UNIVERSITY NEUROSCIENCE

Patient Information

Welcome to University Neuroscience and Augusta Back! In order to serve you better we have implemented a new electronic medical record system to benefit your experience at our office. This includes a patient portal MyChart, take the opportunity to sign up!

Primary Care Physician _____ **Referring Provider:** ☐ **Same or** _____

Name _____

SSN# _____ Gender ☐Male ☐Female DOB _____

Address _____

City _____ ST _____ ZIP _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Primary number I wish to have used for contact ☐ Home # ☐ Work # ☐ Mobile #

Email _____

Need Interpreter? ☐ Yes ☐ No Primary Language _____ Marital Status S M D

Ethnicity _____ Religion _____ Race _____

Emergency Contact _____ Relationship _____ Phone _____

Preferred Pharmacy _____

Preferred Laboratory _____

All information given is accurate. I give permission for University Physicians to contact me regarding practice information by the above methods.

Signature _____ Date _____

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PATIENT HISTORY SHEET

To be completed by patient:

Name: _____ Age: _____ Sex: _____ Date: _____
Referring doctor: _____
Reason for visit: _____

Past Medical History - patient

_____
_____
_____

Past Surgical History - Patient

_____
_____
_____

Other Treating Physicians: _____
_____
_____

Significant Family Medical History:

Parents: _____
_____

Siblings: _____
_____

****

To be completed by nurse and physician

Social history: Smoke? _____ Use Alcohol? _____ Married? _____
Occupation: _____

Circle those systems with problem and explain on right

Eye/ear/nose/throat: _____
Lungs: _____
Heart: _____
GU (Kidney/bladder): _____
GI (Stomach/intestines): _____
Muscles: _____
Skin: _____
Psychiatric: _____
Neurological: _____
Endocrinologic: _____
Hematologic: _____

Date: _____ Signature of patient: _____

Date: _____ Signature of doctor: _____

UNIVERSITY NEUROSCIENCE

840 Stevens Creek Road • Augusta, GA 30907
(706) 722-6957

Name Date:

REVIEW OF SYSTEMS WORKSHEET

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING TODAY:

(CONSTITUTIONAL): fatigue, fever, night sweats

(HEENT): eye discharge and vision loss, ear drainage, hearing loss, nasal drainage

(RESPIRATORY): cough, shortness of breath, wheezing

(CARDIOVASCULAR): chest pain, pain in legs when walking, irregular heartbeat/palpitations

(GASTROINTESTINAL): abdominal pain, constipation, diarrhea, vomiting

(GENITOURINARY): painful urination, blood in urine, penile/vaginal discharge, excessive urination

(METABOLIC/ENDOCRINE): cold intolerance, heat intolerance, excessive thirst, excessive eating

(NEURO/PSYCHIATRIC): weakness,gait, disturbance, headache, numbness/tingling, anxiety, depression

(DERMATOLOGIC): itching, rash

(MUSCULOSKELETAL): back pain, bone/joint symptoms, joint swelling, muscle weakness, neck stiffness

(HEMATOLOGY): easy bleeding, easy bruising

(IMMUNOLOGY): environmental allergies, food allergies

IF you are experiencing pain, rate it from 1-10:

1 2 3 4 5 6 7 8 9 10

(No Pain) (Extreme Pain)

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HOME MEDICATION HISTORY

PATIENT NAME _____

DATE _____

COMPLETE ALL SECTIONS BELOW

HOME MEDICATION HISTORY & ORDER SHEET

ALLERGIES * SENSITIVITIES/REACTIONS

1. _____ 1. _____

2. _____ 2. _____

ALLERGIES * SENSITIVITIES/REACTIONS

3. _____ 3. _____

4. _____ 4. _____

DRUG	DOSE	ROUTE	FREQUENCY	REASON FOR TAKING
OVER THE COUNTER MEDICATIONS				
HERBAL MEDICATIONS				

PHARMACY NAME:_____ **PHARMACY PHONE #:**_____

UNIVERSITY NEUROSCIENCE

Financial Policy

Thank you for choosing University Neurosurgery Augusta Back. We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing quality healthcare services to our patients. Our financial policy is as follows:

1. **Payment** - Payment is expected at the time of service.
2. **Insurance** -
   a. Please provide a copy of your insurance card prior to each visit.
   b. We will file insurance for you under most circumstances as long as you provide us with current information. You are ultimately responsible for understanding the details of your coverage and what charges you may incur.
   c. If your insurance company does not respond to us within 60 days of a filed insurance claim, the charges will be sent to you to follow up on and you will be responsible for payment.
3. **Minor Children Patients** -
   a. Minor children patients must be accompanied by a parent or legal guardian.
   b. Charges for services rendered to minor children are the responsibility of the parent who seeks treatment for the child and are due at the time of service regardless of court-ordered responsibility.
4. **Self-Pay Patient Discounts** - We offer discounts to our self-pay patients (patients who have no insurance coverage) who pay in full at the time of service -
   a. 50% for All Services;
   b. Self-Pay Patient Discounts do not apply to co-pays, co-insurance, and/or deductibles.
5. **Restricted Service** – All Account balances must be in good standing prior to receiving additional services. Please contact our office if you are unable to pay your balance.
6. **Missed Appointment Charge** - Please notify our office at least 24 hours in advance if you are unable to keep a scheduled appointment or you may be charged a $25 fee.
7. **Additional Service Charges** - A service charge of up to $35 may be added for each of the following:
   a. Returned Checks;
   b. Additional forms (i.e. disability forms, MVA, attending Physician).
8. **Past Due Accounts** of 60 days or longer may be turned over to a third party for collection, along with collection costs, attorneys' and court fees. You may also be discharged from the practice.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles, are my responsibility.

_____
Patient Printed Name / DOB

_____ _____
Patient Signature or Authorized Person Date

_____
Relationship to Patient

UNIVERSITY NEUROSCIENCE

HIPAA PATIENT QUESTIONNAIRE

Please bring with you at the time of your appointment

PATIENT NAME: _____ DOB:_____

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home.

_____

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, other health care information if other than your home phone number:

( ) _____

I am fully aware that a cell phone is not a secure and private line.

5. Can confidential messages be left on your telephone answering machine?
Yes _____ No ____

6. I am fully aware my health information will/may be transmitted by electronic transmission, by secure fax transmittal, by internet or by email for continued health care needs.

_____ Date _____

Patient Signature (Guardian if under 18 years)