NDx
NEUROLOGY
DIAGNOSTICS

Joel Vandersluis, MD, F.R.C.P.C.
240 W. Elmwood Drive,
Dayton, Ohio 45459
Phone: 937-224-8200
Fax: 937-224-1770

Welcome to Neurology Diagnostics, Inc! We appreciate that you have chosen our practice to serve your medical needs. In order to assist you in the new patient process, please complete the following documents:

·Demographics
·Authorization Page
·Financial Agreement
·Privacy Consent Form
·Patient Data Sheet
·No Show Policy

On the day of your appointment, please bring those completed forms along with the following items:

·Driver's License
·Insurance Card(s)
·Co-Payment Obligation
·Medication List

If you should have any questions prior to your visit, please feel free to call our office. We look forward to seeing you soon!

Sincerely,

Scheduling Department, NDX



Neurology Diagnostics, INC.
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PATIENT DEMOGRAPHICS

FIRST NAME	MIDDLE INITIAL	LAST NAME

PATIENT'S SEX CIRCLE ONE MALE FEMALE	SOCIAL SECURITY NUMBER	AGE	BIRTHDATE - -	MARITAL STATUS CIRCLE ONE SIN MAR SEP DIV WID	EMPLOYMENT CIRCLE ONE F/T P/T RETD UNEM	STUDENT CIRCLE ONE P/T F/T

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME TELEPHONE	CELL	EMPLOYER'S NAME	EMPLOYER'S TELEPHONE NO.

IN CASE OF EMERGENCY, PLEASE NOTIFY:	RELATIONSHIP TO YOU	PHONE

FAMILY PHYSICIAN	REFERRING PHYSICIAN

EMAIL ADDRESS:	

PRIMARY COVERAGE

PRIMARY INSURANCE CO. NAME	PRIMARY INSURANCE CO. CERTIFICATE/CONTRACT NO.

EMPLOYER'S NAME	INSURANCE GROUP NO. OF EMPLOYER

ADDRESS WHERE CLAIMS ARE TO BE SENT

SOCIAL SECURITY NO. OF POLICY OWNER	EMPLOYER'S TELEPHONE NO.	POLICY OWNER'S SEX	PATIENT RELATIONSHIP TO INSURED

FIRST NAME OF POLICY OWNER	MIDDLE INITIAL	LAST NAME OF POLICY OWNER	BIRTHDATE / /

STREET ADDRESS	CITY	STATE	ZIP CODE

SECONDARY COVERAGE

SECONDARY INSURANCE CO. NAME	SECONDARY INSURANCE CO. CERTIFICATE /CONTRACT NO.	PAYOR NO. (N.E.I.C.)

EMPLOYER'S NAME	INSURANCE GROUP NO. OF EMPLOYER

ADDRESS WHERE CLAIMS ARE TO BE SENT

SOCIAL SECURITY NO. OF POLICY OWNER	EMPLOYER'S TELEPHONE NO.	POLICY OWNER'S SEX	PATIENT RELATIONSHIP TO INSURED

FIRST NAME OF POLICY OWNER	MIDDLE INITIAL	LAST NAME OF POLICY OWNER	BIRTHDATE / /

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Authorization

I authorize examination, diagnosis, and general treatment (including but not limited to, the use of x-ray and other non-invasive procedures such as, diagnostic tests) to be performed by the physicians and staff of Neurology Diagnostics, Inc. I realize that if a medical procedure is required, I will be given additional information.

I understand that as part of my healthcare, this practice originates and maintains health records and radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records and radiology films will be retained by Neurology Diagnostics even if my healthcare provider(s) leave the practice.

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment/participates.

I authorize Neurology Diagnostics, Inc. to obtain pertinent medical information from the electronic medical records systems of Premier Health Partners, Inc. and the Kettering Medical Center Network. These results include, but are not limited to labs, imaging, diagnostics, provider visit notes, and assessments.

Authorization for the Use and Disclosure of Protected Health Information to Designated Persons

I authorize Neurology Diagnostics, Inc to disclose the following protected health information, including:

I authorize:
- □ **Labs**
- □ **Imaging**
- □ **Diagnostic Testing**
- □ **Correspondence with Other Healthcare Providers**
- □ **Neuropsychological Assessments**

The following people are designated to receive the above listed information:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I authorize Neurology Diagnostics, Inc. to leave detailed messages regarding the following: □ Appointments on Voice Mail □ Test Results

I understand that I may revoke this authorization by sending a written request for revocation to the office of Neurology Diagnostics, Inc. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that Neurology Diagnostics, Inc. may have already made in reliance on this authorization.

I understand that when Neurology Diagnostics, Inc. discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

By signing the line below you are stating that you have read and agree to all portions of this contract and have been offered a Notice of Privacy Practices.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Representatives relationship to patient *

***A copy of legal authority to act for the patient MUST be presented.**

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FINANCIAL AGREEMENT

Patient Obligation

As a patient of Neurology Diagnostics, Inc., I understand the bill is my responsibility. I assign and authorize payments be made directly to Neurology Diagnostics of all insurance benefits and agree to pay any balance due.

I understand that I will be responsible for any additional fees related to the following:

- Non-payment of co-pays or deductibles at time of service
- Returned Checks
- Missed Appointments
- Copies of Medical Records
- Form Completion (BWC, FMLA, etc.) The fee assessed will be based upon the complexity of the form and will typically be $ 25.00-$ 50.00.

We understand that in these economic times that it is difficult to incur additional medical expenses. Should you meet with challenges in fulfilling your financial obligations to Neurology Diagnostics, Inc. regarding the payment of the provided medical services, the Practice Manager is available to discuss a payment plan with you.

Co-Payments and Deductibles

Neurology Diagnostics, Inc. requires that co-payments and deductibles will be estimated and collected at the time of service. If you have questions regarding the amount of your co-pay and/or your deductible, please inquire with your insurance company prior to your appointment. Co-payments, not collected at the time of service, will have a fee of $ 25.00 assessed.

Missed Appointments

We, at Neurology Diagnostics, Inc., are concerned about your health care. If you must cancel an appointment, please kindly give our office a call with 24-hour advance notice. This allows us to offer another patient your time slot in the event you cannot keep it.

Appointments missed or cancelled without 24-hour notice hinder our ability to provide quality care. If you do not provide a 24-hour cancellation notice you will be charged for the visit. This charge is NOT payable by your insurance carrier and will be your responsibility. Charges may vary from $50.00 to $100.00 depending on the purpose of the visit.

Recurrent “no-shows” may also lead to termination from the practice.

By signing the line below, you are stating that you have read and agree to all portions of this contract and acknowledge your receipt of the financial agreement.

_____ _____

Signature of patient or patient’s representative | Date

_____ _____

Printed name of patient or patient’s representative | Representative’s relationship to patient. A copy of legal authority to act for the patient must be presented.

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PRIVACY CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, we are required under federal law to obtain your consent.

I consent to **Neurology Diagnostics, Inc.** using or disclosing my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that if I fail to sign this consent, the physicians and **Neurology Diagnostics, Inc.** may refuse to provide care or treatment to me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. **Neurology Diagnostics, Inc.** is not required to agree to these restrictions. However, if **Neurology Diagnostics, Inc.** agrees to a restriction that I request, the restriction is binding on **Neurology Diagnostics, Inc.** and the physicians of **Neurology Diagnostics, Inc.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Neurology Diagnostics, Inc.** or the physicians of **Neurology Diagnostics, Inc.** has taken action in reliance on this consent.

I understand I have a right to review **Neurology Diagnostics, Inc.**'s Notice of Privacy Practices prior to signing this consent form. The Notice of Privacy Practices gives a more complete description of the permissible uses and disclosures of my protected health information. The Notice of Privacy Practices for **Neurology Diagnostics, Inc.** is also provided in the waiting room for my review.

Neurology Diagnostics, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail asking for one at the time of my next appointment.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

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No Show Policy Statement

Patient Name: _____

To be respectful to the medical needs of our patients, please be courteous and call our medical office promptly if you are unable to attend an appointment. This appointment time will be reallocated to someone who is in urgent need of treatment.

If it is necessary to cancel or re-schedule your appointment, **we require that you call at least 24 hours in advance**. Appointments are in high demand, and your early cancelation will give another patient the possibility to have timely access to medical care.

Cancelations that are less than 24 hours in advance will be considered as a "NO SHOW". Appointments missed or cancelled without 24-hour notice hinder our ability to provide quality care. If you do not provide a 24-hour cancellation notice you will be charged for the visit. This charge is NOT payable by your insurance carrier and will be your responsibility. Charges may vary from $50.00 to $100.00 depending on the purpose of the visit.

Please anticipate possible dismissal from Neurology Diagnostics if there are two (2) no-show/ late canceled appointments.

Patient/Guardian: _____ Date: _____
(Signature)

Name_____DOB _____ Date_____

Previous Medical History	Y	N	Date of Onset (if known)		Y	N	Date of Onset (if known)
Diabetes				Seizure			
High Blood Pressure				Anemia			
Heart Disease				Cancer			
Lung Disease				Psychiatric illness			
-Asthma				-depression			
-Bronchitis				-anxiety			
-COPD				Kidney Failure			
Stroke				Other			

Surgeries/ Hospitalizations	Allergies

Medications		

Social History	Y	N	
Tobacco			Packs/ day_____ how long_____ Quit in year_____
Alcohol			Beer/ day _____ wine _____ liquor ____ Quit in year _____
Caffeine			Cups/ day _____ Coffee____ Tea ____ Pop ____
Street Drugs			Marijuana _____ Cocaine _____ Crack cocaine____ Heroin ___
Marital status Single _____ Married____ Divorced____ Widowed_____ # of children____			

Family History (please list family member)	Multiple sclerosis
Cancer	Parkinson's disease
Diabetes	Seizure/ epilepsy
Heart disease	Stroke
High cholesterol	Dementia/ Alzheimer's
Psychiatric illness	Migraine