CHARLES COUNTY NEUROLOGY
MICHAEL K. GREENBERG, MD
11637 TERRACE DRIVE SUITE 100
WALDORF, MD 20602
PHONE: (301) 870-7287 or (301)932-7189
FAX: (301) 870-0687
EMAIL: neuro11637@gmail.com

PATIENT NAME FIRST MIDDLE LAST			DATE OF BIRTH	AGE
HOME ADDRESS	CITY	STATE	ZIP CODE	
OCCUPATION EMPLOYED RETIRED	SOCIAL SECURITY NO.	MARITAL STATUS	SEX	CONTACT NUMBERS
EMPLOYER	ADDRESS			HOME PHONE
SPOUSE (OR PARENT) NAME	SPOUSE OR PARENT PHONE NUMBER			WORK PHONE
EMERGECY CONTACT	EMERGENCY CONTACT PHONE NUMBER			CELL PHONE
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN			
PRIMARY PHARMACY/PHARMACY LOCATION	EMAIL ADDRESS			

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I AGREE TO PROMPTLY PAY ALL CHARGES WHEN BILLED FOR MEDICAL SERVICES RENDERED AND ACCEPT LEGAL RESPONSIBILITY FOR ANY AND ALL CHARGES FOR THE PATIENT NAMED ABOVE. I HAVE READ AND UNDERSTAND FULLY THE BILLING POLICY IMPLEMENTED BY THE PRACTICE OF MICHAEL K, GREENBERG, MD I ALSO TAKE FINANCIAL RESPONSIBILITY IF I SHOULD FAIL TO COMPLY WITH MY CONTRACTUAL AGREEMENT WITH MY HEALTH CARRIER AND NOT PRESENT AT THE TIME OF SERVICE DOCUMENTS REQUIRED TO PROCESS MY HEALTH CARE CLAIMS.

SIGNATURE_____ DATE_____

BILLING AND INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER		
SECONDARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER	SUBSCRIBERS S.S.N.	EFFECTIVE DATE
SUBSCRIBERS NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBERS ADDRESS	WORK PHONE	SUBSCRIBERS DATE OF BIRTH		

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BILLING OFFICE.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO MICHAEL K. GREENBERG, MD FOR ANY SERVICES FURNISHED ME. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFIT APPLY.

I AUTHORIZED ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION.)

SIGNATURE_____ DATE_____

Release Form for individuals involved in care of patient:

I, _____, give Charles County Neurology my permission to speak with the following people regarding my heath status, including diagnosis, treatment options and plans and payment for health services I receive from Charles County Neurology.

This consent is valid until such time as I provide Charles County Neurology written revocation of it.

Charles County Neurology may speak with:

Name:_____ Name:_____
Relationship:_____ Relationship:_____

Name:_____ Name:_____
Relationship:_____ Relationship:_____

Name:_____ Name:_____
Relationship:_____ Relationship:_____

Name:_____ Name:_____
Relationship:_____ Relationship:_____

Name:_____ Name:_____
Relationship:_____ Relationship:_____

Name:_____ Name:_____
Relationship:_____ Relationship:_____

Name:_____ Name:_____
Relationship:_____ Relationship:_____

***Patients Signature**: _____

Date: _____

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Charles County Neurology's notice of privacy policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:_____ Witnessed by:_____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this acknowledgement.

Date: _____

Time: _____

Employee Name: _____

CHARLES COUNTY NEUROLOGY
11637 TERRACE DRIVE SUITE 100
WALDORF, MD 20602
(301)-870-7287
(301)-870-0687 (FAX)

DATE:_____

IN ACCORDANCE WITH HIPPA WE ARE NO LONGER PERMITTED TO LEAVE INFORMATION WHICH MAY BE CONSIDERED SENSITIVE AND GUARDED UNDER THE LAW.

_____YES, I GIVE CHARLES COUNTY NEUROLOGY PERMISSION TO LEAVE A MESSAGE REGARDING MY PHI (PROTECTED HEALTH INFORMATION) ON MY ANSWERING MACHINE/VOICEMAIL IN THE EVENT THEY ARE UNABLE TO REACH ME DIRECTLY.

_____NO, I DO NOT GIVE PERMISSION FOR CHARLES COUNTY NEUROLOGY TO LEAVE A MESSAGE REGARDING MY PHI (PROTECTED HEALTH INFORMATION) ON MY ANSWERING MACHINE/VOICEMAIL IN THE EVENT THEY ARE UNABLE TO REACH ME DIRECTLY.

_____
PATIENT/GUARDIAN SIGNATURE

_____
PRINT PATIENT/GUARDIAN NAME

CHARLES COUNTY NEUROLOGY
11637 TERRACE DRIVE, SUITE 100

1. **MISSED APPOINTMENT FEE:** There is a 24-hour business day notice required to cancel an appointment. The charge for a missed new-patient appointment and EEG and for a missed EMG is $50.00. The charge for a missed follow-up appointment is $25.00. You will not be seen for another appointment until the fee is paid. This fee is paid by the patient and will not be paid by the insurance company. Again, payment for this fee is the **patient's responsibility**. We attempt to make reminder calls to all of our clients. This is a courtesy to you and does not relieve you from your responsibility to give a 24-hour cancellation notice (one business day- not to include Saturday, Sunday or major holidays) for appointments you are unable to keep.

2. **FEES:** At the provider's discretion, a fee will be charged for paperwork written or completed on a patient's behalf. The office will contact you upon completion of the paperwork. Examples of paperwork, include but are not limited to:

   Family Medical Leave Act (FLMA)
   Department of Transportation (DMV) forms
   Disability Forms
   Any report or letter requested by the patient / guardian
   Forms or letters completed for the school

   Copying Records: There is a copying fee, as outlined by the State of Maryland, for the forwarding of medical records to insurance companies, attorneys, and other providers. If this fee is not paid by the requesting company or individual, it then becomes the patient's responsibility.

3. **Miscellaneous:**
   - **All co-pays are due at the time of the visit.**
   - **At the provider's discretion, a fee will be charged for letters written on the patient's behalf. This fee is the patient's responsibility and cannot be filed to the insurance company.**
   - **I have read and been offered a copy of the office's HIPA Policies.**
   - **For all insurance clients, I have read and been offered a copy of the "Patients Bill of Rights."**

   ***It is the patient's responsibility to obtain the initial authorization from their insurance company, if required. Please provide this authorization to the staff.**

   * I have read and understand the office policies of this office.

_____ _____

Signature **Date**

Charles County Neurology

11637 Terrace Drive Suite 100

Waldorf, MD 20602

Phone: 301-870-7287 Fax: 301-870-0687

Consent of Release of Medical Information

I Authorize: Charles County Neurology

To Release to OR Receive From:

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

The following Records:

1. All Records:

2. Lab Dates: _____

3. Imaging Dates: _____

4. Other: _____

Name of Patient: _____

Account #:_____

Address of Patient: _____

_____

Date of Birth: _____/_____/_____

Signature: _____

Charles County Neurology

Prescription Refill Policy

1. It may take 1-3 business days to refill you prescription. We must review your medical records, check for expiration dates, verify the number of refills and ensure refill eligibility. Certain medications require laboratory testing before they can be refilled.

2. You should contact us three (3) days before your medication is due to run out. If you use a mail order company, please contact us fourteen (14) days before your medication is due to run out. Messages should be left on the prescription line.

3. Refill requests may also be made through your pharmacy. The pharmacy will forward the necessary information to our office to begin the research process.

4. We utilize strict controls for medications containing narcotics. Some narcotics cannot be called into the pharmacy for refills. The patient must be seen in the office for those non-refillable pain or other controlled medications to be refilled. Patients taking narcotic medications cannot have the medication refilled until the current prescription is fully expired. Patients taking these medications must be seen by the physician at least every 90 days.

5. A signed "controlled-substance/narcotic policy" agreement is required by the patient. The patient must pick up his/her prescription in person, unless authorized by staff. Proper state issued id must be presented and a consent form must be signed.

6. Refills on medication can only be authorized on medications prescribed by physicians/providers in our office. We will not refill medications prescribed by other physicians.

7. If your prescription bottle indicates you have refills left, you do not need to call our office. Contact your pharmacy and they will refill it for you, be sure to give the pharmacy adequate time to fulfill your request.

8. Routine refills are handled during the weekdays.

9. Prescriptions will not be filled for unauthorized "walk-in" patients.

10. You must follow prescription directions, no early refills.

_____ _____

Patient Name Date

Charles County Neurology

Michael Greenberg, M.D.

Name:

_____

Date of Birth: _____

Race:_____

Ethnicity(Please Circle): Latino/Hispanic OR Non Latino/Non Hispanic

Language Preferred:

_____

Patient Health Survey – Charles County Neurology

Patient Name_____ Date_____

Medication Allergies:

iodine	x-ray dye
aspirin	NSAID's
penicillin	tetracycline
sulfa drugs	latex
novocaine	codeine
Dilantin	phenobarbital
Tegretol	Depakote
other medication allergy (List)	

Family History:

cancer
alcoholism
Alzheimer's disease
cancer of brain
heart problems
diabetes
headaches/migraines
heart attack
high cholesterol
multiple sclerosis
Parkinson's Disease
Huntington's chorea
hypertension
muscular dystrophy
neurological disease
seizures
sickle cell disease
stroke
vascular disease
back or neck problems
hemophilia

Past Surgical History:

pacemaker implant
back surgery
orthopedic surgery
breast tumor removal benign
breast cancer surgery
CABG (Coronary Bypass)
coronary stent
cancer surgery
carotid endarterectomy
craniotomy
carpal tunnel surgery
transplant surgery
Other surgery (List):

Social History:

marital status
tobacco use (amount)
alcohol use (amount)
caffeine use (amount)
STD history
illegal drug use
prescription drug abuse
alternative medicine use
appropriate safety measures
diet habits
exercising regularly
wear seat belts
other

Medication History:

Medication name and strength	Started	Stopped
Continue on back or copy of personal medication card: check box ☐		

Patient Signature_____ Reviewing MD(Date)_____

Past Medical History:

Neurological Hx:

encephalitis/meningitis
herpes
Alzheimer's disease
brain tumor
cerebral aneurysm
multiple sclerosis
neuropathy
Parkinson's disease
seizure disorder
spinal cord injury
stroke
syncope
concussion
migraines
headache

Cardiovascular Hx:

cardiac disease
CAD or MI
cardiac arrhythmias
atrial fibrillation
hypertension
murmur
peripheral vasc dis

Childhood Illnesses:

polio
rheumatic fever
meningitis
asthma
other illness

Dermatologic Hx:

genital herpes
oral herpes
shingles
lupus
melanoma
basal cell carcinoma
squamous cell carc

Endocrine Hx:

hyperthyroidism
hypothyroidism
diabetes
other

GI Hx:

liver conditions
bowel problems
colitis
constipation
diarrhea
irritable bowel synd
ulcerative colitis
hepatitis
ulcer
other

HEENT Hx:

glaucoma
cataracts
macular degen
uveitis
hearing loss
otalgia
sinusitis
tinnitus
vertigo

Hematol/Lymph Hx:

anemia
iron-deficiency
sickle cell
vit B12 deficiency
lymphoma
clotting problems
sickle cell

Immunologic Hx:

HIV/AIDS
immune disorder
sarcoidosis
tuberculosis
polymyalgia rheum
lupus
Lyme disease

Male Reproduct Hx:

BPH
prostate cancer
prostatitis
STD's
impotence
BPH

Female Reproduct Hx:

cervical problems
Cervical cancer
ovarian tumor/cancer
uterine tumor benign
uterine cancer
breast problems
breast cancer
benign tumor(cyst)
STD's

Musculoskeletal Hx:

arthritis conditions
degenerative joint dis
Lyme arthritis
osteoarthritis
rhematoid arthritis
degernative spine dis
myasthenia gravis
myopathy

Respiratory Hx:

asthma
COPD
lung cancer
pulmonary edema
pulmonary embolism
sleep apnea
tuberculosis

Psychiatric Hx:

depression
bipolar
anxiety disorder
obsessive-compulsive
panic
posttraumatic stress
alcoholism
drug abuse

Renal / Urinary Hx:

kidney problems
incontinence
bladder dysfunction
infection
kidney stones
dialysis

Review of Systems:

Constitutional Symptoms:

change in weight gain
change in weight loss
fever
insomnia
chills
malaise
fatigue

Skin:

itching
rash
hives
Skin cancer
ulceration

Ears,Nose,Throat:

loss of hearing
Tinnitus (ringing)
Nasal congenstion
Seasonal allergies
Earache
Nose bleeds
Runny nose
Change in voice
Dizziness/vertigo
Sore throat

Eyes:

blurred vision
Discharge
Pain
Diminished vision
Vision loss
Redness

Respiratory:

Shortness of breath
Cough
Wheezing
Hemoptysis

Cardiovascular:

chest pain
Edema
Palpitations
Syncope/fainting
Short of breath (SOB)
MI/Heart attack
Orthopnea(SOB in bed)
PND (SOB at night)

Gastrointestinal:

Heartburn
constipation
Vomiting
Diarrhea
Bloating
Nausea
Abdominal pain
Blood in stool
PUD/Ulcer symptoms
IBS/irritable bowel

Genitourinary (Male):

Urgency
Dysuria
Penile discharge
Blood in urine
Impotence
Rash
Frequency
Testicular pain
Flank pain

Genitourinary(Female):

Urgency
Blood in urine
Vaginal discharge
Flank pain
Pelvic pain
menorrhagia
Frequency
Dysmenorrhea
Irregular menses

Endocrine:

Breast symptoms
Diabetes
Polyuria
Weight gain
Steroid use
Polydipsia
Hirsutism (hair growth)
Hypoglycemia

Musculoskeletal:

Arthralgia(joint pain)
Neck pain
Back pain
Ambulatory problems
Myalgia (muscle pain)
Joint stiffness
Swelling

Neurological:

Syncope (fainting)
Dizziness
Motor symptoms
Altered mentation
Seizure
Parasthesias
Ataxia (coordination)
Altered Speech
Memory Loss
Stroke
Headache

Psychiatric:

anxious
depression
Mood swings
Stress
Delusions
Hallucinations
suicidal thoughts

Heme/Lymph:

Anemia
Easy Bruising
Bleeding
Swollen Glands

Other Symptoms:

Patient Signature_____ Reviewing MD(Date)_____