MD NEUROLOGY

3120 Medpark Dr. Suite 100
Denton, Tx, 76208-6982

Phone: (940) 383-1770
Fax: (833) 992-0840

Date: _____

PATIENT INFORMATION:

Last name: _____ First name: _____ Middle Initial: _____
Street Address: _____ Apartment # _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell #: _____ E-mail address: _____
Date of Birth: _____ SS#: _____
Sex: ☐Male ☐Female | Race: _____ ☐Decline | Ethnicity: _____ ☐Decline
Marital Status: ☐ Single ☐ Married ☐Widowed ☐Divorced
Alcohol Use: ☐Yes ☐No | Smoking/Tobacco Status: ☐Current ☐Former ☐Never ☐Social

SPOUSE'S INFORMATION:

Name of Spouse: _____ Telephone #: _____ Cellphone #: _____

PERSON NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____
Telephone Number: Home _____ Cell _____ Work _____
Primary Care Physician: _____ Telephone #: _____ Fax #: _____
Pharmacy: _____ Telephone #: _____ Fax #: _____

INSURANCE **(If you have more than one insurance carrier, please list the primary carrier first)**

Primary Insurance: _____ Insured Perso _____ CO-PAY $ _____
Secondary Insurance: _____ Insured Person: _____
Please list name of insured person if other than the patient. _____

CARRIERS REQUIRE WE SEND COPIES OF YOUR INSURANCE CARD. PLEASE FURNISH US WITH YOUR INSURANCE CARD(S) FOR PHOTOCOPYING. ALL CO-PAYMENTS ARE PAID AT THE TIME OF SERVICE PER YOUR INSURANCE CONTRACT.

TO MEDICARE PATIENTS: MEDICARE DOES REQUIRE WE ENTER THE NAME OF THE REFERRING PHYSICIAN ON YOUR CLAIM FORM. WITHOUT THIS INFORMATION, THE CLAIM CANNOT BE PROCESSED.

How were you referred to us? ☐Friend/Relative: _____ ☐Internet Site: _____ ☐Other: _____

Assignment of Benefits / Financial Agreement

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Jerome P. Lisk all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not, paid by insurance. I hereby authorize Dr. Jerome P. Lisk to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Prior Authorization / Referral

I, the undersigned, understand that I am responsible for obtaining all visit prior authorizations and/or referrals. I also understand that if there is not a prior authorization approval or referral on file for any visit, and my insurance denies coverage and payment, I will be financially responsible for any and all balances due on my account.

_____ _____
Signature of Insured/Guardian Date

Consent For Treatment

I do hereby give the healthcare providers of MD Neurology consent to perform all medical health care services, permission to diagnose and treat me until this permission is revoked in writing.

_____ _____
Signature of Insured/Guardian Date

Authorization to Discuss Personal Health Information

Patient: _____,
I give permission to MD Neurology, and its affiliate providers to discuss my personal health information and data *(excluding HIV/AIDS test results/diagnosis)* with the following named people:

Name: (please print)	Initials:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature Date

HIPPA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

TREATMENT:

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides cares to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT:

Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in the following situations without your authorization: As required by law; public health issues as required by law, communicable disease, health oversight, abuse or neglect, Food and Drug Administration requirement, legal proceedings, law enforcement, coroners' office, funeral directors, organ donation, research, criminal activity, military activity and national security, workers compensation. Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on this use or disclose indicated in the authorization.

The following is a statement of your rights with respect to your protected health information (PHI).

You have the right to inspect and copy your PHI: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your PHI: This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also require that any part of your PHI not be disclosed to family members or friends who may be involve in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state, in writing, the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosed your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively.

You have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosers we have made, if any of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMNETS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ➢ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ➢ Obtain payment from third party payers
- ➢ Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

I wish to have the following restriction to the use or disclosure of my health information:

_____

_____

_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment on this Notice of Privacy Practices Acknowledgment but was unable to do so as documented below.

Date:	Initials:	Reason:

FINANCIAL RESPONSIBILITY HANDOUT

Dear Patient,

The information supplied to the office, including all personal and insurance information is current and to date. I understand that if my insurance should deny coverage for any reason, I am responsible for the full payment made payable to MD Neurology and Jerome P. Lisk M.D., Inc.

The following are charges which are **NOT** covered by your medical insurance:

No-Show appointment – Under this policy, the patient will be charged a $50.00 fee for every missed office visit. A No-Show appointment is defined as, any patient who misses a scheduled appointment without proper notification or cancels an appointment with less than 24 hours notice. If you have two no-show appointments within a 12-month period, you will no longer be considered our patient.

Late Arrivals – Patients are expected to notify the office if they might arrive late for their appointment. Follow up patients who check in after their appointment time may have to reschedule due to a lack of available patient time slots for that day. New patients who arrive less than 30 min before their appointment may have to be rescheduled due to time required for nursing intake, especially if previously requested paperwork has not been received or additional paperwork/insurance changes must be processed. Follow ups that are more than 10 min late will be rescheduled.

Charge for Form Completion – Under this policy the patient will be charged a minimum of $35.00 for all forms brought into the office for completion by the physician or staff. Advanced payment required.

Charge for Phone Consult, Document Review and Preparation – Under this policy the patient will be charged a minimum of $50.00 per 15 minutes. Initial advanced payment of $50.00 required. For consults that are longer than 15 minutes, additional payment must be remitted prior call completion. Acceptable forms of payment Debit or Credit Card. Invoicing option not available.
(A Phone Consult constitutes any time spent discussing treatment, options, condition updates, medications, lab results etc.)

Charge for in-office Family Consults – Under this policy the patient or family member will be charged a minimum of $76.00 per 15 minutes. Consults may be scheduled to discuss conditions, treatments, options, updates etc. This option is not billable through insurance as the patient is not present. Invoicing option not available.

Charge for Medical Records – Under this policy the patient and/or firm will be charged an administration fee of $25.00 for the first 20 pages, plus $.50 per additional page. This includes all printing and faxing. Additional charges for postage TBD. Advanced payment required.
(i.e. 25 pages will cost $27.50. This charge is non-refundable & does not carry over to multiple requests.)

FINANCIAL RESPONSIBITY FORM

(Please copy insurance card)

The information I have supplied to the office, including all personal and insurance information, is **current to date.** I understand that if my insurance should deny coverage for any reason, I am responsible for the full payment to the physician prior to the visit. This includes services not covered by my insurance such as Telemedicine, telephone consultations (i.e. conversations with the physician and any other optional service). Procedures such as: EEG's, maintenance and refill, Deep Brain Stimulator Programming, Botox, etc., are secondary insurance. There may be some financial patient responsibility based on your contract with your insurance company, amount of deductible or for services not covered by your insurance carrier. There are instances when an insurance company may reimburse our office 6-12 months after the date of service. If at that time there is a balance due from you, you will be responsible for any unpaid charges. If your account balance becomes 90 days delinquent, we will provide you with monthly payment plan options. Please keep in mind that the patient responsibility charges are between you and the insurance carrier. For any questions on charges from this office, please contact your insurance carrier first and then follow up with a call to our office so that we can assist you appropriately.

Please acknowledge and initial each of the following:
**Please see Financial Responsibility Handout for more information.*

_____ **$**50.00 for all "No Shows" appointments.
(i.e. not calling the office 24 hours prior to the date & time of your appointment to cancel and/or reschedule).

_____ $35.00 for all Fill-in form completion.

_____ Phone Consult Fee will be billed at the cash rate of $50.00 per 15 minutes.
(Any time spent discussing treatment, medications, condition questions etc.)

_____ Family Consult for in-office visits will be billed at the cash rate of $76.00 per 15 minutes.
(Without the patient present.)

_____ Medical Records will be billed at the rate of $25.00 admin fee for pages 1-20. Any and all additional pages above the first 20 pages will be charged at the additional rate of $.50 per page.

I have read the above and understand my financial responsibility, and hereby affix my signature in acknowledgment of the understanding:

Date: _____

Patient's Signature _____

Date of Birth: _____

Name of Insurance: _____

WORK SAEFTY AND ENVIRONMENT POLICY

IT IS THE POLICY OF MD NEUROLOGY TO PROMOTE A SAFE AND HEALTHY WORK ENVIRONMENT THAT IS FREE FROM HOSTILITY, INCLUDING VERBAL AND PHYSICAL INTIMIDATION. WE HAVE A ZERO TOLERANCE POLICY FOR DISRUPTIVE BEHAVIOR (VERBAL, EMOTIONAL AND/OR PHYSICAL), WHICH INTERFERES WITH WORK PERFORMANCE AND THE DELIVERY OF SAFE, HIGH QUALITY PATIENT CARE. PATIENTS THAT EXHIBIT SUCH BEHAVIOR WILL BE IMMEDIATELY DISMISSED FROM OUR SERVICE. THOSE WHO ARE NOT PATIENTS AND EXHIBIT SUCH DISRUPTIVE BEHAVIOR WILL NOT BE ALLOWED IN THE CLINIC.

I have read, understand and agree to the Work Safety and Environment Policy.

_____
Print Name

_____ _____
Signature **Date**

MD Neurology

Jerome Lisk, M.D.
Board Certified Neurologist
Fellowship Trained in Movement Disorders

PORTAL INFORMATION

You can access the Athena portal at: https://22955.portal.athenahealth.com/

- If you were signed up in office, your password is: Last name, year of birth, ! Ex. Jones2021!

Please note the following practice information:

BRING ALL MEDICATIONS, MEDICATIONS BOTTLES AND YOUR AFTER VISIT SUMMARY (INSTRUCTIONS YOU LEFT WITH AT THE END OF YOU PREVIOUS VISIT) TO ALL APPOINTMENTS. MARK THE CHANGES TO ANY MEDICATIONS PRIOR TO COMING TO YOUR APPOINTMENT.

Contacting Our Office:

Please send us messages through the patient portal before calling the office unless it is an urgent medical matter. Reponses through the patient portal usually get answered faster than phone calls, since during the day we are usually in the room with patients and on the phone with pharmacies or insurance companies. Routine calls and messages will be answered with in 72 hours. Urgent phone calls will be returned the same day. If you are having symptoms that need to be evaluated emergently or think you need to go to the ER then you should call 911 immediately and go to the nearest ER or Urgent care. Calls on Thursday if not urgent will be answered on Monday or Tuesday. Repeated Phone Calls the same day will only delay a response.

Medication Refills:

Please call your pharmacy for refills and do not allow your medication to get below a two week supply before doing so. Also do not wait until you are out of medication to call in a refill Friday to Sunday, these will not be filled until Monday at the earliest.

Results (Labs and Imaging):

Labs, Imaging (MRI, CT, DaTScan, etc.) and other results from procedures will be discussed at the next clinic visit. Due to the large number of tests ordered you will only receive a call if you have an abnormal result. If you wish to know the result of a test then call to move up your appointment so the doctor can go over your results in person.