

NEUROLOGY CENTER OF VIRGINIA

PATIENT NAME: _____

DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Do you have any of the following complaints in the past one month?

GENERAL

Fever Yes No
Chills Yes No
General Weakness Yes No
Aches/Pains Yes No
Swollen Glands Yes No
Other _____ Yes No

EAR, NOSE & THROAT

Discharge from Ears Yes No
Hearing Difficulty or Deafness Yes No
Buzzing or Ringing in Ears Yes No
Nosebleeds not due to Injury Yes No
Sinus Trouble Yes No
Difficulty Swallowing Yes No
Mouth, Tooth or Tongue Problem Yes No
Persistent Hoarseness Yes No
Other _____ Yes No

HEART (CARDIOVASCULAR)

Heart Murmur Yes No
Abnormal EKG Yes No
Enlarged Heart Yes No
Heart Attack Yes No
Rheumatic Fever Yes No
Angina Yes No
High Blood Pressure Yes No
Fluttering of Heart Yes No
Chest Pain or Pressure Attacks Yes No
Swollen Ankles Yes No
Leg Cramps Yes No
Other _____ Yes No

LUNGS (PULMONARY)

Shortness of Breath Yes No
Exercise Intolerance Yes No
Frequent Coughs Yes No
Coughing up Blood Yes No
Wheezing Yes No
Other _____ Yes No

NEUROMUSCULAR

Weakness in Arm or Leg Yes No
Difficulty with Balance Yes No
Dizzy Spells Yes No
Fainting Spells Yes No
Speech Difficulty Yes No
Headache Yes No
Memory Loss Yes No
Other _____ Yes No

KIDNEY (URINARY)

Blood in Urine Yes No
Pain or Burning while Urinating Yes No
Difficulty Passing Urine Yes No
Difficulty Controlling Urine Yes No
Getting Up at Night to Urinate Yes No
Other _____ Yes No

BLOOD (HEMATOLOGIC)

Anemia Yes No
Easy Bruising Yes No
Other _____ Yes No

GASTROINTESTINAL

Poor Appetite Yes No
Indigestion or Heartburn Yes No
Nausea or Vomiting Yes No
Vomiting Blood Yes No
Abdominal Pain or Cramps Yes No
Abdominal Swelling Yes No
Diarrhea Yes No
Constipation Yes No
Change in Bowel Habits Yes No
Pass Blood from Rectum Yes No
Black, Tar-Like Bowel Movements Yes No
Other _____ Yes No

BONES-JOINTS (MUSCULOSKELETAL)

- Painful Joints Yes No
- Swollen Joints Yes No
- Loss of Muscle Strength Yes No
- Lump on Bone Yes No
- Back Pain Yes No
- Other _____ Yes No

ENDOCRINE (GLANDS)

- Thirsty all the time Yes No
- Cold most of the time Yes No
- Too Warm most of the time Yes No
- Unusually Tire or Sluggish Yes No
- Unusually Jumpy or Nervous Yes No

EYES

- Double Vision Yes No
- Loss of Vision Yes No
- Seeing Flashes Yes No
- Floater or Spots Yes No
- Temporary Loss of Vision Yes No
- Pain in Eyes Yes No
- Other _____ Yes No

WOMEN

- Breast Lump Yes No
- Discharge from Nipple Yes No
- Other Breast Problems Yes No
- Vaginal Discharge Yes No
- Vaginal Bleeding or Spotting Yes No
(Not Associated with Periods)
- Hot Flashes Yes No
- Pain with Intercourse Yes No
- Possibly Pregnant Yes No
- Change in Periods Yes No
- Pain Associated with Periods Yes No
- Other _____ Yes No

MEN

- Breast Lump Yes No
- Discharge from Penis Yes No
- Sore on Penis Yes No
- Lump in Testicles Yes No
- Difficulty having Erections Yes No
- Other _____ Yes No

PSYCHOLOGIC

- Do you find your life?
 - Generally Unsatisfactory Yes No
 - Too Demanding Yes No
 - Boring Yes No
 - Satisfactory Yes No
 - Other _____ Yes No
- Do you?
 - Cry Easily Yes No
 - Often Feel Depressed Yes No
 - Feel Anxious or Upset Yes No
- Have you ever?
 - Considered Suicide Yes No
 - Attempted Suicide Yes No

Reviewed with Patient: _____ **Date:** _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Neurology Center of Virginia, LLC (NCV) is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. NCV will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by the NCV, as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: With your consent, NCV may use and disclose your health information for the following purposes.

TREATMENT: NCV may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your attending physician, consulting physician(s), nurses, technicians, medical students, and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. NCV also may disclose your health information to people outside NCV who may be involved in your medical care after you leave NCV, such as family members, clergy and others used to provide services that are part of your care. Other ways we may use or disclose your health information for purposes related to treatment are:

- Treatment Alternatives: To tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Appointment Reminders: To contact you as a reminder that you have an appointment for treatment or medical care at NCV.

PAYMENT: NCV may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record, which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used. We may also provide payment information to other care providers who have been involved in your care, e.g., an ambulance company.

ROUTINE HEALTHCARE OPERATIONS: NCV may use and disclose your health information during routine healthcare operations, including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of NCV, medical research and educational purposes. NCV may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the "business associates" of NCV. NCV may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on NCV's behalf. Examples of business associates, include, but are not limited to, a copy service used by NCV to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. NCV requires the business associate to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: NCV may not disclose your health information to persons outside of NCV for purposes other than treatment, payment or healthcare operations without your authorization. In addition, NCV may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to NCV.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT:

FAMILY/FRIENDS: NCV may disclose your health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends of your condition and that you are in the Hospital. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES REQUIRED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION FOR CLINICAL RESEARCH: Under certain circumstances NCV may use and disclose your health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

REGULATORY AGENCIES: NCV may disclose your health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: NCV may disclose your health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, NCV may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, NCV is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well being of the general public.

WORKERS' COMPENSATION: NCV may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: NCV may disclose your health information as required by military command authorities, if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: NCV will disclose your health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION: Although all records concerning your treatment obtained at NCV are the property NCV, you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request NCV only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by your physician or by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. If we are able to agree to your request, we will abide by the restrictions.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

RIGHT TO REVOKE CONSENT OR AUTHORIZATION: You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact:

NCV
2436 Colony Crossing
Midlothian, VA 23112
(804) 302-4400

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with NCV or with the Secretary of the Department of Health and Human Services. To file a complaint with NCV, please contact: (804)-302-4400. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE: NCV will abide by the terms of the Notice currently in effect. NCV reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. NCV will mail any revised Notice to the address indicated on the General Admission Agreement, or Patient Information Forms, or such other address you may provide to us from time to time.

NOTICE EFFECTIVE DATE: The effective date of the Notice is October 1, 2008.

NEUROLOGY CENTER OF VIRGINIA, LLC
CONDITIONS FOR HEALTHCARE SERVICES

Authorization for Medical Treatment:

I authorize and consent to healthcare services including, but not limited to, diagnostic procedures and medical treatment at and by the Neurology Center of Virginia, LLC (hereinafter referred to as "NCV"). I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services.

X _____
Responsible Party Date

Deemed Consent (HIV/Hepatitis):

I understand that if a healthcare provider is exposed to my blood or other body fluids in a manner, which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV, the virus which causes Acquired Immune Deficiency Syndrome) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider and that the Virginia Department of Health will be notified and appropriate counseling provided if the results are positive.

X _____
Responsible Party Date

Medicare Lifetime Signature Agreement (if applicable):

I authorize any holder of medical or other information about me and their agents to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment under Medicare be made either to me or to the provider, physician or other supplier for services or supplies furnished by the provider, physician or other supplier.

X _____
Responsible Party Date

Financial Agreement:

In consideration for healthcare services provided to me by NCV for this and all subsequent services, I, the responsible party, hereby agree to pay all charges in accordance with NCV's regular rates and terms of payment submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care contract organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which may arise during the course of treatment. I assume full financial responsibility for payment of all charges associated with the healthcare services provided to me including any portion of physician charges not paid or not considered to be a covered service by my insurer and/or a third party insurer or other payer. Should my account be referred for collection, I agree to pay all collection costs and expenses, including attorneys' fees and I waive homestead and all other exemptions to such debt. I further agree that any lawsuit to collect sums owed by me/patient shall be brought in the county of Chesterfield.

X _____
Responsible Party Date

Co-Guarantor:

I, _____, understand that by signing this document, I agree to accept financial responsibility for healthcare services provided by NCV to the patient identified below. If the patient is unable to sign at registration, I accept this "Conditions for Healthcare Services" on behalf of the patient.

Co-Guarantor: _____ Date: _____

Signature

SS#: _____ Relationship to Patient: _____

Print Name

Release And Assignment Of Benefits To The Provider:

I, the undersigned responsible party hereby authorize NCV/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I authorize this office and/or its employees to release, via fax machine, medical records that are needed in order to provide the patient with the most appropriate medical care.

In consideration for healthcare services provided to me by NCV for this and all subsequent services, I hereby assign to NCV any and all rights, benefits and claims I may have under any policy of insurance (hospitalization, major medical, automobile, liability, workers compensation and any other) and the proceeds from any claim that I may have for injuries. Such assignment hereby authorized direct payment to NCV under and /or from any such policy of insurance or proceeds.

X _____
Responsible Party Date

Notice Of Privacy Practices:

I, the undersigned have received a copy and understand the Privacy Practices of the Neurology Center of Virginia, LLC.

X _____
Responsible Party Date

Neurology Center of Virginia, LLC may disclose my health care information to:

NAME: _____ RELATIONSHIP: _____

This authorization is effective from _____ to _____ and includes only personal health information pertaining to Neurology Center of Virginia, LLC and its providers.

X _____
Responsible Party Date

I certify that I have reviewed this document in full, understand its terms and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked by NCV.

Patient: _____
Print Name

Signature

Date: _____

Unable to Sign at Registration: Reason _____

Patient Received Above Information: Yes No

NCV Representative: _____ Date: _____
Print Name Signature

- Patients with Health Plans, please present your insurance ID Card and photo ID to the Front Desk after completing this form.
- Some contract Health Plans (HMO, PPO, IPA, etc) require a copayment or deductible at the time of service. All copayments and deductibles are due at the time of service.