Central Virginia Neurology, PLC

14355 Sommerville Court
Midlothian, VA 23113
(804)379-7721
Fax (804) 379-7699

Last Name: ____________________ First Name: ______________Middle: ____________________

Date of Birth: ____________________ Male or Female

Social Security Number **and/or** State Driver's License Number: _____________________________

Primary Insurance Company: __________________ Insurance ID: ___________________________

Secondary Insurance Company: ________________ Insurance ID: ___________________________

Race: __________ Ethnicity: ____________________ Marital Status: ____________________

Street Address: ____

City: _______________________________ State: ___________ Zip Code: ______________________

Home Phone: ____________________________Work/Cell Phone: ___________________________

Patient's Employer: ______________________________ Full / Part Time / Retired

E-Mail Address: ____

Pharmacy- Name: __________________Address:_______________________Phone:________________

Emergency Contact: ___________________________________ Relationship: ____________________

Daytime Phone: ___________________ Authorize Dr. to contact regarding medical matters: Yes No

Referring Physician: ____

Primary Care
Physician: ____

Advanced Directive and/or Living Will: Yes No

Flu shot this season: Yes No

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:

- We realize confidentiality is a very important part of your treatment. Therefore, we will not release any information regarding our patients without a signed release from the patient or guardian other than those situations outlined in our office privacy policy.
- You will be expected to make your co-payment at the time of your appointment unless you have made prior arrangements with our business office.
- Unless you have an emergency, 24 hours notice is required for cancellations. Our policy is to charge $80 for missed appointments without a 24 hour notice or no show appointments.
- There may be fees charged when miscellaneous services are requested such as completing DMV forms, disability forms or rewriting/refilling prescriptions at times other than at the appointment date with the physician. A list of the miscellaneous fees is supplied upon request.
- I understand and agree, it is my responsibly 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 full payment.
- 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 not on file for today's visit.
- The parent or guardian of a minor child will be held responsible for the co-pay or any amount the insurance does not pay.
- If the patient account is not paid and has to be turned over for collection, the patient will be responsible for all costs of collection; including but not limited to collection fees or attorney fees of not less than 33 1/3% plus court costs.
- I authorize Central Virginia Neurology, PLC electronic access of my medical information collected by HCA Hospitals, Bon Secours Health System, and/or Virginia Department of Health Professions, relating to patient care or Schedule II-V controlled substances for the purpose of providing my medical care.

I authorize release of health information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable directly to the doctor.

X____ Date: ______________________________

Signature of patient (or parent/guardian if a minor)

X____

Printed Name of Patient

This signed consent shall remain in effect for one year from the date signed