The NeuroGenesis Project

PATIENT INFORMATION

Last Name First Name Middle

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

DATE OF BIRTH: ____/____/_____ AGE: _____ SEX: ☐ Male ☐ Female
M D Y

Street Address

City State ZIP Code

Home Phone Number
(☐ Preferred)

Cell Phone Number
(☐ Preferred)

Email Address

Social Security Number

Occupation

Employer

Name of Referral Source: ☐ Physician ☐ Hospital ☐ Family ☐ Friend ☐ Self

Pharmacy Location Phone Number

By signing below, I hereby authorize **Center for Brain Care** to obtain my prescription medication history from pharmacies set up to electronically send prescription information and allow **Center for Brain Care** to electronically transmit my prescription and refills.

The NeuroGenesis Project at
The CENTER FOR BRAIN CARE
140 Lakes Blvd. Suite G-1 • Kingsland, GA 31548
Office: (912) 771-1101 Fax: (912) 809-4858

The NeuroGenesis Project

Patient/Guardian Signature Date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____

Signature of Patient or Legal Representative

I *authorize the following people* to be involved in my care. This consent for disclosure includes both health and financial information.

Name: _____ Relationship _____ Ph.# _____

Name: _____ Relationship _____ Ph.# _____

Name: _____ Relationship _____ Ph.# _____

Name: _____ Relationship _____ Ph.# _____

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REQUEST FOR RESTRICTION REGARDING THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

☐ Restriction for the disclosure of Protected Health Information (PHI) (Individuals or means where by P.H.I. cannot be disclosed.) Please be specific in your request for anyone you DO NOT want to receive your records:

_____

_____

_____

_____

_____

Signature of Patient or Legal Representative Date of Request

For Practice Use Only:

_____ Signature of Employee receiving request

Request for restriction/exception has been: ☐ Approved ☐ Denied

Reason for denial:

_____

_____

_____

Signature of Privacy Officer

_____

Date Received

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AUTHORIZATION TO TREAT

Please select the most appropriate option below:

☐ 1. I authorize the staff of the Center for Brain Care at The NeuroGenesis Project to provide me with medical treatment. I will inform the staff if I have any concerns about my healthcare.

OR

☐ 2. I am the parent/legal guardian of:_____. I authorize the staff of the Center for Brain Care at The NeuroGenesis Project to treat my legal ward named above.

Name: _____

Signature: _____

Date: _____

A copy of this form is as valid as the original.

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PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by The NeuroGenesis Project. I understand that I am obligated to pay The NeuroGenesis Project, directly for services rendered and invoiced. I acknowledge that I may request reimbursement from my insurance company, and I am aware that my insurance company may not pay for all charges incurred by myself or my dependent. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even if/when the physician agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that I may be charged for appointments not canceled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by The NeuroGenesis Project, in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Name: _____

Signature: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize The NeuroGenesis Project, PLLC, to release the information necessary to secure full payment of my account through other parties, such as a collection agency or court of law, if my account becomes delinquent.

_____

Name:

_____

Signature:

_____

Date:

OFFICE BUSINESS POLICIES

The NeuroGenesis Project at
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The NeuroGenesis Project

NAME: _____

DATE: _____

1. APPOINTMENT 'NO SHOW' POLICY

_____ A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show." A fee of $150 will be charged for a no-show.

2. APPOINTMENT CANCELLATION POLICY

_____ Because we make every effort to accommodate patients, we ask for your understanding that, if you need to cancel your appointment, you do so with at least 24 hours notice to us. Failure to give us at least 24 hours' notice will result in a $150 charge.

3. LATE APPOINTMENT POLICY

_____ We recognize that unforeseen events may delay your arrival, and we make every effort to accommodate our patients. However, please note that you will be considered late if you arrive more than **10 minutes past** your scheduled appointment. If you should arrive late for your scheduled appointment, it will be up to the discretion of your physician whether you can be worked back into that day's schedule or whether you will need to reschedule for a later date.

4. DISCHARGE FROM PRACTICE

_____ I acknowledge that if I "no-show" or cancel less than 24 hours from time of appointment for three times, then this may serve as grounds for discharge from the practice. Also, clinical non-compliance to recommended medical treatment as well as non-compliance to this signed "Office Business Policies" agreement may result in dismissal from the practice.

5. PATIENT RESPONSIBILITY

_____ I understand that it is my responsibility to obtain any and all necessary authorizations should I choose to seek reimbursement from my insurance company for medical services provided by Center for Brain Care. I agree to be personally financially responsible for the total charge of rendered services at the time of service.

6. AFTER HOURS SERVICES

_____ I understand that messages left after hours will be returned on the next business day. I know the business hours for **Center for Brain Care** are:

Regular:
Monday through Thursday – 9:00 a.m. until 5:00 p.m.
Friday – 9:00 a.m. until 12:00 p.m.

Extended:
Monday through Thursday – 8:00 a.m. until 9:00 p.m.
Friday – 8:00 a.m. until 5:00 p.m.

_____I also understand that should I be in need of immediate medical attention during the hours the practice is closed, that I should contact or proceed to the closest available urgent care or emergency department for triage and treatment.

7. ACKNOWLEDGEMENT OF HIPAA PRIVACY AUTHORIZATION

_____I acknowledge that I have read and understand the HIPAA PRIVACY AUTHORIZATION FOR USE and DISCLOSURE of PERSONAL HEALTH INFORMATION behind this form.

8. RELEASE OF PRESCRIPTION MEDICATION HISTORY

This affects the electronic transmittal of prescription information. *Please choose one of the following:*

_____ □ I hereby authorize Center for Brain Care to obtain my prescription medication history from pharmacies set up to electronically send prescription information and I hereby authorize Center for Brain Care to electronically transmit my prescription and refills.

OR

_____ □ I do not authorize Center for Brain Care to obtain my prescription medication history from pharmacies set up to electronically send prescription information and I do not authorize Center for Brain Care to electronically transmit my prescription and refills. I

acknowledge that this may prohibit me from receiving certain medications that, by law, require surveillance and/or reporting.

9. MEDICAL RECORDS FEES

_____ I acknowledge that, in order to process requests for medical records copies, I will be required to sign a release of information form. A fee will also be charged for copies of my records, and this fee, which is compliant with State Statues, is due prior to their release. For all third party requests for records, I will be responsible for fees if not paid within 60 days by the requesting party.

10. MEDICAL FORM AND LETTER FEES

_____ I acknowledge that, in the event that I need a letter from the doctor or forms completed, there will be a fee for these services. The fee will be due after completion of the form. The fees vary and I will be notified of the exact cost, depending on my specific need (minimum of $25.00). These services may take up to 7 business days to complete due to the volume of requests.

11. PRESCRIPTION REFILLS

_____ I acknowledge that refill requests will be processed Monday through Friday, 9:00 a.m. to 4 p.m.; that prescriptions cannot be refilled on weekends or after hours; and that a 48-hour notice is required for all prescription refill requests. Many insurance plans now require pre-authorization for prescriptions, and I acknowledge that the Center for Brain Care at The NeuroGenesis Project does not pursue pre-authorizations but instead encourages me to work with my insurance company if I am denied medication that I am entitled to according to my health insurance plan.

12. TEST RESULTS

_____ I understand that I will be notified if test results indicate that immediate action is required. Otherwise, routine and non-urgent results may be reviewed during my next regularly scheduled appointment. They may also be reviewed in the context of a Video Tele-encounter, which I may schedule through the patient portal.

13. INSURANCE AUTHORIZATION AND REFERRALS

_____ I understand that many times, insurance companies require prior authorization or a referral for testing. Referral may be provided for me upon request. However, I understand that the prior authorization requirement is a tactic often used by the insurance industry to ration my care to which I may be entitled based upon my insurance coverage. The Center for Brain Care will make every effort possible to refer me to testing locations that provide reasonable rates for tests in order to avoid this problem. It also will make every effort to prescribe responsibly and work with me to

stay within a formulary, provided it comports with the standard of care and therapeutic rationale. The Center for Brain Care does not have a referrals department, because it generally trusts its patients to make wise decisions based upon their own financial status, insurance coverage, and judgement. If an insurance company denies a test based upon the need for a prior authorization, the Center for Brain Care recommends that I follow my insurance company's appeals process and, if necessary, consider filing a complaint with the State's Insurance Commissioner's office.

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