Tidewater Neurologists, Inc. &
Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PATIENT REGISTRATION

SLEEP DISORDER CENTERS

3235 Academy Avenue Suite 305 Portsmouth, VA 23703 Tel. 757-686-9300 Fax 757-686-1514	300 Medical Parkway Suite 108 Chesapeake, VA 23320 Tel. 757-549-8800 Fax 757-547-8180	2713 Magruder Blvd Suite G3 Hampton, VA 23666 Tel. 757-262-0390 Fax 757-262-0391	4480 Holland Office Park Bldg 2, Suite 225 Virginia Beach, VA 23452 Tel. 757-228-5801 Fax 757-228-5063

Date:_____ Account #_____

Name:_____ SS# _____ Age:_____

Please write name EXACTLY as it appears on your insurance card.

DOB:_____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D

Race: _____

(American Indian / Asian / Black / Hispanic / Latino / Native Hawaiian / White / Unreported or Refused to Give)

Ethnicity: _____

(Hispanic / Latino - Non-Hispanic/Latino - Unreported or Refused to Give)

Preferred Language: _____

(English / American Sign / Arabic / French / German / Hindi / Urdu / Japanese / Mandarin / Portuguese / Russian / Spanish)

Address: _____

City: _____ State:_____ Zip Code: _____

Home #: _____ Cell #: _____

Email:_____

Responsible Person for this Visit:_____

Please list name of SUBSCRIBER on your insurance card.

Relationship to Patient:_____

Patient or Guardians Employer: _____

Business Address: _____ Business Phone:_____

Emergency Contact

Person: _____ Phone #:_____

Do you have a living will? ☐ Yes ☐ No

Tidewater Neurologists, Inc. &
Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PATIENT REGISTRATION

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

INSURANCE INFORMATION

Primary Insurance Co:_____

Subscriber Name: _____ SS# _____ DOB: _____

Sponsor Name: _____ SS# _____ DOB: _____

Secondary Insurance Co: _____

Subscriber Name: _____ SS# _____ DOB: _____

Sponsor Name: _____ SS# _____ DOB: _____

******PLEASE PRESENT INSURANCE CARDS AND PERSONAL ID WITH THIS REGISTRATION FORM******

Patient Name:_____ Date:_____

MEDICAL INFORMATION

Primary Care Physician: _____ Office #: _____

Address of PCP:_____

Referring Physician: _____ Office #: _____

Preferred Pharmacy: _____ Phone #:_____

Address/Location of Pharmacy:_____

Current List of Medications / Dose / And How Medication Is Taken

_____

_____

_____

_____

_____

Revised: 10-25-16

Tidewater Neurologists, Inc. &
Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

FINANCIAL POLICY

Thank you for selecting **Tidewater Neurologists, Inc. and Sleep Disorder Specialists** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment.

All patients must complete our Patient Registration form and sign **all policies** before seeing the doctor. We also ask that you present your insurance card and a picture ID at each visit and notify us as soon as possible of any changes in your insurance coverage, address and/or telephone numbers. We would like to keep your patient information as current as possible.

- CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH / CREDIT CARDS /OR PERSONAL CHECKS
  (*NOTE: $40.00 FEE IS CHARGED FOR RETURNED CHECKS.)

IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN THE PROPER INSURANCE REFERRALS FOR ALL VISITS

- INSURANCE CLAIMS ARE FILED AS A COURTESY TO OUR PATIENTS

FILLING OUT FORMS:
The charge for filling out forms brought in by patients are (example: employment, disability, life insurance, DMV, etc.)

$10.00 - for one (1) page form
$25.00 - for up to three (3) pages
$40.00 - for four (4) or more pages

The charges for filling out forms is the patient's responsibility and fees are collected before the patient can pick up the forms.

MEDICAL RECORDS:
We have contracted **HEALTH PORT** to copy and send out all requested medical records. If you have any questions about your records any member of our staff can give you Health Port's toll free phone number. There is a charge generated by Health Port for their services.

For Dr. Hemang Shah and Dr. Eric Goldberg's patients access to their medical records is available thru the Patient Portal at http://patientportal.trimedtech.com/tidewaterneurologists.

PARTICIPATION (Insurance):
Tidewater Neurologists, Inc. participate with most health insurance plans including Medicare and Medicaid in the Tidewater area. Each plan has unique rules and regulations that must be followed by patients and physicians. **Please familiarize yourself with the particular benefits and rules of YOUR health care plan, since the contract is between the Patient and their Insurance Carrier.** Below you will find short summaries of how our practice addresses the particular requirement of each patient according to their health insurance coverage. If you have questions about which summary is applicable to you and your health insurance plan, please call our office Monday thru Friday at (757) 686-9300 between 9:00am and 4:00pm.

NOT PARTICIPATION (Insurance):
If your insurance plan is one with which we are not a participating provider, you will be responsible for payment for your visit(s). As a courtesy we will file your insurance claim and have the payment sent directly to you. In the event that your insurance carrier pays directly to our office, we will refund the payment to you as soon as possible.

INSURANCE REFERRALS:
Certain health insurance plans (HMO) require that you obtain a referral from your Primary Care Physician (PCP) before visiting a Specialist's office. It is the patient's responsibility to acquire this referral and keep track of the number of visits allowed and the start and end date of this referral. Alternative payment arrangements or rescheduling of your appointment may be necessary if proper authorization or referral is not obtained.

PRESCRIPTION REFILLS:
All refills require at least 7 days advance notice to be approved by your Doctor and sent into your pharmacy. **Do not wait until you run out of your medication to call in for a refill.**

WORKERS COMPENSATION:
We require approval/authorization by your employer and/or your worker's compensation carrier and your Employer's first report of injury prior to your initial visit. If our claim is denied, you will be responsible for payment in full for all visits.

PERSONAL INJURY:
If you are involved in a personal injury lawsuit or claim, we will bill your medical insurance carrier. In the absence of medical insurance, you will be responsible for payment of services on day of service(s). Tidewater Neurologists, Inc. does not participate in litigation cases.

SELF-PAY:
Payment in full is expected at time of service.

Thank you for understanding our financial policy. Please let us know should you have any questions or concerns.

(Please sign both places below:)

FINANCIAL AGREEMENT

I have read, understand and accept the above financial policy. In the event of non-payment by my insurance carrier for whatever reason, I understand I am responsible for the payment of the balance owed inclusive of any costs of collections, including collection agency fees and attorney fees of 33 1/3 percent of the amount past due and any court costs incurred to collect any amount that is past due.

_____ _____

Patient Signature Date

ASSIGNMENT OF BENEFITS
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits directly to Tidewater Neurologists, Inc.

_____ _____

Patient Signature Date

** This Financial Agreement is in effect as long as you are a patient in this practice.

Tidewater Neurologists, Inc. &
Sleep Disorder Specialists
PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PATIENT NO SHOW/ CANCELLATION POLICY

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

S. HABEEB RAHMAN, M.D.
Diplomate of the American Board of Neurology and Psychiatry

ERIC GOLDBERG, M.D.
Diplomate of the American Board of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN

HEMANG SHAH, M.D.
Diplomate of the American Board of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN
Diplomate of the American Board of Sleep Medicine

Any Patient that fails to show up for a scheduled office appointment without calling the office to cancel the appointment or reschedule the appointment 24 hours in advance, or as soon as possible in an extreme emergency situation will be charted a **$25.00** fee, billed directly to the patient after the "**second**" no show appointment. This charge will be used to help cover the expenses incurred in preparing the patients chart for the office visit. **Your insurance company will not be responsible for this charge.**

We make every effort to make an appointment reminder call to our patients the day prior to the appointment, ***however***, there is no guarantee that we can reach all patients, so please keep up with your re-appointment cards. If we are able to reach our patients cancellations will be acceptable at that time.

The goal of our Physicians and Staff is to provide the most efficient care possible to meet the needs of **ALL** our patients. In order to do this we need to manage our Physicians time as wisely and productively as possible.

We ask the help of all patients in this endeavor and thank you in advance for your help and cooperation.

Sincerely,
Tidewater Neurologists, Inc. and Sleep Disorder Specialists

I have read and understand the Patient No Show / Cancellation Policy.

Patient Signature _____ Date _____

** This Patient No Show/Cancellation Policy is in effect as long as you are a patient in this practice.

Revised: 10-25-16

Tidewater Neurologists, Inc. &
Sleep Disorder Specialists
PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PRESCRIPTION MEDICATION POLICY

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

S. HABEEB RAHMAN, M.D.
Diplomate of the American Board of Neurology and Psychiatry

ERIC GOLDBERG, M.D.
Diplomate of the American Board of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN

HEMANG SHAH, M.D.
Diplomate of the American Board of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN
Diplomate of the American Board of Sleep Medicine

REFILLS:

- Patients are to call the office to request refills (when at least one week supply is left in the bottle). **Refills WILL NOT be called in the same day as the request.** _____ Patient Initial
- Refills will take 5 to 7 days for the office to process. **NO EXCEPTIONS.** _____ Patient Initial
- Any medication **SAMPLES** will be given to patients by the Doctor ONLY at the time of appointment.
- Any medication changes will be made at Patient's office visit ONLY. (i.e.: New medication WILL NOT be started from phone messages
- Refills will not be called in for any patient who has not been seen in over **ONE YEAR.** _____ Patient Initial
- Refills will not be called in for **Controlled medications / pain medications** if patient has not been seen for more then **SIX MONTHS**.
- Patients taking controlled medications will be subject to random drug screenings at the patient's expense.

NARCOTIC / PAIN MEDICATIONS:

- Prescriptions for Narcotic medication are used for acute problems only. If long term use is necessary patients will be referred back to the Primary Care Physician or to a pain management specialist.

PRESCRIPTIONS MISUSE, ALTERATION OR FORGERY:

- Alteration of a prescription or use of a medication against medical advise WILL NOT be tolerated. It will result in termination of your care and prosecution as directed by state and federal law.

I have read and understand the Prescription Medication Policy.

_____ _____

Patient Signature Date

** This Prescription Medication Policy is in effect as long as you are a patient in this practice.

Revised: 10-25-16

Tidewater Neurologists, Inc. & Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the Patient's signature in acknowledgement of this ***Notice of Privacy Practices,*** but was unable to do so as documented below:

Date:_____Initial:_____Reason:_____.

<u>This HIPPA Privacy Form will be in effect as long as you are a patient in this practice.</u>**

Tidewater Neurologists, Inc. &
Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

HISTORY & PHYSICAL

Name:_____ DOB _____ Date: _____

CHIEF COMPLAINT

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

- ❑ Headache/Migraine _____
- ❑ Headache/Tension _____
- ❑ Epilepsy/Seizures _____
- ❑ Cerebro Vascular_____
- ❑ Other Neuromuscular _____
- ❑ Head Injury_____
- ❑ Spinal Cord Injury _____
- ❑ Cervical Spine Disease _____
- ❑ Lumbar Spine Disease_____
- ❑ CNS Malignancy_____
- ❑ Depression_____
- ❑ Coronary Artery Disease _____
- ❑ MI _____
- ❑ Arrhythmias _____
- ❑ Congestive Heart Failure _____
- ❑ Murmur _____
- ❑ Hypertension_____
- ❑ COPD _____
- ❑ Pneumonia _____
- ❑ Asthma_____
- ❑ Peptic Ulcer Disease _____
- ❑ Colonic Polyps_____
- ❑ Anemia_____
- ❑ Diabetes_____
- ❑ Peripheral Vascular Disease _____
- ❑ Thyroid Disease_____
- ❑ Menstrual/Sexual Dysfunction _____
- ❑ Other Endocrine_____
- ❑ Liver Disease/Hepatitis _____
- ❑ Renal Disease_____
- ❑ Genitourinary Disease _____
- ❑ Venereal Disease_____
- ❑ Arthritis _____
- ❑ Cancer _____
- ❑ Tuberculosis _____
- ❑ HIV_____
- ❑ E+OH Abuse _____
- ❑ Drug Use_____
- ❑ Exposures _____
- ❑ Mumps _____
- ❑ Measles _____
- ❑ Polio_____
- ❑ Rheumatic Fever _____
- ❑ Allergy/Hay Fever _____
- ❑ Other _____

DRUG ALLERGIES

_____

_____

_____

PRIOR SURGERIES / HOSPITALIZATIONS

Reason:_____

_____

Pregnant now? ❑ YES ❑ NO

Tidewater Neurologists, Inc. &
Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

HISTORY & PHYSICAL

Name:_____ DOB _____ Page #: _____

REVIEW OF SYSTEMS - GENERAL

- ❑ Fatigue_____
- ❑ Weight Loss _____
- ❑ Fevers _____
- ❑ Depression_____
- ❑ Ear / Nose / Throat _____
- ❑ Cardiac_____
- ❑ Respiratory_____
- ❑ Peripheral Vascular _____
- ❑ Gastrointestinal_____
- ❑ Other _____
- ❑ Genitourinary _____
- ❑ Musculoskeletal _____
- ❑ Dermatologic_____
- ❑ Hematologic _____
- ❑ Other _____

REVIEW OF SYSTEMS - NEUROLOGIC

- ❑ Headache_____
- ❑ Dizziness _____
- ❑ Syncope_____
- ❑ Confusion_____
- ❑ Concentration_____
- ❑ Memory _____
- ❑ Lethargy_____
- ❑ Personality Change _____
- ❑ Hallucinations_____
- ❑ Speech Difficulty_____
- ❑ Spells _____
- ❑ Nausea _____
- ❑ Vomiting _____
- ❑ Trouble with Smell _____
- ❑ Blurred Vision _____
- ❑ Diplopia _____
- ❑ Amaurosis _____
- ❑ Other Visual Changes_____
- ❑ Difficulty Chewing _____
- ❑ Facial Numbness / Tingling_____
- ❑ Drooling _____
- ❑ Difficulty Tasting _____
- ❑ Tinnitus _____
- ❑ Vertigo _____
- ❑ Decreased Hearing R / L _____
- ❑ Dysphagia_____
- ❑ Hoarseness_____
- ❑ Choking _____
- ❑ Weakness - Arms_____
- ❑ Weakness - Legs _____
- ❑ Numbness - Arms _____
- ❑ Numbness - Legs _____
- ❑ Paresthesias _____
- ❑ Stiffness _____
- ❑ Clumsiness _____
- ❑ Pain _____
- ❑ Poor Balance _____
- ❑ Poor Coordination _____
- ❑ Trouble Walking_____
- ❑ Incontinence - Bladder _____
- ❑ Incontinence - Bowel _____
- ❑ Other _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disorder	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
CNS Tumors	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑	❑
Neuromuscular	❑	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑	❑

ADDITIONAL REMARKS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____