Patient Name: _____ Date: _____

Date of Birth: _____ Referring Provider: _____

Please describe the problem you are seeing the doctor for: _____

_____

| System Review (Please Check) | Yes | No |
|---|---|---|
| 1. Bowel/Bladder Problems | | |
| 2. Difficulty sleeping | | |
| 3. Dizziness | | |
| 4. Do you use a CPAP? | | |
| 5. Falls/Gait disturbance | | |
| 6. Headache | | |
| 7. Memory Changes | | |
| 8. Numbness/Tingling | | |
| 9. Recent Weight Change | | |
| 10. Seizures | | |
| 11. Trouble Swallowing | | |
| 12. Trouble Talking | | |
| 13. Vision Disturbance | | |
| 14. Weakness | | |

| Health History (Please Check) | Yes | No |
|---|---|---|
| 1. Anxiety | | |
| 2. Blackouts | | |
| 3. Blood Clots | | |
| 4. Depression | | |
| 5. Diabetes | | |
| 6. Headache/Migraine | | |
| 7. Heart Conditions | | |
| 8. High Blood Pressure | | |
| 9. High Cholesterol | | |
| 10. Mental Disorder | | |
| 11. Pacemaker | | |
| 12. Seizures | | |
| 13. Stroke | | |
| 14. Thyroid Disorder | | |

| **Family History** (Please list relationship) Do any family members have a history of: | Yes | No | Relationship |
|---|---|---|---|
| 1. Cancer | | | |
| 2. Carotid Disease | | | |
| 3. Dementia | | | |
| 4. Diabetes | | | |
| 5. Heart Disease | | | |
| 6. High Blood Pressure | | | |
| 7. Migraine/Headache | | | |
| 8. Parkinsons | | | |
| 9. Peripheral Artery Disease | | | |
| 10. Seizure | | | |
| 11. Stroke | | | |
| 12. Tremors | | | |

**Surgery History**
Please list Major Surgeries & approximate dates:

**Habits/Social History**

1. Have you ever smoke/chewed tobacco?
   Packs/day _____ Years Smoked_____ Year Quit_____
2. Do you follow a special diet?
3. Do you use caffeine? Amount/day_____
4. Do you use Alcohol? Amount/day_____
5. Do you have a history of substance use/addiction?
6. Occupation _____
7. Marital Status _____
8. Which is dominant hand? ❑ Right ❑ Left

Have you had any of the procedure performed listed below? If so, when and where?

| | Yes | No | Location |
|---|---|---|---|
| Carotid Doppler's | | | |
| CT Scan | | | |
| EEG | | | |
| EMG | | | |
| MRI Scan | | | |

**Bryan Physician Network**

**NEUROLOGY ASSOCIATES**
**HEALTH HISTORY**

*DTM0169*

Place Patient Label Here

**Patient Name** _____ **Date of Birth:** _____

**Allergies**
Please list any medications for which you have had an allergic reaction

| Name of Medication | Describe Allergic Reaction |
|---|---|
| | |
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**Medications**

| Name of Medication | Dose | How often Taken |
|---|---|---|
| | | |
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Patient Name: _____ Date Of Birth: _____

At Bryan Health, our goal is to serve our patients with respect for your time. To do this we ask that you help us by arriving on time and giving us notice when you can't make an appointment. This allows us to remain on schedule and honor the time commitments of all our patients, and to open cancelled appointments to patients who need to be seen.

**Late Arrivals:** If you arrive after your scheduled appointment time, we will try to work you into our schedule if that is an option without delaying the appointments of other patients. However, if this is not possible, we may ask you to reschedule your appointment.

**Cancellation/No Show:** We ask that you give 24 hours' notice if you need to cancel an appointment. We understand that emergencies do happen, and 24-hour notice may not always be possible. If you do not show up for your appointment without calling or giving advance notice for three appointments or if you repeatedly cancel appointments, we will evaluate whether we can continue to care for you as a patient due to the disruption in the schedule that this causes for our other patients.

Signing this form shows that you understand the importance of arriving on time to your appointment and calling in advance to cancel an appointment, as outlined above.

_____ _____

Patient Signature Date

**Bryan Health** **CANCELLATION/LATE ARRIVAL POLICY**

*DTM0207*

Place Patient Label Here

**Patient Name:** _____ **Date of Birth:** _____

**MEDICAL CONSENT**

I voluntarily consent to care at Bryan Health Physician Practices (Bryan), including routine, diagnostic procedures and medical treatment such as examinations, blood tests, x-rays, blood transfusions, photographs, therapies and other procedures that my physician, and other physicians and health care providers may deem necessary and appropriate. I understand that no guarantees have been made as to the results of such medical care. I agree to all the terms and conditions as described in this financial and treatment agreement. I understand that some procedures and treatments will be performed by Bryan employees, and others by independent practitioners who are neither employees nor agents of Bryan. I hereby consent to the use of telemedicine/telehealth services. I understand the service provider will be at a different location from me. I can decline telemedicine/telehealth services at any time without affecting my right to future care or treatment to which I would otherwise be entitled. Bryan personnel will use real time video with audio or audio only to communicate and share necessary details of my medical history, examinations, diagnostic testing and/or results, photographs or other images. The same confidentiality protections that apply to my "in person" or face to face medical care apply to the telemedicine/telehealth service provided. Access to all medical information resulting from the telemedicine/telehealth service will be available as provided by law. Dissemination of my patient identifiable images or information from a telehealth visit to researchers or other entities will not occur without my additional consent to do so. I also understand that students, residents, fellows, medical trainees and medical company representatives may observe my procedures and treatments, and, when allowed by law and properly supervised by qualified personnel, may participate in performance of such services I authorize Bryan to collect, use, and disclose information to a third party engaged in the collection or dissemination of my medication information. In some cases, proper treatment of a medical condition requires continuing treatment or diagnosis over a course of repeated outpatient visits. In such cases, the request, consent, and agreement contained herein apply to all repeat visits and all continuing treatment and diagnosis for the same condition.

**FINANCIAL AGREEMENT AND RELEASE**

I agree to pay Bryan and other health care providers for services rendered to me at the rates now in effect or to become effective during the course of my treatment. It is my responsibility to obtain prior authorization and/or physician referrals if required by my insurance carrier. I understand that if I am hospitalized without authorization, I will be responsible personally for all or part of the cost of hospitalization and professional services. I understand that all billings for services are due and payable at the time of service. If there is an overpayment by me or on my behalf, or by my insurance carrier, I direct Bryan or other health care providers to apply the overpayment to any other unpaid account I may have with them. I understand that Bryan and other health care providers are unable to finance patient account balances and may at their option, contract with independent agencies, finance companies and/or financial institutions to make financial information and services available for patients with outstanding account balances. I authorize the disclosure of patient demographic and financial information, including but not limited to the amount of my outstanding account balance, from my record for the purpose of making such financial information and services available to me.

**AGREEMENT OF INSURANCE BENEFITS**

I assign to Bryan all insurance benefits to which I may be entitled to the extent of professional charges owed to Bryan. This assignment includes, but is not limited to, major medical and disability insurance proceeds and benefits, and the proceeds of any settlement, structured or otherwise, or judgement awarded for personal injuries caused by a third party. I hereby authorize direct payment of all such insurance benefits to Bryan and I agree to pay for any and all hospital charges not paid pursuant to this agreement. I also assign insurance benefits to which I may be entitled, as defined in the previous paragraph, to persons, corporations or their entities providing health care services to me in cooperation with Bryan, its staff and employees during my hospitalization, whose services are deemed necessary and requested by my treating physician.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the release of all or any part of the contents of my medical record to the following: (1) to persons, corporations or other entities involved in my medical care or part of my medical care provider team for the purpose of immediate treatment, continuity of care and/or payment for healthcare operations.

**TELEPHONE NUMBERS**

By providing us with your landline or cell phone number(s), you are giving your consent for us, our agents, and to our collection agents, to contact you at these numbers, or at any number that is later acquired by you, and to leave live, pre-recorded, or text messages regarding accounts, billing, services, appointments, surveys, or marketing material. For greater efficiency, calls may be delivered by an autodialer. Providing us a telephone or cell number is not a condition of receiving our services, however.

**VERBAL COMMUNICATION**

Bryan Health may communicate information to the following people regarding my care as needed or on an emergent basis:
❑ **DO NOT** speak to anyone about my health status - **Leave contacts blank**

| | | **Type of information** | | | |
|---|---|---|---|---|---|
| | | All | Scheduling/ Appointments | Medical | Billing/ insurance |
| Name: _____ | | ❑ | ❑ | ❑ | ❑ |
| Relationship: _____ | Phone Number: _____ | | | | |
| Name: _____ | | ❑ | ❑ | ❑ | ❑ |
| Relationship: _____ | Phone Number: _____ | | | | |
| Name: _____ | | ❑ | ❑ | ❑ | ❑ |
| Relationship: _____ | Phone Number: _____ | | | | |

**INFORMATIONAL**

I acknowledge receipt of the Notice of Privacy Practices.

The undersigned certifies that he/she is the patient or is duly authorized by the patient to sign this document for the patient, that he/she has read and understands the contents stated above, and that he/she agrees to the items noted in this medical and financial consent form. The information which has been provided is true and complete. A photocopy of this medical and financial consent form shall be as valid as the original.

| | | |
|---|---|---|
| Patient or Person Authorized to Consent for Patient / Relationship (if not patient) | Date | Time |
| Printed Patient Name | Date of Birth | |
| Reason Patient was Unable to Consent or Sign | Date | Time |
| Clinic Rep - Witness to Signature | Date | Time |
| Secondary Witness to Signature if Telephone/Verbal Consent | Date | Time |

**Interpreter Declaration** (Consent signature must be complete)
I have interpreted the form for the patient or patient and/or the patient's representative in the _____ language. The form as, completed above, was reviewed in my presence with the patient or patient's representative.

Interpreter's Name: _____

Signature of Interpreter Date / Time OR Remote Interpreting Number

**Bryan Health**

**CLINIC MEDICAL AND FINANCIAL CONSENT**


Place Patient Label Here

Epic: PAT level to Consent to Treat - Clinic Annual
Description: Clinic Name
Form M1150 (Rev. 12/23)