The Clinic for Neurology, P.A.
185 Chateau Drive, Ste. 301
Huntsville, Al 35801
Phone: (256) 533-4402 | Fax: (256) 551-1902

You have been scheduled an appointment with one of the follow physicians:

Dr. Scott C. Hitchcock or Dr. David G. Greer

Name: _____

Date & Time of Appointment: _____

Please arrive a few minutes early for your appointment, so we can collect your information.

Our office hours are Monday-Thursday from 8am to 5pm and on Friday from 8am to 3pm. The phone service is available from 8:30am to 4pm Monday-Thursday and 8:30am to 12pm on Fridays. *We do not close for lunch however the phones will be off from 11:30am to 1:30pm.*
All co-payments are due at the time of service. If you are unable to make your co-payment, please discuss this with our billing department.
If you have any questions, please contact our office at (256) 533-4402

YOU WILL NEED TO BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:

- ✓ Driver's License or Picture ID
- ✓ Insurance card(s)
- ✓ Current Medication List

****PLEASE MAIL BACK YOUR COMPLETED PAPERWORK OR DROP IT OFF PRIOR TO YOUR SCHEDULED APPOINTMENT****

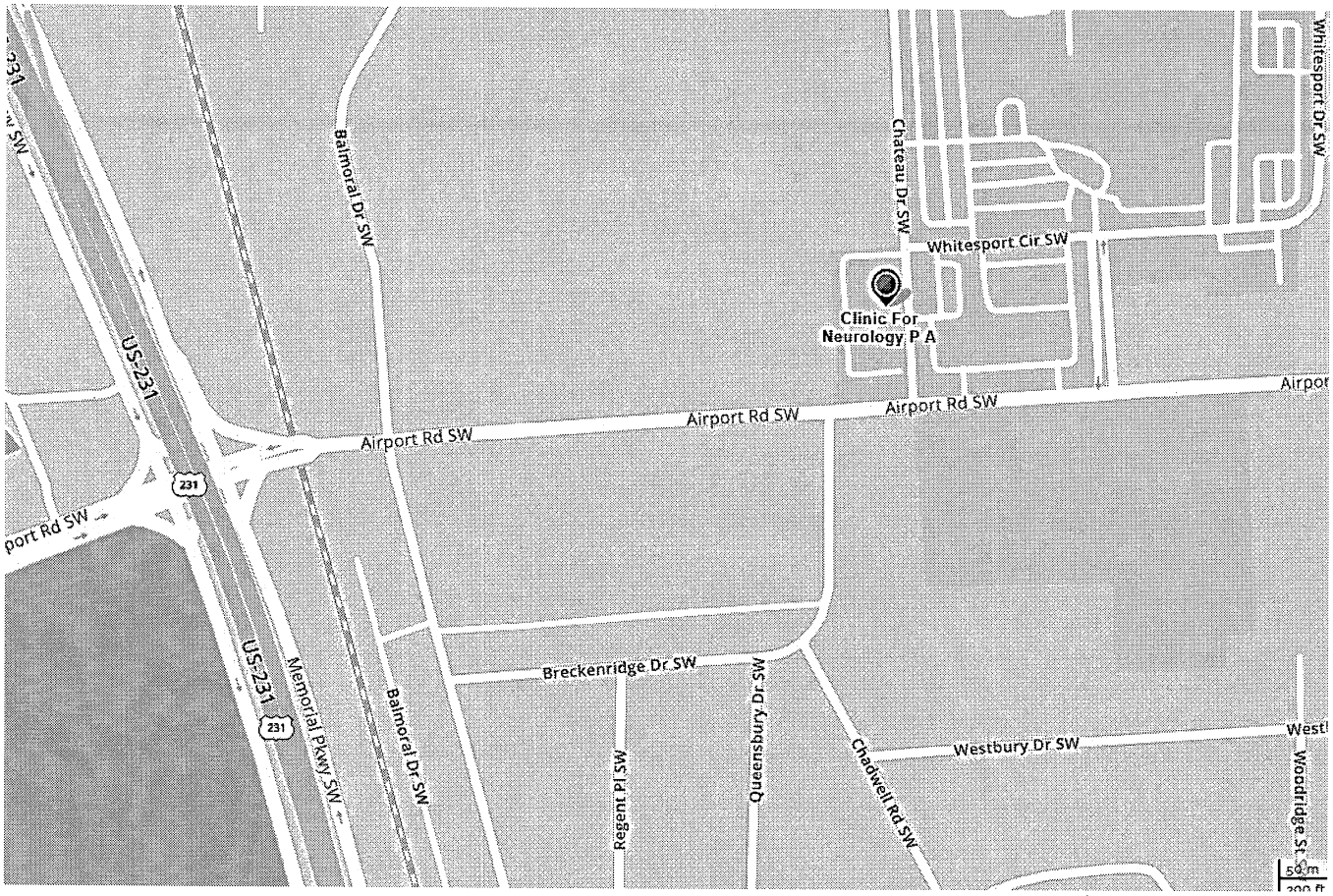
**** IF YOU WOULD LIKE TO BE WAIT LISTED FOR A SOONER APPOINTMENT PLEASE COMPLETE & RETURN AT YOUR EARLIEST CONVENIENCE. ****

If you have had a CT, MRI, X-Ray, or any other testing done, please bring a copy with you to the appointment.
Thank you for your cooperation and we look forward to having you as a patient.

-The Clinic for Neurology doctor and staff

****MAP ON BACK****

185 Chateau Drive SW, Suite 301, Huntsville, AL 35801
The Clinic for Neurology



From South Memorial Parkway:
Go north on Memorial Parkway. Take the Airport exit and turn right onto Airport Road. Follow Airport Road and then turn left onto Chateau Drive. We are the second building on the left, Crestwood Women's Center. You will see a statue out front of a woman with a child. Our clinic is located on the 3rd floor of the Crestwood Women's Center, Suite # 301.

From North Memorial Parkway:
Go south on Memorial Parkway. Take the Airport exit and turn left onto Airport Road. Follow Airport Road and then turn left onto Chateau Drive. We are the second building on the left, Crestwood Women's Center. You will see a statue out front of a woman with a child. Our clinic is located on the 3rd floor of the Crestwood Women's Center, Suite # 301.

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INITIALS	OFFICE USE ONLY
ENCOUNTER NO.	

Date: _____

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First	MARITAL (S M W D SEP)	DATE OF BIRTH	AGE	SEX

RACE: ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN / WHITE ❑ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ❑ AMERICAN INDIAN / ALASKA NATIVE ❑ DECLINED ❑ UNKNOWN

PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER _____	ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED ❑ UNKNOWN	
ADDRESS	CITY , STATE & ZIP	EMAIL

SOCIAL SECURITY NO.	HOME PHONE NO. ( )	BUSINESS PHONE NO. ( )	CELL PHONE NO. ( )

PREFERRED METHOD OF COMMUNICATION: ❑ PHONE ❑ MAIL ❑ EMAIL

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	RELIGION (OPTIONAL)

EMPLOYER'S ADDRESS	CITY, STATE & ZIP

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

EMERGENCY CONTACT/RELEASE OF INFORMATION	RELATIONSHIP	HOME TELEPHONE NO. ( )	BUSINESS PHONE NO. ( )

REFERRING PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

FAMILY PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

PERSON RESPONSIBLE FOR BILL: _____

IF OTHER THAN PARENT, S.S.# _____

ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY

CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:

SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY

CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:

OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY

CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:

REV 09/18

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER

OVER

The Clinic for Neurology, P. A.
185 Chateau Drive, Ste. 301
Huntsville, Al 35801

Medication List

Patient: _____ Date of Birth: _____

Pharmacy Name and Phone #: _____

Medication	Strength	Dosing Instructions	Indication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Date: _____

NEUROLOGY HISTORY AND PHYSICAL

Name SS # Date

Address Occupation

Phone (Home) (Work) Date of birth

Referring physician

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS

PREVIOUS NEUROLOGIST

	Dates of Treatment

MEDICAL HISTORY

- ☐ Headache/migraine
- ☐ Headache/tension
- ☐ Epilepsy/seizures
- ☐ Cerebrovascular
- ☐ Other neuromuscular
- ☐ Head injury
- ☐ Spinal cord injury
- ☐ Cervical spine disease
- ☐ Lumbar spine disease
- ☐ Peripheral nerve
- ☐ CNS malignancy
- ☐ Depression
- ☐ Coronary artery disease
- ☐ MI
- ☐ Arrhythmias
- ☐ Congestive heart failure
- ☐ Murmur
- ☐ Hypertension
- ☐ COPD
- ☐ Pneumonia
- ☐ Asthma
- ☐ Peptic ulcer disease
- ☐ Colonic polyps
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Diabetes
- ☐ Peripheral vascular disease
- ☐ Thyroid disease
- ☐ Menstrual/sexual dysfunction
- ☐ Other endocrine
- ☐ Liver disease/hepatitis
- ☐ Renal disease
- ☐ Genitourinary disease
- ☐ Veneral disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Tuberculosis
- ☐ HIV
- ☐ E+OH abuse
- ☐ Smoking
- ☐ Drug use
- ☐ Exposures
- ☐ Mumps
- ☐ Measles
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Allergy/hay fever
- ☐ Other

DRUG ALLERGIES

PRIOR SURGERIES/HOSPITALIZATIONS

Reason

Pregnant now ☐ Yes ☐ No

REVIEW OF SYSTEMS - GENERAL

☐ Fatigue	☐ Cardiac	☐ Genitourinary
☐ Weight loss	☐ Respiratory	☐ Musculoskeletal
☐ Fevers	☐ Peripheral vascular	☐ Dermatologic
☐ Depression	☐ Gastrointestinal	☐ Hematologic
☐ Ear/nose/throat	☐ Other	☐ Other

REVIEW OF SYSTEMS - NEUROLOGIC

☐ Headache	☐ Nausea	☐ Tinnitus	☐ Stiffness
☐ Dizziness	☐ Vomiting	☐ Vertigo	☐ Clumsiness
☐ Syncope	☐ Trouble with smell	☐ Decreased hearing R/L	☐ Pain
☐ Confusion	☐ Blurred vision	☐ Dysphagia	☐ Poor balance
☐ Concentration	☐ Diplopia	☐ Hoarseness	☐ Poor coordination
☐ Memory	☐ Amaurosis	☐ Choking	☐ Trouble walking
☐ Lethargy	☐ Other visual changes	☐ Weakness - arms	☐ Incontinence - bladder
☐ Personality change	☐ Difficulty chewing	☐ Weakness - legs	☐ Incontinence - bowel
☐ Hallucinations	☐ Facial numbness/tingling	☐ Numbness - arms	☐ Other
☐ Speech difficulty	☐ Drooling	☐ Numbness - legs	☐ Other
☐ Spells	☐ Difficulty tasting	☐ Paresthesias	☐ Other

REMARKS

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
CNS tumors	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐

ADDITIONAL PERSON FOR THE RELEASE OF INFORMATION

Purpose: To ensure authorization that releases CFN to speak with additional persons regarding patient care.

I, _____, patient of CFN, authorize the following individuals to be able to discuss my care and/or appointments at The Clinic for Neurology, P.A. with my physician and clinical staff, as well as any insurance or billing issues.

_____	_____	_____	_____
Name	Relationship	Name	Relationship
_____	_____	_____	_____
Name	Relationship	Name	Relationship

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by The Clinic for Neurology, P.A. for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of The Clinic for Neurology, P.A. or until patient revokes authorization.

ACKNOWLEDGEMENT/AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

The signature below serves as authorization for The Clinic for Neurology, P.A. to release or receive medical information for the purpose of patient referral. I understand and have been offered a CFN Notice of Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing the acknowledgement; that CFN reserves the right to change its notice and practices. A copy of this signature is as valid as the original. Authorization is continuing while the patient is under care of The Clinic for Neurology, P.A. or until patient revokes authorization.

Signature: _____ Date: _____

The Clinic for Neurology, P. A. Financial Policy

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. We are committed to providing you with the best possible care. The following is our financial policy:

Payment:

1. All co-payments, coinsurance and deductibles are due and payable at the time of service, regardless of who brings the patient in for their appointment. Sitters, grandparents, divorced parents, etc., must be prepared to pay at the time of service. The Clinic for Neurology, P. A. accepts cash, credit/debit cards (Discover, MasterCard, and Visa). We reserve the right to assess a service charge to accounts that require multiple billing for co-payments.
2. There is a $35.00 charge for returned checks. We serve the right to report returned checks to the Madison County District Attorney's Worthless Check Unit. After receiving one returned check, The Clinic for Neurology will only accept cash or credit/debit card payments for future balances.
3. If you need financial assistance or have questions, please contact our billing department.
4. If you fail to meet financial obligations agreed upon in the financial policy or other payment arrangements made with The Clinic for Neurology, P. A., your outstanding balance will be sent to a collection agency and you will be required to pay the entire amount plus any collection agency fees before being scheduled for any future appointments.
5. Over-payment will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your written or verbal refund request.
6. The Clinic for Neurology, P. A. requires a 24 hour notice to cancel or reschedule an appointment. If the office is closed due to a weekend or holiday, you will need to call the previous business day to change or cancel your appointment. **If our office is not notified 24 hour prior to a routine office visit, you will be charged a $25.00 fee. For any procedures or test, you will be charged a $50.00 fee.**

Insurance:

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card and driver's license to each visit and to notify us of any changes.
   - Know you co-payment amount and be prepared to pay this amount at each visit.
   - Know your insurance company benefits (physical exam coverage, diagnostic testing co-payment amounts, and per-certification requirements, etc.)
   - If you are enrolled in a Managed Care Insurance Plan (HMO), it is your responsibility to obtain or ensure a referral is supplied to our office from your primary care physician prior to the time of your appointment. If we do not have your referral by the time of your appointment, The Clinic for Neurology, P. A. has the right to reschedule your appointment to a later date.
2. It's the patient's responsibility to make sure we participate with your plan. If your insurance coverage is through a plan The Clinic for Neurology, P. A. does not participate with, our office will file it for the patient as a courtesy. However, you are responsible for payment in full at the time of service and you will be reimbursed upon payment being received from your insurance company in the event that the payment is not made directly to you.

3. We file secondary insurance claims as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

I have read and understand "The Clinic for Neurology, P. A. Financial Policy." I agree to assign insurance benefits to The Clinic for Neurology, P. A. whenever applicable. In the event of non-payment of default, I am responsible for all cost of collections, including, but not limited to: collection agency fees, court cost and reasonable attorney fees. The Clinic for Neurology, P. A. reserves the right to change or amend this financial policy at any time and at their discretion.

_____ _____

Signature of Patient/Responsible Party Printed Name of Signer

_____ _____

Patient Date of Birth Date

The Clinic for Neurology, P. A.
185 Chateau Drive
Suite 301
Huntsville, Al 35801

Phone: 256-533-4402 Fax: 256-551-1902

Scott C. Hitchcock, D.O. David G. Greer, M.D.

Electronic Consent Form

Acknowledgment of Electronic Submission of Prescriptions, Consent to Retrieve Medication History, and Consent for Referrals.

I authorize The Clinic for Neurology, P. A. to submit the following electronically:

- Prescriptions to my preferred pharmacy
- Retrieve my prescription history via the SureScript clearinghouse
- Make referrals on my behalf and share relevant clinical and demographic information

Patient Name (Printed): _____

Patient Address: _____

_____

Patient E-mail Address: _____

Please complete the following questions:

- Patient Pharmacy:_____
- Which is your dominate side? RIGHT or LEFT

You may choose to decline the following questions:

- Race: _____
- Hispanic Non-Hispanic Unknown Decline

_____ _____

Patient Signature **Date**

We appreciate your patience.

ALL PAGES ARE TWO SIDED

Please Complete Front And Back Of ALL Pages