge you to request this information from them in writing when possible.

PLEASE CONTINUE ON OTHER SIDE

CREDIT/DEBIT CARD POLICY

A valid Credit/Debit card on file will be required for ALL patients

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 (cancellation/no-show/forms), 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 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 **fail to show up for an appointment** without prior notification or **cancel an appointment with less than 24 BUSINESS hours' notice** 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 MGB Patient Gateway; a secure communication system.
- To access this system, please register at patientgateway.massgeneralbrigham.org
- This system will allow you to communicate electronically and securely with our office and physicians.
- For an in depth or complex discussion 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.