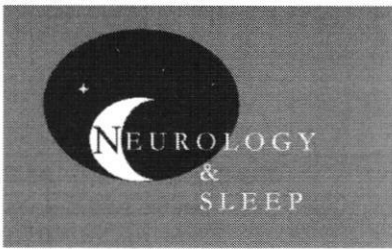


403 Gilead Road, Suite B
Huntersville NC, 28078
(P) 704.464.1509
(F) 704.464.1393
www.ncneuro.com

NEW PATIENT CHECK LIST

- **Please arrive 20-30 minutes before your scheduled appointment time.** We will need to enter your information into our computer system and prepare your chart so the physician will be able to see you at your scheduled appointment time. We make every effort to try and stay on schedule. Unfortunately delays may occur, but being on time for your appointment will help us in achieving this goal.
- **Please bring ALL of your insurance cards.** If we are unable to verify your insurance, you will be responsible for the full cost of the visit at the time of the appointment. This can be reimbursed at a later date when proof of coverage is verified.
- **Please bring a list of all medications you are currently taking.** This includes prescriptions, birth control pills, vitamins, and over-the-counter medications. Please include doses and frequency. Should the physician need to prescribe a medication it will be important for him to verify any potential drug interactions.
- **Please arrive with your "New Patient" paperwork filled out.** Otherwise, you may be delayed beyond your scheduled appointment time.
- **Please bring pertinent records.** If another physician has referred you to our practice and they have performed bloodwork or other tests, please bring copies of the results with you. If you have had recent imaging (X-rays, CT, or MRI scans), please obtain a CD copy of these images. These can be obtained through the facility where your imaging was previously performed.
- **Patients with a "Medical Power of Attorney".** Please provide proper paperwork at the time of the appointment.
- **A parent or guardian for all appointments must accompany patients under 18 years of age.**
- **Patients with memory disorders.** These patients should be accompanied with a family member or friend to help provide a thorough medical history.
- **Payment is expected at the time of each office visit.** This includes co-pays, and patient responsibility payments.
- **Directions to our office are available on our website.** Please allow extra time for traffic delays and construction. If you are delayed beyond your appointment time, we may have to reschedule your appointment.
- **"No cell phone use" policy.** Please silence cell phones in the waiting room and during your appointment with the physician.
- **For pediatric evaluations, please only bring the patient being seen.** If you have multiple children, we ask that you please make arrangements for your other children. The physician wants to focus solely on the patient being evaluated in order to conduct a full-comprehensive examination and provide the best treatment plan for your child.



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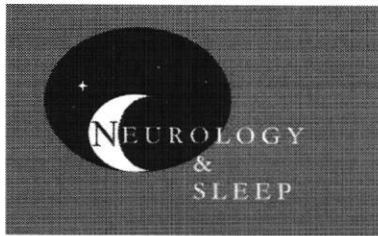
Prescription Refill Policy

North Carolina Neurology & Sleep receives a large volume of calls daily for medication refill requests. In order for us to provide the highest quality care in the most efficient manner possible, we are implementing a new prescription refill policy.

- 1. Before your appointment, please review your medications to ensure that no prescription refills are needed. It is the patient's responsibility to schedule an appointment before the last refill date. It is always encouraged to schedule your next follow-up appointment at "check-out" before leaving the office.**
- 2. Some medication requests; specifically, controlled substances, will require patients to pick up the prescription during business hours. A valid photo ID must be presented each time of pick-up to obtain the prescription. All controlled substances prescribed on a regular basis require a 3-month (minimum) follow-up appointment.**
- 3. If any medication refills are needed between office visits, please understand that there is a 48-hour "business day" turnaround time for any prescription refill called in, faxed, or electronically submitted. Medication refill requests received after 12:00 pm (noon) on Friday, will not be processed until the following business work-day and will take up to 48 hours to process.**

Thank you,

NC Neurology & Sleep



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"Helping you on your road to good health."

Welcome to North Carolina Neurology & Sleep: We look forward to assisting you with your healthcare needs. Dr. Giallanza will work closely with you and your primary care physician in determining the optimal treatment plan for your medical needs.

Arrival Time: Please arrive **30 Minutes Prior** to your scheduled appointment so that we may process your paperwork and have everything ready for Dr. Giallanza.

Paper Work: Please complete the enclosed paperwork, and bring it with you to your first visit. **Please do not mail the forms back to our office.** If you are late or have not filled out your paperwork, your appointment time may be delayed or shortened or you may be asked to reschedule your appointment due to delaying other patients who have arrived on time.

Patient Medical History Form: This form will become a part of your permanent medical record. To maximize the benefit of your first appointment, please bring a medication list with the names and doses of all of your medications. You may be able to obtain a current list from your pharmacy. Be aware of any medication refills you may need and make a list of questions/concerns you would like to discuss during your appointment. Medical records, lab reports, and/or x-ray reports from your previous physicians are helpful. If you have had a recent MRI or CT scan of the brain/spinal cord, please bring a copy (CD) of these images with you to your appointment. You can obtain these images by contacting the radiology department where the scans were performed.

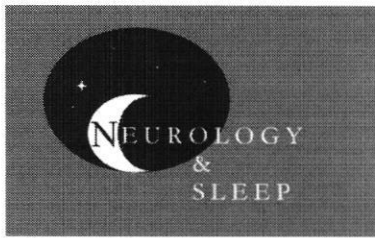
No-Balance Policy Practice: All patients are responsible for knowing and understanding their insurance policies. We do request payment for services at the time of your visit. Depending on your insurance, this may be the entire fee or solely your specialist co-pay. Payments can be made via Visa, MasterCard, personal check, or cash. We will gladly discuss financial arrangements if necessary. Please be sure to bring your insurance card(s) and photo I.D. with you at the time of all visits. **We have a 24-hour cancellation policy** to assure that patients who need an appointment to have that opportunity. **A fee of \$50.00** will be applied to any New Patient appointment cancelled with less than a 24-hour notice since an extended time frame is allocated for new patients.

Mission Goal: Our physician and staff are committed to providing patients excellent care. We believe in taking the time to know our patients and treat them with the best quality care possible. We are sensitive to each patient's needs and concerns. We strive to help our patients the best way possible and are always open to feedback. We genuinely want and will do whatever we can to help our patients be in their best health.

Sincerely,

North Carolina Neurology & Sleep

403 GILEAD ROAD, STE. B / HUNTERSVILLE, NC 28078 / PHONE: 704-464-1509



403 Gilead Road, Suite B
Huntersville NC, 28078
(P) 704.464.1509
(F) 704.464.1393
www.ncneuro.com

North Carolina Neurology & Sleep is located at:

403 Gilead Road, Ste. B Huntersville, NC 28078

We are located off Exit 23 from Interstate 77.

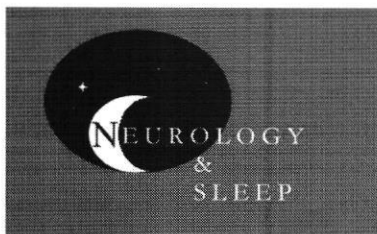
If you are traveling south on I-77 (from Mooresville/Statesville) you will take a left onto Gilead Rd.

If you are traveling north on I-77 (from Charlotte/University) you will make a right onto Gilead Rd.

In approximately 0.5 miles you will turn right into 403 Gilead Road "Gilead Commons Building". Parking is located in the rear of the building and the entrance is through the back of the building.

We are located on the 1st floor at the end of the hallway in Suite B.





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DEMOGRAPHICS

Date: _____

Patient: _____ Sex: __M__F / __Single__Married__Widowed__Sep__Div
(Last Name) (First Name) (Initial) (Preferred Name)

Home Phone: _____ Cell: _____ Age: _____ Date of Birth _____ E-Mail: _____

Address: _____ City _____ State _____ Zip _____

***Who is your Primary Care Physician?** _____

Employer: _____ Business Phone: _____ ext. _____

Occupation: _____

Responsible for payment (if under 18) _____ Relationship to patient: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ SS # _____ Date of Birth _____

Employer: _____ Employer's Phone Number: _____

| <u>Primary Insurance:</u> | <u>Secondary Insurance:</u> |
|----------------------------------|------------------------------------|
| Policy Number: _____ | Policy Number: _____ |
| Company Insured Through: _____ | Company Insured Through: _____ |
| Policy Holder's Name: _____ | Policy Holder's Name: _____ |
| Policy Holder's SS #: _____ | Policy Holder's SS #: _____ |
| Insured's Date of Birth: _____ | Insured's Date of Birth: _____ |

Persons to contact in case of Emergency: 1) Name: _____ Number: _____
2) Name: _____ Number: _____
3) Name: _____ Number: _____

Who may we thank for referring you? (Doctor, Family, Friend, Other) _____

- Can we leave lab/path results and billing information on your voice mail? _____ (your initials)
- May we remind you of your appointment via automated phone system? _____ (your initials)
- May we remind you of your appointment via e-mail? _____ (your initials)
- List anyone that we may discuss your account & medical information with (spouse, family member, etc.)

Name _____ Relationship _____
Name _____ Relationship _____

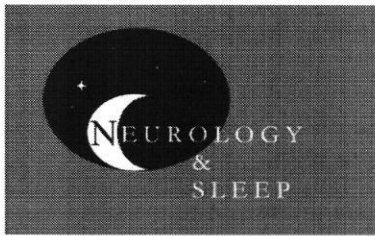
RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have been informed that a copy of North Carolina Neurology and Sleep "Notice of Privacy Practices" is available at my request.

Signature _____ Date _____

PLEASE SIGN TO AUTHORIZE RELEASE OF MEDICAL INFORMATION TO AUTHORIZED PARTIES:

Signature: _____ Date: _____



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We send Prescriptions electronically. Please list your preferred Pharmacy, Location, and Phone Number of Pharmacy:

Pharmacy: _____ Location: _____ Phone # of Pharmacy: _____

FINANCIAL POLICY (EFFECTIVE 05.01.2016)

We have adopted the following financial policy. If you have any questions about this policy, please discuss them in advance with our front office personnel or our billing specialist.

Payment is due and expected at the time of service. We accept cash, check, Money Order, VISA and MasterCard.

If you pay by check and it is returned to our office for any reason, the amount of the check will be reinstated to your existing balance, along with a service charge of \$20.00 (NO EXCEPTIONS). Payment of these amounts must be made immediately in the form of cash or money order.

We have contractual arrangements with many insurers and other healthcare plans to accept an assignment of benefits. We will bill those plans for which we have an agreement. We will collect co-pays and balances owed at check-in when you arrive for your appointment. Other fees may be due during check-out such as deductibles, coinsurance and services not covered by your insurance plan. These amounts are due and expected at this time.

Medicare Patients

Our office is required by law to file your Medicare claims for you. We accept assignment on Medicare. This means we have agreed to accept Medicare approved amounts as full payment. However, Medicare only pays 80% of the approved amount, leaving a 20% copay to be paid by the patient.

Medicare will not pay for a list of services they have deemed not medically necessary. For those services, Medicare requires NC Neurology and Sleep to have you sign a waiver acknowledging that you have been informed that Medicare will not pay, and that you will be solely responsible for payment of that service. Payment is expected at the time of service for these non-covered services.

Medicaid Patients

We do accept Medicaid, it is the patient's responsibility to bring a signed valid card with you to all visits. If you do not have a valid card with a proper authorization, your appointment will be rescheduled. For adults on Medicaid, the co-pay can vary from \$3.00 or a \$6.00 co-pay which is expected at the time of the visit.

Surgery Patients

- All surgery patients will receive a separate billing statement from Pathology.

Failure of insurance company to pay does not excuse the patient's responsibility. It is the patient's responsibility to know what is covered and not covered by policy. When in doubt, please contact your insurance company for clarification.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient for payment.

MISSED APPOINTMENTS

- NC Neurology and Sleep requires a **24-hour advance notice to cancel or reschedule appointments**. Please call us as early as possible if you know you will need to reschedule your appointment. **A \$25.00 fee for Established Patients** will be charged to your account for all missed or rescheduled appointments without a 24-hour notice because time has been allotted for your appointment and another patient could have been seen.
- **Missed "New Patient"** visits where the patient has not called and cancelled before the 24-hour timeframe will be charged a **\$50.00 fee**. We allot 45 minutes for new patient appointments. Many patients who are scheduled several weeks out and are on our "wait list" and would have desired your cancelled time slot.

I have read NC Neurology's Financial Policy and agree to be bound by its terms.

(Signature of Patient or Responsible Party)

(Print Patient's Name)

(Date)

We accept what Medicare approves. Your co-payment and yearly deductible are part of what Medicare approves. MEDICARE PATIENTS only:

"I request that payment of authorized Medicare benefits be made on my behalf to North Carolina Neurology and Sleep, PLLC for any services furnished to me by physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____



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Email: info@ncneuro.com

Date: _____

Patient Name _____

DOB _____

REASON FOR VISIT: _____

PATIENT'S CONCERNS: Check all that apply

- | | | | | |
|--|---|---|---|---------------------------------------|
| <input type="checkbox"/> Abdominal pains | <input type="checkbox"/> Abnormal growth | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back pain | <input type="checkbox"/> Birthmark | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Chokes easily | <input type="checkbox"/> Clumsy/poor coordination | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Depression | <input type="checkbox"/> Hostile/Angry | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Excessively sleepy | <input type="checkbox"/> Fainting or passing out | <input type="checkbox"/> Shy | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Frequent falls | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart murmur | |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Nasal congestion | |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Pain in arms or legs | <input type="checkbox"/> Pain with urination | |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Reactive Airway Disease | <input type="checkbox"/> Tremor | |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Stares off into space | <input type="checkbox"/> Trouble sleeping | |
| <input type="checkbox"/> Trouble hearing | <input type="checkbox"/> Trouble learning | <input type="checkbox"/> Trouble seeing | <input type="checkbox"/> Wets self during the day | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight change | <input type="checkbox"/> Wets self during sleep | |

BIRTH HISTORY: Check all that apply

- Problems with pregnancy: ☐ Infection ☐ Fever ☐ High blood pressure ☐ Drank alcohol ☐ Used recreational drugs
- Delivery: ☐ Vaginal ☐ Cesarean (C-Section)
- Problems with delivery? ☐ No ☐ Yes ☐ Other _____
- Birth was: ☐ Full term ☐ Late ☐ Early (how many wks? _____) Birth Weight: _____
- Problems as newborn: ☐ Jaundice ☐ Breathing ☐ Infection ☐ Seizure ☐ Heart
- ☐ NICU stay ☐ Feeding

☐ Other Birth Issues: _____

MEDICAL HISTORY: Check or fill in as indicated

Hospitalizations: ☐ No ☐ Yes, for what?: _____

Surgery: ☐ No ☐ Yes, for what?: _____

Past medical problems / illnesses: _____

Immunizations up to date: ☐ No ☐ Yes

Tests performed: ☐ MRI ☐ CT scan ☐ Spinal tap ☐ Genetics ☐ EEG/Brain wave test



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Allergies to medications: _____

Current medications and doses:

| | |
|--|--|
| | |
| | |
| | |

FAMILY MEDICAL HISTORY: Check all that apply and write in relationship of family member to patient to whom it applies.

- ☐ Headaches _____ ☐ Learning difficulties/Developmental Delay _____
- ☐ Behavior (Psychiatric) problems _____ ☐ Speech problems _____
- ☐ Inflammation (lupus, sarcoid, etc.) _____ ☐ Muscle problems _____

☐ Other medical illnesses not listed that run in the patient's family? (i.e. young heart attack/stroke, blindness, deafness, tremors, tics): _____

SOCIAL HISTORY:

Members of household: _____

Current grade placement _____ Name of School: _____

OFFICE NOTES ONLY:

| | | | |
|-----|--|------|--|
| HT | | WT | |
| BP | | HR | |
| POX | | TEMP | |

Doctor Reviewed with family: _____ Date _____



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Allergies to medications: _____

Current medications and doses:

| | |
|--|--|
| | |
| | |
| | |

FAMILY MEDICAL HISTORY: Check all that apply and write in relationship of family member to patient to whom it applies.

- ☐ Headaches _____ ☐ Learning difficulties/Developmental Delay _____
- ☐ Behavior (Psychiatric) problems _____ ☐ Speech problems _____
- ☐ Inflammation (lupus, sarcoid, etc.) _____ ☐ Muscle problems _____

☐ Other medical illnesses not listed that run in the patient's family? (i.e. young heart attack/stroke, blindness, deafness, tremors, tics):

SOCIAL HISTORY:

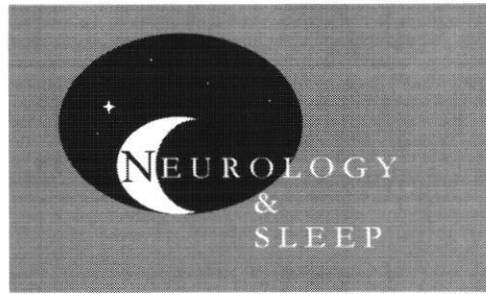
Members of household:

Current grade placement _____ Name of School: _____

OFFICE NOTES ONLY:

| | | | |
|-----|--|------|--|
| HT | | WT | |
| BP | | HR | |
| POX | | TEMP | |

Doctor Reviewed with family: _____ Date _____



CLINIC POLICIES AND PROCEDURES

Office Hours: Monday-Thursday 8:30 am to 5:00 pm

Friday 8:30 am to 12:00 am

Initials: _____

Office Visits:

- **It is the responsibility of the patient to check with their health plan to confirm that NC Neurology and Sleep is included in their plan.** NCN&S may participate in some, but not all, plans offered by your insurance company. Coverage limitations are dependent on individual group contracts. **It will be the patient's financial responsibility if insurance does not cover services.**
- You must be scheduled to be seen - walk in or emergency appointments are not available.
- Patients who arrive ten minutes or more, late to appointment may be rescheduled at the discretion of the physician or office manager.
- Failure to cancel or change an appointment with less than 24-hour notice will be charged a non-negotiable fee. This fee must be paid before another appointment will be scheduled.
- Patients with more than two "No Show" appointments will be dismissed from our practice.
- For **new patient** office visits, please arrive 20-30 minutes before your appointment time, bring all insurance cards, completed new patient paperwork, and a list of medications.

Initials: _____

Prescriptions:

- Please contact your pharmacy regarding refill requests, as there may be a prescription on file, as refills are written to coincide with follow-up appointments. Refill requests take up to 48 hours to process.
- Any refill for pain/controlled medications will not be refilled early. This includes lost prescriptions, whether misplaced or stolen.
- Refills will not be given after hours, on weekends, or holidays. Please do not call the emergency line for refills.
- Any changes in your medication regimen will only be addressed at appointments. If you feel a change is necessary, please contact the office to schedule an appointment.
- If you are taking any controlled substances from a different provider, you must make our office aware at the time of your office visit.
- All controlled substances prescribed on a regular basis require a 3-month follow-up appointment.

Initials: _____

Services Subject to Additional Charges:

- Telephone calls even within business hours consisting of more than a simple question, or requiring a more complex response from our provider.

- "No Show" follow up appointments will be charged \$25 fee.
- "No Show" new patient appointments will be charged \$50 fee.
- "No Show" procedure and sleep appointments will be charged \$100 fee.
- Paperwork with extensive medical questions that needs to be answered by our provider.

Initials: _____

Payments:

- Any co-pay or co-insurance is due at the time of service.
- Patients that have a balance on their account, must pay the balance before they are seen at their next appointment.
- Patients on a payment plan must be current with their payment plan before they are seen at their next appointment.
- "Self-Pay" (not filing insurance) fees are required at the time of service.

Initials: _____

General Clinic Policies:

- The practice strictly follows HIPPA privacy guidelines, no information is shared without a signed release of information form.
- No information even with a release form is given out over the phone.
- We do not tolerate erratic, aggressive, disrespectful or otherwise inappropriate behavior. Clients who exhibit this sort of behavior will have services terminated from our practice immediately.
- Patients with memory disorders should be accompanied with a family member or friend to their appointment to provide a thorough medical history.
- A parent or guardian must accompany patients under 18 years of age to all appointments.

Initials: _____

Contact with Clinic and Providers:

- We are not always available to answer the phone directly; so please leave a voicemail. Calls will be returned within 48 hours from receipt of voicemail.
- If you need more rapid attention for you or someone else's safety, do not delay while waiting for a return call. Please call 911 or go directly to the emergency room.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES:

I have received a copy of NC Neurology and Sleep Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment.

Patient Signature: _____ **Date** _____

If patient is a minor or unable to sign, Authorization is given on the patient's behalf:

Signature: _____ **Date** _____

Printed Name: _____ **Relationship to Patient** _____

Mission Goal: Our physician and staff are committed to providing patients with excellent care. We believe in taking the time to know our patients and treat them with the best quality care possible. We are sensitive to each patient's needs and concerns. We strive to help our patients the best way possible and are always open to feedback. WE genuinely want and will do whatever we can to help our patients