Comprehensive Neurology Specialists, P.C.
6300 Hospital Parkway - Suite 260
Johns Creek, GA 30097
Phone: 770.454.4685

Welcome to our office!

Enclosed you will find your new patient registration papers as well as directions to our office. Please fill out your papers **PRIOR** to arriving in our office. **IF YOU ARE A PATIENT OF DR. HARRIS, ON THE DAY OF YOUR VISIT, YOU WILL BE SEEING OUR PHYSICIAN ASSISTANT, DEBORAH MURRAY FOR YOUR INITIAL CONSULTATION.** When all testing is complete, Dr. Harris will see you to go over all of your results on the day of your follow up appointment. Please bring your insurance card as well as your PCP or referring physician name and phone number. We will send a detailed note regarding your visit. We will need your pharmacy telephone number so that we may send your prescriptions directly to the pharmacy.

If you have had an MRI scan, please try to go to the center where it was done and ask the center for actual films or a CD to bring to your appointment. Please ask your referring provider to send recent lab or other testing to avoid duplicate studies. They may fax records to 770-454-4690 prior to your appointment.

If testing is scheduled, please allow at least one week for the results. If there is something that required immediate attention, the testing facility will call us before you leave for further clarification.

Thank you for choosing Comprehensive Neurology Specialists, P.C. We look forward to seeing you in the office.

Directions to our Office:

Alpharetta: North on GA 400 (Exit 10)
Take the GA-120 exit 10 to Alpharetta. Continue on Old Milton Parkway. The name of the road will change to State Bridge Road (GA-120). Continue on State Bridge until you see Medlock Bridge (also called HWY 141). Turn **left** onto Medlock Bridge. Follow Medlock Bridge (name will change to Peachtree Parkway) until you see McGinnis Ferry Road. Take a left onto McGinnis Ferry. Proceed straight until you approach Hospital Parkway (get in left lane) turn left on Hospital parkway. Go to first stop sign and turn left. Our building will be straight ahead.

Alpharetta: East Side
From Old Milton Pkwy, continue on State Bridge Road. Turn **left** at Kimball Bridge Road. Turn **left** onto Jones Bridge Road. Then turn **right** at Sargent Road which turns into McGinnis Ferry Road. Turn right onto Hospital Parkway and proceed straight in the left lane until you reach a stop sign. Turn left away from the hospital and come straight ahead to our building.

Cumming:
Follow HWY 400 South to Exit 13 (Norcross/HWY 141). Turn **left** onto 141 (Peachtree Pkwy.). Go approximately 6-7 miles on 141 until you reach McGinnis Ferry road and take a **right** .Go past Johns Creek Pkwy and take the next **left** onto Hospital Parkway. Proceed in the left lane to the next stop sign and take a **left.** Our building will be straight ahead. We are across the street from the Emory Hospital Entrance.

Downtown:
Take I-85 north to Lawrenceville-Suwanee Exit. Take a **left** onto Lawrenceville-Suwanee road. Go straight approximately 3 miles and turn **left** onto Peachtree Industrial Road. Go approximately ½ mile and turn **right** onto McGinnis Ferry Road. Stay on McGinnis Ferry crossing over Hwy 141. Pass Johns Creek Parkway and take the next left onto Hospital Parkway. Proceed straight in left lane until you reach the next stop sign. Turn left and our building will be straight across.

Duluth
Follow Pleasant Hill Road west to Medlock Bridge Road. Turn **right** onto Medlock Bridge Road (HWY 141). Go approximately 3-4 miles on Medlock Bridge Road. Proceed straight to McGinnis Ferry Road and turn left. Pass Johns Creek Parkway and take the next left onto Hospital Parkway. Proceed straight in left lane to the next stop sign. Take a left and our building will be straight ahead.

Winder
Take I-85 to Lawrenceville-Suwanee Hwy. Take a right onto Lawrenceville-Suwanee road. Go to Satellite Blvd and take a left to McGinnis Ferry Road. Take a right on McGinnis Ferry Road. Remain on McGinnis Ferry 5-7 miles crossing over Hwy 141. Proceed ahead taking left lane to turn onto Hospital Parkway. Remain in left lane to the next stop sign. Turn left and our building will be straight ahead.

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Comprehensive Neurology Specialists, P.C.

Administrative Policy

Our goal is to provide the best medical care possible in a supportive and caring environment. However, many of our services are not covered by your insurance. To continue providing you with these essential services we have developed a fee schedule which represents the cost of each service. As a courtesy to our valued patients we are offering an umbrella benefit which will cover all these services for a single reduced fee of $75.00. This optional fee is due at check in of your first visit and then will need to be renewed annually. If you do not wish to pay the annual fee before requiring any of the listed services, you will be charged for administrative services individually as you request them. **You cannot pay the annual Administrative Services Fee at the time you request these services.** You will have an opportunity to pay the reduced fee at the beginning of each year. Chargeable items you will pay for on an "as requested" basis include, but are not limited to:

ADMINISTRATIVE FEES PER DOCUMENT:

• Prior authorization for prescription medications	$25.00
• Life insurance forms	$50.00
• Family Medical Leave Act (FMLA) forms	$50.00
• Handicapped parking forms	$25.00
• Assisted Living Forms	$50.00
• Jury Duty Forms	$25.00
• Other/miscellaneous forms or letters	$50 per page

Medical Records:

- As a courtesy we provide our patients with a copy of their office visit notes at check out. If you are requesting duplicate copies, previous visits, testing, etc… A request must be submitted in writing. Minimum $25 fee then $0.50 each page.
- Computer generated reports (extra claims, payment history, itemized statements, etc.. These are used for end of year taxes, flex spending plans) - $15

OTHER:

- Prior Authorizations are **NOT** a guarantee of approval from your insurance. Our specialized team does do everything possible, but the final decision is at the discretion of your insurance company.
- Please allow up to 10 business days for forms and records requests.
- Once forms/ letters are completed we will call you to come pick them up. We ask that you review them for errors prior to leaving. Once you have left no changes will be made.
- The Administrative fee includes all administrative services with the exception of Disability forms. The $75 fee does **NOT** include disability forms. Disability forms are $50 base fee & $25 each additional page.

☑ *I wish to pay the annual administrative fee of $75 at this time.*

☐ *I choose to **NOT** pay the annual administrative fee. I understand that I will have to pay for each individual service as I request them.*

Signature: _____ Date: _____

COMPREHENSIVE NEUROLOGY SPECIALISTS, P.C. FINANCIAL POLICY
Mark I Harris, M.D. Robert Waldrop, M.D. and Deborah E. Murray, PA-C

Thank you for choosing Comprehensive Neurology Specialists, P.C. as your healthcare provider. We are committed to providing our patients with excellent care. The objective of our financial policy is to clearly outline patient and practice financial responsibilities and to make sure matters related to the payment for health care services are as straightforward as possible. Our staff is happy to help with any questions regarding this financial policy, your account, claims or other questions you may have about your bill. **Specific questions about coverage issues can only be addressed by your insurance company. If there is any question regarding coverage, benefits or payment for services provided, it is your responsibility to resolve those issues.**

- **THE RECEPIONIST MUST BE INORMED IF YOU HAVE HAD A JOB OR AUTO RELATED INJURY. WORKERS COMP, AUTO INSURANCE, AND LIENS ARE NOT ACCEPTED. YOU WILL BE DISMISSED FOR WITHOLDING THIS INFORMATION.**

- **RESPONSIBILITY FOR YOUR ACCOUNT ULTIMATELY RESTS WITH YOU. ALL CO-PAYS AND OUTSTANDING BALANCES WILL BE DUE AT THE TIME OF SERVICE. IF YOU DO NOT PAY YOUR BALANCE YOU WILL BE ASKED TO RESCHEDULE.**

- **IT IS THE PATIENTS RESPONSIBILITY TO MAKE SURE WE HAVE CORRECT & UPDATED INSURANCE INFORMATION PRIOR TO YOUR VISIT. YOUR VISIT MAY HAVE TO BE RESCHEDULED IF WE ARE NOT INFORMED PRIOR TO YOUR APPOINTMENT.**

- **WE DO NOT ACCEPT MEDICAID, PEACHCARE, WELLCARE, PATHWAY, X or Y PLANS. DR. HARRIS DOES NOT ACCEPT BCBS POS OR HMO. HOWEVER DR. WALDROP DOES ACCEPT BCBS POS & HMO.**

- **DUE TO THE LARGE NUMBER OF INSURANCE PLANS IT IS IMPOSSIBLE FOR OUR FRONT DESK TO VERIFY YOUR BENEFITS. IT IS YOUR RESPONSIBILITY TO KNOW YOUR PLAN AND HOW IT COVERS.**

Self Pay
If you are a patient that does not have active coverage with an insurance plan upon appointment, payment will be expected in full at the time of service. New patient Consultation is **$300.00**. Follow up visit is $150.00.

PPO Plans
We have agreed to accept the discounted rate from your plan, however, all co-insurance is your responsibility. All co-pays must be satisfied ***PRIOR*** to seeing the doctor at each and every visit. If you have a high deductible plan be prepared to pay for your services. There can be no exceptions due to contracting and uniform compliance rules.

Medicare
As a participating provider, we accept assignment and will bill your Medicare carrier directly. You are responsible for the $25 copay ***PRIOR*** to services, payment of 20% of the approved amount, and your Medicare deductible. Medicare may submit those amounts to your secondary insurance. If not, we will submit to your secondary carrier if you have provided us with the correct insurance information. However, once Medicare has paid their portion, you are responsible for your 20% of the approved amount and any applied deductible.

HMO/POS Plans
You are responsible for getting the proper referral in advance of your appointment. Without a referral, you will be asked to pay for the visit in full at the time of service. Alternatively, you may reschedule your appointment giving you time to obtain proper authorization. All co-pays must be satisfied prior to seeing the doctor at each and every visit. There can be no exceptions due to contracting and uniform compliance rules.

Cancellations & No Shows
Please try to keep all scheduled appointments. If we do not receive a call from you within 48 hrs. prior to your appointment to cancel or reschedule a $25 fee will be placed on your account. This fee also applies if you do not show up for your appointment. The fee will be collected when appointment is canceled or missed.

I have read the Financial Policy. I understand and agree to abide by the financial policy.

X_____ _____
Signature of Patient or Responsible Party Date

Updated 1/1/2015

Patient's Bill of Responsibilities

*****Please read and stay updated on our polices*****

Behavior Policy

LOUD AND ABUSIVE BEHAVIOR WILL NOT BE TOLERATED DUE TO OUR RESPONSIBILITY FOR THE SAFETY OF OUR PATIENTS AND EMPLOYEES. YOU WILL BE ASKED TO LEAVE OR WE WILL CALL SECURITY TO ESCORT YOU FROM OUR OFFICE. IF VIA PHONE THE CALL WILL BE DISCONNECTED (All calls are recorded).

We care about our patients and your concerns. If you have a need to voice a complaint it is to be addressed with Management only. The doctors, nurses, and front office can not stop treating patients to address complaints.

I agree to treat everyone in the office with respect. I understand my relationship with the practice can be terminated at the doctors and managements discretion.

X_____ _____

Signature of Patient Date

Prescription Refills

All Prescription refill requests will have to be done through your pharmacy. You may also request refills through the patient portal but our office does prefer that you use your pharmacy.

Prep for Your Visit

Please make sure that we have all Lab results, Scan reports (MRI, MRA, CT, etc…), and any notes for recent hospitalizations that have occurred since last being in our office. It is the patient's responsibility to make sure you are prepared for your appointment so you can get the most out of your visit with us.

Work In Appointments

If you are added to the schedule within 48 hrs you will be considered a work in. If you arrive late and we are able to still keep the appointment you will be considered a work in. This means that you will be seen around patients that have had their appointments for over 48 hrs. and you may have a wait time of 15 minutes to 2 hours. We have work ins to accommodate our patients but ask that you be understanding of the wait time if you are a work in.

Patient Portal

We are very excited about our patient portal. We are encouraging all patients to sign up with our front office. You will need to provide the front office with your email. We will send you an email to set up your own username and password. By setting up your account you agree for our office to release your information through the portal. You will receive lab results, MRI results, visit notes, can request appointments, confirm appointments, and can communicate with your doctor via the portal.

Thank you for keeping updated on our policies. We look forward to assisting you with all your neurological needs.

Patient Registration Information

Please PRINT and complete ALL sections below!
PLEASE USE BLUE OR BLACK INK ONLY

PATIENT'S PERSONAL INFORMATION

Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed **Sex:** ◯Male ◯Female

Name: _____ _____ _____
Last Name First name Initial

Date of Birth: _____/ _____ / _____ Social Security #: _____ - _____ - _____ Email: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

PATIENT'S/RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ◯Self ◯Spouse ◯Child ◯Other:_____

Name: _____ _____ _____
Last Name First name Initial

Date of Birth: _____/ _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #:_____

Name of Insured: _____ Relationship to Insured: ◯ Single ◯ Spouse

Date of Birth: _____/ _____ / _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #:_____

Name of Insured: _____ Date of Birth: ___/____/____ Relationship to Insured: ◯ Single ◯ Spouse

Date of Birth: _____/ _____ / _____

PATIENT'S REFERRAL INFORMATION

Primary Care Physician Name

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell: (_____) _____

Assignment of Benefits Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Comprehensive Neurology Specialists and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

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(p) 770.454.4685 (f) 770.454.4690

Patient Medical History

Patient's Name: _____ DOB: _____ Date: _____

Briefly Describe What Problem Brings You To The Doctor/ Symptoms: _____

_____

_____

List All Your Medications (Including the dosage, frequency, and any non-prescription medications you take.)

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

Medication Allergies

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History- Please place a check mark if you or your immediate family has ever had any of the following:

PGF-Dad's Father **PGM-** Dad's Mother **MGF**- Mom's Father **MGM-** Mom's Mother

Dementia:	You ☐	Family _____	Psychiatric Problems:	You ☐	Family_____	Heart Disease:	You ☐	Family_____
Migraines:	You ☐	Family ___ ___	High Blood Pressure:	You ☐	Family_____	Liver Disease:	You ☐	Family_____
Seizures:	You ☐	Family _____	High Cholesterol:	You ☐	Family_____	Kidney Disease:	You ☐	Family_____
Stroke/TIA:	You ☐	Family _____	Diabetes:	You ☐	Family_____	Multiple Sclerosis:	You ☐	Family_____
Brain Tumor:	You ☐	Family _____	Mental Illness:	You ☐	Family_____	Sleep Disorders:	You ☐	Family_____
Cancer:	You ☐	Family _____	Heart Attack:	You ☐	Family_____	Thyroid Disease:	You ☐	Family_____
Head Injury:	You ☐	Family _____	Bleeding Problems:	You ☐	Family_____	Lung Disease:	You ☐	Family_____
Neck Injury:	You ☐	Family _____	HIV:	You ☐	Family_____	Parkinson's:	You ☐	Family_____

Please describe any marked illnesses/ Comments:

_____

_____

_____

Past Surgical History:

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

Family Medical History:

						Disease or cause of death
1. Father	Age _____	living	☐	deceased	☐	_____
2. Mother	Age _____	living	☐	deceased	☐	_____
3. Brother	Age _____	living	☐	deceased	☐	_____
4. Brother	Age _____	living	☐	deceased	☐	_____
5. Sister	Age _____	living	☐	deceased	☐	_____
6. Sister	Age	living	☐	deceased	☐	

Social History:

☐ Single ☐ Married

☐ Widowed ☐ Divorced

Do You or Have You Ever:
Used Tobacco? _____
If yes, how much? _____
If quit, when? _____
Drink Alcohol?: _____
How often/ How many? _____
Occupation? _____
Number of children? _____

COMPREHENSIVE NEUROLOGY SPECIALISTS, P.C.
Patient Privacy Act Notice

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique identifiers for health plans, providers, individuals, employers
- Healthcare transaction and code sets for transmitting data electronically
- Privacy regulation over disclosure and use of health information
- Security regulations over protection of electronic health information

In accordance with HIPAA privacy standards, **we will not release confidential and/or unauthorized information over a home telephone answering machine, work or cell phone voice mail and/or pager.** However, in the event that we need to contact you, we would like to have our records reflect your wishes:

PLEASE PROVIDE US WITH NUMBERS WHERE WE MAY CONTACT YOU

Home Telephone: _____ **Work Telephone:** _____

Cell Phone: _____ **Pager:** _____

MAY WE LEAVE CALL BACK OR APPOINTMENT REMINDER MESSAGES – (Circle YES or NO)

YES ◯ NO ◯ On your answering machine?

YES ◯ NO ◯ On your voice mail?

YES ◯ NO ◯ On your cell phone voice mail?

YES ◯ NO ◯ On your pager?

YES ◯ NO ◯ With your answering party on your home phone?

YES ◯ NO ◯ With your secretary or answering service?

PLEASE BE ADVISED THAT IT WILL BE YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES IN WRITING

Information will never be left with an unauthorized person. If you have family members or someone other than yourself that you would like to authorize our staff to discuss your medical information with, please fill out the information and sign the release below:

	PRINT NAME	CONTACT PHONE NUMBER
SPOUSE:	_____	_____
PARENT:	_____	_____
OTHER:	_____	_____

Signature of Patient/Guardian: _____ **Date:** _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize Comprehensive Neurology Specialists, P.C. and staff to fax or mail my medical information to referring and consulting physicians, physical therapists, pharmacists, rehab facilities, and/or other medical facilities who are involved in my medical care. In the event that I wish to change or withdraw the agreement of this release, I accept responsibility of notifying my change(s) or withdrawal in writing to Comprehensive Neurology Specialists, P.C.

Signature of Patient/Guardian: _____ **Date:** _____

PLEASE SIGN: I have been offered an opportunity to review the Comprehensive Neurology Specialists, P.C. Notice of Privacy Practices.

Signature of Patient/Guardian: _____ **Date:** _____

If you do not wish to sign this acknowledgment form, please check the box below and initial.

☐ _____

Comprehensive Neurology Specialists, P.C.

6300 Hospital Parkway, Suite 260
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Phone: (770)454-4685 Fax: (770)454-4690

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME**:** _____ _____
Last Name First Name

DATE OF BIRTH: _____

I hereby authorize Comprehensive Neurology Specialists, P.C., *to obtain or provide (as indicated below) my medical information. I understand that this information will include available diagnostic testing information, hospital records, laboratory information, as well as any psychiatric, mental health, drug, alcohol or substance abuse information.*

PLEASE INDICATE BY CHECKING THE BOX (ES) BELOW:

☐ Obtain my medical information from:
☐ Release my medical information to:

**********OFFICE USE ONLY**********

Name of Hospital/Physician: _____

Phone Number: _____ Fax Number: _____

*****Attention*** Please include the following information:**

☐ Entire Medical Chart
☐ Admission H&P
☐ Discharge Summary
☐ ER Visit Note
☐ Neurology-related Notes
☐ MRI/CT Scan Report(s)
☐ Most Recent Labs
☐ Carotid US Report(s)
☐ Echocardiogram(s)
☐ Neuropysch Evaluation

☐ Other: _____

****

_____ _____
Patient/Guardian Signature Date

This records release form expires on: _____