

REGISTRATION

Patient Name _____ Date of Birth _____ Age _____ Sex: M F

Current Address _____
If nursing home/assisted living please give name & phone

City State & Zip _____ Home Phone _____

Work phone _____ Cell _____ **BEST CONTACT NUMBER** _____

Social Security # (required) _____ Marital Status: Married Single Widowed Divorced

Current Occupation (former if retired/disabled) _____

Employment: Full time Part time Unemployed MedicallyDisabled Retired Military Student

Referring Physician _____ Phone _____

Primary Physician (if different than above) _____ Phone _____

Pharmacy _____ Phone _____

Primary Insurance _____ Secondary _____

If you are NOT the policy holder please complete: ↓

Policy Holder Name _____ Relationship to Patient _____

Social Security # _____ **OR** Birthdate _____

HIPAA Privacy Notice

I understand that **Dr. Bhullar** works very hard to protect my privacy and preserve the confidentiality of my personal health information (**PHI**). Dr. Bhullar may use and disclose my **PHI** to:

- Provide and/or coordinate health care for me
- handle billing and payment,
- take care of other health care operations.

Under the terms of this consent, I can ask Dr. Bhullar to restrict how my **PHI** is used or disclosed to carry out treatment, payment or health care operations. There is a detailed document called "Notice of Privacy Practices". It contains more information about the policies used to protect our patients' privacy. I understand I have the right to read the document before signing this agreement. I understand that I have the right to cancel this consent in writing at any time. If I do cancel the privacy consent, previously disclosed information would not be effected. _____ **Initials**

To whom may we release your information (spouse, grown child, sister, brother, etc)

Name	Relationship	Phone / Address
_____	_____	_____
_____	_____	_____

Patient Signature

Parent if patient is a minor

Date

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

I understand and agree that, regardless of my insurance status, I am legally responsible for the balance on my account for any professional services rendered. I have read and supplied all the information on this form and certify that all the information is true and correct to the best of my knowledge. I will notify this office of any changes in my insurance status or other information. _____ **Initials**

I request that payment of authorized Medicare benefits and /or any other medical insurance benefits be made on my behalf to CUMBERLAND NEUROLOGY/DR. BHULLAR for any services furnished. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related service. _____ **Initials**

Payment is due at the time services are rendered unless you have medical insurance (copays are due) or payment arrangements have been agreed upon in advance. We accept cash and checks and MasterCard or Visa. There will be a fee for all returned checks.

We will gladly discuss your proposed treatment and assist in answering questions related to your insurance. You must realize, however, that:

Your insurance is a contract between you, your employer and the insurance company. We are not part of that contract. As a medical provider our relationship is with you, the patient, not your insurance company.

If we have signed a **preferred provider** contract with your insurance carrier, that means we will disallow a certain discount amount because you, the patient, having chosen a **preferred provider**. Due to constantly changing contracts it is your, the patients', responsibility to check with your carrier to insure we are a **preferred provider**.

Not all services we offer are a covered benefit. Some insurance companies will, at times, select certain services they will not cover. We are not provided this information. **If you have any concerns about coverage of a test or procedure, contact your member a benefit, the number is provided on your card.**

We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, please contact us promptly to assist you. If you have any questions about the above information or any uncertainty regarding insurance, please don't hesitate to ask us. _____ **Initials**

All appointments must be cancelled by 3p.m. the previous day or noon on Friday for Monday appointments to avoid charges for a no-show cancellation. There is a \$25 fee that will be charged to the patient. Insurance allows but will not pay no-show cancellation fees. _____ **Initials**

Name _____ Date _____

List any allergies:

PLEASE SUPPLY A LIST OF YOUR MEDICATIONS AT CHECK IN

Indicate if you have had any of the following medical problems with the **year of illness or diagnosis**

_____ Congenital Heart Disease	_____ Coagulation (bleeding) disorder	_____ Other Problems
_____ Heart Attack	_____ Cancer (type) _____	_____
_____ High Blood Pressure	_____ Depression	_____
_____ Diabetes	_____ Alcoholism	_____
_____ High Cholesterol	_____ Abnormal Pap Smear	_____
_____ Stroke	_____ Thyroid problem (type) _____	
_____ Blood transfusions		

List all your surgeries and the year

Have you ever smoked? Dipped? **Y N** How many packs (cans) a day? _____ for how many years _____

When did you quit smoking? Dipping? _____

Do you drink any alcohol now? **Y N** On average how many drinks a day _____ or a week _____ or a month _____

Were you ever a heavy drinker? **Y N** When did you quit drinking? _____

Do you use any recreational drugs? **Y N**

Do you exercise regularly? **Y N**

Not including you; do any of your family members (**blood relatives**) have:

(M) Mother (F)Father (S)Brother/Sister (GP)Grandparent (O)Aunt/Uncle/Cousin

_____ Alcoholism	_____ Epilepsy	_____ High cholesterol
_____ Asthma	_____ Glaucoma	_____ Lupus
_____ Cancer	_____ Hayfever	_____ Migraine
_____ Diabetes	_____ Heart problems	_____ Stroke
_____ Depression	_____ High blood pressure	_____ Thyroid disorder

Please check any **current** problems you have below

Doctors Notes

General

Y N Recent weight loss

HEENT

Y N Severe headaches

Y N Vision problems

Y N Seizures

Y N Difficulty swallowing or talking

Y N Lumps/ bumps in the neck

LUNGS

Y N Chronic cough

Y N Shortness of breath

HEART

Y N Chest pain

Y N Funny heart beats

Y N High blood pressure

ABDOMEN

Y N Abdominal pain

Y N Liver problems

Y N Digestion problems

Y N Frequent diarrhea or constipation

Y N Blood in stools or urine

Y N Ulcers

Y N Hernia

Y N Nausea or loss of appetite

EXTREMITIES

Y N Ankle swelling

Y N Joint pain

Y N Joint deformity

NEUROLOGICAL / PSYCHOLOGICAL

Y N Numbness in any area

Y N Weakness

Y N Problems with sleep

Y N Anxiety

Y N Depression

FEMALE

Y N Any concerns about

Your period?

Y N Abnormal periods

___ How many pregnancies?

___ How many live births?

CUMBERLAND NEUROLOGY LLC

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM THIRD PARTIES

I authorize Cumberland Neurology, LLC to use certain protected information about me from the parties listed below:

This authorization permits Cumberland Neurology, LLC to use or disclose from:

Please provide name, address and/or fax number of physician

ALL RECORDS PERTAINING TO PATIENT

When my information is used or disclosed according to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing at any time, except to the extent that Cumberland Neurology, LLC had already acted on this authorization. My written revocation must be submitted to CUMBERLAND NEUROLOGY LLC in person.

Patient Name

Date of Birth

Patient or parent/guardian signature

Date

Witness

Date

I _____ hereby revoke this authorization of release of information.

DATE