CNS
2060 Lakeside Centre Way
Knoxville, TN 37922

PATIENT INFORMATION FORM
PERSONAL AND CONFIDENTIAL

(Please Print)
Name: _____ Social Security #: _____
(Last) (First)

Address: _____ City: _____ State: _____ Zip _____

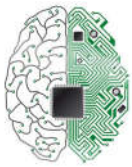
Home Phone: ( ) _____ Cell: ( ) _____ Date of Birth / / Age _____

Please circle one:

Marital Status: Single Married Divorced Widowed **Gender:** Male Female **Language:**

Pharmacy Name:	Phone Number:
Referring Physician:	Phone Number:
Family Physician:	Phone Number:
PERSONAL INFORMATION	
Patient's Employer:	Work Phone:
Are you retired? Yes No	
Spouse's Name:	Birth date: / /
Spouse's Employer:	Work Phone:
Is your spouse retired? Yes No	
Emergency Contact Outside of Home:	
Relationship:	Phone Number:
PERSON RESPONSIBLE FOR THIS ACCOUNT	
Name of responsible for this account:	Relationship to Patient:
Address (if different):	City: State: Zip:
Birthdate: Employer:	Phone:
Driver's License Number: State of License:	Social Security #:
PRIMARY INSURANCE	
Insurance Company Name:	Policy Effective Date:
Name of Insured:	Relationship to Patient:
Birth Date: Social Security #:	Group no:
Policy no:	Co-pay Amount:
SECONDARY INSURANCE	
Insurance Company Name:	Policy Effective Date:
Name of Insured:	Relationship to Patient:
Birth Date: Social Security #:	Group no:
Policy no:	Co-pay Amount:

Patient / Guardian Signature_____ Date_____



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AUTHORIZATION FORM

Please initial each statement, if agreed, and sign below.

_____ **Assumption of Responsibility:** I recognize and accept responsibility for any balance or fees not covered by insurance and agree to pay the balance in a prompt manner (non-covered amounts, set co-pays, deductible amounts and bills payable on receipt). I understand that all unpaid bills over 90 days could be turned over to a collection agency, and I agree to pay any reasonable court costs, interest and legal fees should this become necessary.

_____ **Assignment of Insurance Benefits:** I authorize the release of any medical information necessary to process any medical claims for services I have incurred. I further authorize all medical insurance payments to be paid directly to Comprehensive Neurology Services, PLLC.

_____ **Referrals:** If my insurance requires a referral, I understand that it is my responsibility to obtain it and that it needs to be received before treatment in order to qualify for the maximum benefits from my insurance company. If a referral was not previously arranged, I have been given the opportunity to obtain a referral or reschedule my appointment. I understand that if I refuse, I am taking full responsibility for payment.

My insurance requires a referral when seeing a specialist. ❑ YES ❑ NO

My insurance requires lab and/or pathology work to be sent to a specific lab. ❑ YES ❑ NO If yes, where: _____

My insurance requires radiology services to be performed at a specific facility. ❑ YES ❑ NO If yes, where: _____

My insurance requires hospital services to be performed at a specific facility. ❑ YES ❑ NO If yes, where: _____

_____ **Acknowledgement of Receipt of Privacy Notice:** I acknowledge being given an opportunity to receive and review a copy of Comprehensive Neurology Services, PLLC's Notice of Privacy Practices today. I consent to the use of my protected health information as described in the Notice from treatment, payment and healthcare operations. I understand that I must provide a separate authorization before other disclosures may be made.

_____ **Authorization for Release:** I give permission for Comprehensive Neurology Services, PLLC physicians and their staff to discuss information regarding my test results, billing issues or other situations related to my visit with the following people if I am not available or not otherwise able to take the information myself.

Name	Relationship	Phone number incl. area code

_____ I understand that the office may need to call me. I give permission for Comprehensive Neurology Services physicians and staff to call and understand they will identify themselves when leaving messages on my answering machine or with anyone answering my home phone when trying to reach me. No test results will be left on the answering machine. I understand that no confidential information regarding my medical condition will be discussed with anyone unless they are specifically listed on this form. I grant permission for you to contact me via my:

- ❑ Home Phone Number (include area code): _____
- ❑ Cell Phone Number (include area code): _____
- ❑ Work Phone Number (include area code): _____

By signing below, I acknowledge that I have read, fully understand and agree with the aforementioned statements as initialed by me.

Patient Signature: _____ **Date:** _____

If Guardian, relationship to patient: _____

Comprehensive Neurology Services, PLLC
Dinu C. Nodit, MD
2060 Lakeside Centre Way
Knoxville, TN 37922

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Comprehensive Neurology Services PLLC reserves the right to charge a fee for all missed appointments ("no shows") and appointments which, absent a documented emergency, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient.
They are $200 for missed new patient visits and $100 for follow up visits.
This fee is not covered by insurance, and must be paid in full prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____
Printed Name Date

_____
Signature

Phone: (865) 622-6545
Fax: (855) 233-7164