Kids Neuro Care

Patient Registration

Patient: ____

Date of Birth: ______________________________ Sex: ______________________________

Address: ______________________________ City: ____________ Zip: __________

Email: ____

Race: ______________________________ Ethnicity: ______________________________

Mother/Guardian:

____

Primary Phone: ______________________________ Secondary Phone: ______________________________

Father/Guardian:

____

Primary Phone: ______________________________ Secondary Phone: ______________________________

Insurance Name:

______________________________ **Policy Holder:** ______________________________

Address: ______________________________ City: ____________ Zip: __________

Member ID: ______________________________ Phone: ______________________________

Primary Care/Referring Physician:

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Address: ______________________________ City: ____________ Zip: __________

Phone: ______________________________ Practice Name: ______________________________

Pharmacy: ______________________________

Phone: ______________________________ !ŘŘŜăăŸψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

Parent/Guardian Signature: ____________________ **Date:** ____________________

If a parent or guardian cannot bring the patient to the appointment, a signed letter stating the name of the personbringing the patient and that person's valid ID must be presented at check-in.

Office Policies and Procedures

Cancellations/No Shows: We will not make appointments for patients who excessively cancel/no show to appointments. **You must call our office 24 hours prior to your appointment to reschedule or the FOLLOWING FEES WILL APPLY:**

AMB EEG No-Show Fee:	$100.00	Office Visit No-Show Fee:	$30.00
LTM EEG No-Show Fee:	$100.00	EEG No-Show Fee:	$75.00

Payment for Denied Services: You will be responsible for payment of services that are **NOT** covered by your insurance. Furthermore, it is your responsibility to notify our office prior to your appointment if your insurance plan has changed. It is also your responsibility to request and obtain referrals/authorizations through your PCP if required by your insurance carrier.

Payment for Services: Your copayment and any prior balance is due at the time of service unless otherwise prearranged prior to the appointment.

Medical Records: Medical Records such as EEG's, Labs, MRI's and other test results can be provided for a fee of $1.00 per page. Forms requested for the Doctor to fill out will be a $15.00 flat fee. You will need to fill out a Medical Release form provided by Kids Neuro Care for any and all other records to be forwarded to other Physicians, Attorneys, School etc.

Prescriptions: Bring a list of current medications including dosing and frequency being given to the patient to the appointment and request any prescription refills needed during the appointment. If a refill is needed before the next appointment, call the office during business hours. If your child has not been seen in our office within the past three months, we will **NOT**fill prescriptions without a return visit appointment being scheduled. At appointments, the patient's prescription will be filled to last until the next scheduled appointment.

Parent/Guardian Name: ____________________ **Patient:** ________________

Parent/Guardian Signature: _______________ **Date:** ____________________

Your Signature Will Serve as Consent for the Following

Consent: I, hereby, give consent for Kids Neuro Care to provide the necessary treatment discussed. I authorize use of information to coordinate and manage my child's healthcare and receive payment for services.

Insurance: I understand it is my responsibility to know my insurance coverage and benefits including contracted laboratories and hospitals where my child may receive care.It is my responsibility to provide the office with the necessary information to file claims and to notify the office of any insurance coverage changes prior to visits. I authorize payment of medical benefits directly to Kids Neuro Care for services rendered.

Mail:Kids Neuro Care may send me mail or email that assists the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, patient statements, and school forms.

Medical Release: I authorize any holder of medical records for my child to release to Kids Neuro Care, independent laboratories, and insurance carriers information needed for treatment, claims processing, and payments. I permit a copy of this authorization to be used in place of the original.

Parent/Guardian Name: _______________ **Patient:** ______________________

Parent/Guardian Signature: _____________________ **Date:** ______________

Kids Neuro Care

New Patient Medical History Questionnaire

Child's Name: ____D.O.B:______________

Help us to get to know your child better, please answer these questions to the best of your ability.

Main Reason(s) for Visit: ____

Past Medical History

Medication Allergies	
Serious Illness/Surgeries	
Head injuries	
Hospitalizations	

Birth History

Were any of the following concerns during pregnancy?

☐ No problems ☐ Abnormal Bleeding ☐ High Blood Pressure ☐ Early Labor
☐ Diabetes ☐ Tobacco use ☐ Alcohol/substance use ☐ Trauma

Birth weight ____lbs_____oz	Vaginal ☐ C-section ☐
Born early or late? _______ weeks	Discharged home in 2-3 days ☐ Y ☐ N
Problems during delivery? ☐ Y ☐ N	Newborn Jaundice ☐ Y ☐ N

Developmental History

Any worries about abnormal or slow development	☐ **Yes** ☐ **No**
Has your child ever lost developmental skills?	☐ **Yes** ☐ **No**
Has the child received any therapy for developmental delays?	☐ **Yes** ☐ **No**
Does your child receive special classroom modifications?	☐ **Yes** ☐ **No** **Current Grade_____**

Family History

Has anybody in the family any of the following conditions:

☐ Epilepsy/Seizures	☐ Autism	☐ Migraines	☐ Brain tumor	☐ Aneurysm
☐ Multiple Sclerosis	☐ Muscle/nerve disorder	☐ Birth Defects	☐ Bleeding Disorder	☐ Neurofibromatos is
☐ Learning Disability	☐ Tics/Tourette	☐ Stroke	☐ Psychiatric Disorder	☐ ADD/ADHD

Current Mediations

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Review of Systems **(Please indicate if any of these are problems for your child)**

Confusion Y ☐ N ☐	Headaches Y ☐ N ☐	Dizziness Y ☐ N ☐	Blurred Vision Y ☐ N ☐
Numb/Tingling Y ☐ N ☐	Double Vision Y ☐ N ☐	Nausea/Vomiting Y ☐ N ☐	Ringing in ears Y ☐ N ☐
Poor balance Y ☐ N ☐	Trouble walking Y ☐ N ☐	Stiffness Y ☐ N ☐	Drooling Y ☐ N ☐
Weakness Y ☐ N ☐	Clumsiness Y ☐ N ☐	Swallowing issues Y ☐ N ☐	Speech Difficulty Y ☐ N ☐
SeizuresConvulsions Y ☐ N ☐	Memory Problems Y ☐ N ☐	Mood Changes Y ☐ N ☐	Unable to sleep Y ☐ N ☐
Altered taste/smell Y ☐ N ☐	Change in appetite Y ☐ N ☐	Weight Loss/Gain Y ☐ N ☐	Excessive sleepiness Y ☐ N ☐
Fatigue Y ☐ N ☐	Nose bleeds Y ☐ N ☐	Fainting Spells Y ☐ N ☐	Involuntary Movements Y ☐ N ☐
Staring Spells Y ☐ N ☐	Loss of control bladder or bowel Y ☐ N ☐	Frequent belly pains Y ☐ N ☐	Chronic diarrhea or constipation Y ☐ N ☐
Low Back pain Y ☐ N ☐	Neck Pain Y ☐ N ☐	Joint pain/swelling Y ☐ N ☐	Tremors Y ☐ N ☐
Anxiety Y ☐ N ☐	Depression Y ☐ N ☐	Disruptive behavior Y ☐ N ☐	Poor attention in school Y ☐ N ☐

Kids Neuro Care

Financial Policy

The doctors and staff at Kids Neuro Care would like to welcome you to our Practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- **We only bill primary insurance.**
- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral the day of your visit or faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if its a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.
- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current accordingly; all self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover or American Express.
- A $30 **no show** fee applies for office visits if not cancelled within 24 hours. A $75 **no show** fee applies for EEG if not cancelled within 24 hours. A $125 **no show** fee applies for Ambulatory & Long Term Monitoring (Video EEG) appointments if not cancelled within 48 hours.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.

- A returned check will result in a $30 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $10.
- There is a $25 charge for the completion of paperwork (ex disability, FMLA…)
- Any unpaid balances older than 90 days may be subject to 1.5% interest per month.
- Any balance older than 120 days will be forwarded to a collection agency and may include collection agency fees up to 35%.
- If you are unable to keep your appointment, please notify us so that we may offer that time to another patient. A pattern of repetitive "no shows" or late cancellations may regretfully result in discharge from practice.

If you have any questions about the above information, please do not hesitate to ask us.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

______________________________	____________________________	____________
Patient Name (please print)	Patient Signature	Date
________________________________	______________________________	___________
Responsible Party (please print)	Responsible Party Signature	Date