Name: ____________________ DOB: _________

PERSONAL INFORMATION

Patient: ______________________________ Birthdate: ___________ Gender: _________
Last First Middle

Address: ____Social Security #: _____________

City: _______________________ State: ______ Zip: _______ Email: _______________________

Home # ________________ Cell # __________________

Employer: ____ Phone # ______________

Next of Kin/Spouse: __________________ Phone#: ___________ Work#: _______________

Referring physician: _______________________________ Primary Care Physician: ___________________

Person responsible for bill (if not the patient): __________________________ Phone#: _______________

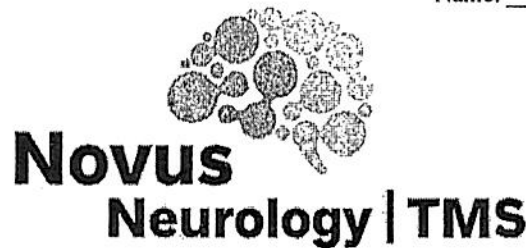
Race: Check one	**Ethnicity:** Check one	**Preferred Language:** Check one
___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Native Hawaiian ___Other Pacific Islander ___White ___ More than one race	____ Hispanic or Latino ____ Non-Hispanic or Latino	____ English ____ German ____ Spanish ____ Other__________________

ACCIDENT INFORMATION

Is visit accident related? **Yes or No** If yes, accident date? ______________

Work related? **Yes or No** If yes, accident date? ______________

Name: ______________________ DOB: _________



Financial Policy

We, Novus Neurology & TMS, attempt to provide the best care possible for our patients. Sometimes certain services or procedures and exams are not covered in whole or in part by insurance policies. You are expected to pay for all such services not paid by your insurance company.

We agree to file the necessary claims with your insurance company when we are furnished sufficient information to do so.

PAYMENT AGREEMENT

I acknowledge and agree that I am fully responsible for payment of all charges for any services rendered to me, my spouse, and my dependent children by Novus Neurology & TMS, and their associates and for payment of any balance not paid by insurance. I further reaffirm and agree to pay all previously incurred and unpaid charges and for future charges rendered to myself and my family I also agree to pay all reasonable collection costs, including a reasonable attorney's fee of one third of the unpaid principal balance due on my account in the event my account is placed with an attorney for collection. I waive any right I may have according to the Constitution and Laws of the State of Alabama, or any other state, to claim exemptions as to personal property as to this obligation.

COMMUNICATION REGARDING MY ACCOUNTS

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

ASSIGNMENT OF BENEFITS

I hereby authorize Novus Neurology & TMS, and their associates to furnish information to insurance carriers concerning services and treatment rendered to myself and my dependents; and I hereby assign to Novus Neurology & TMS all payments for such services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance.

Patient Signature: ____________________________________ **Date:** ________

Patient Name (print): __________________________________

Guarantor (if not patient): ______________________________ **Date:** ________

Name: ____________________ DOB: _________

Novus
Neurology | TMS

Release of Health Information

I authorize Novus Neurology & TMS to release all necessary medical information requested by my health insurance carrier, Medicare, or any other third-party payers.

I authorize Novus Neurology & TMS to release all medical information to my referring physician and my primary (family) physician.

I authorized Novus Neurology & TMS to contact Medicare, Blue Cross Blue Shield, Medicaid, or any other health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy.

I direct Medicare, Blue Cross Blue Shield, Medicaid, or any other health plan administrator to release such information to Novus Neurology & TMS

I authorize the access and release of confidential patient information by Novus Neurology & TMS for purposes of photocopying the information in response to properly authorized requests for copies of patients' medical records

If you anticipate the need for anyone else (spouse, family members, close friend, etc) to have access to this information please complete the information below:

Name _________________________ Relationship___________ Phone__________

Name _________________________ Relationship___________ Phone__________

Name_________________________ Relationship___________ Phone__________

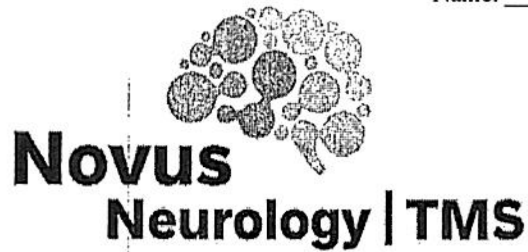
I authorize Novus Neurology & TMS Physician's and staff to leave detailed information on my voice mail if I am unavailable to speak with them directly. [] Yes [] No

Phone number(s) approved for detailed messages: ________________________________

I fully understand and ***accept*** the term of this consent.

Patient Name signature: ________________________________ Date: ____________
Patient Name print: ___________________________________

Name: ______________________ DOB: __________



Notice of Privacy Practices Acknowledgment

I have received a copy of the Novus Neurology & TMS Notice of Privacy Practices, which includes electronic access to medication history. I understand that Novus Neurology & TMS has the right to change its Notice of Privacy Practices from time to time and that I may contact Novus Neurology & TMS at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Signature: ______________________________ Date: _______________

Patient Name (print) ______________________________