West TN Neurology Clinic, PLLC

Dr. Salman Saeed, MD, FAAPM

Last Name: _____ First Name: _____ MI:_____

Address:_____ ZIP:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____ Date of Birth: _____ Sex: ____

Social Security #:_____ Responsible Party:_____ Relationship:_____

Emergency Contact Name/Phone: _____

Primary Insurance: _____ State_____ Subscriber No _____

Relation _____ Insured Name _____DOB_____ Group No_____

Secondary Insurance: _____ State_____ Subscriber No _____

Relation _____ Insured Name _____DOB_____ Group No_____

PCP Name/Number:_____ Referred by: _____

Marital Status: _____ Language: _____ Race: _____ Ethinicity: _____

Pharmacy Name _____ Phone: _____ Address: _____

NOTE: If your insurance requires a referral, it is your responsibility, as the patient, to obtain this authorization and make sure it is available to our office the day of your appointment. Your insurance carrie may not cover expenses occurred without this authorization. If no valid referral is on file, your appointment will be rescheduled.

ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to West TN Neurology. I am financially responsible for non-covered services. I also authorize the physician to release any information required to process this claim. I understand that I am responsible for paying my bill in full after 90 days, if my insurance has failed to do so.

By signing this document I authorize West TN Neurology Clinic to abtain any and all personal health information, including medical treatment and perscription history.

***Continue to next page.**

CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

I hereby give my consent for West TN Neurology Clinic, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). West TN Neurology Clinic, PLLC notice of privacy practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. West TN Neurology Clinic, PLLC reserves the right to revise its notice of privacy practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to West TN Neurology Clinic, PLLC privacy officer at 6570 stage Road, Suite 202 Bartlett, TN 38134.

With this consent, West TN Neurology Clinic, PLLC may call my phone or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, West TN Neurology Clinic, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards in patient statements as long as they are marked personal or confidential.

With this concern, West TN Neurology Clinic, PLLC may email to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements. I have the right to request that West TN Neurology Clinic, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to West TN Neurology Clinic, PLLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, West TN Neurology Clinic, PLLC may decine to provide treatment to me.

Signature: _____ Date: _____

(Patient or Legal Guardian, if minor)

Guarantor Financial Responsibility

At West TN Neurology Clinic, PLLC we strive to give you the best possible care. In order to serve this purpose, it is important you understand the process of reimbursement. Please read this financial responsibility form and sign at the bottom to acknowledge you understand your accountability.

Insurance Coverage, Network Provider

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as authorization requirements. This information can be obtained by contacting your insurance carrier. It is also your responsibility to know if our providers are in or out of network with your particular insurance carrier. If you do not have coverage within your network, you will be responsible for payment in full.

Copayments, Coinsurances & Deductibles

Copayments and coinsurances are your responsibility. Your insurance company expects us to collect from you at the time of service.

You are responsible for your deductible. Deductible is determined by your individual contract with your insurance carrier. We may not have full detailed information about your deductible amount or how much of that has been met. You are responsible for finding out all your deductible information prior to appointment at our office.

Referrals, Non-covered Services & Medical Necessity.

All patients are responsible for payment if their insurance denies payment for any services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary“. To avoid this please check with your insurance carrier prior to receiving any treatment. Obtain required authorizations or referrals before your visit is scheduled.

Self-pay

All cash patients and patients without valid insurance information are considered a self pay patient. A self pay patient is required to pay for the office visit and any testing on the day service is to be rendered to the front desk personnel. Should you have insurance, but are unable to provide information, at the time of your visit you are expected to pay at the time of service until your insurance information is on file.

Cancellation(s) and Missed Appointment(s)

Please note patients will be charged $50.00 for missed appointments, not canceled within 24 hours of the scheduled time.

Signature: _____ Date: _____

(Patient or Legal Guardian, if minor)

PATIENT PORTAL CONSENT

West TN Neurology Clinic, PLLC is offering to secure, confidential tool as a courtesy to our patients. It is an optional service, and we may suspend or terminate it at any time for any reason. By signing below, you acknowledge that you have read and fully understand the policies, guidelines and limitations for using the patient portal and understand the risks associated with online communications and consent to the conditions outlined herein. You acknowledge that using the patient portal is entirely voluntary and your access will not impact the quality or current level of care you receive from West TN Neurology Clinic, PLLC. In addition, you agreed to adhere to the policies set forth, as well as any other instructions or guidelines that may be imposed for online communications. You understand that this agreement will remain in effect for 12 months unless sooner modified or terminated by either party. It is your responsibility to notify West TN Neurology Clinic, PLLC if there is a change in your email account or you feel that your secure password has been breached. Secure messages and information can only be viewed by someone entering the correct username and password to log into the patient portal site. We will assign you this login information upon completion of this form. You agree that West TN Neurology Clinic, PLLC or any of its staff are not liable for network in fractions beyond their control.

Print Name: _____ Date of Birth _____

Email Address: _____ (Please provide a confidential and private email address.)

To access the patient portal, visit https://health.healow.com/wtn

Please answer any 2 of the following security questions. (Answers have a 4 letter minimum.)

- What is your favorite pet's name? _____
- What is your father's middle name? _____
- What was your high school mascot? _____
- Who was your closest childhood friend (first name)? _____

Signature: _____ Date: _____
(Patient or Legal Guardian, if minor)

TO BE COMPLETED BY *West TN Neurology Clinic, PLLC*

Username: _____ Password: _____

Patient Name: _____ Date: _____

Describe your medical problem: _____

List and describe your past medical illness: _____

Have you had any of these? Please circle.

a. High blood pressure
b. Heart disease
c. Cancer
d. Diabetes Mellitus (sugar diabetes)
e. Stroke
f. Epilepsy
g. Mental illness
h. Other: _____

List any operations you've had: _____ _____
_____ _____ _____
_____ _____ _____

List of medications you are taking: _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List all medication allergies: _____ _____
_____ _____ _____

Family History: Father age: _____ illness _____ Cause of death: _____
Mother age: _____ illness _____ Cause of death: _____
Brother(s) _____
Sister(s) _____

Has anyone in your immediate family ever had? Please circle.

a. High blood pressure
b. Heart disease
c. Cancer
d. Diabetes Mellitus (sugar diabetes)
e. Stroke
f. Epilepsy
g. Mental illness
h. Migraine

Weight history: Present weight _____ Usual weight _____
Any major change in weight? _____ How much? _____ How many meals do you eat each day?____

Habit history:

a. Smoking
   1. Cigarettes per day? _____ How long? _____ Date started? _____
   2. Cigars per day? _____ How long? _____ Date started? _____
   3. Pipes per day? _____ How long? _____ Date started? _____
b. Alcohol: Never ____ Occasional _____ Moderate ____ Heavey ____
c. Coffee: Cups per day? ____

COVID-19 QUESTIONAIRE

Patient Name: _____ Date of Birth _____ Tempature: _____

Anyone in your household or you know has been diagnosed with COVID19? Yes ____ No ____

Do you have a cough now or in the last week: Yes___ No___

Do you have fever/chills now or in the last week: Yes___ No___

Do you have repeated shaking with chills now or in the last week: Yes___ No___

Do you have any other respiratory symptoms now or in the last week: Yes___ No___

Do you have muscle aches or pain now or in the last week: Yes___ No___

Do you have loss of taste or smell now or in the last week: Yes___ No___

Do you have a sore throat now or in the last week: Yes___ No___

Do you have diarrhea now or in the last week: Yes___ No___

Do you have shortness of breath or difficulty breathing now or in the last week: Yes___ No___

Have you been in close proximity to anyone who has been sick within the last week? Yes___ No___

Signature: _____ Date: _____

(Patient or Legal Guardian, if minor)

West TN Neurology

Dr. Salman Saeed, MD, FAAPM

6570 Stage RD., Suite 202
Bartlett, TN 380134
P (901) 213-4225
F (901) 213-4226

1150 HWY 51 BYPASS, Suite B
Dyersburg, TN 38024
P (731) 288-1977
F (901) 213-4226

Medical Records Authorization

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name:_____

SSN: _____ DOB: _____

I, the undersigned, authorize and request West TN Neurology to:

_____ Release information to _____ Obtain information from

Name: _____
Address: _____
Phone: _____ Fax: _____

This release applies to:

_____ Complete Medical Records (including; Labs, any test, and radiology reports)
_____ Itemized Bill
_____ Test/Radiology Report(s)
_____ Other: _____

This authorization and request is valid without limitation until written notice of its revocation is received. This authorization is good for the individual/facility noted above. No information will be provided on any other individual/facility without receiving written approval.

You must check one answer for each statement.

Do ____ Do not____ release information and records regarding HIV/AIDS,l which may be a part of the named patients medical records.

Do ____ Do not____ Release phychiatric reports and information, which may be apart of the named patients medical records.

I hereby acknowledge that I have read and understand the information set forth and that any questions have been answered to my satisfaction.

I hereby state that I am the ____ Parent ____ Legal Guardian _____ Other: _____ of the patient and authorized to sign for the release of healthcare infromation on their behalf.

Date: _____ Signature: _____