

Montgomery Office

10550 Montgomery Road
Suite 34
Cincinnati, Ohio 45242

Direct: (513) 322-7300
Fax: (513) 322-7307

Dear

Thank you for choosing the **Riverhills Interventional Pain Management Division** to assist in your treatment. The following are important steps that must be taken to help us address your clinical concerns in the most comprehensive and efficient manner possible.

1. **Registration:**

You may have already completed the registration process when you scheduled your appointment. If you have made any changes such as address, phone number, etc., or need to cancel or change your appointment, please call (513) 322-7300.

2. **Questionnaire:**

Having this information ahead of time allows us to devote as much time as possible to your clinical concerns and to help solve your health-related problems. **Please return the completed questionnaire to our office via mail, secure fax line (513) 322-7307 or in person at least 3 business days prior to your initial appointment. Failure to do so may result in a prolonged wait or your appointment being rescheduled.**

3. **Prior Testing:**

For your evaluation to be complete, it is necessary for you to bring all prior testing pertaining to the problems for which you are being seen. **This includes the ACTUAL films or CD of the images, as well as written reports and any other testing information associated with your current clinical concern.**

4. **Insurance:**

Some insurance plans require a referral from your primary care doctor. **It is your responsibility to obtain this referral, or to assume responsibility for services that may not be paid without such a referral.** You must also sign the "Patient Consent and Financial Responsibility" form outlining our financial policies.

www.RiverhillsNeuro.com

RESPONSIBLE PARTY INFORMATION (if patient is a minor provide parent info)

Name _____ Relationship to patient _____

Soc Sec # _____ **Date of Birth** _____ **Phone #** _____

E-mail Address _____ **Cell Phone #** _____

Address _____ City _____ ST _____ Zip _____

Employer & Address _____ Work # _____

 Yes, I would like to receive information and updates via email.

PATIENT INFORMATION

Patient Name _____ Home Phone # _____

Address _____ City _____ ST _____ Zip _____

Soc Sec # _____ **DOB** _____ **Age** _____ **Sex** _____ **Marital Status** S M W D SEP

Occupation _____ **Cell Phone #** _____ **E-mail** _____

Patient' Employer _____ Work # _____

Work Address _____ City _____ ST _____ Zip _____

Spouse's name or Both Parents _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

INJURY INFORMATION (if applicable)

Is this (circle) Work Related Auto Accident Other Accident

Date of injury/onset _____ How did injury happen _____

Area to be treated _____ Were X-rays/MRI taken _____ Where _____ When _____

Off work due to this injury YES NO If YES, first date missed _____

Insurance carrier _____ Address _____ City/ST/Zip _____

Phone # _____ Fax # _____ Contact Person _____

Claim # _____ Injury occurred in (circle) Kentucky Ohio Other

INSURANCE INFORMATION
Primary Insurance

Insurance Name _____

Address _____

Phone # _____

Policy No _____

Group No _____

Subscriber Name _____

Soc Sec # _____

Date of Birth _____

Employer _____

Secondary Insurance

Insurance Name _____

Address _____

Phone # _____

Policy No _____

Group No _____

Subscriber Name _____

Soc Sec # _____

Date of Birth _____

Employer _____

Allergies _____ History of Metal/Schrapnel _____ Smoker _____

Pharmacy _____ Phone # _____ Address _____

Family Phy (first/last) _____ Address _____ Phone # _____

Referring Phy (first/last) _____ Address _____ Phone # _____



**Interventional Pain Management
and Spine Treatment**
Please answer completely

PATIENT QUESTIONNAIRE

Your Name :

Your Date of Birth:

(Check, circle, or write in all that apply to you)

Referring MD:

Primary Care MD:

Describe the pain or discomforting symptoms you are experiencing. _____

Describe your pain: aching burning cramping cutting dull excruciating grinding increasing
(circle all that apply) intense intolerable itching just tolerable like an electric shock moderate
numb piercing pulsing severe sharp shooting squeezing
stabbing stinging strong throbbing tingling uncomfortable weak

When did your pain start? (month/year) _____ Did it increase recently? ___ Yes ___ No

How did the pain start? ___ Auto accident ___ Work related ___ Following surgery ___ Fall
___ Just Started ___ Other _____

When does your pain occur? ___ constant ___ intermittent (off & on) ___ early AM ___ PM
___ at rest ___ walking ___ sitting ___ standing ___ lying down

Do you have numbness/tingling? No (Yes in _____ Right Left)

Does your pain move to other parts of your body? No (Yes Neck to arm Right Left
 Back to leg Right Left

How many times a night do you wake up because of pain? _____

Circle the numbers below that best describe how pain has interfered with your daily functioning
0 = Does not interfere 10 = Completely interferes

General activity	0	1	2	3	4	5	6	7	8	9	10
Walking ability	0	1	2	3	4	5	6	7	8	9	10
Normal work routine (if still working)	0	1	2	3	4	5	6	7	8	9	10
Normal home routine	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
Relations with other people	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10

If 0 = no pain and 10 = the worst pain I can imagine, what is the highest number I can live with and still function.

0 1 2 3 4 5 6 7 8 9 10

ALLERGIES: (please list all other medication, environmental, food allergies)

Have you ever been allergic to: Iodine Xray Dye Shellfish Latex Beestings

I HAVE NO KNOWN MEDICATION ALLERGIES

Medications:	Type of reaction
Environmentals/Food:	Type of reaction
History of allergy testing	Treatment

PAST MEDICAL HISTORY: (Check or circle all that apply to you).

ENDOCRINE: Diabetes (Insulin Oral Meds. Diet Control) Addison's disease
 Thyroid Disease (Low High) No issues or symptoms in this area

LUNGS: COPD Emphysema Asthma: Last attack was _____ History of TB
 Sleep Apnea Uses C PAP at night No issues or symptoms in this area

CARDIAC/CIRCULATION: High Blood Pressure Angina History of MI, when _____
 Cardiac Stents # _____ Carotid Artery Disease Shunts Pacemaker Defibrillator
 Artificial valve Coronary Artery Disease Peripheral vascular disease (PVD) - Legs
 No issues or symptoms in this area

HEMATOLOGY/INFECTIOUS DISEASE: Anemia History of Hepatitis (A B C) HIV/AIDS
 No issues or symptoms in this area

GASTROINTESTINAL: Liver Disease Gallbladder Disease Heartburn Reflux GERD
 Hiatal Hernia Esophageal Stricture No issues or symptoms in this area

UROLOGIC: Kidney Disease _____ No issues or symptoms in this area

NEURO: Stroke, when _____ Alzheimer's disease Parkinson's disease Multiple Sclerosis
 No issues or symptoms in this area

SKIN: Psoriasis Shingles No issues or symptoms in this area

Cancer History No History of Cancer
 Type _____ Date(s): _____
 Treatment: Surgery _____ Radiation Chemotherapy

PSYCHOSOCIAL HISTORY

I live : alone with spouse with significant other
 Parent(s) other relative _____ Friend(s)
 Children # ___ Ages _____
 Grandchildren # ___ Ages _____

My residence is: House, condo, apartment Retirement Facility
 Assisted Living Nursing Care Facility Shelter
 Other _____

Are you working at this time? ___ Yes ___ No ___ Retired ___ Workers' Comp ___ Disabled

Your current occupation or occupation before retired or disabled: _____

Primary language _____

Is a lawyer involved with your pain situation? ___ Yes ___ No Name : _____

Tobacco:
 Never
 Former - Stop Date: _____
 Use Smokelss Tobacco

Alcohol:
 Never
 Former - Stop Date: _____

Marijauna/ Recreational Drugs:
 Never
 Former/Stop Date: _____
 What was used? _____

Current Smoker
 How much/day? _____
 How many Years? _____

Current Drinker
 Rare
 Occasional
 Drinks /day
 Drinks/ week

Current User
 Marijuana
 Other: _____

FAMILY HISTORY

Have Parents, Grandparents or Siblings had any of the following medical conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> No signifcant family history | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain Syndromes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neuropathy | _____ |

What Tests or Diagnostic Studies have you had related to your problem?

MRI(s)	When	Where
<input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder		
CT Scan		
Xrays		
Myelogram		
EMG/Nerve Conduction		
Bone Scan		
Other		

Previous Treatments you have had for this problem:

- | | | |
|--|--|---|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> TENS | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Aquatic therapy | <input type="checkbox"/> Home exercise | <input type="checkbox"/> Massage therapy |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Pain Psychologist | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Decompression Therapy | <input type="checkbox"/> Nutrition counseling | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Pain Management- Name of MD or Clinic _____ | |
| <input type="checkbox"/> Injections or nerve blocks-
When? _____
How Many? _____
What Type? _____ | | |

List all medicines you have tried in the past for this condition that you are no longer taking that were not helpful or caused intolerable side effects (Prescription and over-the-counter).

Surgical History (List all past surgeries and Dates)

MD Notes:

What Medicines are you currently taking?

(Please include all prescriptions, over-the-counter medicines, herbals, vitamins, and natural products.)

<u>Name of Medicine</u>	<u>Dose/Frequency</u>	<u>Reason taking</u>	<u>Prescribing MD</u>
-------------------------	-----------------------	----------------------	-----------------------

Nurses Notes:

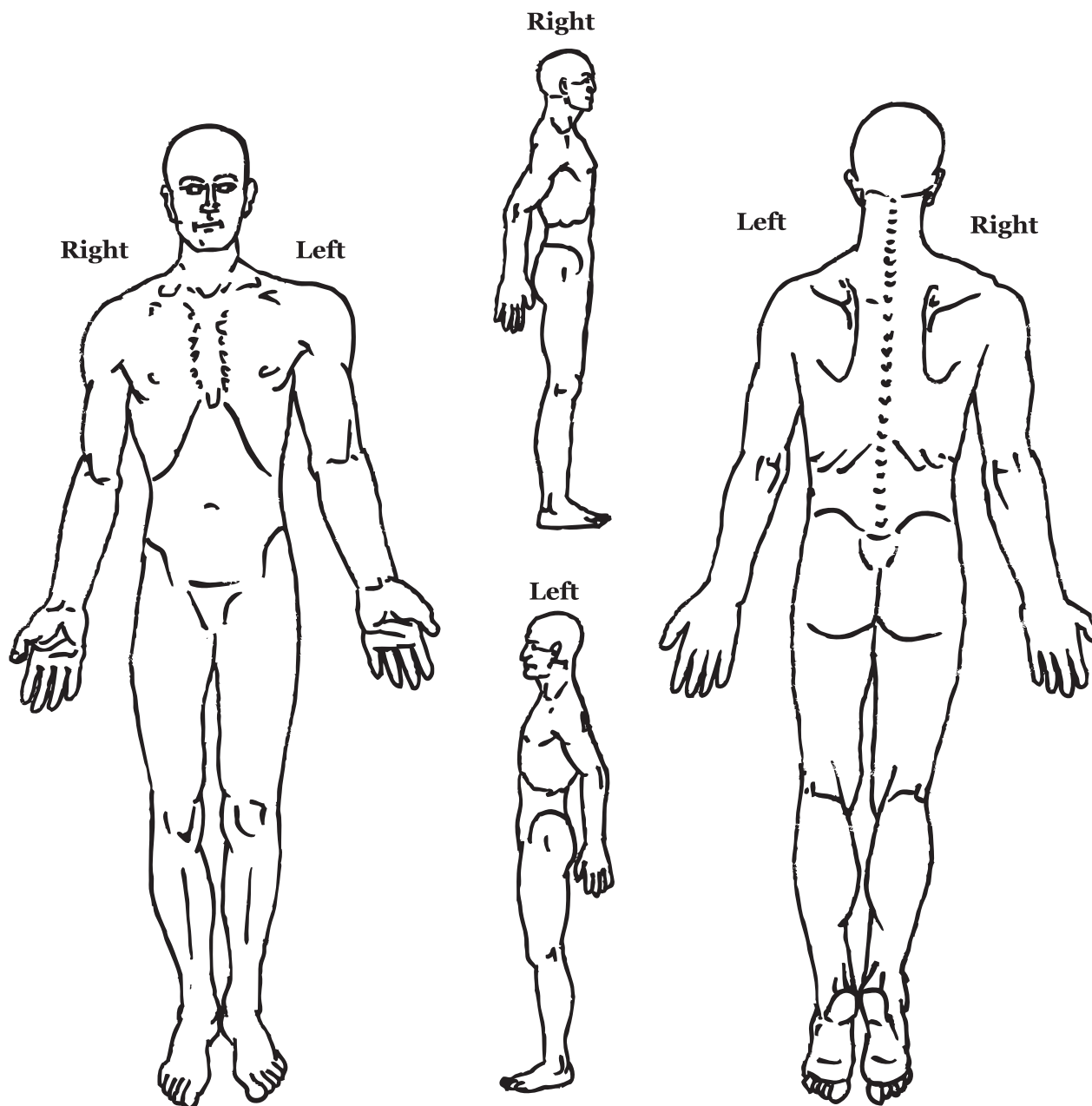
Temp. _____ BP _____ / _____ P _____ R _____

WT _____ HT _____

Current Pain Score or Average Pain / Discomfort Level _____

PAIN MAP

Please shade/draw in where your pain is located on the figures below.



REVIEW OF SYSTEMS (Check or circle all that apply to you).

Constitutional		
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Other _____	<input type="checkbox"/> Recent weight loss ____ lbs.	<input type="checkbox"/> Chronic Fevers
	<input type="checkbox"/> Recent weight gain ____ lbs.	

Eyes		
<input type="checkbox"/> Cataracts	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Glasses / Contacts
<input type="checkbox"/> Other _____	<input type="checkbox"/> Blurred Vision	

Head, Ears, Nose, Throat (HENT)		
<input type="checkbox"/> Hearing loss (Right / Left)	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> Nasal Septal Deviation
<input type="checkbox"/> Hearing aid (Right / Left)	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Ringing/Buzzing/Chirping	<input type="checkbox"/> Dentures (Upper / Lower)	(Seasonal / All Year)
<input type="checkbox"/> Other _____	<input type="checkbox"/> Partial (Upper / Lower)	

Cardiovascular		
<input type="checkbox"/> Chest Pain-last episode ____	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> History Blood Clots
<input type="checkbox"/> History of Rheumatic Fever	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Irregular Heartbeat	
Have you ever fainted or passed out with needles or procedures? Yes / No		
Do you take Blood thinners? Yes / No		
If yes, <input type="checkbox"/> Coumadin <input type="checkbox"/> Plavix <input type="checkbox"/> Pletal <input type="checkbox"/> Lovenox <input type="checkbox"/> Effient		
Name of MD managing Blood thinner _____ Phone # _____		

Respiratory (Lungs and Breathing)		
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> Home Oxygen
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Snoring	

Gastrointestinal		
<input type="checkbox"/> History of Ulcer (date) _____	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> Chronic Diarrhea
<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Irritable Bowel Syndrome(IBS)	<input type="checkbox"/> Chronic Constipation
<input type="checkbox"/> Lap Band	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Colostomy
<input type="checkbox"/> Bleeding stomach/bowels	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ileostomy
<input type="checkbox"/> Other _____	<input type="checkbox"/> Ulcerative Colitis	

GenitoUrinary		
<input type="checkbox"/> Kidney pain	<input type="checkbox"/> I have no issues or symptoms in this area	<input type="checkbox"/> LMP _____
<input type="checkbox"/> Burning	<input type="checkbox"/> History of Kidney Stone	<input type="checkbox"/> Post Menopausal
<input type="checkbox"/> Urgency	<input type="checkbox"/> Chronic Infections	<input type="checkbox"/> Hysterectomy, when _____
<input type="checkbox"/> Frequency	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Uterine Ablation
<input type="checkbox"/> Hesitancy	<input type="checkbox"/> Ureterostomy	<input type="checkbox"/> Birth Control (Type) _____
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Prostate Enlargement	<input type="checkbox"/> Tubal Ligation
	<input type="checkbox"/> Sexual Difficulty	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Catheter (Type) _____	

Skin (Integument)		
<input type="checkbox"/> Eczema <input type="checkbox"/> Sores <input type="checkbox"/> Rash <input type="checkbox"/> Bruises <input type="checkbox"/> Cellulitis	<input type="checkbox"/> I have no issues or symptoms in this area <input type="checkbox"/> Cuts <input type="checkbox"/> Burns <input type="checkbox"/> Incision <input type="checkbox"/> Itching <input type="checkbox"/> Other _____	<input type="checkbox"/> Dry Skin <input type="checkbox"/> Lumps <input type="checkbox"/> Ulcers <input type="checkbox"/> Abscess

Neurological		
<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches (How often) _____ <input type="checkbox"/> Seizures, last seizure _____ <input type="checkbox"/> TIA <input type="checkbox"/> Numbness(Location) _____	<input type="checkbox"/> I have no issues or symptoms in this area <input type="checkbox"/> Paralysis(Right /Left) <input type="checkbox"/> Weakness(Right /Left) <input type="checkbox"/> Problems with Speech <input type="checkbox"/> Tremors <input type="checkbox"/> Confusion <input type="checkbox"/> Tingling (Location) _____	<input type="checkbox"/> Problems with memory <input type="checkbox"/> History of Head Injury (Date) _____ <input type="checkbox"/> History of falls <input type="checkbox"/> Incoordination <input type="checkbox"/> Other _____

Musculoskeletal		
<input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> other pain(Location) _____ <input type="checkbox"/> Arthritis (Rheumatoid / Osteo) <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> I have no issues or symptoms in this area <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Joint replacement (Location) _____	<input type="checkbox"/> Amputation (Location) _____ <input type="checkbox"/> Artificial limb (Location) _____ <input type="checkbox"/> Other _____

Endocrine		
<input type="checkbox"/> Excessive thirst / urination	<input type="checkbox"/> I have no issues or symptoms in this area <input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Other _____

Psychological		
<input type="checkbox"/> History of depression <input type="checkbox"/> ADHD <input type="checkbox"/> History of abuse by another person (Past / Current) <input type="checkbox"/> Suicidal thoughts / attempts, when _____ <input type="checkbox"/> Seeing psychologist/psychiatrist(Name) _____	<input type="checkbox"/> I have no issues or symptoms in this area <input type="checkbox"/> History of Bipolar Disease <input type="checkbox"/> History of Schizophrenia	<input type="checkbox"/> Anxiety <input type="checkbox"/> Panic Attacks

Hematologic/Lymphatic		
<input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Blood disorder _____	<input type="checkbox"/> I have no issues or symptoms in this area <input type="checkbox"/> Lymph Node Swelling <input type="checkbox"/> Factor deficiency (type) _____	<input type="checkbox"/> Other _____

Information is complete and accurate.

Patient Signature: _____

Signature of person completing forms: _____

For: (Patient Name) _____

Pain Medication Treatment Agreement

Patient's Name: _____

Patient's DOB: _____

The goal of pain treatment is to reduce pain, increase ability to function/work, and improve quality of life.

I recognize that I the patient or the person, of whom I am legal guardian, may be treated with potent medications, which are considered controlled substances by local, state and federal agencies. Controlled substances are regulated by the Federal Government to prevent abuse and overuse. While patients are expected to use medications correctly, Riverhills also feels obligated to closely monitor medication usage.

I understand that possible complications of pain medication therapy includes addiction, chemical dependence, constipation, which could be severe enough to require medical attention, difficulty with urination, drowsiness or reduced mental alertness, nausea, itching, depressed respirations, (and an overdose can cause respiratory arrest and death) reduced sexual dysfunction, and other complications which may be discussed with me by my physician. I understand that the use of pain medication could possibly impair my ability to drive a motor vehicle or use machinery. If I experience any side effects that impair my ability to operate machinery or a motor vehicle, I agree that I will not do so and will report this to my physician.

I understand that if I take more medications than what is prescribed, a dangerous situation could result, such as coma, organ damage, respiratory arrest or even death. I understand that if I run out of my medications too soon, or if my medication is stopped suddenly that I could have pain medication withdrawal symptoms, which can be very uncomfortable and dangerous.

I therefore agree to follow the conditions listed below:
(INITIALS REQUIRED AFTER EACH STATEMENT)

* I am responsible for my controlled substance medications. I am responsible for taking the medication in the dose prescribed and for monitoring the amount of medication left. I understand that Schedule II prescriptions (OxyContin, Percocet, etc.) will be written only during an office visit. By law, Schedule II prescriptions cannot be mailed or called in.

initials

* I may not request nor accept controlled substance medications from any other physician or individual (for the condition I am being treated) while I am receiving such medications from Riverhills Neuroscience.

initials

* I understand that if I run out of controlled substance medication sooner than prescribed, I will not be given a refill until the scheduled time, and that it will be my responsibility to seek emergency care.

_____ initials

* I agree to comply with regularly scheduled office visits.

_____ initials

* I agree not to take or ingest any illegal substances and agree to refrain from using alcohol.

_____ initials

* I understand that the physician is not obligated to replace prescriptions that are lost or stolen.

_____ initials

* I understand that I may be selected for a random drug test to verify the dosage prescribed medication in my system and/or for any type of illicit drug. If an illicit drug is positive in the screening, I may be dismissed from Riverhills Neuroscience. I am responsible for the payment coverage of this testing.

_____ initials

* I understand that if I violate any of the above conditions, my relationship with Riverhills Neuroscience may be terminated. It will be my responsibility to seek care elsewhere.

_____ initials

Please note:

- A 24-hour advance notice is required for refills.
- Refill requests must be phoned in during office hours of 9:00 a.m. to 4:30 p.m. Monday through Friday.
- Refill requests are not permitted during nights, holidays or weekends.
- When permitted, refills will be telephoned to your pharmacy, so please have your pharmacy telephone number available when calling RHN.

To further emphasize the importance of communication with your physician RHN feels it is necessary to inform you of the current laws in place to prevent patients from obtaining medications from different physicians.

It can be a serious offense to receive prescriptions from two separate physicians without both of the physician's prior knowledge. It is important for you as the patient to communicate all treatment/prescriptions received from other physicians. A patient does not have to intentionally hide this fact in order to be found in violation of the law. Silence can be considered deception and therefore an offense.

**SIGN
HERE**

Patient Signature: _____

Date: _____

Print Name: _____

DOB: _____

Witness: _____

Date: _____



Patient Financial Policy

Thank you for choosing Riverhills Neuroscience to provide your neurologic health care needs. We are dedicated to providing you with quality medical care and we value our relationship with you. The following information details our patient payment and administrative services policies.

Patient Payment Policy

Insured Patients

Patients are expected to pay their full co-pay and any balance due at the time of service. Failure to pay your full co-pay and balance due at the time of service will result in your being assessed a \$15.00 Service Fee. I understand that Riverhills Neuroscience may verify insurance coverage and benefits prior to services being rendered and that any out of pocket expenses, to include but not limited to co-payments, co-insurance, deductibles and non-covered services, will need to be paid at the time services are rendered. You will receive a statement for any balance due. If there is an overpayment a refund to you will be issued in a timely manner. Insured patients are responsible for charges incurred, regardless of whether their insurance company pays or not.

Self Pay Patients

For self pay patient office visits, the typical charge is \$200 to \$530 depending on the level of service. The standard amount to be paid at the time of service is \$200. If a procedure is to be performed during the visit, an additional estimated amount for that service is due at the time of service. You will receive a statement for any balance due. If there is an overpayment a refund to you will be issued in a timely manner.

If you find yourself in a position of financial hardship and are unable to comply with the Patient Payment Policy, please speak with a member of our billing staff to discuss payment plans and options moving forward. Understand that you are responsible for all charges incurred. Failure to comply will result in your account being sent to a collection agency.

Administrative Services Policy

Riverhills Neuroscience physicians will, on occasion, provide administrative services to patients. These services are non-covered services that are not billed to any insurance policy. The list of services does not include “medically necessary treatments” or other “covered” expenses. The following table outlines administrative services that may be provided and the corresponding fee associated with such services. We will expect prompt payment at the time the service is requested.

Disability Placard	\$10.00
Disability Form	\$35.00
Life Insurance Form	\$35.00
FMLA Form	\$35.00
Narrative Report	\$500.00
Functional Capacity Report	\$100.00
Service Form (Duke, Cincinnati Bell, etc.)	1 st form @ no charge, each additional form @ \$35.00
Medical Records	No charge for first copy of medical records. Additional requests will be charged the allowable charge per page based on Ohio Law at the time of the request.



Patient Consent and Financial Responsibility

I authorize Riverhills Neuroscience to submit claim(s) to my health insurance carrier(s) and their agents, whether private or governmental, for all services rendered by Riverhills Neuroscience physicians or other providers involved in my care. I authorize Riverhills Neuroscience to act on my behalf in pursuing and appealing benefit determinations by my insurance carrier. I hereby authorize, request and direct my health insurance company or third party payer of record to release my pharmaceutical history and to pay directly to Riverhills Neuroscience.

I also authorize Riverhills Neuroscience to release all medical, psychiatric, psychological and/or other pertinent information to my health insurance carrier(s) and their agents in order to collect any claim(s) for payment, and to any physician or provider involved in my care, including healthcare professionals not employed by Riverhills Neuroscience to whom I am referred for my care or who have referred me to Riverhills Neuroscience for care. This information may also be released to any third-party payers, benefit administrators and guarantors for payment of services, verification of benefits, to determine necessity and appropriateness of services, for authorization of services, to process claims for benefits and/or hearings or appeal processes regarding payment for treatment expenses, including, but not limited to, Medicaid's hearing and appeal process.

Lastly, my information may be released to any outside entity, under an obligation of confidentiality that may be performing a review of records to assure compliance with applicable laws and accreditation requirements or to assure quality treatment or to determine my eligibility to enroll in a clinical trial. This may include the information regarding diagnoses, drug and/or alcohol related conditions and psychiatric and psychological conditions.

By signing below, I accept and acknowledge financial responsibility to Riverhills Neuroscience for services rendered and I assign insurance benefits to Riverhills Neuroscience for services rendered.

PAYMENT UP FRONT

I understand that in accordance with law, as well as many participation agreements with third-party payers, Riverhills Neuroscience does not waive, fail to collect, or discount co-payments, deductibles, coinsurance, or other patient financial responsibility. I understand that Riverhills Neuroscience may verify insurance coverage and benefits prior to services being rendered and that any out of pocket expenses, to include but not limited to co-payments, co-insurance, deductibles and non-covered services, will need to be paid at the time services are rendered. I agree to pay a \$15.00 "Service Fee" for failure to pay my full co-pay and balance due at time of service. I further agree to pay Riverhills Neuroscience a \$24.00 "No Show Fee" for failure to provide 24 hours notice for a missed office appointment or \$100.00 for a missed procedure appointment.

INSURANCE FOLLOW-UP

I understand that I am responsible for charges incurred regardless of whether my insurance pays or not.

PAST DUE BALANCES

I understand that any balance not paid upon receipt of an initial statement is considered past due and will be subject to interest at the rate of 7% per annum. I understand that past due balances will be placed with a professional collection agency and reported to a credit bureau. I will be responsible for collection fees, interest, attorney fees, and other cost incurred. *I also understand that if I have a past due balance, I may not be able to schedule appointments and/or may be discharged from the practice.*

I understand that the information contained in this form will be used when submitting claims for payment and I certify that such information is correct. I permit a copy of this authorization to be used in place of the original and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying Riverhills Neuroscience of any pre-certifications, referrals or co-payments required by my insurance company.

I reviewed the Patient Financial Policy and understand and agree to the terms.



Signature: _____ **Date:** _____

Print Name: _____

Dear Patient:

The government has issued regulations requiring physicians to meet guidelines for the use of electronic health records. One of the regulations requires physicians to report the Race, Primary Language and Ethnicity for each of his/her patients.

To assist us with the one-time collection of this information, please check the appropriate boxes below. Thank you for your help.

Race: Select one or more

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Declined |

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Declined

Primary Language:

- | | | |
|-----------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Hindi | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Italian | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Japanese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> French | <input type="checkbox"/> N/A | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> German | <input type="checkbox"/> Other | <input type="checkbox"/> Declined |
| <input type="checkbox"/> Greek | | |

Preferred Communication:

- Mail
- Phone
- Email: _____



Patient Signature: _____

Date: _____

Print Name: _____

DOB: _____

HIPAA Privacy Practices Acknowledgement Form

I acknowledge that I have read the attached information, which includes the rights and responsibilities of both Riverhills Neuroscience and myself, as it pertains to confidentiality of medical information. I have received a copy of this privacy policy on this date.

Patient Health Information Disclosure

The HIPAA privacy rule was created to give individuals the right to restrict the release of their medical information and to designate to whom their information may be given. If so desired, the patient may request confidential communications of Riverhills (protected health information) and/or designate where this information should be sent, such as home or office.

The physicians and staff of Riverhills Neuroscience may contact me in the following manner:
(Please check all that apply)

Home Telephone: _____
 Yes. You may leave information on my home voicemail.

Cellular Telephone: _____
 Yes. You may leave information on my cellular voicemail.

Work Telephone: _____
 Yes. You may leave information on my work voicemail.

Written communication.

Mail to my home address.

Email to: _____

Your Private Health Information (PHI) may be released to the following:

**SIGN
HERE**

Patient Signature: _____

Date: _____

Print Name: _____

DOB: _____

This disclosure authorization remains in effect until revoked by the patient.