*LANCASTER NEUROLOGY*

# PATIENT INFORMATION

**NAME:**_____ **DATE:**_____

**SS #**_____ **DOB:**_____

**Sex: M F Marital Status: S M D W Race:**_____ **Religion:**_____

**ADDRESS:**_____

**CITY**_____ **STATE**_____ **ZIP**_____

**Tel # (H)**_____ **(C)**_____ **(W)**_____

**Primary/Family Dr:**_____

**EMERGENCY CONTACT INFO:**

**Name**_____ **Relation:**_____ **Tel#**_____

**Address**_____

**NEXT OF KIN (not living at same address)**

**Name**_____ **Relation:**_____ **Tel#**_____

**Address**_____

**PRIMARY INSURANCE:**

**Insurance Co:**_____ **Policy**_____ **Gr#** _____

**Policy Holder/Name:**_____ **DOB**_____ **SS#**_____

**SECONDARY INSURANCE:**

**Insurance Co**_____ **Policy#**_____ **Gr#**_____

**Policy Holder/Name:**_____ **DOB**_____ **SS#**_____

**Responsible Party**_____ **Relation:**_____

**Address:**_____

**DOB**_____ **Soc Sec No**_____

_____ _____

**Print Name** **Signature**

# CONSENT FOR TREATMENT / ASSIGNMENT FOR BENEFITS

Patient Name _____ SOC _____

## CONSENT FOR TREATMENT / SERVICES

I hereby voluntarily consent for treatment provided by Lancaster Neurology. I permit the Facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s).

## ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY

I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

## NOTICE OF PRIVACY PRACTICES

*Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA)*

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.

| **The undersigned certifies s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.** | |
|---|---|
| Patient's Signature or Legal Representative | Date |
| | |
| Relationship to Patient | Time |
| | |
| Witness of Signature | Interpreter, if utilized |
| | |
| | If Telephone Consent, Second Witness' Signature |
| | |

# Lancaster Neurology

834 W Meeting St Ste G
Lancaster, SC 29720
(803)285-1111

RE: Appointment/No Show Policy

Appointments that are not cancelled within 24 hours will be considered a "NO SHOW".
If you have "three "no shows within a twelve month period you will be immediately terminated from the practice. We are always willing to reschedule your appointment, but you must contact the office 24 hours before your appointment.

We greatly appreciate your understanding and cooperation in this matter going forward.

_____
Print Name

_____ _____
Signature Date

_____ _____
Witness Date

APPT/NS History

1st Date: Time:

2nd Date: Time:

3rd Date: Time:

# LANCASTER NEUROLOGY
## Dr Tooba Khan
### 834 W Meeting St Ste G
### Lancaster, SC 29720
**Tel: 803-285-1111**


Please note that our office hours are Monday through Friday 8 a.m.-5 p.m.

If you have an EMERGENCY after those hours please go to your nearest hospital emergency department. If you have non-emergent questions after our office is closed please leave a message and your call will be returned next business day.

***Our office is not obligated to fill out any forms for Workers Comp or Disability Cases.***

***Office Evaluation notes clearly document Exam and will be provided to the requesting Authorities/Physicians with Patients permission.***

Date: _____

_____

**Print Name**

_____

**Signature**

***signature indicates that I have read and understand the above communication***