Center For Neurology Care, LLC
Gonzalo F. Pares, MD
P.O. Box 170158
Spartanburg, S.C. 29301
864-574-8925

Welcome To Our Practice

Dear New Patient: Appointment Date: _____
Time: _____

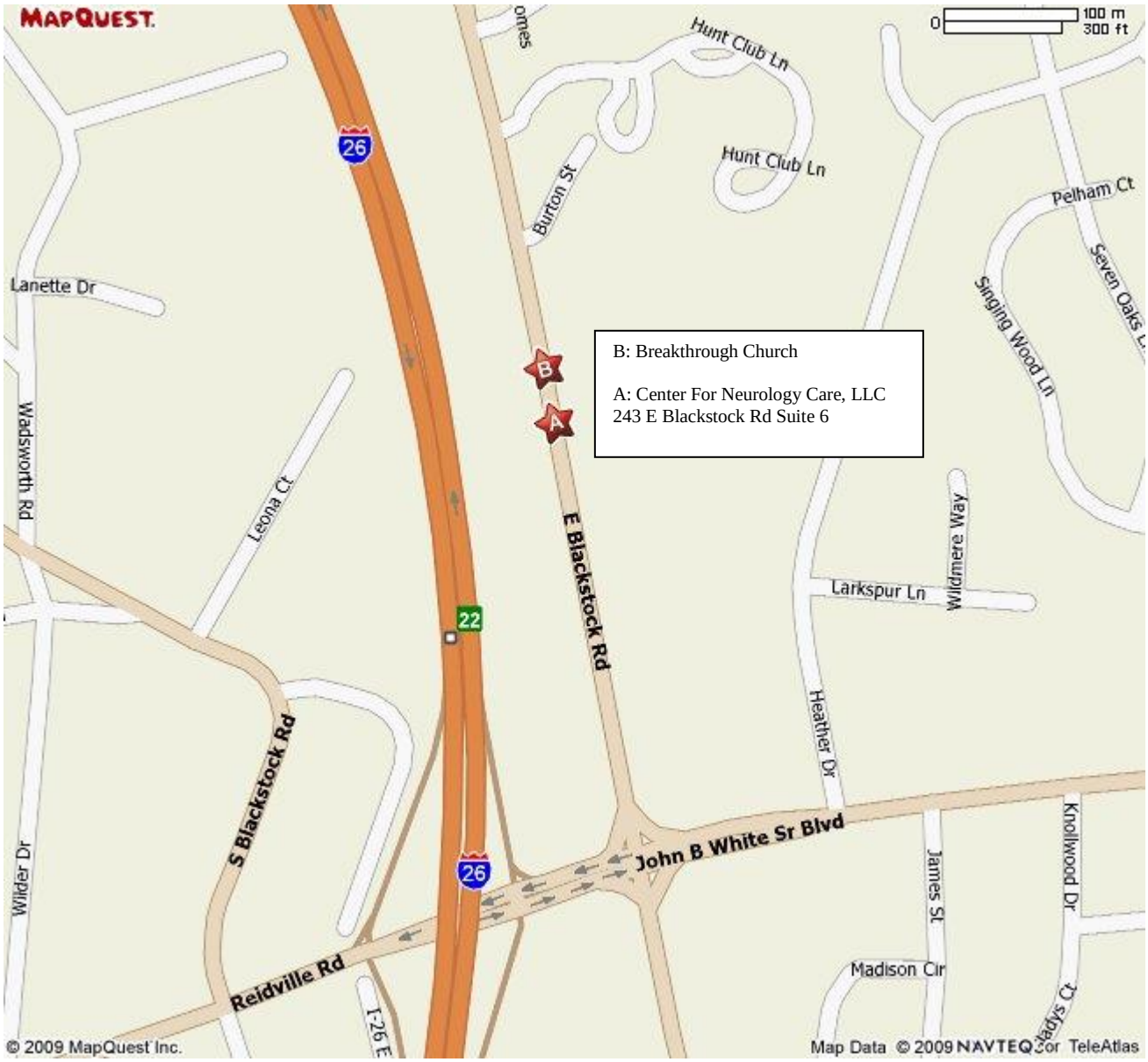
Welcome and thank you for choosing our practice for your neurological healthcare. For those of you that have been referred by another physician, our staff welcomes you to our practice. Enclosed please find a copy of all paperwork required for your medical chart. Please complete this paperwork and bring it with you or if time allows you may mail it to our office before your scheduled appointment. You will need to allow a minimum of 45 minutes to complete your paperwork if you do not bring the enclosed packet. Please bring your insurance card/cards. Please be prepared to pay any co-pays/coinsurance that may be due for office visits per your insurance, we will not be able to defer your co-pays/coinsurance on a first visit.

Our office hours are: 9:00am-5:00pm on Monday thru Friday, closing for lunch 12:00-2:00pm (patients will still be seen during this time period). Our answering service will answer the phone on Fridays, and also when the office is closed for lunch, from 12:00pm to 2:00pm. **Please remember to bring your medications and inform the assistant of any lab work, CT's, MRI's or records that need to be reviewed.** If you are unable to come on your scheduled appointment date please inform us 24 hours in advance. If you do not give us 24 hours' notice or you miss 2 scheduled appointments you will not be rescheduled. If you were referred by another physician, we will inform him/her of any missed appointments.

If you have been referred and scheduled for an EMG/NCS please come prepared to stay for an hour and a half.

A map of our location is printed on the back of this letter. Our phone listing is (864) 574-8925 and the fax number is (864) 574-8922. Again, thank you for choosing our practice.

Gonzalo F. Pares, M.D and Staff



We are located in the Keller Williams Realty Park
next to the Breakthrough Church

Center For Neurology Care, LLC

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____
Last *First* *Middle*

Maiden Name: _____ Date of Birth: _____
Month/Day/Complete Year

Home Phone: _(____)_____ Cell Phone: _(_____)_____

Address: _____ SS#: _____-_____-_____ Sex: (*Male or Female):* _____

City, State, Zip: _____County: _____

Mailing Address if different from above:
_____

Preferred Language: _____ E-mail address: _____

Marital Status: _____ Race: _____
Single, Married, Divorced, Widowed, Partnered *Caucasion, Native American, African American, Other*

EMPLOYMENT

Occupation: _____ Employer: _____

Work Phone: (_____)_____ Address: _____

City, State, Zip:
_____

EMERGENCY CONTACT

Name: _____ Home Phone: _(_____)_____

Address: _____ Cell Phone _(_____)_____Work Phone: _(____)_____

Relationship: _____

IMMEDIATE FAMILY

	Name	Lives with me
Spouse/Partner:	_____	Y_____ N_____
Children:	_____	Y_____ N_____
	_____	Y_____ N_____
	_____	Y_____ N_____
	_____	Y_____ N_____
Others:	_____	Y_____ N_____
	_____	Y_____ N_____

Signature of Patient/Guardian: _____ Date: _____

ACCIDENTAL INJURY

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc) Yes/No _____

GUARANTOR INFORMATION (This is the person responsible for the balance after insurance pays on the account)

Parent/guardian presenting minor child for treatment will be listed as the guarantor. This person will be responsible for any balances due after insurance has paid. If 18 or older, you are your own guarantor and do not have to complete this section unless there is a legal designation for your care, such as a power of attorney.

Guarantor Name: _____ Guarantor SS #: _____-_____-_____

Relationship: _____ Home Phone: ___(_____)_____

Address: _____ Cell Phone: ___(_____)_____

City, State, Zip: _____

Guarantor Employer: _____

Employer Address: _____

City, State, Zip: _____ Work Phone: ___(_____)_____

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: _____

Co-Pays: Specialist $: _____ Effective Date: _____

Patient Employment Status: _____

(*full-time, part-time, unemployed, retired, military, retired military, full or part-time student)*

SUBSCRIBER INFORMATION (This is the person insured by the company listed above)

Patient Relationship to Subscriber: _____

Full Name: _____ Sex: _____ Date of Birth: _____

M orF *Month/Day/Year*

Address: _____ SS#: _____-_____-_____

City, State, Zip: _____ Phone: ___(_____)_____

Employer: _____ Work Phone: ___(_____)_____

Address: _____

City, State, Zip: _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____ Insured Name: _____

Effective Date: _____

AUTHORIZATION

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and treatment. I hereby authorize payment from my insurance company to Center For Neurology Care, LLC for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian: _____ Date: _____

Center For Neurology Care, LLC

FINANCIAL POLICY

Patient Name (PRINT) _____ Date: _____

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by Center For Neurology Care, LLC.

Payment for Service: Our office will inform you of the amount due when you check in. This amount is due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment and/or any charges not covered by your insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards or debit cards.

Returned Checks: A $25.00 service charge will be added on al checks returned to us for insufficient funds.

Non-appointment prescriptions refills: A $15.00 charge per incidence may be added for non-appointment prescription refills.

Copies of Medical Records: There will be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities.

- $0.65 per page for the first 30 pages
- $0.50 per page for all other pages
- Clerical fee not to exceed $15.00
- If mailed: actual postage

No-show, No Call Appointments: A fee of $25.00 for a follow up visit and $50.00 for a new patient visit may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by during normal office hours, or our answering service after hours.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-574-8925 to make payment arrangements We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

Signatures: I have read and understand these financial policies.

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Office Representative/Title: _____ Date: _____

DISCLOSURE OF MEDICAL INFORMATION

Patient Name (Print): _____ Date: _____

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you unless they are listed below.)

Name of Person	Relationship to Patient
_____	_____
_____	_____
_____	_____

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you. If we are unsuccessful in reaching you at these numbers please list others along with their phone number who may be contacted to get a message to you.
Home: _____ Cell: _____ Work: _____ Other: _____

Name of Person	Relation to Patient	Phone Number
_____	_____	_____
_____	_____	_____

Messages: I authorize any medical information regarding myself to be left on any answering machine or voice mail (*check all that apply*)

☐ Home ☐ At Work ☐ On my cell phone ☐ I do not authorize

NOTE: This does not include appointment reminders or requests for return calls. This notice will remain in effect unless a new disclosure is requested and signed by the patient.

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Center For Neurology Care, LLC

CONSENT FOR TREATMENT

The following are the conditions for services provided by Center For Neurology Care, LLC.

Medical Consent

I consent to all treatment given under the general and special instructions of the attending physician. Treatment may include, but is not limited to, diagnostic procedures, use of prescribed medication, the collection of laboratory specimens, referrals to radiology and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physician or his designees.

If a health care worker comes in direct contact with a patient's blood or body fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus or HIV (Human Immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker (in accordance with South Carolina State Statute title 44, chapter 29, section 44-29-230). The results of the testing will be made available to the patient.

Assignment of Insurance Benefits

I understand that I am responsible for any charges not covered by insurance, Medicare, Medicaid or other benefits. I further warrant and represent that any insurance or any plan that I assign is valid insurance and in effect and that I have the right to make this assignment. In the event a claim for payment submitted to my insurance carrier or plan administrator is denied, I herby authorize Center For Neurology Care, LLC to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy.

Financial agreement

I understand that if my insurance plan or policy requires a co-payment from me, I am required to pay that co-payment at the time service is rendered. I understand that if I am self-funded, full payment is due at time of service. I understand that I am obligated to pay the patient account according the regular rates and terms of Center For Neurology Care, LLC. I appoint Center For Neurology Care, LLC as my true and lawful attorney to collect the claims, endorse the checks and give full receipt for all amounts collected. In the event that this account is placed with a collection agency or and attorney for collection, I will pay all collection fees and reasonable attorney's fees.

Disclosure/Use of Health Information

I authorize Center For Neurology Care, LLC to provide any health information related to this patient to the insurance company or other payer for purposes of payment for the health care provided. I also authorize Center For Neurology Care, LLC to provide health information to other physicians and healthcare facilities for continuing care.

Patient Name (PRINT) _____ Date: _____

Signature: _____