NEURO CARE

Adult and Child Neurology
Behavioral Neurology & Neuropsychiatry
Headache Medicine

MICHAEL HOFMANN, MD
3050 Henderson Drive
Jacksonville, NC 28546
Office 910.353.2660 • Fax 910.353.2770

PATIENT INFORMATION

Date: _____
SS/HIC/Patient ID#: _____
Patient Name: _____
Last Name
_____
First Name Middle Initial
Address: _____
City: _____
State: _____ Zip _____
Home Phone: _____
Cell Phone: _____
E-mail: _____
Sex: _____ Age: _____ Birthday: _____
Race: ☐ American Indian ☐ Asia ☐ Pacific Islander
☐ African American ☐ White ☐ Hispanic ☐ Other ☐ Refused
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Language: ☐ English ☐ Indian ☐ Spanish ☐ Russian ☐ Other
Occupation: _____
Patient Employer/School: _____
Employer/School Address: _____
_____
Employer/School Phone: _____
Spouse's Name: _____
Spouse's Date of Birth: _____
Spouse's SS#: _____
Spouse's Employer: _____
IN CASE OF EMERGENCY, CONTACT: _____
Name: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Who may we thank for referring you? _____
_____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient: _____
Birth Date: _____ SS#: _____
Insurance Co: _____
Group #: _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name: _____
Birth Date: _____ SS#: _____
Relationship to Patient: _____
Insurance Co: _____
Group #: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
_____
and assign directly to Neuro Care 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. I authorize the use of my signature on all insurance submissions.
The above named office may use my health care information and may discuss such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Neuro Care for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical and other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian, or Personal Representative
_____
Please print name of Beneficiary, Guardian, or Personal Representative
_____ _____
Date Relationship to Beneficiary

FAMILY HISTORY

Date of last physical examination:
What is the reason for your visit:

	FATHER	Present Health	MOTHER	Present Health	Spouse	Present Health
Alive	☐		☐		☐	
Deceased	☐		☐		☐	
BROTHERS	NO. ALIVE	Present Health		NO. DECEASED AND CAUSE OF DEATH		
SISTERS	NO. ALIVE	Present Health		NO. DECEASED AND CAUSE OF DEATH		
CHILDREN	NO. ALIVE	Ages and Present Health		NO. DECEASED AND CAUSE OF DEATH		

Check (✓) any illnesses which have occurred in any of your **BLOOD RELATIVES:** ☐ Nervous illness ☐ Allergy ☐ Diabetes ☐ Heart disease ☐ Cancer ☐ Bleeding tendencies ☐ Kidney disease ☐ Tuberculosis ☐ Stroke ☐ Other: _____

MEDICAL HISTORY: All information is strictly confidential—Check (✓) symptoms you currently have or have had in past year

GERERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid Heart beat
- ☐ Poor circulation
- ☐ Varicose veins
- ☐ Swelling of ankles

EYE, EAR, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty swallowing
- ☐ Double Vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Changes in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual cramps
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period: _____

Date of last Pap Smear: _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

MEDICATIONS/ALLERGIES

List medications you are currently taking: _____

_____

_____

Pharmacy Name: _____

_____

Phone: _____

List allergies to medications or substances _____

_____

_____

_____

HEALTH HABITS

Check (✓) which you use and how:	Check (✓) if your work exposes you to:
☐ Caffeine _____	☐ Stress
☐ Street Drugs _____	☐ Heavy Lifting
☐ Tobacco _____	☐ Hazardous Substances
☐ Other _____	☐ Other _____

Your occupation: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

_____ _____

Printed name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date

___ Initial Release Form
___ Addition to Previous Release(s)
___ Replaces Previous Releases

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Compound Authorization for Release of Verbal Information

Name of Patient _____ Date of Birth _____

Neuro Care is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. *Check each person/entity that you approve to receive information.*	Description of information to be released. *Check each that can be given to person/entity on the left in the same section.*
☐ Voice Mail	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Give information to employer (provide name)_____ ☐ Give information to school (provide name)	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Patient's Spouse (provide name) _____	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Patient's Parent (provide name) _____	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Other (provide name / relationship to patient) _____ _____	☐ Appointment information ☐ Financial information ☐ Medical information
☐ Support Group / Group Home (provide name) _____	☐ Appointment information ☐ Financial information ☐ Medical information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Neuro Care. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative — Date

Description of Personal Representative's Authority (attach necessary documentation)

_____

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If the following information is not completed in full, there may be a delay in fulfilling your request while we obtain the necessary information.

Patient _____

Date of Birth _____

Parent/Guardian Name _____

POSITIVE IDENTIFICATION OF RECIPIENT IS REQUIRED

Prescriptions May Be Picked Up On My Behalf By the Following Individuals:

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Correspondence May Be Picked Up On My Behalf By the Following Individuals:

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

Name(please print)_____ Relationship to Patient _____

A COPY OF THIS SIGNED AND WITNESSED FORM IS AVAILABLE UPON REQUEST.
I hereby request and authorize the above named agency, organization or individual who possesses information relative to the patient named above to release information, as specified, to the individual(s) named on this request.

I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be disclosed without my written consent unless otherwise provided for by state and federal law. I understand that any documents or information disclosed pursuant to this authorization, upon receipt by the above named individual(s), may no longer protected by HIPAA Privacy Rule. Proof of authority to act for a patient must be provided.

This consent shall not expire without express written revocation. Consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

_____ _____
Printed Name of Patient — Printed Name of Legal Representative

_____ _____
Patient Signature — Date — Legal Representative Signature — Date

_____ _____
Witness Signature — Date — Relationship to Patient

NOT VALID WITHOUT WITNESS SIGNATURE

NAME	DOB	CHART NO.	INITIALS

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Patient Name _____ DOB _____

Identity Theft Protection and Detection (and Red Flags Rule Compliance)

It is the policy of Neuro Care that our Identity Theft Prevention and Detection (and Red Flags Rule Compliance) program is as follows:

- All patients (or legal guardian) must present a photo ID with the patient's current address at check in and current insurance card. If the photo ID does not show the patient's current address, then a current utility bill with the current address must be shown.
- On their first visit, a photo will be taken of the patient. The photo becomes a part of their medical record, and will be protected as such.
- If the patient (or legal guardian) refuses to allow a picture to be entered into their medical record, they will be required to show their current photo ID and insurance card to the front office staff at the time of check in and to the clinician at every visit. Please note, only the legal guardian of record (listed on the patient's paperwork) will be able to bring the patient to their appointments.

I have read and understand the above Identity Theft Prevention policy.

_____ _____
Signature Date

IT IS THE POLICY OF NEURO CARE:

That a parent or guardian needs to remain in the building during the appointment for children 16 years of age and younger. This is for safety purposes of the child(ren). We are unable to be responsible for the well-being of a child left unattended.

Failure to comply with this policy could result in additional fees that your insurance company will not reimburse.

_____ _____
Parent/Guardian Printed Name Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

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CONSENT TO TREATMENT

By signing below, I am authorizing Neuro Care to evaluate and treat the following person:

_____

I accept full responsibility for payment of services rendered. I authorize insurance benefits be paid directly to Neuro Care, realizing that I am responsible for paying non-covered services. I consent to the release of pertinent medical information for treatment, payment, and health care operations.

_____ _____
Print Patient Name Date of Birth

_____ _____
Signature of patient, parent, legal guardian Date

_____ _____
Witness Date

I acknowledge receipt of the notice of privacy practices of Neuro Care.

_____ _____
Signature of patient, parent, legal guardian Date

_____ _____
Witness Date

Description of Restriction:

_____

NAME DOB CHART NO. INITIALS

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PATIENT CARE COMMUNICATION FORM

Patient Name _____ Date of Birth _____

As part of Neuro Care's pledge to offer quality care for our patients, we would like your permission to communicate with your primary care physician (and/or other clinician who referred you to us) about your health care.

I, _____, hereby authorize Neuro Care to

Please check one:

- ☐ To release any applicable mental health information to my primary care physician (PCP) or other referring clinician, named below.
- ☐ To release any applicable substance abuse information to my PCP or other referring clinician, named below.
- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

PrimaryCare
Physician/Clinician Name _____ Phone Number _____

Practice Name _____

Practice Address _____

_____ Print Name of Patient

_____ Print Name of Guardian

_____ Date

_____ Signature

_____ Signature

Date of Initial Appointment

NAME DOB CHART NO. INITIALS

Health Net FEDERAL SERVICES | TRICARE

TRICARE Other Health Insurance Questionnaire

Do you or any member of your family have Other Health Insurance coverage or have you had Other Health Insurance in the last 12 months? (TRICARE supplements are not OHI) ☐ YES ☐ NO

If **YES**, please complete the following for each insurance policy. THIS FORM MAY BE COPIED

Type of coverage: ☐ HMO/PPO ☐ Single ☐ Group ☐ Individual ☐ Medicare ☐ Supplemental ☐ Medicaid ☐ Other

Policy Holder's Name: _____ SS #: _____

Name of Insurance Company: _____

Insurance Company's Address / Phone Number: _____

_____

Policy / Group / Plan Number: _____

Effective Date: _____ Expiration Date: _____

Does this Policy provide Pharmacy, Dental, Mental Health or Durable Medical Equipment (DME) benefits? (circle all that apply)

Please list who is covered by this policy

Name	Sex	Relationship to Policy Holder	Date Of Birth	SS#
_____	____	_____	____/____/____	_____
_____	____	_____	____/____/____	_____
_____	____	_____	____/____/____	_____
_____	____	_____	____/____/____	_____

(If additional people are covered please attach a separate listing. This form may be copied.)

PRIVACY ACT

1) Authority: 5 USC 552a; 10 USC 1079, 1086; 38 FR 45318; 32 CFR 199.7. 2) Purpose: To evaluate for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE program. 3) Uses: Information from claims forms and related documents may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE program. 4) Disclosure: Voluntary, however, failure to provide information may result in a delay or denial of claims for medical services, or may result in the TRICARE beneficiary not receiving maximum benefits from their health coverage.

The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department of agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ _____ _____ ____/____/____

Signature | Sponsor's SSN | Relationship to Sponsor | Date

Please mail this form to our claims processing subcontractor at the address below.

TRICARE North - OHI Questionnaires
P.O. Box 870159
Surfside Beach, SC 29587-9759