



Montgomery Office

10550 Montgomery Rd. Suite 33
Cincinnati, OH 45242

Direct: (513) 791-6400 ext. 2128

Fax: (513) 791- 8085

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.

- ❑ **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.

- ❑ **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.**

- ❑ **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.

- ❑ **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 the event that pain medication is managed in this office, you will be required to sign a "Chronic Pain Medication Treatment Agreement".**

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PATIENT NAME _____

TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHARMACY TELEPHONE # _____

PHYSICIAN YOU ARE SCHEDULED TO SEE _____

APPOINTMENT DATE _____

HOME TELEPHONE # _____

WORK TELEPHONE # _____

MOBILE TELEPHONE # _____

REFERRING PHYSICIAN

NAME _____

ADDRESS _____

TELEPHONE _____

PRIMARY PHYSICIAN

NAME _____

ADDRESS _____

TELEPHONE _____

Describe Your Pain Symptoms

1. Where is your pain? _____

2. How long ago did your pain start? _____ Days ago _____ Months ago _____ Years ago

3. Rate your pain on a scale of 0 to 10 (10 being the worst pain imaginable) _____ out of 10

 4. Did your pain begin with an injury? Yes No If yes, what was the date of your injury/accident? _____

 If you were injured, did the injury occur? At Work From a Motor Vehicle Accident Other Injury

If other, please explain _____

 Is a lawyer involved with your pain situation? Yes No

 5. Does your pain: Get better as the day goes on Get worse as the day goes on

 6. Is your pain: Constant Nearly constant Intermittent Occasional

 7. Have you been to the Emergency Room in the last year for your pain? Yes No If yes, how many times? _____

 8. Does your pain interfere with any of the following? Sleep Daily Activities Work Relationships

 9. Does your pain make you feel? Angry Depressed Frustrated Helpless/Hopeless Suicidal

 If so, do you have plans to hurt yourself? Yes No

 Will you hurt yourself if you go home? Yes No Maybe

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Pain Rating Scale

- | | | |
|-----------------------|-----------------------|--|
| 0 – No Pain | 4 – Tolerable Pain | 8 – Horrible Pain |
| 1 – Slight Discomfort | 5 – Distressing Pain | 9 – Unbearable Pain |
| 2 – Very Mild Pain | 6 – Intense Pain | 10 – Worst Pain Imaginable or Possible |
| 3 – Mild Pain | 7 – Very Intense Pain | |

10. On a scale of 0-10, what is your AVERAGE daily pain? _____

11. On a scale of 0-10, what is the intensity of your WORST daily pain? _____

12. On a scale of 0-10, what is the intensity of your BEST daily pain? _____

13. Since your pain began, has it:

- Increased Decreased Stayed the same Both up and down

14. How would you describe your pain?

- | | | |
|---|--|--|
| <input type="checkbox"/> Gnawing | <input type="checkbox"/> Aching | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Heavy | <input type="checkbox"/> Punishing / Cruel |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tender | <input type="checkbox"/> Deep |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Splitting | |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Tiring/Exhausting | |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Sickening | |
| <input type="checkbox"/> Hot/Burning Pain | <input type="checkbox"/> Pressure | |

15. Select all the things that make your pain WORSE.

- | | | | |
|---|-----------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bending Backward | <input type="checkbox"/> Driving | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Exercise | <input type="checkbox"/> Rest | <input type="checkbox"/> Touch |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Walking |

16. Select all the things that make your pain BETTER.

- | | | | |
|---|-----------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bending Backward | <input type="checkbox"/> Driving | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Exercise | <input type="checkbox"/> Rest | <input type="checkbox"/> Touch |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Walking |

17. Please check any tests you have had related to your pain:

- | | | | |
|------------------------------|--------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> MRI | <input type="checkbox"/> X-ray | <input type="checkbox"/> Bone Scan | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> EMG | <input type="checkbox"/> Blood tests | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Discogram |

When and where? _____

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18. Please check any treatments you have had for your current pain, did they help?

<u>Treatments I've Had</u>	<u>Helpful</u>	<u>Not Helpful</u>	<u>Temporarily Helpful</u>
<input type="checkbox"/> Epidural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Radiofrequency Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spinal Cord Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Trigger Point Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vertebroplasty / Kyphoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Discectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spine Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Decompression Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nutrition counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurontin (Gabapentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lyrica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Topamax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Savella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ibuprofen (Advil / Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Naproxen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nortriptyline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tizanidine (Zanaflex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Flexeril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skelaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Robaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Baclofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tramadol (Ultram)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lidoderm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vicodin / Hydrocodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Percocet / Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dilaudid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Oxycontin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Duragesic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____			

19. Is there any chance you could be pregnant? Yes No N/A

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20. GOALS:

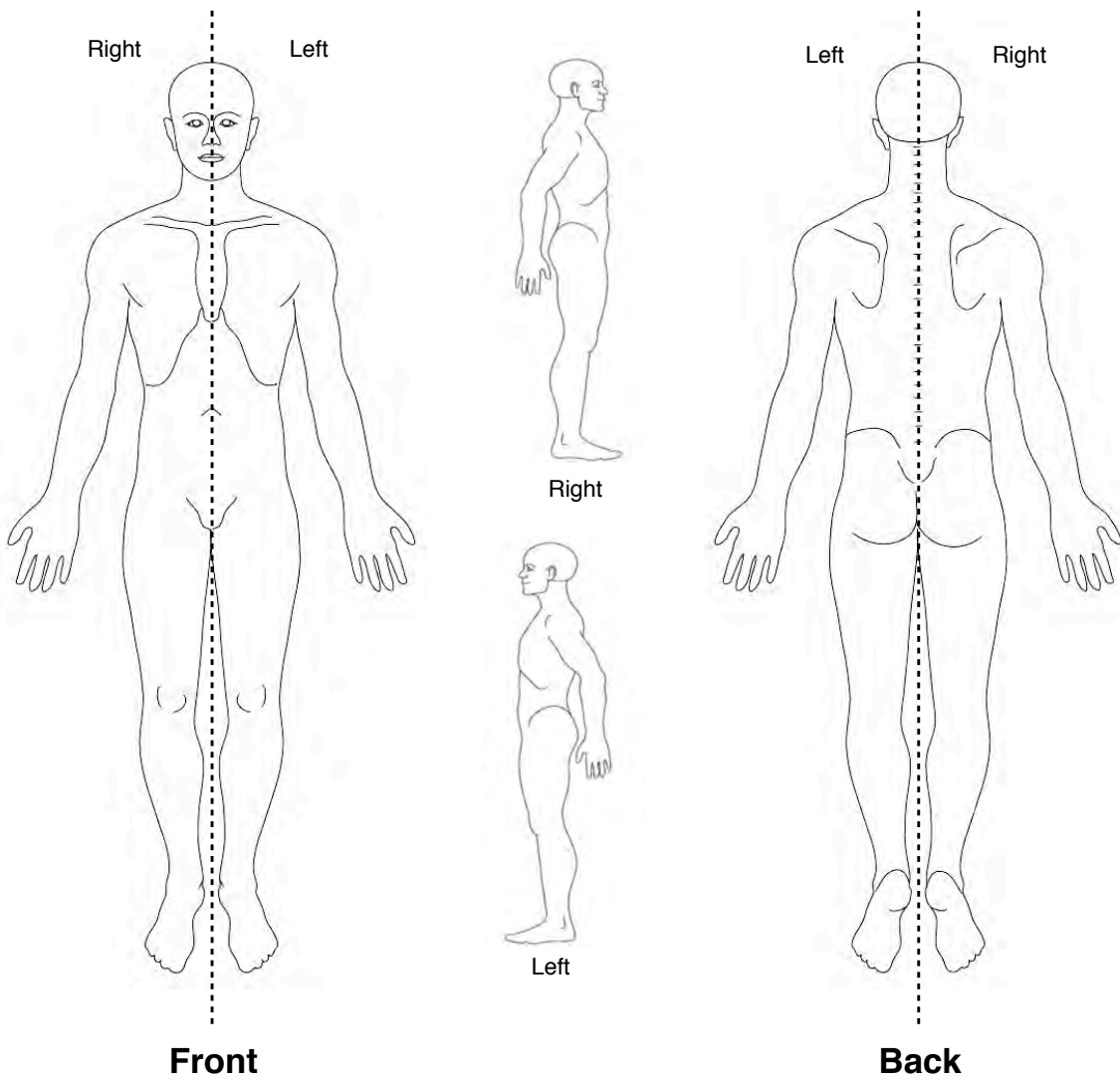
What are you hoping to gain from your visit with the Pain Clinic?

- Pain Relief
- Improved Mobility
- Improved Relationships
- Decreased Irritability
- Return to Work
- Decreased use of Pain Medication
- Other: _____

Realistically, what percentage of pain relief do you feel would make your treatment worthwhile? _____ %

21. WHERE IS YOUR PAIN?

Please shade the areas of your pain in the diagrams below.



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22. PAST MEDICAL

Have you ever had any of the following medical conditions? (Check all that apply)

Endocrine

- Diabetes
- Thyroid Problems High Low

Lungs

- COPD / Emphysema
- Sleep Apnea (use CPAP at night)
- History of TB
- Asthma

Cardiac / Circulation

- High Blood Pressure
- Heart Attack (when _____)
- Heart murmur (please specify)
- Aneurysm
- Stroke
- Bleeding disorder
- Do you take antibiotics prior to any procedure or dental work?
- Angina
- Cardiac Stents (when _____)
- Artificial Valve
- Carotid Artery Disease
- Pacemaker / Defibrillator
- Rheumatic fever

Infectious Disease

- HIV or AIDS
- Hepatitis (B C)

Gastrointestinal

- Liver Problems (please specify)
- Ulcers
- Heartburn
- GERD

Renal / GU

- Kidney Disease

Neurological

- Seizures
- Multiple Sclerosis

Musculoskeletal

- Fibromyalgia

Skin

- Psoriasis
- Shingles

Cancer

- Type _____
- Other: _____
- Radiation Chemotherapy Surgery

23. PAST SURGICAL

Please list any previous surgery you have had: (Include the month and year each surgery was done)

24. ALLERGIES

- No known drug allergies
- Iodine
- X-Ray Dye
- IV Contrast
- Shellfish
- Latex

Please list all allergies and/or intolerances to medications: _____

Please list all allergies and/or intolerances to foods/environment: _____

25. MEDICATION

Are you taking blood thinners? No Yes: Please specify:

- Coumadin
- Plavix
- Lovenox
- GinkoBiloba
- Aggrenox
- Brilinta
- Pradaxa
- Effient
- Other: _____

26. Please list any medications you are currently taking with their doses and number of times taken per day.

Include "over the counter" drugs and herbal supplements.

Drug	Dose	Taken How Often

27. FAMILY HISTORY

Do you Parents, Grandparents or Siblings with any of the following medical conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> No significant family history | <input type="checkbox"/> Adopted / Unknown | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Neck Pain/Problems | <input type="checkbox"/> Back Pain/Problems | <input type="checkbox"/> Pain Syndromes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Addiction / Substance Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding Disorders | |
| <input type="checkbox"/> Other: _____ | | |

28. SOCIAL HISTORY

What was the highest level of education you completed?

- High School College Graduate School (Masters, PhD, etc...)

What is your marital status?

- Single Married Separated Divorced Widowed

How many children do you have? _____

Do you smoke?

- No Yes

If yes, how many packs/day _____ How many years have you been smoking? _____

Do you drink alcohol?

- No Yes

If yes, how much and often do you drink? (e.g. 2 glasses of wine/day) _____

Do you use recreational drugs?

- No Yes: If yes, please describe _____

Do you exercise regularly?

- No Yes: If yes, how often? _____

29. WORK HISTORY

Are you currently working? No Yes Retired Worker's Comp

If yes, who is your current employer? _____

What is your occupation? _____

Are you on disability? No Yes

If yes, how long have you been disabled? _____

What caused you to become disabled? _____

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

Constitutional

- Fever
- Recent weight gain _____ lbs.
- I have no issues or symptoms in this area
- Fatigue
- Recent weight loss _____ lbs.
- Chills
- Other _____

Head, Ears, Nose, Throat (HENT)

- Hearing loss (Right / Left)
- Nosebleed
- Loss of taste or smell
- I have no issues or symptoms in this area
- Ringing/Buzzing/Chirping
- Sore Throat
- Earaches or Drainage
- Sinus Problems (Seasonal / All Year)
- Bleeding/Sore Gums
- Swollen Glands in Neck
- Other _____

Breasts

- Tenderness
- I have no issues or symptoms in this area
- Lumps
- Discharge

Cardiovascular

- Chest Pain-last episode _____
- Irregular Heartbeat
- Other _____
- I have no issues or symptoms in this area
- Congestive Heart Failure
- Swelling of feet/hands
- Palpitations
- Leg Cramps

Have you ever fainted or passed out with needles or procedures? Yes / No

Do you take Blood thinners? Yes / No

If yes, Coumadin Plavix Pletal Lovenox Effient

Name of MD managing Blood thinner _____ Phone # _____

Respiratory (Lungs and Breathing)

- Shortness of Breath
- Painful Breathing
- Home Breathing Treatments
- I have no issues or symptoms in this area
- Coughing Blood/Sputum
- Wheezing
- Tuberculosis
- Home Oxygen
- Other _____

Gastrointestinal

- History of Ulcer (date) _____
- Constipation
- Nausea/Vomiting
- I have no issues or symptoms in this area
- Bleeding Stomach/Bowels
- Painful Swallowing
- Food Intolerance
- Diarrhea
- Heartburn/Indigestion
- Other _____

GenitoUrinary

- Burning
- Incontinence
- Flank or Pubic Pain
- Female: Abnormal Vaginal Bleeding, Discharge, or Pain
- I have no issues or symptoms in this area
- Urgency or Frequency
- Painful/Difficult Urination
- Dark or Bloody Urine
- Female: Change in Menstrual Cycle
- LMP: _____
- Hesitancy
- Male: Erectile Dysfunction
- Post Menopausal

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REVIEW OF SYSTEMS - Continued

Skin (Integument)

- Sores
Rash
Bruises
Excessive Sweating
Severe Skin Infections

- I have no issues or symptoms in this area
Burns
Incision
Itching
Skin Color Change
Abnormal hair growth

- Lumps
Ulcers
Abscess
Nail Abnormalities
Other

Neurological

- Dizziness
Fainting
Headaches/Migraine
Seizures, last seizure
TIA
Numbness (Location)

- I have no issues or symptoms in this area
Problems with Speech
Weakness
Tremors
Confusion
Tingling (Location)

Please Circle: Right / Left

- Problems with memory
History of Head Injury
Date
History of falls
Loss of coordination
Sensation Change/Loss

Musculoskeletal

- Back pain
Neck pain
Other Pain
Restricted Motion

- I have no issues or symptoms in this area
Joint Pain or Swelling
Muscle Pain, Swelling, Cramps
Joint Stiffness
Joint replacement

- Amputation
Artificial limb
Other

Endocrine

- Excessive thirst / urination
Glandular or Hormone Problems

- I have no issues or symptoms in this area
Heat or Cold Intolerance

- Increase in hat/glove size

Psychological

- History of depression
Nervousness or Irritability
Sleep Disturbance
History of abuse by another person
Suicidal thoughts/attempts
Seeing psychologist/psychiatrist

- I have no issues or symptoms in this area
History of Bipolar Disease
History of Schizophrenia
Poor Concentration

- Anxiety/Tension
Panic Attacks
ADHD

Hematologic/Lymphatic

- Bruise or Bleed easily
Blood Disorder

- I have no issues or symptoms in this area
Lymph Node Swelling
Tenderness, Neck, Armpits, Groin

- Abnormal Clotting
Factor Deficiency

Type

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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 hereby authorize, request and direct my health insurance company or third party payor 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 co-pays, co-insurance, deductibles, and services not covered by insurance are due 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 \$25.00 "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.

**SIGN
HERE**

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: _____

**SIGN
HERE** 

Patient Signature: _____

Date: _____

Print Name: _____

DOB: _____



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.