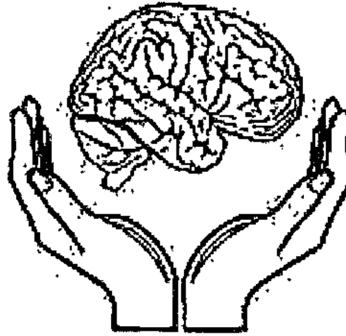


BG NEUROLOGY

Dr. Bogdan Gheorghiu

1071 Boiling Springs Rd. Spartanburg, SC 29303

P-864-577-9107 F-864-699-1999

Please bring the following with you to your appointment:

- Completed New Patient Forms
- Insurance Cards
- Insurance Copay/Coinsurance/Deductible
  (if you do not have insurance you will need to be prepared to pay a self-pay fee of $157.56 at check-in)
- Picture Identification
- Current Medication List

We would ask that you arrive no more than 30 minutes prior to your scheduled appointment. This will allow us to help each patient in a timely fashion. This will also prevent our parking lot from becoming too overcrowded.

If you are unable to make your appointment, please let our office know by calling 864-577-9107 at least 24hrs. in advance to reschedule your appointment. Patients who fail to call and no-show for their appointment may be charged a no-show fee.

BG Neurology

Demographics and Insurance

(ALL FIELDS ARE REQUIRED)

Date: ________________

Name: ____ DOB: ____________________

Mailing Address: ____

City: ___________________________ State: ________________ Zip: _________________

Home Phone: __________________________ Cell Phone: __________________________

SSN: ___________________________ Email Address: _____________________________

Male: _____ Female: _____ Race: __________ Marital Status: ____________________

Employer: _________________________________ Work Phone: ____________________

Spouse Name: ______________________________ DOB: ___________________________

Emergency Contact: __________________________ Phone: _________________________

Referring Doctor: ____________________________ Phone: _________________________

Primary Care Doctor: _________________________ Phone: _________________________

Pharmacy: __________________________________ Phone: _________________________

Are you in a Nursing Home/Hospice Facility? (circle one) YES NO

Name of Nursing Home/Hospice Facility: ____

Nursing Home/Hospice Contact #__________________________

Primary Insurance: _________________________ Member ID/Policy#___________________

Policy Holder's Name: ______________________________ DOB: ______________________

Secondary Insurance: _______________________ Member ID/Policy #__________________

Policy Holder's Name: ______________________________ DOB: ______________________

I hereby authorize BG Neurology to furnish information to insurance carriers concerning my treatment and herby assign to the doctor all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance.

Patient Signature: ______________________________ Date: ______________________

General Consent for Care and Treatment Consent

<u>TO THE PATIENT</u>: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: ______________________________ **Date:** ______________

POA/ Signature: ______________________________ **Date:** ______________

Printed Name: ____

REVIEW OF SYSTEMS

Patient Name: ______________________________ Date of Birth: __________

****PLEASE CHECK ONLY SYMPTOMS THAT YOU ARE CURRENTLY HAVING TODAY****

CARDIOVASCULAR

____Chest Pain ____Fainting ____Palpitations ____Shortness of Breath with Exertion

EARS/NOSE/THROAT

____Congestion ____Decreased Hearing ____Difficulty Hearing ____Earache ____Loud Snoring
____Sore Throat ____Tinnitus (Ringing)

ENDOCRINE:

____Cold/Heat Intolerance ____Excessive Thirst ____Excessive Weight Loss/Gain
____Frequent Urination

EYES

____Blurred Vision____Double Vision____Sensitivity to Light____Vision Loss

GASTROINTESTINAL

____Abdominal Pain ____Bloody Stool ____Constipation ____Diarrhea ____Jaundice
____Nausea ____Vomiting

GENERAL

____Fatigue____Fever____Headache____ HIV Exposure ____Loss of Appetite

GENITOURINARY

____Blood in Urine ____Burning with Urination ____Incontinence ____Urgency

HEME/LYMPHATIC

____Abnormal Bleeding ____Abnormal Bruising ____Enlarged Lymph Nodes

INTEGUMENTARY (Skin)

____Abnormal Lesions ____Itching ____Rash ____Ulcerations

MUSCULOSKELETAL

____Joint Pain/Swelling ____Low Back Pain____Muscle Cramps____Neck Pain ____Stiffness
____Tremors

PSYCHIATRIC

____Anxiety ____Can't Focus ____Delusions/Hallucinations ____Depressions ____Memory Loss
____Paranoia ____Suicidal Ideation

RESPIRATORY

____Bloody Cough ____Cough ____Shortness of Breath ____Sputum ____Wheezing

OTHER CURRENT MEDICAL ISSUES:

____

Patient/POA Signature:______________________________ Date: ________________

UNIVERSAL MEDICATION FORM

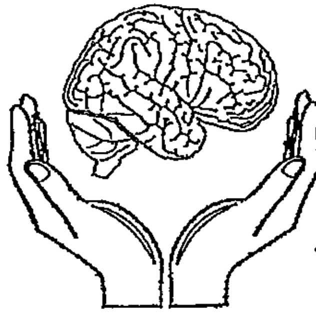
Name:	DOB:
Address:	Phone:

Allergies:

Smoking: Yes ____ No ____	Alcohol: Yes ____ No ____	Illegal Drugs: Yes ____ No ____
How Often:	How Often:	Which:

Please List the medications you are currently taking or attach a list (Including prescriptions, over-the-counter, and herbal)

Medication/Dose	Directions	Prescribing Doctor



HIPAA

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Disclosure:

Your protected health information will be used by BG NEUROLOGY or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Appointment Reminders:

We will contact you by phone regarding appointments, treatment, and/or other information pertinent to your healthcare.

Please indicate your preferred contact information: (ex: phone #, email, mailing address)

____

Please list the persons authorized to receive or discuss your health information:

____

Right to terminate or revoke consent:

You may revoke or terminate this authorization by submitting a written revocation to BG NEUROLOGY.

I have reviewed this consent form and give my permission to BG NEUROLOGY to use and disclose my health information in accordance with this consent.

Name of Patient/POA: ______________________________

Signature of Patient/POA: ______________________________ date: ___/___/____

BG NEUROLOGY

Patient Name: ______________________________ DOB: ____________________

Financial policy of BG Neurology

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1) We ask that you present your insurance card at each visit. It is your responsibility to provide us with correct information to bill your insurance.

2) If you have a change of address, telephone number, or employer, please notify the receptionist.

3) Deductibles, co-payments or charges for non-covered services are due at the time of service. We accept cash, checks, and major credit cards.

4) You are expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, contact our billing manager at 864-577-9107 ext. 349. We reserve the right to refuse service.

5) SELF PAY PATIENTS: Patients with no insurance are expected to pay at time of service. New patients = $157.46, Established patients = $71.51. If you can't pay in full, contact our billing department prior to seeing the doctor to make payment arrangements.

6) No show or missed appointments - When an appointment is scheduled with the doctor, time is specially allocated for you. If you are unable to keep an appointment, we ask the courtesy of a phone call to cancel your appointment. We prefer a 24 hour notice of cancellation.

Remember, whether you do or do not have insurance, you are ultimately responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing manager at 864-577-9107 ext. 349.

I have read and have full understanding of the financial policy of BG Neurology.

Signature: ____________________________________ Date: ________________

BG NEUROLOGY

Bogdan P. Gheorghiu

1071 Boiling Springs Rd. Spartanburg, SC 29303

P – 864.577.9107 ext. 324

No Show Policy

Thank you for trusting your medical care to BG Neurology. When you schedule an appointment with BG Neurology we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

-We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact Tara at ext. 324 to reschedule. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

-Any patient who fails to show or cancels an appointment without 24 hour notice will be charged a $50.00 fee.

- After three no shows/cancellations, without 24 hour notice, we will be unable to continue to reserve time for you within our practice.

- Any new patient who fails to show for their initial visit ,without 24 hour notice, unfortunatlely can not be rescheduled.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

______________________	______________________
Signature (Patient/POA)	Relationship to Patient
______________________	______________________
Printed Name	Date