NEUROCARE CENTER, LLC

3290 N. Ridge Rd. Suite 240 Ellicott City, MD 21043
Tel. (410) 730-6911 Fax: (410) 730-1599

☐ **Dr. Babkes** ☐ **Dr. Romanow** ☐ **Dr. Reaven** ☐ **EEG** ☐ **EMG** ☐ **Other:**

☐ **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Dr** **Last Name** _____ **M.I.** _____ **First Name** _____

Sex: ____ **Male** ____ **Female** **Birth Date** _____ **Email** _____

Street Address _____ **City** _____

State _____ **Zip Code** _____ **Emergency Contact:** _____ **Tel.:** _____

Cell: (____)_____ **Home:** (____)_____ **Work:** (____)_____

Preferred Telephone: _____ **cell /** _____ **home /** _____ **work** _____

Primary Care Physician: Name _____ **Tel.** _____ **Fax:** _____

Other Referring Provider: Name _____ **Tel.** _____ **Fax:** _____

(**Optional**: Race: _____ Ethnicity: ___ Latino ___ Non-Latino Preferred Language: _____)

Financial Information:

_____ **I am responsible for my account OR (please complete):**

Financial Guarantor's Name: _____ **Relationship:** _____

Address: _____

Tel. _____ **Email:** _____

_____ **Please bill my health insurance OR:** _____ **Self-pay (and provide me with a receipt)**

Primary Health Insurance: (Name) _____

Subscriber (if other than the patient): _____ **Subscriber's date of birth:**_____

Secondary Health Insurance: (Name) _____

Subscriber (if other than the patient): _____ **Subscriber's date of birth:**_____

Tertiary Health Insurance: (Name) _____

Subscriber (if other than the patient): _____ **Subscriber's date of birth:**_____

NEUROCARE CENTER, LLC PATIENT ACKNOWLEDGMENT AND CONSENT FORM

1. Consent for treatment: I or my representative agree/s to have NeuroCare Center, LLC (NCC) evaluate and treat my condition. If a proposed treatment has significant risks, then I will be offered an additional consent form.

2. Consent for Information Use and Disclosure: I consent to use of my protected health information for treatment, payment, and health care operations.

3. Electronic prescribing: I authorize my pharmacy to release my medication refill history to NCC for the purpose of ongoing treatment.

4. NCC Notice of Privacy Practices: I acknowledge access to a copy on the NCC website or in the office.

5. Telephone Consumer Protection: By providing my telephone numbers to NCC, I consent to receive calls and messages related to scheduled appointments, test or lab results, prescription information, my account or bills related to services I receive from NCC, its staff or independent contractors. If I wish to opt out of any communication, I will provide a request in writing to NCC. Providing a telephone number is not a condition of receiving services.

6. Payment for Services: I will provide NCC now (and for future services) up to date health insurance information to bill my health plan for care that I receive. Payments from my health plan may go directly to NCC. If I should receive the payments, I will be responsible for paying NCC.

I agree to pay copays, deductibles and any other part of my bill that my health plan says I must pay. I know that I must pay these before receiving treatment. If I am unable to pay in full, I will request the NCC **no interest** payment plan and make partial payments according to the agreed upon payment schedule of such plan. I understand that NCC reserves the right to add interest to any balances that are 60 days overdue, and to send delinquent accounts to a collection agency, whose fees are my responsibility.

I am responsible for payment to NCC in the following circumstances:

- when I receive services not covered by my health plan or choose to pay for services rather than use my health plan
- when I choose to have a service covered by my health plan but I do not obtain the referral or authorization my health plan requires
- when my health plan does not participate with NeuroCare Center, LLC

If I reserve an appointment time, fail to use it or to cancel it with one business day notice (24 hours), I agree to self-pay the $30 no show fee, which is not covered by my health insurance.

7. I authorize the following individuals to access and disclose my protected health information re: treatment, payment or other healthcare operations:

Name: _____ Relationship: _____

Tel: _____ Email: _____

Name: _____ Relationship: _____

Tel: _____ Email: _____

Name: _____ Relationship: _____

Tel: _____ Email: _____

Patient Signature: _____ Date: _____

Representative's Signature: _____ Rep. Name: _____

Representative's Tel: _____ Rep. Email: _____