

Chattanooga Neurology Associates
721 Glenwood Drive, Suite 467-West - Chattanooga, TN 37404
Phone (423) 698-3423 FAX (423) 698-1380

DATE _____ REFERRED BY DR. _____

PATIENT'S PRIMARY CARE PHYSICIAN: _____

PATIENT NAME _____ SS# _____
(Last) (First) (MI)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

AGE _____ DATE OF BIRTH _____ MARITAL STATUS _____ SEX _____

EMPLOYER _____ EMP PHONE _____

SPOUSE, PARENT, NEXT OF KIN _____ PHONE _____

DATE OF BIRTH _____ SS# _____ CELL PHONE _____

EMPLOYER _____ EMP PHONE _____

EMERGENCY CONTACT (OTHER THAN ABOVE) _____

PHONE NUMBER: _____ CELL PHONE _____

NATURE OF ILLNESS OR INJURY _____

DATE OF FIRST SYMPTOM OR DATE OF INJURY _____

IS THIS WORKMAN'S COMPENSATION? _____ VERIFIED _____

WORKMAN'S COMP CARRIER _____ PHONE _____

ADUSTOR'S NAME _____ CLAIM# _____

EMPLOYER AT TIME OF ACCIDENT/SYMPTOMS _____

HEALTH INSURANCE -- PRIMARY CARRIER _____

CARRIER ADDRESS _____ CITY _____ ST _____ ZIP _____

GROUP# _____ CONTRACT OR ID# _____

Name of Insured _____ Covered thru (Emp) _____

Date of Birth _____ SS# _____

HEALTH INSURANCE -- SECONDARY CARRIER _____

GROUP# _____ CONTRACT OR ID# _____

Name of Insured _____ Covered thru (Emp) _____

Date of Birth _____ SS# _____

PATIENT MEDICAL HISTORY

EMG LAB

DO YOU CURRENTLY HAVE, OR DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL CONDITIONS?

	YES	NO
HEART DISEASE	_____	_____
CANCER	_____	_____
DIABETES	_____	_____
HEPATITIS	_____	_____
HIV POSITIVE	_____	_____
AIDS	_____	_____
TUBERCULOSIS (TB)	_____	_____

PATIENT SIGNATURE

HAVE YOU EVER HAD EMG OR NERVE CONDUCTION STUDIES PERFORMED? _____

IF YES, WHERE? _____

Chattanooga Neurology Associates, PLLC

Hytham A. Kadrie, M.D. Sharon N. Farber, M.D. Adele B. Ackell, M.D. Thomas G. Devlin, M.D.
Matthew H. Kodsí, M. D. Tareck A. Kadrie, M.D. Sally E. Horne, M. D.

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Chattanooga, TN 37404
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PAYMENT POLICY WITH MEDICARE

1. We accept MEDICARE ASSIGNMENT
2. You are expected to pay ONLY THE AMOUNT DETERMINED BY MEDICARE TO BE YOUR RESPONSIBILITY. This amount will include any deductible not met as well as 20% of the ALLOWABLE CHARGE.
3. We send all claims to Medicare and we will file claims with your secondary or supplemental insurance.
4. Payments are due within 30 days after your insurance has paid their portion.
5. If at any time we show a credit on your account resulting from an overpayment by the insurance company or you, a refund will be made.

PAYMENT POLICY WITH OR WITHOUT MEDICAL INSURANCE

It is IMPERATIVE that you are familiar with the requirements of your insurance plan. Please present your card(s) to the receptionist at the time of your visit. We will require a photocopy to put into your medical record to verify coverage and benefit information necessary to process your claims correctly.

1. All CO-PAYS are due at the time services are rendered.
2. While our office participates with the majority of insurance plans, we DO NOT participate in any TennCare programs, TrustMark, Health Springs, BCBS of GA HMO, PHCS, Cariten Senior Health or out-of-state Medicaid programs.
3. Your insurance is a contract between you and the insurance company. Not all services are covered benefits. Each insurance company develops their own guidelines, and it is your responsibility to be informed with your policy.
4. Returned checks are subject to a \$25.00 return check charge and balances over 60 days may be subject to interest charges of 1.5% per month.
5. If you are unable to comply with our policies, our business manager is available to discuss a payment plan with you prior to your appointment.

The undersigned agrees to pay all costs of collection procedures, including a reasonable attorney fee.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Signature: _____ Date: _____

I request and consent to treatment and promise to pay for all services and materials furnished. I authorize release of medical benefits for services to Chattanooga Neurology Associates. I authorize the release of medical information necessary to process my claim, or to any physician or entity that a physician with Chattanooga Neurology Associates may refer me for my medical care.

Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____, have reviewed a copy of Chattanooga Neurology Associates' Notice of Privacy Practices.

Signature: _____ Date: _____

Legal Guardian

Relationship to Patient

Chattanooga Neurology Associates, PLLC, IPA
721 Glenwood Drive, Suite 467 West, Chattanooga, TN 37404

Patient Name: _____

May we leave messages including test results on your answering machine? Yes ___ No ___

May we call you on your cell phone: Yes ___ No ___

Cell Phone # _____

May we give test results to your family members? Yes ___ No ___

If yes, please list their names below:

Name	Phone	Cell Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact: _____

Phone _____ Cell _____

May we call you at work, if necessary? Yes ___ No ___

If yes and unavailable, may we leave a message? Yes ___ No ___
Work Phone: _____

Do you have a durable power of attorney for healthcare? Yes ___ No ___

If yes, please provide the following:

Name: _____

Relationship: _____

Address: _____

Phone: _____

Signature: _____ Date: _____