Today's Date: ____________________ (Please Print)

-Patient Information-

Name____ Soc. Sec. # ________________

Address____

City ______________________________ State ______________ Zip ________________

Age: ________ Birth date: ________________ Gender: M F Other ________________

Check boxes to allow message containing personal medical information to be left by staff.

_Home #__________________ _Daytime #__________________ _Cell # __________________

_Email: ____

Patient Employed by: ______________________________ Occupation: ______________________

Whom may we thank for referring you? ____

Primary Care Physician: ____

-Primary Insurance-

Name of Primary Insurance: ______________________ Policy Holder: ______________________

Relationship to Patient: __________________ Birth Date: ______________ Soc Sec #: ______________

Insurance ID / Policy #: __________________________ Group #: ______________________

-Additional Insurance-

Secondary Insurance Yes No Insurance Name: __________________ Policy Holder: ________________

Relationship to Patient: __________________ Birth Date: ______________ Soc Sec #: ______________

Insurance ID / Policy #: __________________________ Group #: ______________________

In case of emergency who should be notified? __________________________ Phone: ________________

- Assignment, Release and Financial Responsibility –

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to David M Katz, MD/ Bethesda Neurology, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including reasonable attorney's fees and costs of collection in the event of default. I hereby authorize Dr. Katz to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

______________________________ ______________________ ______________________

Responsible Party Signature Relationship Date

Office Policy

Health Insurance

Our office will do its best to assist you with your insurance reimbursement for Dr. Katz's services; however, it is your responsibility to be informed of your insurance benefits and requirements. Please understand that your health insurance policy is a contract between you and your insurance carrier, not between you and Bethesda Neurology, LLC. Therefore, you are responsible for any pre-authorizations and/or referrals required to see Dr. Katz. Most patients with health insurance also have deductibles and co-pays that are due at the time of service. Any fees not paid by your insurance company by 60 days after treatment are your responsibility. If you have no health insurance, you must pay in full at the time of the visit.

Missed or Cancelled Appointments

Your appointment is time reserved for you. Dr. Katz does not "double book" patients. Please be assured that we make every effort to honor your appointment time and ask that you extend the same courtesy to us. If unanticipated circumstances require you to cancel your appointment, please provide at least one business day's notice prior to the appointment, or you will be charged a $50.00 missed appointment fee.

Collection Fees

Please be advised that fees incurred to collect payment, including but not limited to the cost of mailing statements will be the patient's responsibility. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

Service Charges

- 1.5% monthly interest rate will be applied to all balances over 30 days.
- To defray the cost of collecting payment after the date of service, a monthly $5.00 billing fee will be added to all monthly statements sent out.
- There will be a $25.00 fee for any returned checks.
- If you require extraordinary non-medical services (insurance forms, disability forms, etc.) which require significant staff time, a minimum $25.00 fee will be charged.

Financial Consent and HIPAA Privacy Acknowledgement

I certify that I have read, understand, and agree to the terms of this policy. I also acknowledge receipt of Bethesda Neurology, LLC Notice of Privacy Practices.

Responsible Party Signature:______________________________ Date:__________

Print Patient Name:______________________________

Please list names of any persons authorized to discuss medical information (Family Members, etc.):______________________________

____

HEALTH HISTORY

Bethesda Neurology, LLC

NAME:______________________________ **Today's Date**:______________________________

Age:______________ **Birthdate**:______________ **Referring physician:**______________

Reason(s) for today's visit?

____

____

Past Medical History (Check any medical conditions past and/or present)

☐ Stroke / TIA	☐ Diabetes	☐ Heart Valve Replacement	☐ Thyroid disease
☐ Migraine	☐ Macular degeneration	☐ Tuberculosis	☐ Sarcoidosis
☐ Multiple sclerosis	☐ Glaucoma	☐ Lung disease	☐ Cancer:__________
☐ Parkinson's disease	☐ Cataract surgery	☐ Liver disease	☐ Currently pregnant
☐ Loss of consciousness	☐ Heart disease	☐ Arthritis	☐ Prostate disease
☐ Epilepsy/seizures	☐ Pacemaker	☐ Lupus	☐ Sickle cell disease
☐ Head injury	☐ High blood pressure	☐ Kidney disease	☐ HIV or other STD
☐ Neuropathy	☐ High cholesterol	☐ Ulcer	☐ Other(s):__________

Other Symptoms (Please List on Back of Page)

Review of Symptoms (Please check any of the following symptoms you are experiencing)

Neurological:			
☐ Double vision	☐ Headache	☐ Vertigo/spinning	☐ Confusion
☐ Blurred vision	☐ Muscle weakness	☐ Dizzy/lightheaded	☐ Memory loss
☐ Eye pain	☐ Speech problems	☐ Walking problems	☐ Tingling /numbness
☐ Eyelid drooping	☐ Swallowing difficulties	☐ Balance problems	☐ Tremors or tics
Cardiovascular:	**ENT:**	**Genitourinary:**	**Psychologic:**
☐ Chest pain	☐ Hearing loss	☐ Incontinence	☐ Depression
☐ Irregular pulse	☐ Ringing in ear(s)	☐ Pain during urination	☐ Anxiety / nervousness
☐ Poor circulation	☐ Nose bleeds	☐ Blood in urine	☐ Hallucinations
☐ Heart murmur	☐ Sinus problems	☐ Frequent urination	☐ Fatigue
General:	**Dermatology:**	**Endocrine:**	**Pulmonary:**
☐ Weight change	☐ Rash	☐ Too hot or cold	☐ Cough
☐ Fever/chills	☐ Birth marks	☐ Breast discharge	☐ Shortness of breath
☐ Sleep disturbance	☐ Skin lesion(s)	☐ Irregular periods	☐ Wheezing
Hematology:	**Gastrointestinal:**	**Gastrointestinal:**	**Musculoskeletal:**
☐ Easy bruising	☐ Abdominal pain	☐ Nausea/vomiting	☐ Neck/low back pain
☐ Anemia	☐ Diarrhea/constipation	☐ Blood in stool	☐ Swollen joints

HEALTH HISTORY (Continued)

Bethesda Neurology, LLC

FAMILY History (Please check any that apply)

☐ Headaches/migraines	☐ Multiple sclerosis	☐ Diabetes	☐ Thyroid
☐ Stroke	☐ Nerve/muscle disease	☐ Heart disease	☐ Alcoholism/addiction
☐ Aneurysms	☐ Dementia	☐ Cancer:__________	☐ Sickle cell disease
☐ Seizures/Epilepsy	☐ High blood pressure	☐ Arthritis	☐ Other:___________

Medications / Dosage

Allergies (medication, foods, latex, etc.)

Hospitalizations / Surgeries (Please include dates)

Social History

Tobacco User? O Yes O No O Quit (when?)_______ If yes, how many packs per day?__________

Alcohol (beer/wine/liquor)? O Yes O No O Quit (when?)_________ If yes, how many drinks per day?______

Drug Use? O Yes O No O Quit (when?)_________

Caffeinated Beverages? O Yes O No If yes, how many cups/cans per day?_______

Occupation:____

Please List Other Symptoms

Please List Any Questions for the Doctor

Reviewed: ________