Michael S. Baugh, M.D.
Kannan Narayana, M.D., M.B.B.S.

GAINESVILLE NEUROLOGY GROUP, LLC

Kristina James, FNP-C

Patient Information

_____ _____ _____ _____ _____

First Name **Middle Initial** **Last Name** **Social Security No.** **Date of Birth**

_____ _____ _____ _____ _____

Emergency Contact **Relation to Patient** **Phone Number** **Pharmacy Name** **Pharmacy Number**

E-MAIL ADDRESS_____

Home

Mailing Address: _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone _____

Ok to Leave msg? _____ Home _____Cell _____ Both

Guarantor

Name: _____ Relation: _____

Address: _____

City_____ State _____ Zip _____

Home Phone: _____ Cell phone: _____

DOB: _____ SSN: _____

Primary Care Physician

Name_____

Address _____

Office Phone_____ Fax_____

Referring Physician

Name_____

Address _____

Office Phone_____ Fax_____

Employer

Company Name_____

Address_____

City_____ State _____Zip_____

Phone _____ Ok to leave msg? ____Yes ___ No

Primary Insurance

Insurance Co. Name_____

Mailing Address _____

City _____State_____ Zip Code_____

_____ _____

Phone Number Subscriber ID Number

_____ _____ _____

Subscriber Group No Co-Pay Deductible

Subscriber Name_____

_____ _____ _____

Subscriber DOB Subscriber SSN Subscriber Rel. To Patient

Secondary Insurance

Insurance Co. Name_____

Mailing Address _____

City _____State_____ Zip Code_____

_____ _____

Phone Number Subscriber ID Number

_____ _____ _____

Subscriber Group No Co-Pay Deductible

Subscriber Name_____

_____ _____ _____

Subscriber DOB Subscriber SSN Subscriber Rel. To Patient

How did you hear about us? Please circle all that apply:

Mall of Georgia In Print (i.e. The Times) Friend
11 Alive.com WDUN (AccessNorthGa.com) Other
Search Engine (i.e. Google, Bing, Yahoo, etc…) Referring Physician

Patient/Legal Guardian_____ Date_____

Compound Authorization (Family HIPAA) for Release of Information

Name of Patient: _____ Date of Birth: _____

Gainesville Neurology Group, LLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions and care.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
[ ] Voice Mail/Answering Machine (please circle: Home/Cell/Both)	**[ ]** Results of labs and other diagnostic procedures **[ ]** Other
[ ] Spouse (Provide Name) _____	**[ ]** Medical/Clinical **[ ]** Financial/Billing
[ ]Family Member (Provide Name/Relation) _____	**[ ]** Medical/Clinical **[ ]** Financial/Billing
[ ] Parent (Provide Name) _____	**[ ]** Medical/Clinical **[ ]** Financial/Billing
[ ] Other (Provide Name/Relation) _____	**[ ]** Medical/Clinical **[ ]** Financial/Billing
[ ] Other (Provide Name/Relation) _____	**[ ]** Other _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the Privacy Officer at Gainesville Neurology Group, LLC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

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

_____ _____

Witness Printed name of Witness and Title

Name: _____

Date: _____

GAINESVILLE NEUROLOGY GROUP, LLC

Check Here if No Known Drug Allergies ☐

Please list your drug allergies below.

_____

_____

_____

Medications	Please list your medicines below	
Drug	Dosage	How taken/How often

Personal/Family Medical History — Check all that apply

	Patient	Family
Angina		
Asthma		
Anxiety		
Bipolar disorder		
Breast cancer		
Colon cancer		
Prostate cancer		
Depression		
Diabetes		
Emphysema/COPD		
Endometriosis		
Gastritis		
GERD		
Glaucoma		
Gout		
Headache		
Heart Attack		
Heart Failure		
High cholesterol		
Hypertension		
Lupus		
Kidney stones		
Migraine		
Obesity		
Osteoarthritis		
Rheumatoid arthritis		
Seizures		
Stroke		
Thyroid disease		
Ulcers		
Other: (Please list)		

Personal Past Surgical History — Check all that apply

- Angioplasty
- Appendectomy
- Back surgery
- C-Section
- Cataract surgery
- Carpal tunnel surgery
- Coronary bypass
- Gallbladder surgery
- Hemorrhoid surgery
- Hernia repair
- Hysterectomy
- Laparoscopy
- Mastectomy
- Neck surgery
- Pacemaker
- Prostate surgery
- Sinus surgery
- Splenectomy
- Thyroid surgery
- Tonsillectomy

Other: (Please list)

Comments: _____

_____

_____

Review of Systems

Constitutional: ☐Night sweats ☐Anxiety ☐Fever and chills ☐ Fatigue ☐Depression ☐Weight loss ☐Excessive thirst ☐ Panic attacks

Eyes: ☐Eye pain ☐Blurred vision ☐Double vision

ENT: ☐Dizziness ☐Runny nose ☐Loss of smell ☐Difficulty swallowing ☐ Hearing loss ☐Sinus stuffiness ☐Frequent colds ☐Bleeding gums ☐ Ringing in ears ☐Earaches ☐Nose bleeds ☐Hoarseness ☐Sores in mouth

Cardiovascular: ☐Heart murmur ☐Shortness of breath when lying down ☐ Chest pain ☐ Leg pain on walking ☐ Palpitations

Respiratory: ☐ Shortness of breath ☐ Cough ☐ Coughing up blood ☐ Wheezing

Gastrointestinal: ☐Nausea/vomiting ☐Constipation ☐ Blood in stools ☐ Heartburn ☐ Vomiting Blood ☐Diarrhea ☐Hemorrhoids ☐ Indigestion ☐Abdominal pain ☐Tarry stools

Genitourinary: ☐ Difficulty starting urination ☐Blood in urine ☐Pain on urination ☐Frequent UTIs ☐ Frequent urination ☐ Incontinence

Musculoskeletal: ☐Joint pain ☐Weakness ☐ Joint swelling ☐ Muscle pain ☐ Muscle cramps

Skin/Breast: ☐Hair loss ☐Breast lumps ☐Skin changes ☐ Breast tenderness ☐ Breast discharge ☐Dry skin

Neurologic: ☐Numbness ☐Memory loss ☐Weakness ☐Paralysis ☐ Headaches ☐Loss of consciousness ☐ Tremor

Endocrine: ☐Heat or Cold intolerance

Hematologic/Lymphatic: ☐Blood clots ☐Swollen lymph nodes ☐ Free bleeding

Allergic/Immunologic: ☐Rash ☐Frequent infections ☐Hay fever

Sleep: Do you: ☐ Snore ☐Stop Breathing while sleeping
Do you have: ☐ Excessive daytime sleepiness ☐Trouble falling asleep

Patient/Legal Guardian_____ **Date**_____

Michael S. Baugh, M.D.
Kannan Narayana, M.D., M.B.B.S.

GAINESVILLE NEUROLOGY GROUP, LLC

Kristina James, FNP-C

Social History Form

Please provide the following requested information.

Tobacco use:

Smoking: Y/N Former smoker: Y/N If yes, how long since your last smoke: _____

If yes, how often: every day ::: some days but not every day

If yes, how much: < 5, 6-10, 11-20, 21-30, <30

How soon after waking do you smoke: < 5 minutes, 6-30 mins, 31-60 mins, > 60 min

Are you interested in quitting: Y/N

Smokeless Tobacco: Y/N

If yes, what kind: Chewing Tobacco, Dipping Tobacco/snuff

If yes, how often: every day ::: some days but not every day

If yes, how much: < 1 can/pouch a day, 1 can/pouch a day, > 1 can/pouch a day

Alcohol intake:

Do you drink: Y/N

How often: Occasional intake, Regular intake, In recovery

Illegal/Illicit Substances:

Do you use illegal/illicit substances: Y/N

If yes, please provide type(s): _____

Marital Status:

Are you: Single, Married, Divorced, Widowed, Partnered

Ethnicity/Race: African American, Native American/Alaskan, Caucasian, Hispanic/Latino,

Other_____, Refused to report

Preferred Language: English, Spanish, Other: _____ (please list)

Household:

Children at home, if any: ____

Other adults at home, if any:____

Secular information:

Do you work: Y/N

Occupation:_____ (if retired, please provide previous profession)

Education: Finished ___ Middle School ___High school ___ Some college __ Bachelor's degree

___ Post graduate (Master's, MD, DO, PhD, etc…)

Patient/Legal Guardian_____ Date_____

The Doctors and Staff of Gainesville Neurology Group, L.L.C. Want You to Know How We Will Protect Your Private Health Information

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on 14 April 2003, new regulations became effective under a new federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). These regulations cover physicians and all other healthcare providers, health insurance companies, and their claims processing staff. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plan providers, and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable with civil and criminal penalties;
- Try to balance the need for individual privacy with requirements for public responsibility that require disclosures to protect public health.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices on the first visit after 13 April 2003. The notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below acknowledging that we have provided you with a copy of the attached notice for review. You are entitled to a personal copy of the notice at any time to review and keep for your records.

Thank you for your cooperation.

Acknowledgment of receipt of Gainesville Neurology Group, L.L.C.'s Notice of Privacy Practices.

Patient/Legal Guardian: _____

(Please Sign)

_____ _____

Print name of Patient/Guardian or Personal Representative Date

Our financial policy

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept CareCredit, MasterCard, Visa, American Express and Discover.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; in other words, if you agree, the insurance company pays the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you; therefore, our charges for your care are due at time of service.

5. Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

7. I also understand that Gainesville Neurology Group does not bill auto insurance companies for the medical part. I am responsible for the payment at time of service in full.

8. I agree to pay all co-payments, deductibles, percentages and all other amounts delegated to me by my contracted insurance company with this practice. I agree to pay each visit in full if my primary insurance company is not contracted with this practice. I agree to pay interest of 1.5% per month on overdue accounts. I also agree to pay legal expenses, collection expenses of 40% plus my balance if my account has to be turned over to a collection agency. I understand there is a $36 returned check fee if my check is returned to the practice uncashable for any reason. I authorize claims to be filed by electronic means and authorize direct payment to the physician. I authorize the physician to release any information necessary to allow payment of this claim and any information acquired in the course of my examination or treatment to my referring physician. Please be advised if you do not keep your appointment or fail to give a 48 hour notice of appointment change there will be a $25 charge. This charge is not covered by insurance.

   I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or responsible party, if minor) Date

Please print the name of the patient

10/10

GAINESVILLE NEUROLOGY GROUP, LLC

Pain Medication and Refill Policy

As a patient of Gainesville Neurology Group, LLC, I:

1. Will keep all appointments as recommended.
2. Agree to allow 48 hours for prescription refills.
3. Understand that prescription refills requested after 4:00 p.m. will not be seen and processed until the next working day.
4. Understand that a follow-up visit may be required from my physician in order to obtain a refill.
5. Agree to take all medication exactly as instructed and am not allowed to change the dosage amounts or scheduled time to take the medication without first speaking to my physician.
6. Understand that prescription refills will not be phoned in after-hours or on weekends as the on-call physicians do not have access to patient records at those times.
7. Understand that GNG will not refill prescriptions that have been lost, stolen or otherwise misplaced.
8. Will not combine any narcotic medication with the consumption of alcohol.
9. Understand that I may be terminated from the practice with 30 days notice for noncompliance in the taking of their medications.
10. Am aware that I will be terminated from the practice immediately if I:
    - Obtain narcotics from any other physician while under our care for a condition for which we are the main treating physician.
    - Give, trade, or sell medication to others.
    - Alter or forge a prescription (this is a felony and will be reported).

Understand that the physician may refuse to prescribe medication if I, the patient, do not agree to these terms.

I have read and understand the above policy and agree to abide by it.

Signed: _____Date: _____

Gainesville Neurology Group is located in the Guilford Clinics building just east of Northeast Georgia medical Center. Enter the building at the South Entrance. Our office is the first office on the left, suite 400.
Phone: 770.534.1117Fax:770.503.7285