Central Virginia Neurology, PLC
14355 Sommerville Court
Midlothian, Va 23113
PH (804) 379-7721 FAX (804) 379-7699

Last Name: _____First Name: _____Middle: _____

Date of Birth: _____ Male or Female Marital Status: _____

SS# _____ DL# _____

Race: _____ Ethnicity: _____

Primary Ins. Comp. _____ Secondary Ins. Comp. _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Full time Part time Retired Unemployed

E-Mail address: _____

Pharmacy: _____ Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Physician: _____Primary Care Physician: _____

Advanced Directive and/or Living Will: Yes or No (please circle one)

Flu shot this season: Yes or No (please circle one)

OVER

It is our goal at Central Virginia Neurology, Plc to serve you in a caring and professional manner. We feel it would be helpful to make you aware of the following:

- Confidentiality is a very important part of your treatment. Therefore, we will not release any information regarding your medical care without a signed release from the patient or guardian.
- Unless you have an emergency, 24 hours' notice is required for cancellations. The policy is to charge $80 for missed, or no-show appointments without a 24-hour notice.
- There may be fees charged when miscellaneous services are requested. IE: DMV forms, disability forms, FMLA forms.
- I understand and agree, it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by my insurance or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make payment in full.
- It is the patient's responsibility to obtain and keep a current insurance referral to see our doctors if your health insurance company requires one. By signing below, you are aware that you will be billed for services in full in the event an insurance referral is no0t on file for today's visit.
- The parent or guardian of a minor child will be held responsible for the copay or any amount the insurance does not pay.
- I authorize Central Virginia Neurology, PLC electronic access of my medical information collected by HCA Health System, Bon Secours Health System, and/or Virginia Department of Health Professions, relating to patient care of Schedule II-V controlled substances for the purpose of providing my medical care.

Financial Policy:

I, the undersigned, assign directly to Central Virginia Neurology, PLC, all medical insurance benefits, if any, otherwise payable to me, for services rendered. Payment-In-Full is due at time of service unless other arrangements have been made in advance. Any balance not paid at time of service will be considered an extension of credit and may incur finance charges up to eighteen percent (18%). I understand that I am financially responsible for all charges whether or not paid by Insurance, and in the event any amount due remains unpaid after a bill is rendered, I agree to pay a collection penalty of Twenty-five percent (25%) of the then principle account balance and any other fees, including reasonable attorney fees. If you pay by check and it is returned for ANY reason, you will be charged a return check fee as allowed by law. You also agree to allow us, our agent, successors or assigns to turn your check into an electronic transaction at our discretion and to debit your checking account for any return check fees.

Telephone Communications:

You authorize us, our successors or assigns, to call, email or send you a text message to any number, email, address you provide or at any number at which we reasonable believe we can contact you, including calls or texts to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1)suspected fraud or identity theft; (2)obtaining information necessary or desirable; (3)your account transactions or servicing; and (4)collecting on you Account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns. You agree to pay any fee (s) or charge (s) that you may incur for incoming calls from us, our successors or assigns, and/or outgoing calls to us, our successors or assigns, to or from any such number, without reimbursement from us.

Signed _____ Date _____

(Patient/Subscriber, or Parent of Minor)