

Comprehensive Neurology Specialists, P.C.  
6300 Hospital Parkway - Suite 260  
Duluth, Georgia 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. **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 3 days 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.

Your appointment is scheduled on: \_\_\_\_\_

## **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 McGinnisFerry 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.

Comprehensive Neurology  
6300 Hospital Parkway  
Suite 260  
Johns Creek, GA 30097  
Phone: (770)454-4685

# 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: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell 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  
 Child  Other  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY Insurance Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Insured:  Single  Spouse  
 Child  Other  
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: \_\_\_\_\_

# Comprehensive Neurology Specialists, P.C.

6300 Hospital Parkway, Suite 260  
 Johns Creek, Georgia 30097  
 (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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**Medication Allergies**

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

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:

- |  |  |   |
|--|--|---|
| Dementia: You <input type="checkbox"/> Family <input type="checkbox"/>   | Psychiatric Problems: You <input type="checkbox"/> Family <input type="checkbox"/> | Heart Disease: You <input type="checkbox"/> Family <input type="checkbox"/>   |
| Migraines: You <input type="checkbox"/> Family <input type="checkbox"/>  | High Blood Pressure: You <input type="checkbox"/> Family <input type="checkbox"/>  | Liver Disease: You <input type="checkbox"/> Family <input type="checkbox"/>   |
| Seizures: You <input type="checkbox"/> Family <input type="checkbox"/>   | High Cholesterol: You <input type="checkbox"/> Family <input type="checkbox"/>     | Kidney Disease: You <input type="checkbox"/> Family <input type="checkbox"/>  |
| Stroke/TIA: You <input type="checkbox"/> Family <input type="checkbox"/> | Diabetes: You <input type="checkbox"/> Family <input type="checkbox"/>             | Kidney Stones: You <input type="checkbox"/> Family <input type="checkbox"/>   |
| Cancer: You <input type="checkbox"/> Family <input type="checkbox"/>     | Heart Attack: You <input type="checkbox"/> Family <input type="checkbox"/>         | Thyroid Disease: You <input type="checkbox"/> Family <input type="checkbox"/> |
| Type of Cancer? _____  | Bleeding Problems: You <input type="checkbox"/> Family <input type="checkbox"/>    | Lung Disease: You <input type="checkbox"/> Family <input type="checkbox"/>    |

**Past Surgical History:**

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

**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? \_\_\_\_\_

Family Medical History:				Disease or cause of death	
1. Father	Age _____	living <input type="checkbox"/>	deceased <input type="checkbox"/>		
2. Mother	Age _____	living <input type="checkbox"/>	deceased <input type="checkbox"/>		
3. Brother	Age _____	living <input type="checkbox"/>	deceased <input type="checkbox"/>		
4. Brother	Age _____	living <input type="checkbox"/>	deceased <input type="checkbox"/>		
5. Sister	Age _____	living <input type="checkbox"/>	deceased <input type="checkbox"/>		
6. Sister	Age _____	living <input type="checkbox"/>	deceased <input type="checkbox"/>		

**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 pager?
YES	NO	On your voice mail?	YES	NO	With your answering party on your home phone?
YES	NO	On your cell phone voice mail?	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. FINANCIAL POLICY**

**Mark I Harris, 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.***

**TELL THE RECEPTIONIST IF THIS VISIT IS FOR A JOB OR AUTO RELATED INJURY. AUTO INSURANCE AND LIENS ARE NOT ACCEPTED.**

**RESPONSIBILITY FOR YOUR ACCOUNT ULTIMATELY RESTS WITH YOU.**

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS AS PAYMENT. ANY CO-PAYS OR OUTSTANDING BALANCES WILL BE DUE AT THE TIME OF SERVICE.**

**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.

**Disability claim forms**

There is a \$25 dollar charge for claim forms and letters. Please allow 5 days for completion. Fee must be paid when claim s or letters are picked up.

**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.

**You will be expected to pay all outstanding balances as they come due.**

**Medicare**

As a participating provider, we accept assignment and will bill your Medicare carrier directly. You are responsible for 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 and sign a waiver stating that you understand we will not bill your insurance for that visit. 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.

**I have read the Financial Policy. I understand and agree with this financial policy.**

X \_\_\_\_\_  
Signature of Patient or Responsible Party Date

**LOUD 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.**

# Comprehensive Neurology Specialists, P.C.

6300 Hospital Parkway, Suite 260

Johns Creek, GA 30097

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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Entire Medical Chart    | <input type="checkbox"/> MRI/CT Scan Report(s) |
| <input type="checkbox"/> Admission H&P           | <input type="checkbox"/> Most Recent Labs      |
| <input type="checkbox"/> Discharge Summary       | <input type="checkbox"/> Carotid US Report(s)  |
| <input type="checkbox"/> ER Visit Note           | <input type="checkbox"/> Echocardiogram(s)     |
| <input type="checkbox"/> Neurology-related Notes | <input type="checkbox"/> Neuropsych Evaluation |
| <input type="checkbox"/> Other: _____            |  |

\*\*\*\*\*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

This records release form expires on: \_\_\_\_\_