MICHIGAN NEUROSCIENCE CLINIC

Faisal I. Ahmad, M.D. Nawaf H. Murshed, M.D. Omar I. Ahmad, M.D. Payam S. Sadry, D.O.

11780 Telegraph Rd, Ste. 100 Taylor, MI 48180
P: 734-374-1112 **F: 734-374-1119**

Thank you for scheduling an appointment; it is our pleasure to welcome you to Michigan Neuroscience Clinic in advance of your first visit. The following is some information that will help familiarize you with our practice.

Payment policy: It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. This may only be your co-payment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept all major credit cards.

Co-payment: This is the cost-sharing part of your bill that is a fixed dollar amount designated by your insurance company that is your responsibility to pay at each visit (also known as a co-pay). Common co-payment rates are $10 or $20 per visit, but be aware that co-payment rates vary from insurance company to insurance company.

Deductible: This is the amount of cost sharing that you must pay for medical services, often before your health insurance company starts to pay.

Coinsurance: The part of your bill, in addition to a co-pay, that you must pay. Coinsurance is usually a percentage of the total medical bill—for example 20%.

No-call no show fee: We block off time for your scheduled appointment. If you are unable to make this appointment we request a 24-hour cancellation or reschedule. If you do not call to reschedule your appointment we charge **$20.00** for office visits; **$50.00** for any testing (EMG, VNG and EEG) to your account.

- Please note, specific testings are time sensitive and may need to be rescheduled if the patient arrives late. Refer to testing sheets for instructions.

Referrals and Authorizations: Many insurance plans require referrals for services to be covered. A referral is permission from your primary care physician and your health plan to see a particular provider or to have specific procedures done. If your plan requires a referral, your primary care physician must provide the referral prior to services being rendered.
You may be responsible for payment if the necessary approvals are not in place.

Documents and Forms: A **fee** will be charged for all forms brought in to be completed by Michigan Neuroscience Clinic. Please allow 7-10 business days.

Hearing Impaired: Our policy allows the patient-doctor to communicate with a pen and paper method. Patients are more than welcome to use their own interpreter and bring them for clinic visit. (Patient will be financially responsible for their interpreter). If you would like our office to set up an interpreter through our own third party service, please contact our office two weeks prior to scheduled appointment.

If you have any questions after reading this information, we will be happy to answer them for you prior to your visit by telephone at (734) 374-1112. Please see enclosed patient registration form and a privacy form to be completed prior to your scheduled visit. These forms may be faxed to (734) 374-1119, or you may bring them to your appointment.

Please bring the following information to your visit, if you have not already given it to us prior to your scheduled visit:

Insurance card(s)
Driver's license or other photo identification
Referral from PCP (if needed for your insurance)

We appreciate you selecting Michigan Neuroscience Clinic for your medical care and will work hard to serve your needs.
I've read, understood, and agree to MNC, LLC terms and policies.

Patient Signature: _____

Michigan Neuroscience Clinic

Patient Registration

Patient Name: _____ Patient's Social Security Number: _____

Street Address: _____ City: _____ Zip: _____

Date of Birth: _____ Marital Status: S M W SEP D Sex: M F T

Telephone #: Home _____ Work # _____ Cell #_____

Where would you like us to call you first? _____ Home _____ Work ____ Cell

Email: _____ Race: _____ Ethnicity: _____Language:_____

Spouse's Name: _____ Spouse's Tel #: _____

Emergency Contact: _____ Tel# _____ Relationship: _____

Pharmacy Name: _____ Street: _____ City:_____

Mail Order Pharmacy: _____

Referring Physician: _____ Primary Care Physician: _____

Advance Directive: (circle one) Self DNR (Do Not Resuscitate) DPOA (Durable Power of Attorney)
LV (Living Will) PAD (Patient Advocate Designation /Health Care Power of Attorney)

Insurance Information

Primary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Relationship to patient: _____ DOB: _____

Subscriber Address (if different than patient's): _____

ID# _____ Group# _____ Tel# _____

Secondary Insurance: _____ Effective Date: _____

Subscriber Name: _____ Relationship to patient: _____ DOB: _____

Subscriber Address (if different than patients): _____

ID# _____ Group# _____ Tel# _____

Patient Consent

Consent to Treat & Financial Authorization

I hereby authorize my provider to treat my symptoms and apply for benefits on my behalf for any services rendered by him or his order
I request that payments of authorized benefits from Medicare/Insurance Company be made directly to my provider
I authorize my provider to release any medical information about me to HCFA/my insurance and its agents, any information needed to determine these benefits or the benefits payable to related services. I authorize the use of this authorization for any of my insurance submissions. I understand that I am responsible for any amount not covered by my insurance company(s). I certify that the information that I have reported with regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place of its original. This authorization may be retrieved by either me or my insurance company at any time in writing

Patient Signature _____ Parent Signature _____

Rx History Consent

I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to**:** determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature _____ Parent Signature _____

HIPAA Consent

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review it carefully.

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for the purpose of treatment, payment or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization is in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services. You may want a friend or family member to discuss care with a physician(s), or staff member, take messages, and pick up prescriptions or other medically related communications.

- **Please indicate if there is a friend or family member to whom we are allowed to release medical information to:**

  Name: _____ **Phone:** _____ **Relationship** _____

  Name: _____ **Phone:** _____ **Relationship** _____

You may also identify a friend or family member to whom we are specifically restricted from releasing medical information to:

Name: _____ **Phone** _____ **Relationship** _____

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Resources. We will not retaliate against you for filing a complaint.

For more information, please contact us at: 734-374-1112 This notice is effective: 11/14/2014

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

_____ _____

Signature Date

Permission to Communicate my Health Information Electronically

Our office is pleased to inform you that we now participate in a health information exchange. As you may be aware, health information exchanges allow for electronic communication and access to your electronic medical record. This electronic access, in turn, supports opportunities for improved continuity of care by physicians and other healthcare personnel who are involved in your care. Most important is that health information exchanges create a means by which healthcare data may be accessed in a shorter period than has been traditionally the case with paper records.

Participation in the health information exchange could give your healthcare provider access to critical information such as your home address, past medical history, surgical history, hospitalizations, family history, social history, vital signs, immunizations, allergies, chronic medical conditions, previous and current medications, laboratory and radiology test results. Of course, your privacy protections through HIPAA would remain and providers will be expected to access information consistent with these rules.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW.

______ **YES**, I want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have been informed about information that will be communicated and have had the opportunity to ask any questions about this decision. I understand that I have the right to change my mind and can withdraw permission by updating this form by checking the NO section and entering a revised date. If I withdraw permission any information in my electronic medication record will not be accessible by the health information exchange. At that point my doctor will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

OR

_____ **NO**, I do not (or no longer) want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have had the opportunity to ask any questions about this decision. I understand that my information will continue to be stored in my electronic medical record but will not be accessible by the health information exchange. I understand that by not participating it may be more difficult for physicians and other healthcare providers to coordinate my care, especially in an emergency situation or when my physician is not available. My physician will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

____
Print First Name, Last Name, DOB

_______________________________________ ______________________
Signature of Patient or Representative Date

_ _

I, ________________________________ authorize my reports/records to be sent to the following:

Primary Doctor (PCP):________________________ Location/Phone: _________________________

Referring Doctor: ____________________________ Location/Phone: _________________________

Attorney: __________________________________ Location/Phone: _________________________

Case Manager: ______________________________ Location/Phone: __________________________

Signature: _____________________________________
Date: ____

Patient History Form

Patient Name: _____ Date of Birth: _____

Medications List

Medication Name (Include over the counter medication)	Strength / Dose (mg)	Number of pills per dose	Number of times Per day
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8._____	_____	_____	_____
9. _____	_____	_____	_____
10._____	_____	_____	_____

Past Medical History

Diabetes	____ Yes	___ No	Colitis	____ Yes	___ No
High Blood Pressure	____ Yes	___ No	Hepatitis	____ Yes	___ No
Stroke	____ Yes	___ No	Tuberculosis	____ Yes	___ No
Heart Disease / Heart Attack	____ Yes	___ No	HIV/AIDS	____ Yes	___ No
Kidney Disease	____ Yes	___ No	Cancer	____ Yes	___ No
Hypo/Hyperthyroidism	____ Yes	___ No	• Cancer Type		
Epilepsy	____ Yes	___ No	Other		
Asthma	____ Yes	___ No			
Heart Murmur	____ Yes	___ No			
High Cholesterol	____ Yes	___ No			
Pulmonary Embolism	____ Yes	___ No			
Cataracts	____ Yes	___ No			
Crohn's Disease	____ Yes	___ No			

Allergies

Drug/Non-Drug Allergy	Allergic Reaction

Patient Name: _____ Date of Birth: _____

Family History

	Stroke	Seizure	Brain Tumor	Muscle Disease	Brain Aneurysm	Neuropathy	Alzheimer	Parkinson Disease	Multiple Sclerosis
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐

Patient Social History

Use of Tobacco:	___Never ___Previously, years quit? ___Current Packs/Day ____
Use of Alcohol:	___Never ___Rarely ___Moderate ___Daily
Use of Drugs:	___Never ___Yes, Type/Frequency_____
Exercise:	___No ___Yes, Type/Frequency_____
Caffeine:	___No ___Yes, Type/Frequency_____

Have you had any of the following tests? If so, where and when?

Test	No	Yes	Location
MRI Brain			
MRI Spine			
CT Head			
Carotid Ultrasound			
EEG			
Emg Upper/Lower Extremities			

Previous Hospitalizations and Surgeries

Surgeries/Hospitalizations	Year

Michigan Neuroscience Clinic PLLC Financial Policy

Patient Name: _____ **Date of Birth:** _____

BASIC POLICY Payment for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH) All MDCH patients must provide current, valid **MIhealth** card and any additional Health Maintenance Organization (HMO) identification cards issued by your insurance.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

WORKER'S COMPENSATION If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

YEARLY HEALTH CHECKS Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made either to me or on my behalf to **Michigan Neuroscience Clinic PLLC** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurances please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to _____. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature: _____ **Date:** _____

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Advance Directive Selection Form

Please select one of the following advance directive options by checking the appropriate box. If you wish to provide additional information, please do so in the space provided. This will help us ensure that your health care preferences are respected.

Please choose one of the following options:

1. Durable Power of Attorney (DPOA)
   I designate a durable power of attorney to make healthcare decisions on my behalf if I am unable to do so.
   ☐ Yes
   ☐ No

   If yes, please provide the contact details of your appointed DPOA:
   Name: _____
   Phone Number: _____
   Relationship to you: _____

2. Living Will (LV)
   I have a living will that outlines my preferences for healthcare if I am unable to communicate.
   ☐ Yes
   ☐ No

3. Patient Advocate Designation (PAD)
   I designate a patient advocate to make healthcare decisions for me if I am unable to do so.
   ☐ Yes
   ☐ No

   If yes, please provide the contact details of your appointed advocate:
   Name: _____
   Phone Number: _____
   Relationship to you: _____

4. Self
   I prefer to make my own healthcare decisions at all times.
   ☐ Yes
   ☐ No

By signing below, I confirm that the information provided is accurate, and I understand the nature of the advance directive I have selected.

Patient Name: _____ DOB: _____
Signature: _____ DATE: _____