Michigan Neurology Associates, P.C.
FINANCIAL POLICY (2012)
34025 Harper Avenue, Clinton Township, MI 48035 • Phone: (586)445-9900 Fax: (586) 464-2641

Thank you for choosing Michigan Neurology Associates, P.C. (MNA) as your neuroscience healthcare provider. We are committed to a comprehensive approach to your diagnosis and treatment. Payment for our services, compliance with medical instructions and MNA office policies are considered your responsibilities within the therapeutic relationship. The following is a statement of our financial policies and is important to maintaining our professional relationship and services.

If you supply our staff with a copy of your insurance card we will bill your insurance as a courtesy. **If we are unable to verify your insurance coverage, full payment is due at the time of service.** We accept cash, check, VISA, MasterCard credit and debit cards. There is a $25 charge for returned checks payable by cash, credit card or money order. If payment is not received from your insurance carrier within our contract limits, any balance will become your responsibility. Extended payment arrangements are available on request. Please speak to one of our front desk staff for assistance in arranging a payment plan.

Co-pay and deductibles: Payment of your co-pay and deductible is due on the day of service. If you do not pay your co-pay on the day of service an additional one-time $5.00 statement fee will be applied to your account.

Referrals, Preauthorization's and Non Coverage: If your insurance company requires a **referral**,it is **your responsibility** to secure it from your primary care office in advance of your visit to MNA. If a referral is not obtainable at the time of your visit you may choose to be financially responsible for that visit.Our staff will provide a Financial Responsibility Form.

If your carrier requires a **preauthorization** for a service, it is MNA's staff responsibility and we will make every effort to secure it in a timely fashion prior to your appointment.

You may also accept financial responsibility if you wish to override these procedures by completing a form indicating so. Failure to obtain the referral and/or preauthorization or making payment, may result in rescheduling non-urgent appointments or procedures. Some treatments/procedures may not be covered by insurance and will be expected to be partially or fully paid in advance of your visit or on the day of service.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your co-pay and deductible. If you have supplemental insurance we will bill those carriers for you as well. Any remaining balance will be billed to you. All **co-pays and deductibles** are due at the time of service.

HMO/PPO/Commercial: We participate with most but not all plans. You are responsible for verifying what covered benefits your insurance plan will pay and that our Physicians **participate** in your plan.All **co-pays and deductibles** are due on the day of service.

Workers Compensation and Motor Vehicle Accident Claims: In the case of a worker's compensation injury or automobile accident, you must supply the date of injury/accident, claim number, phone number, contact person and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Transportation to receive our services may be a covered benefit – please inquire as needed.

Cash Patients: A deposit of 50% of the published Prompt Pay price will be required prior to scheduling any service. Any subsequent charges will be due on the day of service.

Minor patients: We will bill the insurance carrier of the presenting parent or guardian. **Co-pay and deductibles** are due on the day of service.

No Show or Failure to Cancel Appointment Fees: MNA requires 24-hour notice of appointment cancellation. Any missed appointments may be charged a fee of, $50 for missed Physical Therapy sessions, $200 for Sleep Testing (requires 48 hour notice of appointment cancellation), Neuro-Psych testing or interventional pain procedures, $150 for MRI's, CT's, Psychotherapy/Counseling sessions, and Neuro-diagnostic testing. If you miss 3 consecutive appointments you may no longer expect refills, maybe dismissed from our practice at the discretion of you physician, or may not longerbe eligible for a "reserved appointment"in the future.

Monthly Statements: Statements are generated by our billing service on a monthly billing cycle. They represent a request for payment of what is currently the patient's financial responsibility. These patient balances are due and payable upon receipt of our statements, unless special payment arrangements have previously been made with our Billing Director.

Collections: Patients on payment plans that have missed a payment, all accounts that have a balance after the third statement, and accounts where no payment has been made in the last 30 days will be assigned to a collection agency. The person financially responsible for the account will be responsible for all collection costs. Patients with collection accounts may be dismissed from our practice at the discretion of their treating physician when the outstanding fees are for professional services.

Refunds: MNA will automatically refund patients in full for credit balances exceeding $25.00 (this may take up to 6 weeks to process). Credit balances of less than $25.00 will be held on your account and applied toward future charge activity. If you feel you might be owed a refund please speak to our front desk staff or indicate same in writing on your statement.

Authorization to Release Information and Assignment of Medical Benefits: I authorize the release of medical information necessary to process insurance claims, pharmacy and other provider services orders for treatment. **I understand I am responsible for any amount not paid by insurance.** I have read the above policy and agree to comply with its provisions.

Patient Signature: _____ Date: _____

Patient Name (Print) _____

Michigan Neurology Associates
& Pain Consultants

New Patient Intake

Welcome to Michigan Neurology Associates. Our goal is to provide you with exceptional medical care and to be sure that all of your health concerns are addressed during your visit with us. Please take a moment to write down questions or issues you would like to cover with our health care team during your visit today.
Name: _____ DOB: _____ Date: _____

Problems we are addressing:	Date Onset	Related to motor vehicle or work related injury
1. _____	____/____/____	_____
2. _____	____/____/____	_____
3. _____	____/____/____	_____

Medications:
Please list all medications along with doses and how often you take them:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies:

1. _____
2. _____
3. _____

Please complete the reverse side of this form.

Michigan Neurology Associates
& Pain Consultants

Michigan Neurology Associates
Controlled Substance Agreement

Patient Name:_____Date:_____

I understand that my Physician of Record is prescribing a medication identified by the DEA as a controlled substance. This medication is to assist me in managing my chronic medical condition that has not responded to other treatments. The risks and potential side effects including the potential for overuse, rebound headaches, analgesic hypersensitivity, drug dependency, overdose and death of self or someone with easy access to my prescriptions as well as the potential benefits have been explained to me. I understand these risks and agree to the following:

1. I will participate in all other treatments which Michigan Neurology Physicians recommend, including psychological counseling, and will be ready to taper or discontinue the controlled substance as other effective treatments become available.
2. I will take the medication exactly as prescribed and will not change the medication dosage or schedule. I understand that MNA physicians will not prescribe medications at dosages or schedules above those recommended by the FDA and that all prescriptions are a 30 day supply and early refills will **NOT** be given.
3. If I consume my medications in an amount above that which is prescribed, sell them, or give them to someone else, my physician has the right to refuse to prescribe additional controlled substances or to continue any further treatment.
4. I understand that it is my responsibility to secure my medications and that lost or stolen medications, lost or stolen prescriptions, broken bottles, etc. **will NOT be replaced**. I will purchase a lock box to secure my medications if necessary.
5. If I have another condition that requires the prescription of a controlled substance (like opioids, tranquilizers, barbituates, or stimulants) from a non-MNA physician, I will obtain written documentation from the prescribing non-MNA physician and bring it to my next appointment. I understand that as a result of starting a new medication, my MNA physician may change or discontinue my old medication.
6. I will be responsible for keeping track of my medication and number of refills remaining so I will not run out of my medication. **Refills require an office visit and will not be given over the phone. Notifying the on call physician after business hours for medication refills is not appropriate.**
7. I agree to abstain from all illegal and recreational drugs (including alcohol) while on this Controlled Substance Agreement, and I agree to provide urine samples for drug screening whenever asked.
8. I understand the need to use care when making the decision to drive a car or operate dangerous machinery as the medication I am on may cause drowsiness and the use of alcohol may intensify the effect.
9. I will provide my pills to be counted within 24 hours of a request by MNA staff in order to assure pills are being taken as directed.
10. I will keep all appointments and schedule my next appointment at check-out. If I cancel or do not show up for my scheduled visit without just cause my medications will not be refilled without another office visit.
11. I will not engage MNA staff with any verbally abusive or threatening behavior. If my words or actions are felt as abusive or threatening, I understand I may be immediately discharged from the practice.
12. I authorize Michigan Neurology Physicians and/or staff to discuss my care and treatment with my primary/referring physician and any other medical facilities involved in my care.
13. I understand that this contract is binding for as long as controlled substances are deemed necessary by my MNA physician.
14. It is understood that my medical treatment is initially a trial, and that continued prescriptions are contingent on evidence of benefit
15. (Males Only) It is understood that chronic opioid use has been associated with opioid hyperalgesia syndrome with low testosterone levels in males. This may affect mood, stamina, sexual desire and physical and sexual performance.
16. (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking the controlled substance, I will immediately call my obstetric doctor and this office to inform them. I am aware that the use of opioids is not generally associated with the risk of birth defects. However, birth defect can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking controlled substances

I have had time to review and ask questions and I agree to all items outlined above. I verbalized understanding that any deviation from or violation of these rules may result in a discontinuation of medication and possible dismissal from this practice. I have received a copy of this contract for my record.

Patient Signature_____Date_____

Witness _____

Drugs to be refilled only as follows:

Drug #1_____Drug #2_____Drug#3_____

Amount_____Amount_____Amount_____

Directions_____ Directions_____ Directions_____

Michigan Neurology Associates, P.C.
Patient Registration
(PLEASE PRINT)

Patient Name_____

Responsible Party (if minor)_____

If PT is a minor Mothers DOB_____Fathers DOB_____

Street Address_____Apt #_____Phone(_____)_____

City_____State_____Zip Code_____

E-Mail Address_____Cell Phone(_____)_____

Sex: Male / Female Maritial Status: M S W D Age:_____ Birth Date_____/_____/_____

Social Security_____Spouse's Social Security_____

Patient Employer_____Occupation_____

Business Address/City_____Phone(____)_____

Do you have medical insurance? ___Yes___No ___Worker's Comp ___Auto Claim

Injury/Accident Date_____Claim Number_____

Primary Insurance_____

Contract or ID#_____Group_____

Subscriber_____Subscriber's DOB_____

Secondary Insurance_____

Contract or ID#_____Group_____

Subscriber_____Subscriber's DOB_____

ALLERGIES_____

Pharmacy Name/Location_____

Emergency Contact_____Phone(____)_____
OTHER THAN SPOUSE

Referring Physician_____ Phone(____)_____

Primary Physician_____ Phone(____)_____

ASSIGNMENT OF RELEASE:
I authorize any holder of medical or other information about me to release to all carriers any information needed for this or any related medical insurance claim. I permit a copy of this authorization to be use in place of the original, and request payment of medical insurance benefits to myself or third party who accepts assignment. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand it is at the discretion of this office to charge me a $25.00 fee for a missed *scheduled appointment* if I do not give a 24 hour cancellation notice.

_____ _____
Signature of Insured/Guardian Date

Account # _____

Michigan Neurology Associates
& Pain Consultants

New Patient Review of Systems

Please circle any of the following symptoms that you are experiencing, initial below and return this form.

Constitutional	**Recent weight gain** **Recent weight loss**
Eyes	**Recent vision change** **Eye injury** **Double vision**
HEENT	**Recent hearing change** **Tinnitus** **Ear drainage** **Bad breath or bad taste** **Voice change**
Cardiovascular	**Chest pain** **Swelling of extremities** **Varicose veins** **Palpitations** **Cold extremities** **Shortness of breath** **Leg pain while walking**
Respiratory	**Frequent cough** **Wheezing** **Coughing up blood**
Gastrointestinal	**Trouble swallowing** **Loss of appetite** **Fequent diarrhea** **Abdominal pain** **Nausea/vomiting** **Black stool** **Constipation** **Indigestion/heart burn**
Genitourinary	**Frequent urination** **Night time urination** **Sexual difficulty** **Burning/painful urination** **Change in force/stream** **Urinary urgency** **Urinary incontinence**
Integument	**Rash** **Itching**
Neurologic	**Headache** **Paralysis** **Leg cramps/jerks** **Light headed/dizzy** **Memory loss** **Unrefreshed in the AM** **Passing out** **Concussion** **Morning headache** **Head injury** **Convulsions/seizures** **Numbness/tingling** **insomnia** **Excessive day sleepiness** **Tremors** **Weakness** **Snoring**
Musculoskeletal	**Joint Pain** **Joint stiffness** **Joint swelling** **Muscle weakness** **Neck pain** **Back Pain** **Muscle pain/cramps** **Difficulty walking**
Endocrine	**Hormone problem** **Excessive thirst** **Change in hat/glove size** **Cold intolerance**
Psychiatric	**Depression** **Panic attacks** **Nervousness** **Anxiety** **Street drug use in family** **Easy/uncontrolled crying** **Easy/uncontrolled laughing**
Heme-Lymph	**Easy bruising** **Prolonged bleeding**

Patient Initials:_____

Reviewed By:_____

Michigan Neurology Associates
& Pain Consultants

Patient: _____ DOB: _____

THE EPWORTH SLEEPINESS SCALE

Using the following scale of 0-3, rate the following situations:

0= would never doze 1= sight chance of dozing
2= moderate chance of dozing 3= high chance of dozing

Situation:	**Chance of dozing:**
1. Sitting and reading	___
2. Watching TV	___
3. Sitting inactive in a public place	___
4. As a passanger in a car for an hour without a break	___
5. Lying down to rest in the afternoon	___
6. Sitting and talking to someone	___
7. Sitting quietly after lunch without alcohol	___
8. In a car, while stopped for a few minutes	
9. In traffic	___

Total: ____

Screening Fall Risk

Patients 65+ Years

1. Have you had 2 or more falls in the last 12 months? **YES / NO**
2. Were you injured during a fall this year? **YES / NO**
3. Do you use: ***Cane Walker Wheelchair***
4. Do you feel unsteady when you stand/walk? **YES / NO**
5. Any recent loss or change in vision or hearing? **YES / NO**

Immunization

Last Influenza Vaccination: ____/_____/_____ (or not completed)
Last Pneumonia Vaccination: ____/____/_____ (or not completed)

Depression Screening, Part 2

Over the *last two weeks*, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total Score: _____

Preventative care

Females:

Have you had a Mammogram: Yes / No

Date: ____/____/_____

Result: _____

Are you diabetic? Yes / No

Hemoglobin A1C result: _____%

Date: ____/____/_____

Colon cancer screening?
Yes / No

Examples: (circle which applies)

Stool smear in office
Cologuard (send in stool sample)
Sigmoidoscopy
Colonoscopy

Date: ____/____/____
Result: _____