Josephson Wallack Munshower Neurology PC

PATIENT REGISTRATION INFORMATION

IN ORDER TO PROCESS YOUR CLAIM PROPERLY AND ADHERE TO THE HIPAA REQUIREMENTS ALL APPLICABLE INFORMATION MUST BE COMPLETED BELOW.

For Office Use Only:

Account Number: _____ JWM MD: _____

Date HIPAA Form Signed: _____ Notes: _____

Last Name:	**First Name:**	**Middle Name:**
Middle Name 2:	**Maiden Name:**	**Credentials:**

Prefix: ○ Mr ○ Mrs ○ Ms ○ Dr **Suffix:** ○ I ○ II ○ III ○ IV ○ Sr ○ Jr

Date of Birth:	**Sex:** ○ Male ○ Female	**Religion:**

Marital Status: ○ Married ○ Single ○ Divorced ○ Unknown

Drivers License State: Number:	**Social Security Number:**
Address Line 1:	**Address Line 2:**

Zip Code:	**City:**	**State:**

Contact Information:	**Email Address:**	**Home Phone:**

Work Phone:	**Cell Phone:**	**Fax Number:**	**Pager:**

Which Number do you consider your primary phone number: ○ Home ○ Work ○ Cell ○ Pager

What is your Preferred Communication Method: ○ Patient Portal ○ Home Phone ○ Work Phone ○ Cell ○ Text ○ Email

Local Pharmacy Name:		**Mail Order Pharmacy Name:**	
Address:		**Address:**	
Phone:	**Fax #**	**Phone:**	**Fax #**

Employer Name:	**Occupation:**
Address:	**Phone #:**

Responsible Party (Guarantor of the Account - statements will be sent to this address.) ○ Same as above.

Name:	○ Male ○ Female	**Relationship to Patient:**	
Date of Birth:	**Home Phone:**	**Cell Phone:**	**Work Phone:**
Address:		**Email Address:**	

Emergency Contact:

Name:	○ Male ○ Female	**Relationship to Patient:**	
Date of Birth:	**Home Phone:**	**Cell Phone:**	**Work Phone:**
Address:		**Email Address:**	

Primary Care Physician:	**Referring Physician:**

Josephson Walock Munshower Neurology PC

PATIENT REGISTRATION INFORMATION - Continued

IN ORDER TO PROCESS YOUR CLAIM PROPERLY AND ADHERE TO THE HIPAA REQUIREMENTS ALL APPLICABLE INFORMATION MUST BE COMPLETED BELOW.

PRIMARY INSURANCE:	
Name of Insurance Company:	
Claims Address:	
Policy Holder Name:	Patient Relationship to Policy Holder:
Policy Holder Social Security Number:	Policy Holder Date of Birth:
Policy Number:	Group Number:
Effective Date:	Office Copay:

SECONDARY INSURANCE:	
Name of Insurance Company:	
Claims Address:	
Policy Holder Name:	Patient Relationship Policy Holder:
Policy Holder Social Security Number:	Policy Holder Date of Birth:
Policy Number:	Group Number:
Effective Date:	Office Copay:

Worker's Compensation and/or Accident Information (if applicable)					
Date of Injury	Job Related	Yes	No	Auto Related	Yes	No

Worker's Compensation Information:	
Name of Employer	Case Number:
Contact Person	Phone Number:
Claims Address:	

Auto Accident Information:	
Name of Insurance Company:	
Claim Address:	
Policy Holder Name:	Patient Relationship to Policy Holder:
Policy Holder Social Security Number:	Policy Holder Date of Birth:
Policy Number:	Claim Number:

I attest that all of the information presented is true and correct to the best of my ability and knowledge:

Signature: _____ Date: _____

Witness: _____ Date: _____

Josephson Wallack Munshower Neurology PC

FINANCIAL POLICIES, TERMS, CONDITIONS AND RELEASES

Financial Policies and My Financial Responsibility:

- I acknowledge and accept full financial responsibility for services provided by Josephson Wallack Munshower Neurology PC (JWM).
- JWM will accept assignment of benefits from me for my insurance and will bill my insurance as a courtesy but it is my responsibility to ensure my insurance company pays for the services provided promptly.
- I authorize JWM to file an appeal on my behalf with my insurance company should the situation arise that an appeal is required in order to obtain payment.
- I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including deductibles and coinsurance.
- I understand that payment of copayment or coinsurance is expected at time of service, as well as any prior balance that I owe. I agree to pay any balance due after insurance pays within 30 days.
- Patients without insurance coverage are considered self-pay accounts. Liability cases are also considered self-pay accounts. JWM does not accept attorney letters or contingency payments. Payments for all self-pay accounts are due in full at the time of service.
- Self-pay patients will receive a 30% discount from charges when payment in full is made at time of service.
- Our offices accept CASH, Checks, Money Orders, VISA, MasterCard, American Express and Discover. One or all of these cards may be used to pay your bill, and may be kept on file by us to facilitate billing. Always ask for a receipt when making payment. If you have a credit balance after paying for a service JWM may apply it to any outstanding balances on your account.
- There will be a $25 service charge on all returned checks.
- I shall be responsible for any attorney fees, court costs, and collection agency fees as well as any pre-judgment and/or post-judgment interest at the current legal rate.

Proof of Identity: I agree to bring my government-issued photo identification and my insurance card(s) on every visit.

Insurance Pre-certification / Prior Authorization or Referral Approval: Some insurance companies require pre-certification, prior authorization or a referral from your primary care physician before certain services are provided. It is your responsibility to ensure that pre-certification, prior authorization, or a referral is obtained. It is your responsibility to ensure the services are obtained within the dates that the pre-certification, prior authorization and/or referral are approved. Failure to do any of the above will make you financially responsible for all denied payments.

Assignment of Benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other plans to Josephson, Wallack, Munshower Neurology PC. This assignment will remain in effect until revoked by me in writing. I hereby agree to pay Josephson Wallack Munshower Neurology PC the charges for all medical services rendered.

Josephson Wallack Munshower Neurology PC

FINANCIAL POLICIES, TERMS, CONDITIONS AND RELEASES

TCPA Consent: The Telephone Consumer Protection Act (TCPA) regulations define "prior express written consent". I acknowledge under the TCPA that by providing my land line and/or cell phone number, that I am giving my prior express written consent that Josephson Wallack Munshower Neurology PC and its affiliates and business partners, have the authorization to call via auto-dialer, pre-recorded voice messages, SMS messages and live calls for any communication that would be associated with my account in this practice.

Email Consent: I acknowledge that by providing my email address, that I am giving my express written consent that Josephson Wallack Munshower Neurology PC (JWM) and its affiliates, have authorization to contact me by the email address I have provided for any non-urgent communications that would be associated with my account at JWM. JWM uses encrypted email when Protected Health Information is included in communications related to patients.

Patient Portal Consent:

- JWM provides a patient portal to facilitate secure and confidential communications between you and the practice.
- You are encouraged to sign up to use the portal.
- This will enable us to quickly send you test results, respond to prescription refill requests, respond to your questions and inquiries, and facilitate setting up future appointments. It will also allow you to access and print portions of your health record.
- DO NOT USE the portal in an emergency situation.
- You will be required to acknowledge and agree to the portal's use each time you sign on to use it.

Late Arrival: Patients should arrive 30 minutes prior to their scheduled appointment time for each visit. Failure to arrive 30 minutes prior to your appointment may require rescheduling.

Missed Appointments: Appointment must be cancelled 24 hours in advance or there will be a $50 charge.

Release of Information: I hereby authorize Josephson Wallack Munshower Neurology PC (JWM) to furnish such professional information as may be necessary to complete my insurance claim from the medical records compiled during my treatment and JWM is hereby released from all legal liability that may arise from the release of the information requested.

I hereby accept and acknowledge all of the Policies, Terms, Conditions and Consents above by signing below:

Signature: _____ Date: _____

Witness: _____ Date: _____

Josephson Wallack Munshower Neurology PC

Comprehensive Neurological Expertise
Compassionate Patient Care

HEALTH HISTORY AND REVIEW OF SYSTEMS

Name:_____ Date:_____

Age:_____ Date of Birth:_____ Sex:_____

Check (X) below any illness the patient has had:

- ❑ Asthma
- ❑ Bedwetting
- ❑ Behavioral Problems
- ❑ Bleeding Tendencies
- ❑ Bronchitis
- ❑ Cancer-Tumors
- ❑ Cerebral Palsy
- ❑ Chicken Pox
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Eczema
- ❑ Epilepsy
- ❑ Eye Disease
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Meningitis
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Muscle Weakness
- ❑ Otitis Media
- ❑ Rheumatic Fever
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Skin Diseases
- ❑ Stomach Trouble
- ❑ Tuberculosis
- ❑ Urinary Tract/ Bladder Infection
- ❑ Venereal Disease
- ❑ Gynecologic Problems
- ❑ Allergies(Food/Drug) Please List:

_____
_____
_____
_____
_____
_____

LIST OTHER ILLNESSES:

_____
_____
_____
_____

OPERATIONS: (TYPE)	DATE	HOSPITAL

PREGNANCIES:

FRACTURES:

LIST MEDICATIONS NOW TAKING, INCLUDING VITAMINS, OVER-THE-COUNTER MEDICATIONS, AND BIRTH CONTROL PILLS.

_____
_____
_____
_____
_____
_____

IMMUNIZATION	YEAR	IMMUNIZATION	YEAR
❑ Diphtheria	_____	❑ Smallpox	_____
❑ Polio	_____	❑ Pertussis	_____
❑ Tetanus	_____	❑ Hepatitis	_____
❑ Measles	_____	❑ Hem. Influ.	_____
❑ Mumps	_____	❑ Pneumonia	_____
❑ Rubella	_____		

History and Review of Systems Reviewed by:

_____ _____
Physician **Date**

Form No. 0023B-3 Rev. 01/12

HABITS

(Please indicate past and current usage and frequency per day.)

	AMOUNT
❑ Cigarettes	
❑ Beer	
❑ Wine	
❑ Whiskey	
❑ Other	

EDUCATION

	YEARS COMPLETED
Grade School	
High School	
College (no.of years)	
Graduate	
Other	

TYPE OF WORK

NUMBER OF CHILDREN

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Other

FAMILY HISTORY: (Check below if any of the conditions have occured on either side of patient's family.)

- ❑ Allergies
- ❑ Bone Disease
- ❑ Blood Disease
- ❑ Cancer or Tumors
- ❑ Cardiovascular Disease (Heart)
- ❑ Congenital Deformities
- ❑ Deafness
- ❑ Epilepsy
- ❑ Gastrointestinal Disease
- ❑ Mental Disease
- ❑ Migraine
- ❑ Pulmonary Disease (Lung)
- ❑ Kidney Disease
- ❑ Thyroid Disease
- ❑ Tuberculosis

LIST OTHER ILLNESSES:

	IF LIVING Health Status				Known Illnesses	AGE AT DEATH	IF DECEASED Cause of Death
	AGE	GOOD	FAIR	POOR			
Father							
Mother							
Brothers							
Sisters							

Form No. 0023B-4 Rev. 01/12

Josephson Wallack Munshower Neurology PC

Comprehensive Neurological Expertise
Compassionate Patient Care

REVIEW OF SYSTEMS

Name: _____ Date: _____

Do you have now or have you had witin the past year?

Weight loss/ Appetite Change	YES	NO
Thyroid problems	YES	NO
Fevers/Chills	YES	NO
Sinus problems	YES	NO
Vision problems	YES	NO
Hearing problems	YES	NO
Seasonal or environmental allergies	YES	NO
Neck Pain	YES	NO
Back Pain	YES	NO
Joint Pain	YES	NO
Chest Pain	YES	NO
Rashes	YES	NO
Diabetes	YES	NO
Breathing problems	YES	NO
Heart disease	YES	NO
High blood pressure	YES	NO
Kidney problems	YES	NO
Stomach problems	YES	NO
Bowel Problems	YES	NO
Nausea/Vomiting	YES	NO
Anemia	YES	NO
Depression	YES	NO
Psychiatric problems	YES	NO
Cancer	YES	NO
Stroke	YES	NO
Seizures	YES	NO
Headaches	YES	NO
Gynecologic Problems	YES	NO

Patient Signature: _____ **Date:** _____

JWM REGISTRATION INFORMATION (CONTINUED)
RACE, ETHNICITY, AND PRIMARY LANGUAGE
(Requested at the Direction of the Federal Government)

Patient Name:_____ **Date:** _____

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Other Pacific Islander
- ☐ More Than One Race
- ☐ Do Not Want to Disclose

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Do Not Want to Disclose

Primary Language:

- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Brazilian Portuguese
- ☐ Chinese
- ☐ Chinese (Cantonese)
- ☐ Chinese (Mandarin)
- ☐ Croatian
- ☐ Czech
- ☐ Danish
- ☐ Dutch
- ☐ English
- ☐ Farsi
- ☐ Filipino
- ☐ Finnish
- ☐ French
- ☐ French Canadian
- ☐ French Creole
- ☐ German
- ☐ Greek

Primary Language (continued)

- ☐ Gujarati
- ☐ Hebrew
- ☐ Hindi
- ☐ Hmong
- ☐ Hungarian
- ☐ Indian
- ☐ Japanese
- ☐ Khmer
- ☐ Korean
- ☐ Lao
- ☐ Maori
- ☐ Mien
- ☐ Navajo
- ☐ Norwegian
- ☐ Oromo
- ☐ Other
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Slovak
- ☐ Somali
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Tigrinya
- ☐ Turkish
- ☐ Ukrainian
- ☐ Undefined
- ☐ Urdu
- ☐ Vietanmese
- ☐ Visayan
- ☐ Yiddish