Howard Mandell, MD, FRCPC • Poonam Poonam, MD
Benjamin T. Colston, PA-C
www.metrolinaneurology.com

PATIENT INFORMATION SHEET

NAME: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ SEX (CIRCLE ONE): MALE FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

MAY WE TEXT YOU FOR APPOINTMENT REMINDERS (CIRCLE ONE): YES NO

DO YOU WANT ACCESS TO THE PATIENT PORTAL? (CIRCLE ONE): YES NO

EMAIL ADDRESS FOR PATIENT PORTAL: _____

EMPLOYMENT STATUS (CIRCLE ONE): Full Time Part Time Unemployed Retired Student

NAME OF EMPLOYER (if applicable): _____ WORK PHONE: _____

MARITAL STATUS (CIRCLE ONE): Single Married Divorced Widowed

RACE ORIGIN (CIRCLE ONE): African American Asian Caucasian Hispanic Other Race

INSURANCE INFORMATION

PRIMARY INSURANCE (CIRCLE ONE): SELF SPOUSE PARENT

NAME OF INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

***(If this policy is under your spouse/parent please fill out this section below with **THEIR** information)

SPOUSE/PARENT NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ PLACE OF EMPLOYMENT: _____

SECONDARY INSURANCE (CIRCLE ONE): SELF SPOUSE PARENT

NAME OF INSURANCE COMPANY: _____

POLICY #: _____ GROUP #: _____

EMERGENCY CONTACT

CONTACT NAME: _____ PHONE #: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

Metrolina Neurological Associates-Medical and Family History

Name:_____ **Date of Birth:**_____

Pharmacy: _____ **Referring MD:** _____

Chief Complaint:

_____

History of Present Illness:

_____

_____

Height_____ft._____in Weight_____lbs.

Review of Systems: Please circle any of the following problems that you are currently having:

General:	Chills Fever Weight Gain Weight Loss
HEENT	Diplopia Eye Pain Visual Disturbances Ear Problems Nose Problems Sinusitis Throat Problems Slurred Speech
Neck:	Neck Pain Neck Stiffness
Respiratory:	Difficulty Breathing Sputum Production
Cardiovascular:	Chest Pain Hypertension Shortness of breath
Gastrointestinal:	Abdominal Pain Difficulty Swallowing Nausea Vomiting
Musculoskeletal:	Back Pain Joint Pain Muscle Weakness
Neurological:	Black-Outs Bladder Symptoms Blurred Vision Bowel Symptoms Confusion
	Convulsions Difficulty with gait/walking Dizziness Double Vision Falling
	Headaches Hearing Loss Imbalance Memory Loss Muscle Cramping
	Muscle Twitching Numbness Pain Speech Disorder Syncope
	Tinnitus Vertigo Visual Loss Weakness
Psychiatric:	Anxiety Depression Disorientation Hallucinations Inability to Concentrate
	Uncontrollable Crying or Laughing
Endocrine:	Appetite Changes Heat/Cold Intolerance Thyroid Problems
Hematology:	Easy Bruising Easy Bleeding Painful Lymph nodes

Metrolina Neurological Associates-Medical and Family History

Name_____ **Date**_____

Are you right or left handed? ☐ **Right** ☐ **Left**

MEDICAL HISTORY

- o Epilepsy/Seizure_____
- o Cerebrovascular disease_____
- o Other Neuromuscular_____
- o Head injury_____
- o Spinal Cord injury_____
- o Cervical Spine disease_____
- o Lumbar Spine disease_____
- o Peripheral Nerve_____
- o CNS Malignancy_____
- o Depression_____
- o Coronary artery disease_____
- o Myocardial infarction_____
- o Arrhythmias_____
- o Congestive Heart Failure_____
- o Headache/Tension_____
- o Headache/Migraine_____
- o Genitourinary Disease_____
- o Venereal Disease_____
- o Arthritis_____
- o Cancer_____
- o Exposures_____
- o High Cholesterol_____
- o Murmur_____
- o Hypertension_____
- o COPD_____
- o Pneumonia_____
- o Asthma_____
- o Peptic Ulcer Disease_____
- o Colonic polyps_____
- o Bleeding disorder_____
- o Anemia_____
- o Diabetes_____
- o Peripheral Vascular Disease_____
- o Thyroid Disease_____
- o Menstrual/sexual dysfunction_____
- o Other Endocrine_____
- o Liver Disease/Hepatitis_____
- o Renal Disease_____
- o Mumps_____
- o Measles_____
- o Polio_____
- o Rheumatic Fever_____
- o Allergy/Hay Fever_____
- o Other_____

Allergies_____

Current Medications:

Metrolina Neurological Associates-Medical and Family History

Name_____ **Date**_____

Past Surgical: Please list any past surgeries that you have had and the approximate dates.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

	Father	Mother	Father's Parents	Mother's Parents	Brother	Sister	Children
Heart Disease							
Hypertension							
Diabetes							
Cancer							
Arthritis							
Bleeding Disorder							
Kidney Disease							
Epilepsy/Seizures							
Stroke							
Mental Illness							
Dementia							
Thyroid Disease							
Headache							
Increased Lipids/High Cholesterol							
Neuromuscular/Nerve or muscle disease							

SOCIAL HISTORY:

Tobacco Use: ___Current every day Smoker ____Current Some Day Smoker ___Former Smoker-When did you quit? __
___Packs per day___Chewing tobacco____Snuff ____Never Smoked or used tobacco products

Alcohol Use: ___Occasional alcohol use ___Moderate alcohol use (2-3 drinks per day)
___ Heavy Alcohol Use (4 or more drinks per day) ___Past alcohol use ____Never used alcohol

Illicit Drug Use: ___No Illicit Drug Use___Occasional Drug use ___Moderate Drug Use
____Heavy Drug Use If you use any illicit drugs, list them and how often they are used:
_____
_____

Highest Level of Education: __Less than High School ___High School Graduate ___Some College
__College Graduate ___Post Graduate ____Other:_____

Work___None____Part-Time_____Full-Time____Student. If you work, list the type of work that you do:
_____

Marital Status: __Single ___Married___Widowed____Divorced

Living Situation: ___Alone___With Spouse__With Parents___With Caregiver___Group Home___Other: _____

Where do you Live:_____

Exposure to HIV: __Yes __No___Unknown

METROLINA NEUROLOGICAL ASSOCIATES

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Insurance Policy and Agreement

Revision Date: 07/22/23

We are contracted with most major insurance carriers, such as Medicare, Aetna, Blue Cross Blue Shield, Blue Choice, Cigna, MedCost, United Healthcare, and many others.

However, every insurance plan is different. Since there are many different types of insurances and plans, it is your (the patient and/or guarantor's) responsibility to confirm coverage with your insurance carrier prior to being seen for your appointment. We will file all insurances, but it does not guarantee coverage or payment from your insurance company. If you have a question about your insurance coverage and/or if we are an in-network provider, please contact your insurance company directly.

Coinsurance and Copayments are due at the time of service. If you are unable to pay for your visit or balance at the time of service, please contact the Billing Department at 803-366-6135. Payment plans are available for large balances.

Please note: If we do not have your current insurance information and your claim is denied, you will be responsible for the bill. If you do not bring your insurance card to your visit, your account will be marked self-pay until you are able to return with the card.

Acknowledgement

I have read the above information and am aware of the updated Insurance Policy and Agreement.

Guarantor Signature: _____ Date: _____

Guarantor Name: _____

Patient Name: _____

Relationship to Patient (if applicable) _____

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NO CALL/NO SHOW

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. It is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Metrolina Neurological Associates sends text messages and call reminders 5 days, and 2 days prior to your appointment time.

If your schedule changes and you cannot keep your appointment, please contact us to reschedule to accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we will assess a $50 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

If you have any questions, please don't hesitate to speak to someone before signing.

Patient's Name: _____
Patient's/Guardian's Signature: _____
Date: _____

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You will be charged a $50 no-show fee if either of the follow applies:

- You fail to show up for a visit.

- You cancel or reschedule a visit less than one business day prior to your appointment.

If you are classified as a "no-show" three times in one 12-month period, you will no longer be able to schedule appointments at Metrolina Neurological Associates.

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PRIVACY INFORMATION

This section must be completed to authorize Metrolina Neurological Associates to release/discuss your health information with someone other than you (the patient). This release is good until you (the patient) make changes or cancels the authorization by informing us in writing.

LIST PEOPLE BELOW THAT WE MAY CONTACT OR SPEAK WITH ON YOUR BEHALF.

(Example: Family member(s) or anyone directly participating in your ongoing medical care)

Name	Phone/Fax	Relationship

I, _____, have read and authorize Metrolina Neurological Associates to
(Patient Name and Date of Birth)
release my healthcare information to the above listed people or organizations.

Signed: _____ Date: _____

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read and understand the HIPAA/Privacy Policy for Metrolina Neurological Associates.

Signed: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITIES:

- The patient is ultimately responsible for payment of treatment and care.
- If your insurance requires a referral to a specialist, it is **YOUR** responsibility to get the referral before your scheduled appointment or you will be responsible for the visit.
- We will bill your insurance for you; however, the patient is required to provide the correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, deductibles, and all other procedures or treatments not covered by your insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles, and non-covered items are due 30 days from the receipt of billing. If you are unable to pay within 30 days, we will be happy to set up a payment plan with you.

I have read and understand the Financial Policy for Metrolina Neurological Associates.

Signed: _____ Date: _____

• Metrolina Neurological Associates, PA

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.
803-366-6135

Effective Date: April 14, 2003 **Revised: May 1, 2024**

We are committed to protecting the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment, or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.metrolinaneurology.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits.
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- <u>If required by law:</u> The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- <u>Public health activities:</u> The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- <u>Health oversight agencies:</u> We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- <u>Legal proceedings:</u> To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Treatment alternatives: We may provide you with notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.

- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information.
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Please direct these written requests to the Privacy Officer of the Practice.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you with a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request, we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request an alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment, or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you with a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights, or you have a complaint about our privacy practices you can contact:

Privacy Officer at 803-366-6135.

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint, we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003, **or date practice adopted the Notice**