NEUROLOGIC ASSOCIATES, PLC

MARK A. LANDRIO, M.D.
ANNE B. SOLOMON, FNP-C STACY L. KONYAR, FNP-C

905 CEDAR CREEK GRADE, SUITE 200 PHONE [540] 722-8882
WINCHESTER, VA. 22601 FAX [540] 722-8883

Welcome to Our Office

Dear _____,

This letter is to serve as confirmation of your appointment at Neurologic Associates, PLC on_____at_____am/ pm.

For this appointment please arrive at least 30 minutes early

Included in this Welcome Packet is our Promise to Pay and Patient Questionnaire. Please read each page *carefully* and fill out *all necessary* information.
It is preferable that you return the completed forms prior to the date of your visit.

To mail completed paperwork, send to:
905 Cedar Creek Grade
Winchester, VA 22601
To fax completed paperwork, send to:
540-722-8883

In addition, to care for you efficiently and avoid delay in evaluating your condition, it is required that you bring with you the following:

- Your **Insurance Card(s)**
- Your **Co-pay,** should one be required**.**

*If there is no copay indicated on the card you will be required to pay 20% of your bill at the time of the visit.

*If you have a high deductible plan, the allowable insurance fee for the procedure will be taken at the time of the appointment.
(This excludes patients with two or more insurance policies that cover all acquired expenses.)

For financial policies and payment options please refer to the next page.

- All Applicable **Medical Records**

It may be necessary for you to contact your primary or referring physician prior to your visit in order to obtain the above information. If your insurance requires a referral, please make sure to contact your primary care physician and have his/her office submit it before your scheduled appointment.

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Date: _____

Patient Name: _____ Date of Birth: _____
Mailing Address: _____
_____
SSN: _____ Phone: (home) _____ (cell) _____
Email Address: _____
Patient employer/phone: _____
Emergency contact: _____ Phone: _____
Insurance: _____ Policy Number: _____
Insurance policy holder (**if different from patient**): _____
Insured's employer: _____
Date of birth (policy holder): _____ SSN (policy holder): _____

CO-PAY IS DUE AT THE TIME OF YOUR APPOINTMENT. IF YOU HAVE A HIGH DEDUCTIBLE PLAN, THE ALLOWABLE INSURANCE FEE FOR THE PROCEDURE WILL BE TAKEN AT THE TIME OF THE APPOINTMENT.

*Please list anyone authorized by you to receive information on your behalf:

_____

If the patient is under the age of 18, please print the name of the responsible party:

_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made either to me or on my behalf to Neurologic Associates, PLC for any services given to me by the physician/supplier. I authorize each holder of my medical records to release any information needed to the health care financing administration and its agents to determine these benefits or the benefits payable to related services. By signing this the patient is in agreement to pay the services rendered by the physician/supplier that are not covered by the patients' insurance company **or if SELF PAY, agrees to pay in full at the time of each visit.** (Anything over $300, half is due up front and the patient will be responsible for the balance of charges remaining after that deposit). Any balance remaining, after insurance has processed, that is not paid in full within 45 days of the date of service is subject to a 1.5% per month service charge and may be turned over to collections/attorney at our discretion. The patient is personally liable for damage to or failing to return any equipment belonging to this office.

WE REQUIRE NOTICE FOR CANCELLATION OF APPOINTMENTS WITHIN 1 BUSINESS DAY AND 2 BUSINESS DAYS FOR SLEEP STUDIES.

FEES FOR NO SHOWS AND/OR LATE CANCELLATIONS WILL BE ASSESSED AND THE PATIENT WILL BE RESPONSIBLE FOR THE FEE AT THE CURRENT RATE. CURRENT RATES AS OF 2/1/2016 ARE AS FOLLOWS:

- FOLLOW-UP APPOINTMENTS- **$85.00**
- NEW PATIENT APPOINTMENTS- **$150.00**
- TESTING (EMG/EEG/SLEEP STUDIES)- **$250.00**

All no show fees will be posted to the patient's account and will not be billable to insurance. There is a **4% convenience fee** for all credit card transactions. A copy of this authorization may be used in place of the original or signature on file may be entered on a claim form instead of a signature. **By signing this you are confirming receipt of the HIPAA compliance form.**

Signature: _____ Date: _____

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This is a list of insurances we currently accept. Please contact your insurance company if you have any questions regarding referrals, or prior authorization.

****If your insurance requires a referral it is your responsibility to obtain the needed information****

Par Insurance List:

- Medicare (includes Today's Options) *NO Freedom Blue
- Cigna Government Services- Medicare DME
- RR Medicare
- Humana Medicare PPO
- Tricare Standard/ Tricare for Life *NO Tricare Prime
- VA Medicaid (Straight VA Medicaid, VA Premier) Aetna Better Health, Anthem HealthKeepers Plus, Magellan Complete Care of VA, Optima Health Community Care, UnitedHealthcare Community Plan, Virginia Premier Health Plan
- Anthem Blue Cross Blue Shield (Carefirst, Highmark, Federal BCBS) *Must have PPO in suitcase
- Cigna (Open Access Plus, PPO and HMO) *No Connect Network *No DME
- Aetna (PPO, HMO, HNO, Medicare PPO/HMO)
- Aetna Innovation Health
- United Health Care
- HealthSmart PEIA
- Department of Labor

NON PAR WITH WEST VIRGINIA MEDICAID

NON PARWITH WITH WEST VIRGINIA WORKERS COMP

NON PAR WITH GREAT WEST

NON PAR WITH ANY ANTHEM HEALTHKEEPERS

NON PAR WITH OPTIMA

PLEASE SIGN TO ACKNOWLEDGE RECEIPT OF INSURANCE INFORMATION:

_____ Date: _____

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Patient and Responsible Party/HIPPA Authorization

I, _____, authorize ***NEUROLOGIC ASSOCIATES, PLC*** to apply for benefits on my behalf for the covered services rendered and requested that payments for the above insurance company be made directly to provider for the treatment person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above agent. After payment is received from your insurance company, any outstanding balance will be transferred to your personal responsibility. At that time, you will be asked to settle your account. Failure to pay your bill in a timely manner will result in our practice forwarding your account to a collection agency. Should we proceed with collections, you will be responsible for any costs charged to us by our collection agent. In addition, we will schedule no further appointments until you have settled this outstanding balance. In all cases, professional fees are the patient, spouse, guardian and/or parent's responsibility.

Patient or Responsible party further agree to pay any and all collection fees incurred and any legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the for the collection of past due debts.

I authorize the release of medical records from another party to ***MARK LANDRIO, MD*** to assist in my care and authorize the release of records to another physician said assignee who is consulting in my care. I permit a copy of the authorization to be used in place of the original. I have been made aware of my privacy rights and have received the ***NEUROLOGIC ASSOCIATES, PLC*** HIPPA Privacy Notice.

Patient Signature _____ Date _____

NEW PATIENT INFORMATION

PATIENT NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____

CHIEF COMPLAINT _____

OCCUPATION (if retired, please list last occupation) _____

DO YOU HAVE ANY DRUG ALLERGIES? _____

ANY FOOD OR OTHER ALLERGIES? _____

PHARMACY (name & location): _____

PRIMARY CARE PHYSICIAN (name & location):

_____

WORK INJURY/AUTO ACCIDENT: **YES NO**

If you suffer from **headaches** please answer the following. **Circle** your best answer.

1. When you have headaches, how often is the pain severe?
   Never Rarely Sometimes Very often Always

2. How often do headaches limit your ability to do usual daily activities including household work, school, work or social activities?
   Never Rarely Sometimes Very often Always

3. In the past 4 weeks, how often have your felt too tired to do work or daily activities because of your headaches?
   Never Rarely Sometimes Very often Always

4. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?
   Never Rarely Sometimes Very often Always

If you suffer from **fatigue and/or excessive daytime drowsiness,** please answer the following.
Circle Yes or **No.**

1. Do you snore? YES NO
2. Does your snoring bother others? YES NO
3. Has anyone noticed that you quit breathing in your sleep? YES NO
4. Do you wake up feeling tired? YES NO
5. Have you ever fallen asleep while driving? YES NO
6. Do you have high blood pressure? YES NO

PATIENT NAME_____ DATE OF BIRTH_____

FAMILY HISTORY

Please list relative and any disorders/diseases they may have. Please include any hereditary diseases. If they are deceased, please give approximate age and cause of death.

Mother _____
Father _____
Sister(s) _____
Brother(s) _____

Please list any surgery or recent hospitalizations. Please include approximate date.

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY: **Circle** any problem that you may have experienced.

Weakness	Lung Disease	Bowel Problems	Knocked Unconscious
Numbness	Rheumatic Fever	Sexual Dysfunction	Memory Loss
Cancer	Heart Disease	Back Pain	Depression
Double Vision	High Blood Pressure	Arm Pain	Anxiety
Eye Problem	Ulcer Disease	Hand Pain	Diabetes
Neck Pain	Venereal Disease	Meningitis	Blood Disorder
Tuberculosis	Incontinence	Seizure	Thyroid Disorder

Please explain further any circled item:

_____
_____
_____

COMPLETE REVIEW OF SYSTEMS:

Explain any difficulty or problem that you have with any system below:

Head/Eyes/Ears/Nose/Throat _____
Skin _____
Chest/Lungs _____
Heart/Vascular _____
Abdomen/Intestines/Liver _____
Urinary System/Genital System _____
Musculoskeletal (Joints/Muscles) _____

Have you had any of the following testing, if yes, when?

EEG (Brain Wave) _____
CT Scan (Brain or Spine) _____
MRI Scan (Brain or Spine) _____
EMG/Nerve Conductions _____
Myelogram _____
Arteriogram _____
Other Testing _____

PATIENT NAME_____ DATE OF BIRTH_____

Marital Status – **Circle One**
Married Widowed Divorced Separated Single Live-In

Do you have children? _____ How Many? _____

How often do you use alcohol? **Circle One**
Never Seldom Occasionally Moderately Daily

Which of the following alcohol do you consume? **Circle** all that apply.
Beer Wine Liquor

Do you use tobacco?
YES NO

How often do you use tobacco? _____

Which of the following tobacco products do you use? Circle all that apply.
Chewing tobacco Cigars Cigarettes Pipe

Do you use recreational drugs? YES NO

PLEASE LIST ALL CURRENT MEDICATIONS (OVER THE COUNTER ALSO):

Medication Name	Medication Strength (i.e. 50mg)	How many times a day do you take this medication?