

Montgomery Office

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Cincinnati, OH 45242

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www.RiverhillsNeuro.com

Welcome to Riverhills Neuroscience

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 should 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) 791-6400 ext. 2121.
- 2. Questionnaire:** We have found it most helpful to have an orderly, written depiction of our patient's complaints, testing, and other related medical conditions prior to initiating our evaluations. **Please complete the enclosed questionnaire and use the provided envelope to return it to our office within 3 business days. 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, if required, 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.
- 5. Pain Medication:** In most cases, we ask that your family doctor or current prescribing physician continue to manage your medication needs unless it is determined that you are in need of surgical intervention. In that instance, medication management may be temporarily assumed by the surgeon handling your case. **In the event that pain medication is managed in this office, you will be required to sign a "Chronic Pain Medication Treatment Agreement".**

Thank you for taking the time to comply with the above requests. 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.

Riverhills Neuroscience

PATIENT NAME _____

TODAY'S DATE _____

DATE OF BIRTH _____ **AGE** _____

PHYSICIAN YOU ARE SCHEDULED TO SEE _____

ADDRESS _____

APPOINTMENT DATE _____

CITY _____ **STATE** _____ **ZIP** _____

HOME TELEPHONE # _____

MALE **RIGHT HANDED**

WORK TELEPHONE # _____

FEMALE **LEFT HANDED**

MOBILE TELEPHONE # _____

REFERRING PHYSICIAN

PRIMARY PHYSICIAN

NAME _____

NAME _____

ADDRESS _____

ADDRESS _____

TELEPHONE _____

TELEPHONE _____

HISTORY OF ILLNESS / REASON FOR OFFICE VISIT

DESCRIBE THE SYMPTOMS YOU ARE EXPERIENCING _____

HOW DID YOUR SYMPTOMS BEGIN? _____

THE SYMPTOMS STARTED ON (GIVE SPECIFIC DATE, IF KNOWN) _____

SINCE YOUR SYMPTOMS BEGAN, THEY HAVE GOTTEN: **BETTER** **WORSE** **NO CHANGE**

NAME ANY OTHER PHYSICIANS WHO HAVE TREATED YOU FOR THIS PROBLEM

PHYSICIAN'S NAME	TYPE OF PHYSICIAN	MONTH/YEAR
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENT(S) FOR THIS ILLNESS OR INJURY?

(CHECK ALL THAT APPLY)

- | | | |
|---|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> PHYSICAL THERAPY
WHEN (MONTH/YEAR) _____
WHERE _____ | <input type="checkbox"/> EPIDURAL STEROID INJECTION
DATE _____ |
| <input type="checkbox"/> TRACTION | | <input type="checkbox"/> CHIROPRACTIC MANIPULATION |
| <input type="checkbox"/> ICE | <input type="checkbox"/> HOT PACKS | <input type="checkbox"/> ELECTRICAL STIMULATION |
| <input type="checkbox"/> ULTRASOUND | | |
| <input type="checkbox"/> PAIN MANAGEMENT PHYSICIAN | | |
| <input type="checkbox"/> MEDICATION | WHAT MEDICATION HAVE OR ARE YOU NOW TAKING FOR THIS CONDITION? _____ | |

Patient Name _____ DOB _____

DIAGNOSTIC TESTS

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSTIC TESTS FOR THIS ILLNESS OR INJURY?

INDICATE WHEN AND WHERE TESTS WERE DONE

	MONTH	YEAR	WHERE
<input type="checkbox"/> PLAIN SPINE X-RAYS	_____	_____	_____
<input type="checkbox"/> MRI SCAN	_____	_____	_____
<input type="checkbox"/> CT SCAN	_____	_____	_____
<input type="checkbox"/> MYELOGRAM/CT SCAN	_____	_____	_____
<input type="checkbox"/> EMG/NERVE CONDUCTION	_____	_____	_____
<input type="checkbox"/> BONE SCAN	_____	_____	_____
<input type="checkbox"/> OTHER	_____	_____	_____

MEDICAL HISTORY OF PATIENT

HAVE YOU EVER BEEN DIAGNOSED WITH?

<input type="checkbox"/> DIABETES CONTROLLED BY: <input type="checkbox"/> INSULIN <input type="checkbox"/> DIET <input type="checkbox"/> ORAL AGENTS	<input type="checkbox"/> HYPERTENSION <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> EMPHYSEMA/COPD <input type="checkbox"/> VENEREAL DISEASE <input type="checkbox"/> CANCER (TYPE & TREATMENT) _____	<input type="checkbox"/> GOUT <input type="checkbox"/> HEART ATTACK (MI) <input type="checkbox"/> SEIZURES/CONVULSIONS <input type="checkbox"/> DEPRESSION <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> HEREDITARY DEFECTS _____	<input type="checkbox"/> ASTHMA <input type="checkbox"/> ANGINA (CHEST PAIN) <input type="checkbox"/> THYROID PROBLEMS <input type="checkbox"/> ANXIETY <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> BLEEDING TENDENCY
<input type="checkbox"/> ACUTE INFECTION	<input type="checkbox"/> REFLUX DISEASE (GERD)	<input type="checkbox"/> CONGESTIVE HEART FAILURE	<input type="checkbox"/> HISTORY OF HEART ATTACK OR HEART DISEASE IF YES, CARDIOLOGIST NAME _____ PHONE _____ ADDRESS _____
<input type="checkbox"/> OTHER _____			

SURGICAL HISTORY

LIST ALL TYPES OF SURGERY AND YEAR YOU HAD THE SURGERY

_____	_____
_____	_____
_____	_____

MEDICATION HISTORY

LIST ALL YOUR MEDICATION(S) (PRESCRIPTION, OVER-THE-COUNTER, HERBAL)

NAME	AMOUNT	NUMBER PER DAY	NAME	AMOUNT	NUMBER PER DAY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

DO YOU TAKE BLOOD THINNERS? ASPIRIN COUMADIN PLAVIX OTHER

DO YOU HAVE ANY ALLERGIES? NO KNOWN PENICILLIN SULFA DEMEROL MORPHINE

LATEX CONTRAST DYE IODINE TAPE SHELLFISH

OTHER _____

Patient Name _____ DOB _____

- HAVE YOU BEEN TREATED FOR BLOOD CLOTS? YES NO
- HAVE YOU BEEN TREATED FOR EXCESSIVE BLEEDING? YES NO
- HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO
- IS THERE ANY REASON YOU CANNOT RECEIVE A BLOOD TRANSFUSION? YES NO

IF YES, EXPLAIN _____

HAVE YOU EVER BEEN SERIOUSLY INJURED? YES NO INJURY DATE ____/____/____

IF YES, EXPLAIN _____

HAVE YOU BEEN HOSPITALIZED IN THE PAST YEAR? YES NO

IF YES, EXPLAIN _____

FAMILY MEDICAL HISTORY

HAVE YOUR PARENTS OR SIBLINGS (BROTHERS/SISTERS) EVER BEEN DIAGNOSED WITH?

- HEART DISEASE DIABETES STROKE CANCER
- KIDNEY DISEASE DEPRESSION HIGH BLOOD PRESSURE BRAIN TUMOR
- ANEURYSM LUNG PROBLEMS MULTIPLE SCLEROSIS PARKINSON'S DISEASE
- ALZHEIMER'S/MEMORY PROBLEMS OTHER _____

MOTHER: LIVING DECEASED AGE _____ CAUSE OF DEATH _____

FATHER: LIVING DECEASED AGE _____ CAUSE OF DEATH _____

SIBLING(S): # ALIVE _____ # DECEASED _____ AGE(S) _____ CAUSE OF DEATH _____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

DO YOU LIVE ALONE? YES NO

DO YOU HAVE ANY CHILDREN? YES NO

IF YES, LIST THE AGE(S) AND IF THEY LIVE AT YOUR HOME _____

DO YOU NOW USE ANY TOBACCO PRODUCTS? YES NO

IF YES, SPECIFY CIGARETTES SNUFF TOBACCO CIGARS PIPE

HOW MUCH /DAY _____ FOR HOW MANY YEARS? _____

DID YOU USE ANY TOBACCO PRODUCTS IN THE PAST? YES NO

IF YES, FOR HOW LONG _____ HOW MUCH /DAY _____ WHEN DID YOU QUIT? _____

DO YOU DRINK ALCOHOL? YES NEVER NOT CURRENTLY, BUT USED TO DRINK _____ DRINKS A WEEK

IF YES, SPECIFY BEER WINE LIQUOR AMOUNT PER WEEK _____

FOR HOW MANY YEARS? _____ WHEN DID YOU QUIT? _____

DO YOU USE ANY RECREATIONAL DRUGS? YES NO

IF YES, SPECIFY MARIJUANA COCAINE/CRACK SPEED HALLUCINOGENS NARCOTICS

FOR HOW MANY YEARS? _____ WHEN DID YOU QUIT? _____ DATE LAST USED _____

Patient Name _____ DOB _____

WORK HISTORY

HIGHEST LEVEL OF EDUCATION: GRADE SCHOOL HIGH SCHOOL COLLEGE POST GRADUATE

WORK STATUS: EMPLOYED UNEMPLOYED DISABLED RETIRED

EMPLOYER _____ LENGTH OF EMPLOYMENT _____

JOB TITLE _____ HOW LONG HAVE YOU PERFORMED THIS JOB? _____

DO YOU WORK OUTSIDE THE HOME? YES NO

IF YES, ARE YOU CURRENTLY WORKING WITH THESE SYMPTOMS? YES NO

IF NO, WHEN DID YOU STOP WORKING? _____

DID A PHYSICIAN PLACE YOU OFF WORK? YES NO

DOES YOUR JOB REQUIRE YOU TO PERFORM THE FOLLOWING ACTIVITIES?

- LIFT SIT USE A COMPUTER
 BEND STAND LIFT OR REACH OVER HEAD

DOES YOUR JOB REQUIRE HEAVY LIFTING? YES NO

IF YES, WHAT IS THE MAXIMUM WEIGHT? ____ LBS. ____ /HR., ____ /DAY

**SIGN
HERE**

SIGNATURE OF PATIENT: _____

SIGNATURE OF PERSON FILLING OUT FORM: _____
(IF OTHER THAN PATIENT)

OFFICE USE ONLY:

REVIEWED BY _____ DATE _____

Patient Name _____

DOB _____

REVIEW OF SYSTEMS

CHECK ALL THAT APPLY TO YOU

CONSTITUTIONAL / GENERAL HEALTH

- FATIGUE
- FEVER
- WEIGHT GAIN IN LAST 12 MONTHS
HOW MUCH? _____
- WEIGHT LOSS IN LAST 12 MONTHS
HOW MUCH? _____

EYE

- BLURRED VISION
- DOUBLE VISION
- LIGHT SENSITIVITY
- LOSS OF VISION
- WEAR GLASSES / CONTACT LENSES
- GLAUCOMA
- CATARACTS

EARS / NOSE / THROAT

- LOSS OF TASTE OR SMELL
- LOSS OF HEARING
- EARS RING (TINNITUS)
- EARACHES OR DRAINAGE
- CHRONIC SINUS PROBLEMS OR RHINITIS
- NOSE BLEEDS
- BLEEDING GUMS
- SWOLLEN GLANDS IN NECK

BREAST

- DISCHARGE
- LUMPS

CARDIOVASCULAR

- CHEST PAIN
- FAINTING
- FEET SWELLING
- PALPITATIONS

RESPIRATORY

- CHRONIC OR FREQUENT COUGHS
- SPITTING UP BLOOD
- SHORTNESS OF BREATH
- ASTHMA / WHEEZING
- TUBERCULOSIS

GASTROINTESTINAL

- ABDOMINAL PAIN
- NAUSEA
- VOMITING
- DIARRHEA
- BLOOD IN STOOL
- FREQUENT HEARTBURN

GENITOURINARY

- BLOOD IN URINE
- INCONTINENCE
- KIDNEY STONES
- HESITANCY
- SEXUAL DIFFICULTY

FOR FEMALES

- PREGNANT
- MENSTRUAL IRREGULARITY
DATE OF LAST MENSTRUAL PERIOD

INTEGUMENTARY / SKIN

- RASH
- ITCHING
- SORES
- ABCESS

NEUROLOGICAL

- HEADACHES
- SEIZURES
- LOSS OF CONSCIOUSNESS
- LIGHTEADED
- SPINNING OR VERTIGO
- WEAKNESS
- PROBLEMS WITH SPEECH
- CONFUSION
- FALL
- DIFFICULTY WITH COORDINATION
- NUMBNESS
- TINGLING
- STROKE
- HEAD INJURY

MUSCULOSKELETAL

- JOINT SWELLING
- JOINT REDNESS
- JOINT PAIN
- GAIT PROBLEMS

ENDOCRINE

- EXCESS SWEAT
- EXCESS THIRST
- EXCESS HOT
- EXCESS COLD
- GLANDULAR OR HORMONE PROBLEMS

INTELLECTUAL FUNCTION / PSYCHIATRIC

- MEMORY LOSS OR CONFUSION
- DEPRESSION
- SEEN A DOCTOR FOR PSYCHIATRIC PROBLEMS
- PANIC ATTACKS
- ANXIETY
- TAKE ANY MEDICATION FOR ANXIETY

HEMATOLOGIC / LYMPHATIC

- BLEEDING TENDENCIES
- HEPATITIS TYPE: A B C
- HIV OR AIDS
- EASY BRUISING
- LYMPH NODE SWELLING

- SPINE QUESTIONNAIRE -

List ALL symptoms for why you are here (Reason for Visit): _____ Pain _____ Numbness/Tingling _____ Muscle Weakness

OTHER _____

How did the symptoms BEGIN?

_____ Spontaneously with no known cause _____ As a result of an AUTOMOBILE accident - **Date of Auto Accident:** ___/___/___
 _____ As a result of an injury at WORK - **Date of Injury:** ___/___/___ _____ As a result of an injury outside of work

My pain is located in my: _____ Neck _____ Low back _____ Mid-Back Other: _____

Rate your pain: Use this PAIN SCALE of 0 to 10 (0=NO PAIN AND 10=WORST POSSIBLE PAIN) for each affected area:

Neck _____ /10 Low Back _____/10 Mid-Back _____/10 Other affected areas: _____/10

If you have NECK and/or ARM pain: What percentage of the pain is in your NECK? _____ %
 What percentage of the pain is in your ARM(s) + _____ %
Total Arm/Neck Pain: _____ 100 % (should be 100%)

If you have BACK and/or LEG pain: What percentage of the pain is in your BACK? _____ %
 What percentage of the pain is in your LEG(s) + _____ %
Total Back/Leg Pain: _____ 100 % (should be 100%)

The PAIN is: _____ Constant _____ Intermittent

The PAIN is described as: _____ Sharp/Stabbing _____ Dull/Aching _____ Burning _____ Throbbing

The symptoms IMPROVE with: _____ Standing _____ Walking _____ Sitting _____ Laying Down

The symptoms GET WORSE with: _____ Standing _____ Walking _____ Sitting _____ Laying Down _____ Bending
 _____ Bowel Movements _____ Sneezing _____ General Activity

Since your condition started, have you experienced any bladder dysfunction? _____ Yes _____ No

How long can you stand with NO or MINIMAL PAIN? _____ Minutes _____ No problem standing for long periods of time.

What distance can your walk with NO or MINIMAL PAIN? _____ up to 1 block _____ 2-3 blocks _____ 6 blocks _____ No Limit

Do you need SUPPORT to help you walk? _____ YES _____ NO If yes, specify:
 _____ Use a WHEELCHAIR _____ Use A WALKER _____ Uses a CANE _____ Must rely on some PERSON or FURNITURE for support to walk

Do you wear a NECK or BACK brace? If yes, _____ Neck Brace _____ Back Brace

How long have you worn the brace? _____ Days _____ Weeks _____ Months _____ Years

Please check mark the pictures with all symptoms that apply

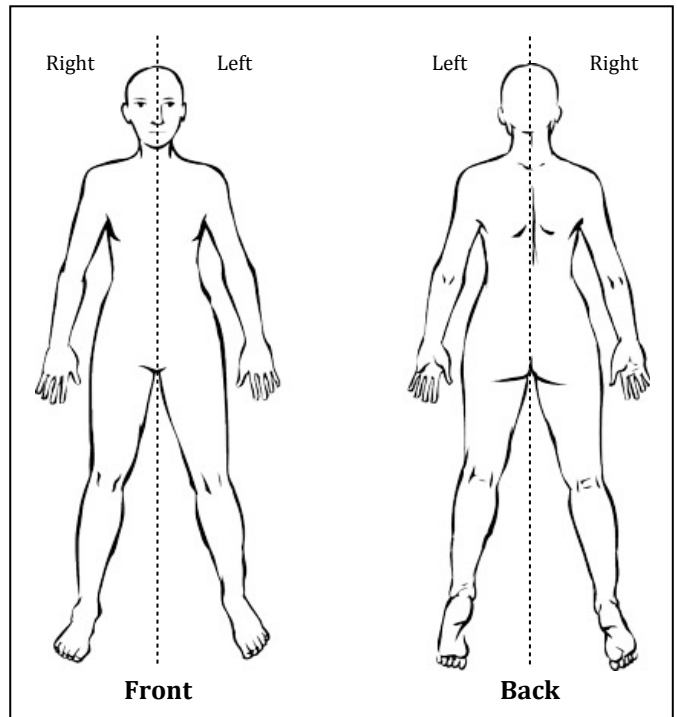
by using the following letters on the picture:

P = Pain

N = Numbness/Tingling

W = Weakness

R = Radiates (moves from main are into other areas of the body)



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: _____



Important

To assist us in providing the best patient care, please **bring** all of your medications with you to every visit with your physician.

We need to keep an accurate record of the medicines you are **currently** taking.