Patient's Preferred Pharmacy **Pharmacy Phone #**

ALCOVY NEUROLOGY, P.C.

Patient Registration Form

PATIENT INFORMATION		
Last Name:	First Name:	Middle:
Street Address (Apt or Suite #)		
City / State / Zip Code:	Email Address:	
Home Telephone #:	Cell Phone #:	
Sex: Male / Female	Marital Status: □ Single □ Married □ Divorced □ Widowed	
Date of Birth:	Referring Doctor Name:	
Social Security #:	Address:	
Employer:	City / State / Zip Code:	
Address (Suite #):	Phone #:	
City / State / Zip Code:	Emergency Contact:	
Employer Phone #:	Emergency #:	
Occupation:	Relationship:	
RESPONSIBLE PARTY / BILLING INFORMATION		
Last Name:	First Name:	Middle:
Relationship:	Social Security #:	
Date of Birth:	Employer Name:	
Home Address:	Employer Address:	
City / State / Zip Code:	Phone #:	Ext:
PRIMARY INSURANCE		
Name of Company:	Member ID #:	
Claims Mailing Address:	Group #:	
City / State / Zip Code:	Policyholder Name:	
Company Phone #:	Poilcyholder SSN:	
Effective Date:	Poilcyholder DOB:	
SECONDARY INSURANCE		
Name of Company:	Member ID #:	
Claims Mailing Address:	Group #:	
City / State / Zip Code:	Policyholder Name:	
Company Phone #:	Poilcyholder SSN:	
Effective Date:	Poilcyholder DOB:	

PATIENT AUTHORIZATION

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all my medical records to the referring physician and to my insurance company
I allow fax and mail transmission of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Alcovy Neurology, P.C.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangments have been made prior to treatment.
I agree to pay all attorney fees and collection costs in the event of default of payment of my charges.
I authorize and request that insurance payments be made directly to Alcovy Neurology, P.C.
I give permission to Alcovy Neurology, P.C. to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Date

Signature

Alcovy Neurology, PC

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment: _____

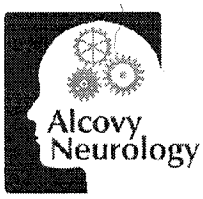
_____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers: _____

_____ _____

Individual Signature Date

As a personal representative, I have authority to act for the individual because I am the individual's_____



Alcovy Neurology, P.C.
3535 Hwy 81 Loganville GA 30052
Phone: (678)905-9625 Fax: (770) 674-5880

Financial Policy Statement

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Our Financial Policy
You will be asked to provide your insurance card(s) at your **initial visit** and verification will occur every visit. This is to ensure the information we have is correct, and your plan is current and one in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim.

INSURANCE
There are numerous insurance plans we are contracted with so that we may be able to assist your healthcare needs. We bill participating insurance companies as a courtesy to you. You are expected to pay you deducible and co-payments at the time of service. If we have not received payment from your insurance company within 90 days from the date of service, you will be expected to pay the balance in full. You are ultimately responsible for all charges. If the balance remains unpaid after 30 days, a late charge of 5% per month may be applied to the account. We accept cash, checks, debit and credit cards. Unpaid balances of greater than 90 days are subject to referral to a collections agency. Please contact our office for payment arrangements before referral to collections is deemed necessary.

Medical Forms and Patient-Requested Letters
Charges to complete medical forms (driver's license, assisted living, insurance, etc.) and patient-requested letters **are not covered by insurance and are therefore the responsibility of the patient.** Forms unrelated to the patient visit are subject to completion fees. Fees vary according to the length and complexity of the form or patient-requested letter and are determined by the physician. Copies of your medical record at Alcovy Neurology are provided at your request with a fee of **10 cents** per page.

Missed Appointments/Late Cancellations
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We feel this is a very serious matter. **Cancellations are requested 24 hrs prior to the appointment**. Any cancellation without at least a 24 hr notice will be considered a broken appointment. We reserve the right to charge for missed or late-cancelled appointments. A **$50 fee** will be applied to your account. Excessive abuse of schedule appointments may result in discharge from the practice

Agreement

I have read and understand the Alcovy Neurology Financial Policy. I agree to assign insurance benefits to Alcovy Neurology whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for cost of collections.
If I need assistance or have questions, please contact the Office Manager between 9:00 am and 5:00 pm, Monday through Thursday, 9:00am and 3:00 pm Friday.

Signature of Insured or Authorized representative_____ Date:_____

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Office Policies

Appointments
To schedule an appointment, please call our office press **option 2**, stop by the reception desk following your office visit, or request an appointment through the patient portal found on our website at www.alcovyneurology.com.
We make every effort to have patients seen in a timely manner. For emergencies, office visits are not guaranteed to be available on the same day or immediately, so report to the emergency department.

We recognize everyone's time is valuable, we make every effort to maintain the scheduled appointment times, but urgent situations sometimes disrupt the schedule. We ask for your understanding and patience during these delays. We will make every effort to keep your waiting time to a minimum. Dr. Lacayo tries to make sure each of his patients receives the time necessary for thorough evaluation and treatment.

Emergencies and After-Hours Calls
When the office is closed, telephone calls will be sent to voicemail. Please allow up to **72 hours** of business time to have calls returned, but we will make every effort to call you back the same day or the next business day. For emergencies, please do not call our office, but immediately report to the emergency room for urgent evaluation.

Prescription Requests
Alcovy Neurology, P.C. issues non-emergency prescriptions during weekday office hours only. To submit a request, you will need to tell us the name, dose, quantity, and route (oral or by inhaler or injection, for example) of the medication; when you take it; and how many refills you usually receive. Option 5 on our phone system There are certain medications which require a physical prescription; please schedule an appointment for these medication requests and allow yourself plenty of time to make an appointment and obtain a prescription before your current prescription runs out.

***Be advised the physician has up to 3 days to call-in a prescription requested by phone, fax, or email. We suggest you call your pharmacy to make sure that your prescription is ready.**

Our Financial Policy
You will be asked to provide your insurance card(s) at **every visit**. This is to ensure the information we have is correct, and your plan is current and one in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim.

All office co-pays are to be paid at the time of service. **This is an insurance company policy.** We accept cash, checks, and credit or debit cards.

We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

Insurances vary in their coverage, and it is the **patient's responsibility** to understand his/her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any coinsurances, deductibles, and any other non-covered billable services.

We do not bill third parties. It is the responsibility of the patient to satisfy any outstanding balances here. We will provide statements as proof of payment for patients to pursue reimbursement from the third party payer.

Payments

Co-pays are due at the time of the appointment. Statements for any outstanding balance will be issued after the insurance carrier pays its portion of the bill. If the balance remains unpaid after 30 days, a late charge of 5% per month may be applied to the account. We accept cash, checks, debit and credit cards. Unpaid balances of greater than 90 days are subject to referral to a collections agency. Please contact our office for payment arrangements before referral to collections is deemed necessary.

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