Neurologic Associates, PLC
905 Cedar Creek Grade
Winchester, Va 22601
Phone 540-722-8882
Fax 540-722-8883

Welcome to Our Office

Name ____ DOB:__________________________
This letter is to serve as confirmation of your appointment at Neurologic Associates, PLC on

____________________ at _______________ AM/PM. Please arrive at _________ AM/PM

You must arrive 30 Minutes early for your appointment or you may be asked to reschedule.

Included in this Welcome Packet is our Promise to Pay and Patient Questionnaire. Please read each page carefully and fill out all necessary information. It is preferable that you return the completed forms prior to the date of your visit. But you may bring with you to your appointment.

To mail completed paperwork, send to:
905 Cedar Creek Grade
Winchester, VA 22601
To fax completed paperwork, send to:
540-722-8883

In addition, to care for you efficiently and avoid delay in evaluating your condition, it is required that you bring with you the following:

- -Your **Insurance Card(s)**
- -Your **Co-pay,** should one be required**.**
- -Your RX Prescription Card
- -A **Major Credit Card**

*If there is no copay indicated on the card you will be required to pay 20% of your bill at the time of the visit.
*If you have a high deductible plan, the allowable insurance fee for the procedure will be taken at the time of the appointment.
(This excludes patients with two or more insurance policies that cover all acquired expenses.)
For financial policies and payment options please refer to the next page.

It may be necessary for you to contact your primary or referring physician prior to your visit in order to obtain the above information. If your insurance requires a referral, please make sure to contact your PCP to have his/her office submit it before your scheduled appointment.

-By signing below I consent to having my credit held on file for incidental charges and balances remaining after insurance payment.

Signature____ Date:____________________

Neurologic Associates, PLC

Date:___________ Patient Name:____________________ DOB:__________ Sex: Male/Female
SSN:______________________ Phone home:___________________ cell:_________________
Mailing Address: ____
Email Address: __________________________________PCP_________________________
Patient employer/phone: ____
Emergency contact: _________________________________ Phone: _____________________
Insurance: ____________________________ Policy Number: ___________________________
Insurance policy holder (**if different from patient**): ___________________________________
Insured's employer: _______________________________Policy Holder DOB:_____________
SSN (policy holder): ____________Responsible if patient under 18YO ____________________

CO-PAY IS DUE AT THE TIME OF YOUR APPOINTMENT. IF YOU HAVE A HIGH DEDUCTIBLE PLAN, THE ALLOWABLE INSURANCE FEE FOR THE PROCEDURE WILL BE TAKEN AT THE TIME OF THE APPOINTMENT.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made either to me or on my behalf to Neurologic Associates, PLC for any services given to me by the physician/supplier. I authorize each holder of my medical records to release any information needed to the health care financing administration and its agents to determine these benefits or the benefits payable to related services. By signing this the patient is in agreement to pay the services rendered by the physician/supplier that are not covered by the patients' insurance company **or if SELF PAY, agrees to pay in full at the time of each visit.** (Anything over $300, half is due up front and the patient will be responsible for the balance of charges remaining after that deposit). Any balance remaining, after insurance has processed, that is not paid in full within 45 days of the date of service is subject to a 1.5% per month service charge and may be turned over to collections/attorney at our discretion. The patient is personally liable for damage to or failing to return any equipment belonging to this office.

WE REQUIRE NOTICE FOR CANCELLATION OF APPOINTMENTS WITHIN 1 BUSINESS DAY AND 2 BUSINESS DAYS FOR SLEEP STUDIES.

FEES FOR NO SHOWS AND/OR LATE CANCELLATIONS WILL BE ASSESSED AND THE PATIENT WILL BE RESPONSIBLE FOR THE FEE AT THE CURRENT RATE. CURRENT RATES AS OF 9/1/2019 ARE AS FOLLOWS:

FOLLOW-UP APPOINTMENTS	**$85.00**
NEW PATIENT APPOINTMENTS	**$150.00**
TESTING EMG/EEG/SLEEP STUDIES	**$250.00**
INFUSION	**$100.00**

All no show fees will be posted to the patient's account and will not be billable to insurance. There is a **4% convenience fee** for all credit card transactions. A copy of this authorization may be used in place of the original or signature on file may be entered on a claim form instead of a signature. **By signing this you are confirming receipt of the HIPAA compliance form.**

Signature: ____ Date: ______________

Neurologic Associates, PLC

This is a list of insurances we currently accept. Please contact your insurance company if you have any questions regarding referrals, or prior authorization.
****If your insurance requires referrals or prior authorizations it is your responsibility to obtain the needed information****

<u>Par Insurance List:</u>
Medicare (Includes Today's Options) (NO Freedom Blue)
    All Medicare Advantage Plans
    Part D Cards needed
    Cigna Government Services- Medicare DME
    RR Medicare
    Humana Medicare PPO
Tricare Standard Tricare for Life (Tricare Prime ONLY WITH REFERRAL FROM TRICARE)
VA Medicaid (Straight)
    VA Premier
    Aetna Better Health
    Magellan Complete Care of VA
    UHC Community Plan
Anthem BCBS **Must have PPO in suitcase** Anthem Federal BCBS
All Cigna (NON PaR W/Connect & Great West)
All Aetna Plans INCLUDING
United Health Care
UMR
UMR PEIA
Veterans Administration - WPS With Active Referral
Optum Choice & MDIPA Require Referral from Insurance through PCP

NON PAR WITH WEST VIRGINIA MEDICAID
NON PAR WITH WITH WEST VIRGINIA WORKERS COMP
NON PAR WITH ANY ANTHEM HEALTHKEEPERS COMMERCIAL
NON PAR WITH OPTIMA
NON PAR WITH CIGNA CONNECT
NON PAR WITH CIGNA GREAT WEST
NON PAR WITH TRICARE PRIME

PLEASE SIGN TO ACKNOWLEDGE RECEIPT OF INSURANCE INFORMATION:

Signature ____ Date: _______________

Neurologic Associates, PLC

Patient and Responsible party HIPPA Authorization

I, ____, Authorize Neurologic Associates, PLC to apply for benefits on my behalf for the covered services rendered and requested that payments for the above insurance company be made directly to the provider for the treatment person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above agent. After payment is received from your insurance company, any outstanding balance will be transferred to your personal responsibility. At that time, you will be asked to settle your account. Failure to pay your bill in a timely manner will result in our practice forwarding your account to a collection agency. Should we proceed with collections, you will be responsible for any costs charged to us by our collection agent. In addition, we will schedule no further appointments until you have settled this outstanding balance. In all cases, professional fees are the patient, spouse, parent and or guardian's responsibility.

Patient or responsible party further agrees to pay any and all collection fees incurred and any legal expenses, including but not limited to a Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts.

I authorize the release of medical records from another party to Dr. Mark Landrio at Neurologic Associates to assist in my care and authorize the release of records to another physician said assignee who is consulting in myt care. I permit a copy of the authorization to be used in the place of the original. I have been made aware of my privacy rights and have received the Neurologic Associates, PLC HIPPA privacy notice.

Patient Signature____ Date_____________

Neurologic Associates, PLC

HIPAA Form

Patient Name: ________________________________

Patient DOB: ________________________________

Please list anyone authorized to receive information on your behalf:

Name: Relationship:

____

____

____

____

____

____

Signature:_______________________________________ Date:________________

Neurologic Associates, PLC

Patient Name____ DOB ______________________

Chief Complaint:____

Occupation (If retired please list last occupation)_______________________________________

Drug Allergies:____

Pharmacy:____

If you suffer from Headaches please answer the following. Circle the best answer.

1. When you have headaches, how often is the pain severe?
   Never Rarely Sometimes Very Often Always

2. How often do headaches limit your ability to do usual daily activities including household work, school, work, or social activities?
   Never Rarely Sometimes Very Often Always

3. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?
   Never Rarely Sometimes Very Often Always

4. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?
   Never Rarely Sometimes Very Often Always

If you suffer from fatigue and or excessive daytime drowsiness, please answer the following. Circle Yes or No.

1. Do you snore? Yes No
2. Does your snoring bother others? Yes No
3. Has anyone noticed you quit breathing in your sleep? Yes No
4. Do you wake up feeling tired? Yes No
5. Have you ever fallen asleep while driving? Yes No
6. Do you have high blood pressure? Yes No

Family History Please list any relative and disorders they may have. Please include hereditary diseases. If deceased please give age and cause of death.

Mother ____
Father ____
Brother ____
Sister ____

Neurologic Associates, PLC

Patient Name____ DOB _____________________

Please list any surgery or recent hospitalizations. Please include appx date.

____
____
____

Past Medical History: Circle any problems that apply.

Weakness	Lung Disease	Bowel Problems	Knocked Unconscious
Numbness	Rheumatic Fever	Sexual Dysfunction	Memory Loss
Cancer	Heart Disease	Back Pain	Depression
Double Vision	High Blood Pressure	Arm Pain	Anxiety
Eye Problems	Ulcer Disease	Hand Pain	Diabetes
Venereal Disease	Meningitis	Neck Pain	Blood Disorder
Tuberculosis	Incontinence	Seizure	Thyroid Disorder

Please explain circled problems further:

____
____
____

Complete Review of Symptoms:

Explain any problems that you have with the system below:

Head/Eyes/Ears/Nose/Throat: ____

Skin:____

Chest/Lungs:____

Heart/Vascular:____

Abdomen/Intestines/Liver____

Urinary System/Genital System:____

Musculoskeletal (Joints/Muscles)____

Have you had any of the following testing? If yes when?

EEG (BrainWave) ____

CT Scans Brain or Spine____

MRI Brain or Spine____

EMG/Nerve Conductions:____

Myelogram:____

Arteriogram:____

Any Other Testing:____

Marital Status_____________________ Chlidren___________ How many?________________

Neurologic Associates, PLC

How often do you use alcohol? Circle one.
Never Seldom Occasionally Moderately Daily

Which of the following alcohol do you consume? Circle all that apply.
Beer Wine Liquor
Do you use tobacco? Yes No How often do you use tobacco? ________________________

Which of the following tobacco products do you use? Circle all that apply.
Chewing Tobacco Cigars Cigarettes Pipe

Do you use any recreational drugs? Yes No

Please list all current medications (To include and over the counter medications also)

Medication Name	Medication Strength	How many time a day do you take this medication