ALZHEIMER'S MEMORY CENTER | AMC RESEARCH

CREATING HOPE THROUGH RESEARCH

Welcome to our Office!

Please complete the following New Patient forms prior to your visit. Our goal is to provide our patients with quality customer service, and completion of these forms will allow us to appropriately prepare for your appointment.

We ask that you arrive 30 minutes prior to your appointment time to allow you adequate time with the provider. You must bring someone with you to your appointment or it may be canceled. If you are not able to attend your appointment, please notify us within 24 hours of the scheduled appointment time.

Please complete the following forms:

1. Registration Form
2. History Sheet
3. Acknowledgement of Notice of Privacy Practices
4. Authorization for Treatment
5. Authorization for Release Information - Compound Release
6. Late to Appointment Policy
7. Payment & Cancellation Policy
8. Patient Portal

Please bring the following information to your appointment:

1. Completed forms listed above.
2. Insurance Card
3. A complete list of medications
4. Radiology films (if applicable)
5. Medical Records

We hope that you have a pleasant visit with us. Please feel free to contact our office at (704) 364–4000 and we will be happy to answer any questions that you may have.

p: 704.364.4000 f: 704.364.4005
f: 980.498.6672 RESEARCH
a: 10801 Monroe Road Suite # 100 Matthews, NC 28105

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Date ____________________ Primary Phone (___)_________________ Cell Phone (___)_______________

Do we have permission to leave a voicemail message (i.e. appointment reminders) at the contact number? □ Yes □ No

Do we have permission to leave a voicemail message for normal test results at the contact number? □ Yes □ No

PATIENT INFORMATION

Name: ____ SSN #: ________________________

Last Name First Name Middle Initial

Address: ____ Date of Birth: ____________________

City: _________________________ State: ___________________ Zip Code: _______________

Marital Status: _______________________ Preferred Language: __________________________________

Emergency Contact/Caregiver (Relation): ______________________________________ Phone: (___)_____________

Pharmacy Name: ____ Phone: (___)_________________

Pharmacy Address: ____

PRIMARY CARE PHYSICIAN INFORMATION

Doctor Name: ____ Facility Name: ___________________________

Phone: (___)_______________________ Fax: (___)_______________________

Address: ____

City: _________________________________ State: _______________________ Zip Code: __________________

INSURANCE INFORMATION

Insurance Name: ____ Policy #: ____________________________

Have you changed your insurance company since your last visit to our office? □ Yes □ No

Are you currently under Hospice care? □ Yes □ No If yes, please provide the following information:

Facility Name: ____

Address: ____ Phone: (___)_____________________

I certify that I and/or my dependent(s) have insurance coverage with ________________________ and assign directly to

Insurance Name

Our office takes all insurance benefits, if any, otherwise payable to Alzheimer's Memory Center for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named and Insurance Company (ies) and their agents for the purpose of obtaining payment for services determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

____ ____

Signature of Patient or Legal/Responsible Party Date

____ ____

Print Name of Patient or Legal/Responsible Party Relationship to Patient

Alzheimer's Memory Center

Date: ____________________ Patient's Name ______________________ DOB _______________

PERSONAL HISTORY REVIEW:

Please List Current Medications, Dosage, and Frequency Taken:

Medication Name/Dosage/Frequency	Medication Name/Dosage/Frequency

Drug Allergies: ____

PAST MEDICAL HISTORY:

	High Blood Pressure		Asthma/COPD		Kidney Disease		Arthritis
	Heart Attack		Bleeding Ulcer		Diabetes		Alcoholism
	Stroke		Hiatal Hernia		Memory Disorder		Drug Problems
	Seizure		High Cholesterol		Cancer		Pacemaker
	Migraine		Thyroid Condition		Tremors		Metal Implants
	Head Injury		Syncope/LOC		Depression		Anxiety

Surgical History: Have you had any surgeries? □ Yes □ No

If yes, please list surgeries and dates ____

____

____

FAMILY HISTORY:

	High Blood Pressure	Who:		Depression	Who:
	Stroke	Who:		Diabetes	Who:
	Seizure	Who:		Cancer	Who:
	Heart Attack	Who:		Alzheimer's Disease	Who:
	High Cholesterol	Who:		Parkinson's Disease	Who:
	Migraine	Who:		Syncope	Who:

SOCIAL HISTORY:

□ Married □ Divorced □ Widowed □ Single Children □ Yes □ No How Many? ____________

Occupation ____________________________ Highest level of Education? ________________________

□ Alcohol Use □ Smoking □ Substance Abuse

Date: ___________ Patient's Name: ______________________DOB:_____

SYSTEMS REVIEW:

General:	Now	Past Year	**Respiratory:**	Now	Past Year
Fever or Chills			Bronchitis or Cough		
Appetite Change			Wheezing		
Weight gain			Shortness of Breath		
Night Sweats					
			Gastrointestinal:		
Eyes:			Difficulty Swallowing		
Blurred Vision			Heartburn or Indigestion		
Double Vision			Abdominal Pain		
			Nausea or Vomiting		
ENT:			Diarrhea		
Hearing Loss			Rectal Bleeding		
Ringing in Ears					
Sinus Trouble			**Endocrine:**		
Allergies or Hay Fever			Fatigue		
Nose Bleeds			Sensitivity to Heat or Cold		
Hoarseness			Thyroid Goiter or Swelling		
Frequent Sore Throat			Change in Thirst		
Mouth Ulcers			Impotence		
Cardiovascular:			**Genitourinary:**		
High Blood Pressure			Painful Urination		
Chest Pain or Tightness			Frequent Urination		
Irregular Heartbeat			Bladder Control Problem		
Fainting or Dizziness			Blood in Urine		
Leg Cramps Walking			Urinary Infection		
Swollen Ankles or Feet					
Pacemaker					
			Psychiatric:		
Musculoskeletal:			Depression		
Joint Pain			Anxiety		
Back or Neck Pain			Memory Change		
Arm or Leg Pain			Counseling or Treatment		
Muscle Pain or Cramps			Claustrophobia		
			Hallucinations		
Neurological:					
Frequent Headaches					
Numbness of Arms or Legs					
Muscle Weakness					
Poor Coordination					
Falls					
Tremor or Shaking					

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _________________________________, am aware that as part of my health care plan/treatment, Alzheimer's Memory Center maintains paper and electronic copies of my medical records. I am also aware that my medical record serves for:

- A communication among other health care providers who contribute with my medical care.
- The purpose of obtaining payment from Third Party payers is to determine insurance benefits payable for related services.
- As a main source of information to third-party payers to verify services.
- Planning my medical care.

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Alzheimer's Memory Center. I have read and understand my rights.

- The right to request confidentiality of my medical records.
- The right to request restriction of how my health information is disclosed.
- The right to obtain copies of my Professional Health Information (PHI).
- The right to correct my Professional Health Information.
- The right to confidential communication with the providers.
- The right to read the privacy notice prior to signing.

I understand that as part of my medical treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, as described in the notice of privacy practices, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I understand that Alzheimer's Memory Center is not required to agree to the restrictions requested. I agree that I may revoke this consent in writing only, except in the event that the organization has already taken action. I also agree that by refusing to sign this consent or revoking this consent, this provider may refuse to treat me as permitted by Federal regulations. (Code 164.506)
Note:
Alzheimer's Memory Center reserves the right to change the notice of privacy practices policies at any time. However, we will provide you with a copy of any changes via your preferred method such as: email, mail, our web site and at the office. Please indicate preference:

Patient's Signature, or Legal/Responsible Party: _____________________________________

Date: ________________________________

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time
- ☐ The individual refused to sign
- ☐ A copy was mailed with a request for a signature by return mail
- ☐ Unable to communicate with the patient for following reason: ____
- ☐ Other: ____

Prepared By: ____

Signature: ____

Date: ______________________________

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f: 980.498.6672 RESEARCH
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Alzheimer's Memory Center
Authorization for Release of Information – Compound Release

Name of Patient: ________________________________ Date of Birth: _____________

_____________**Alzheimer's Memory Center**________________________________ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	**CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.**
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other______________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* ___________________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ___________________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ___________________________________
☐ For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient's Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ______________________________________ Date: ________

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ______________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

AUTHORIZATION FOR TREATMENT

I voluntarily consent to health care treatment/testing from the physician(s) and staff at Alzheimer's Memory Center.

I am aware that I can stop my treatment at any time without written notice. I understand that I have the right to ask questions regarding my medical care/treatment.

Other Authorization:
I authorize Alzheimer's Memory Center to request medication information from my pharmacy, facilities, and other providers if needed for my medical treatment.

NOTE:
Due to a very demanding schedule, the providers will not be available to see you in the hospital. Inpatient physicians will provide you with the medical care needed. Please contact our office if you need to be seen by Dr. Bolouri or Dr. Doohan.

Signature of the patient or Legal/Responsible Party: ________________________________

Date: ____________________________

APPOINTMENT CANCELLATION POLICY & FORMS FEES

I, ____________________________, am aware that I will be charged a fee of $50.00 if I do not show for my appointment as scheduled. However, if I contact the office at least 24 hours prior to the appointment the fee will not be applied.

I, ____________________________, am aware that after the second no show appointment I will automatically be discharged from the facility.

OTHER CHARGES:

I, ______________________________, am aware that there will be a fee of $50.00 to complete any Disability Form.

I, ______________________________, am aware that there will be a fee of $25.00 for returned checks.

I, ______________________________, am aware that there will be a fee of $50.00 for FMLA (Family and Medical Leave Act) form.

NOTE:
Please be aware that Dr. Bolouri is not an immigration physician. Therefore, he is NOT able to complete immigration forms. Please contact the immigration department if you need help finding a physician.

PATIENTS/RESPONSIBLE PARTY:
Payment in full is expected at the time service is rendered unless the patient is covered by an insurance company with whom we participate. In this case the patient or the responsible party is only required to pay the deductible if not met and/or co-payment/coinsurance dictated by the insurance company at the time of service.

Signature of the Patient or Legal/Responsible Party: __________________________________

Date: ____________________________________

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LATE TO APPOINTMENT POLICY

Attention Patients & Caregivers:
If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule your appointment unless the physician's schedule can still accommodate you.

Priority will be given to the patients who arrive on time, and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule.

Please be aware that when one patient is late can cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

New Patients:
Likewise, if you are a new patient and you arrive at the scheduled appointment time and not 30 minutes early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

"NO-SHOW" POLICY

While we make every effort to provide a reminder call a week and 24 hours prior to your appointment, it is **your responsibility** to contact our office to reschedule your appointment. We charge a $50 missed appointment fee to patients who do not show up for their appointment. If this should happen more than twice, the practice may at its discretion choose to discontinue your care.

____________________________________ ______________________
Patient Signature Acknowledges Receipt Date

____________________________________ ______________________
Legal Guardian Signature Acknowledges Receipt Date

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Patient and family request for ANI Neurology PLLC d/b/a Alzheimer's Memory Center Patient Portal

The Alzheimer's Memory Center Patient Portal is intended to provide our patients with enhanced access to the staff at Alzheimer's Memory Center. The Portal is a convenience allowing the ability to request medication refills, view requested laboratory results, request referrals, request office visits, access medical histories and communicate billing questions.

I understand that the Patient Portal should never be used for urgent or emergency messages, discussions, or requests. If an issue demands immediate attention, I understand that I must call the office by phone directly.

The health summary represents any problems or issues you may have addressed with your provider and may not represent a current assessment of your medical issues. If you would like to make changes to your health summary, medication list, or demographic information, you can notify our office through the Portal.

Alzheimer's Memory Center will respond to all requests or messages sent through the Portal within 48 business hours. Our Portal messages will not be checked during holidays, weekends, or other days when the office is not open. I understand that I must call Alzheimer's Memory Center if I have not heard a response to a message within 48 business hours.

Alzheimer's Memory Center has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information. All messages are encrypted and stored in a secure web-based portal. You can only access your protected information by entering a username and password.

I understand that it is my responsibility to safe keep the username and password that I am assigned. I understand that I should never share this password and accept full responsibility if this information is given to other people. If for any reason, I feel that my username/password combination has been compromised, I will either change the password using the tools provided and/or notify Alzheimer's Memory Center.

I understand that Alzheimer's Memory Center Patient Portal should only allow me to view the records for myself or whom I am legally responsible for. If for some unforeseen reason, I gain access to another patient's information, I am not allowed to view this information and must notify Alzheimer's Memory Center immediately. I agree that Alzheimer's Memory Center will not be liable for the inappropriate disclosure of information due to unauthorized use of my username and password.

Alzheimer's Memory Center will do its best to assure adequate technical support for the Patient Portal but cannot take responsibility for unforeseen technical issues that may compromise functionality of the portal. If, at any point, there is a question about potential technical problems, you should contact Alzheimer's Memory Center.

I understand that violation of this agreement may result in loss of access to the Alzheimer's Memory Center Patient Portal System.

By signing below, I agree to abide by these rules.

Name of Patient ____ DOB ________________

Patient's Signature or Legal Representative ____

Email Address ____

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