

****Please review and update the information below to the best of your ability ****

Patient Information

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle:
Date of Birth:
Patient Email:
Address:
City & State:
Zip:
Cell #:
Work #:
Home #:
Sex:
Social Security #:
Patient Language:
Race:
Patient Ethnicity:

Are you living in an assisted /nursing facility?
Yes No
If yes, which facility?
Address:

Guarantor information (to whom statements are sent)

Last Name:
First Name:
Date of Birth:
Relationship to patient:
Phone:
Email:
Address:
City & State:
Zip:

Emergency Contact Information

Name:
Relationship:
Mobile Phone #:
Email:
Power of Attorney:
POA Phone #:
DNR: Yes No
Living Will: Yes No

****If you have a POA and/or answered “yes” to either DNR or Living Will, our office will need a copy of the legal document for your medical record. ****

PERSONAL INDIVIDUALS WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

Please initial if you do not wish to share any of your medical information: _____

_____	_____	_____	_____
Name	Relationship	Cell/Home Phone	Work Phone
_____	_____	_____	_____
Name	Relationship	Cell/Home Phone	Work Phone
_____	_____	_____	_____
Name	Relationship	Cell/Home Phone	Work Phone

POLICIES, RELEASES AND FINANCIAL RESPONSIBILITY

Payment is due at the time of service unless we are contracted with your insurance company, or you make other arrangements for payment prior to your visit.

1. All patients must complete the patient registration and health history questionnaire prior to being seen by the our providers.
2. All patients are required to provide a current copy of their insurance card and driver’s license at each visit. Patients are also required to notify DCND of any changes to their insurance, demographics and whom we can share information with. DCND will not be responsible for any denials for inaccurate insurance information given or omitted by the patient.
3. I authorize the release of medical record information to the referring physician, other documented physicians, my insurance carrier(s) and the above named in accordance with HIPAA.
4. I consent to treatment necessary for the care of the above named.
5. Co-payments/unpaid balances are to be paid at the time of service, unless DCND is contracted with your insurance company. If you are not able to pay your balance in full, you must contact the DCND billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency.
6. Your insurance policy is a contract between you, your insurance carrier and your employer. It is the patient’s responsibility to know and understand your insurance policy.
7. I authorize my insurance carrier(s) to make payments directly to DCND, if appropriate.
8. If DCND is not contracted with your insurance company and/or in network, it is your responsibility to make payment in full at the time of service. DCND will help you file your claim, but your insurance company will reimburse you directly. If you have a secondary or tertiary policy, you will need to forward a copy of your Explanation of Benefits (E.O.B.) for further billing. Patients are responsible for payment of annual deductibles and co-insurance. DCND is unable to process any third party claims (i.e.: personal injury).
9. If you do not have medical insurance, payment for any DCND service is required at the time of appointment unless prior arrangements have been made with the DCND billing office.
10. If a check is returned unpaid from the bank, a charge of \$50.00 will be applied to your account.
11. If your insurance requires that you have a referral from your primary care physician, it is your responsibility to ensure that our office receives the referral prior to your appointment date. If we do not receive that referral, you will be responsible for payment of services provided or your appointment may be rescheduled.
12. Our DCND staff will try their best to pre-certify any testing that your physician might order. However, it is ultimately the patient's responsibility to check with their insurance company to see if the test needs pre-certification prior to the test being done.
13. If you are unable to make your scheduled appointment, and we are not notified at least 24 hours in advance, you may be charged a \$50 cancellation fee. (Please refer to our Appointment policy for further explanation, by visiting www.dcmdinc.com.) _____ **Initial**
14. I understand I have certain patient rights regarding my protected health information and I authorize DCND to disclose that information to carry out treatment, payment, and health care operations. Please refer to our Notice of Privacy Practices for more information. It can be found at www.dcmdinc.com. _____ **Initial**

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization. I have read the above information regarding my address, insurance and personal representative and certify that it is correct and accurate. I agree to the terms outlined in this policy and understand my obligations regarding any charges incurred.

PATIENT SIGNATURE _____ **Date** _____

REPRESENTATIVE SIGNATURE _____ **Date** _____



APPOINTMENT POLICY

In an effort to provide clear understanding of DCND's scheduling practices, the following policy has been put into place to better inform our patients.

Patients are reminded of their appointment with our office by a phone call two days prior to their appointment. You can also sign up for email and SMS reminders through our patient portal.

If you need to cancel or reschedule your appointment, please contact our office a minimum of 24 hours prior to your scheduled appointment time. Call 937-439-6186.

Arriving Late: If you are more than 10 minutes late for your scheduled appointment time, we will attempt to accommodate your needs. However, this is not a guarantee that the physician or PA can see you. You may have to be rescheduled.

First Missed Appointment: This is defined as a failure to notify us by phone call or secure message through the patient portal within the 24-hour cancellation/reschedule window. Missing your first appointment will result in being placed on the end of DCND's "cancellation list." Please note that this may result in a 3-month wait for an appointment slot. **You may be charged \$50 as reimbursement to the practice for time and resources lost.**

Second Missed Appointment: Failure to notify our office (as defined above) for the second time may result in the cancellation of all future appointments and being terminated from the practice. Please keep in mind that the 2 missed appointments do not have to be consecutive. **You may be charged \$50 as reimbursement to the practice for time and resources lost.**

Interpreter: DCND will provide an interpreter for patients who require this service. However, if you cancel or reschedule your appointment without providing adequate notification (as defined above), the patient/guarantor will be responsible for any cancellation fees billed by DCND and the interpreter service. **Appointments will not be scheduled without acknowledgment of the appointment policy. If you miss an appointment and are billed the cancellation fee, future appointments will not be scheduled prior to receipt of payment.**

Chaperone: The patient has the right to a chaperone during sensitive physical exams. This chaperone is an authorized member of the DCND health care team.

Abusive Patients or Family Members: Patients or family members that are deemed as having an abusive behavior towards our physicians, residents, physician assistants, or staff will result in immediate termination from our practice.

By signing below, you are stating that you understand our appointment policy, and you agree to abide by the statements listed above.

INTERPRETER REQUIRED (SELECT ONE) ___ NO ___ YES LANGUAGE _____

PATIENT NAME (printed) _____ Date of Birth _____

PATIENT NAME (signed) _____ Date _____

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provide better understand your medical concerns and conditions.
If you cannot remember specific details, please approximate. Add any notes you think are important.
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

CURRENT MEDICATIONS - PLEASE LIST THE MEDICATION YOU CURRENTLY TAKE. IF NONE, PLEASE CIRCLE "NONE" NONE

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

MEDICATION/ALLERGY SENSITIVITY - PLEASE LIST ALL MEDICATION ALLERGIES. IF NONE, PLEASE CIRCLE "NONE". NONE

1.
2.
3.
4.
5.
6.

YOUR PROVIDERS - PLEASE LIST ALL OF DOCTORS YOU CURRENTLY SEE

1.
2.

PHARMACIES - LIST NAME, ADDRESS AND PHONE NUMBERS, BOTH LOCAL AND MAIL AWAY.

1.
2.

PAST MEDICAL HISTORY – CHECK ALL BOXES THAT APPLY TO YOU. IF NONE, PLEASE CIRCLE "NONE". NONE

<input type="checkbox"/> Brain Tumor <input type="checkbox"/> Dementia <input type="checkbox"/> Headaches – Migraine <input type="checkbox"/> Headaches – Tension <input type="checkbox"/> Headache - Cluster <input type="checkbox"/> Head Trauma/Injury <input type="checkbox"/> Intracranial Bleed <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Carotid Artery Disease <input type="checkbox"/> Syncope/ Passing Out <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson’s Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Anxiety/Panic Attacks <input type="checkbox"/> Depression <input type="checkbox"/> Cervical Spine Diseases <input type="checkbox"/> Neck Injury <input type="checkbox"/> Lumbar Spine Disease <input type="checkbox"/> Back Injury <input type="checkbox"/> Spinal Cord Injury/Disease	<input type="checkbox"/> Polio <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Muscle Disease <input type="checkbox"/> Other Neuromuscular Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Obstructive Sleep Apnea <input type="checkbox"/> Poor Sleep Quality <input type="checkbox"/> Daytime Sleepiness <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Narcolepsy <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Heart Attack (MI) <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Other Arrhythmias <input type="checkbox"/> Cardiac Valve Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Allergies/Hay Fever <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Exposure to Toxins <input type="checkbox"/> Genito-Urinary Disease <input type="checkbox"/> HIV <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Menstrual/ Sexual Dysfunction <input type="checkbox"/> Mumps <input type="checkbox"/> Peptic Ulcer Diseases <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Reflux <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other:
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REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY TO YOU. IF NONE, PLEASE CIRCLE "NONE"

NONE

<input type="checkbox"/> Headache	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Personality Changes	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Syncope	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Fever
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Trouble Walking	<input type="checkbox"/> Seizures	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cardiac
<input type="checkbox"/> Other Visual Changes	<input type="checkbox"/> Clumsiness	<input type="checkbox"/> Other spells	<input type="checkbox"/> Pain	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Trouble Swallowing/Dysphagia	<input type="checkbox"/> Drooling	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Ear Nose Throat	<input type="checkbox"/> Peripheral Vascular
<input type="checkbox"/> Loss of Taste/Smell	<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Confusion	<input type="checkbox"/> Difficulty Chewing	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Weakness: Arms/ Legs	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Dermatologic
<input type="checkbox"/> Numbness: Arms/ Legs	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Nausea	<input type="checkbox"/> Hematologic
<input type="checkbox"/> Facial Numbness	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Vomiting	

FAMILY HISTORY - PLEASE CHECK ALL THAT APPLY. IF UNKNOWN, PLEASE CIRCLE "UNKNOWN"

UNKNOWN

PROBLEM	IMMEDIATE RELATION	PROBLEM	IMMEDIATE RELATION
<input type="checkbox"/> Aneurysm		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Migraines	
<input type="checkbox"/> Bleeding or Clotting Disorders		<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Brain Tumor		<input type="checkbox"/> Muscle Disease	
<input type="checkbox"/> Cancer (Malignant Neoplastic Disease)		<input type="checkbox"/> Neuropathy	
<input type="checkbox"/> Connective Tissue Disorder		<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Dementia/Alzheimer's		<input type="checkbox"/> Psychiatric Disorders	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Restless Leg	
<input type="checkbox"/> Epilepsy/Seizures		<input type="checkbox"/> Snore	
<input type="checkbox"/> Headaches		<input type="checkbox"/> Sleep Apnea	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Spine Disease	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Stroke (Cerebrovascular Accident)	
<input type="checkbox"/> Insomnia		<input type="checkbox"/> Thyroid Disorder	

SOCIAL HISTORY/LIFESTYLE - PLEASE CIRCLE OR DESCRIBE IN THE ROWS BELOW

Smoking Status: Current / Former / Never	Exercise Level None / Occasional / Moderate / Heavy
Tobacco- years of use:	Aspartame (diet drinks): Yes / No
Occupation:	Are you currently employed? Yes / No
Smoking (how much per day/week?):	Do you currently use a gait aid or other assisted device? Yes / No
Chewing Tobacco: Current / Former / Never	Single or Multi-level home? Single / Multi level
Alcohol Intake: None / Occasional / Moderate / Heavy	Any PT/OT in the last 12 months? Yes / No
Caffeine Intake: None / Occasional / Moderate / Heavy	How many steps in the home?
Illicit Drugs:	Sleep aids?: Yes / No
Marital Status: Single / Married / Divorced / Widow	Sleep aids-what type?:
Number of Children:	Sleep aids- how long?:
Education Level:	General Stress Level: High / Medium / Low

SURGICAL PROCEDURE

Month/Year	Illness/Operation	Complications (Y/N)

To my understanding, this represents an accurate portrayal of my health history. I will inform DCND as changes or updates occur.

Patient Signature

Date

Patient Representative Signature

Relationship

Date

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME

DATE

I **understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I **understand** that Dayton Center for Neurological Disorders may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Dayton center for Neurological Disorders has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I **understand** that I have the right to read the '**Notice**' before signing this agreement. If I ask, Dayton Center for Neurological Disorders will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Dayton Center for Neurological Disorders to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dayton Center for Neurological Disorders has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative)

DATE

Relationship to Patient if signed by another party

DATE

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '**Notice**' at any time by contacting: Dayton Center for Neurological Disorders, 1975 Miamisburg-Centerville Road, Centerville Ohio 45459..

FORM Us