DIANE COUNCE, M. D.
Board Certified Neurologist
Neurodiagnostic Facility & Clinic
(EEG, EMG, NCS, RNS THERAPEUTIC BOTOX)

Before you can be seen, please have this form filled out in its entirety. Accuracy is of utmost importance in order to deliver appropriate care. This document is confidential and will become a part of your medical record. You will not be seen unless this form is filled out and signed.

Name: _____ Date: _____

DOB: _____ Age: _____

Address:_____
Street and apt# City Zip

Referring Physician: _____ Family Physician: _____

Pharmacy Name and Number: _____

List the reason(s) why you are here today:

_____
_____
_____
_____

List ALL past or present diagnoses and conditions from other doctors. This includes anything for which you are taking medicines. Withholding this information may adversely affect your evaluation and treatment here.

_____
_____
_____
_____

List any past surgeries and the approximate dates:

_____
_____
_____
_____

List any accidents or injuries:

_____
_____

Do you have any drug allergies? Yes____ No____
If yes, please list: _____

NAME: _____ DATE: _____

Please list ALL prescription medications and the doses you are currently taking:

_____
_____
_____
_____

Please list ALL over-the-counter medicines, vitamins, supplements and herbs you are taking:

_____
_____
_____
_____

REVIEW OF SYSTEMS:

NEURO
_DIZZINESS
_FAINTING/BLACKOUTS
_FORGETFULNESS
_HEADACHE
_BALANCE TROUBLE
_PAIN
WHERE_____
_WEAKNESS
WHERE_____
_NUMBNESS
WHERE_____

GASTROINTESTINAL
_POOR APPETITE
_BOWEL CHANGES
_NAUSEA
_STOMACH PAIN
_VOMITING
_ULCERS

GENERAL
_CHANGE IN WEIGHT
_FEVERS
_FATIGUE

CARDIOVASCULAR
_PACEMAKER
_CHEST PAIN
_HIGH BLOOD PRESSURE
_LOW BLOOD PRESSURE
_VARICOSE VEINS
_HIGH CHOLESTEROL

SLEEP
_SNORING
_RESTLESS ARMS/LEGS
_DAYTIME SLEEPINESS

EAR, NOSE, EYE, THROAT
_BLURRED VISION
_CROSSED EYES
_DIFF. SWALLOWING
_DOUBLE VISION
_STRANGE ODORS
_CHANGE IN TASTE
_LOSS OF HEARING
_LOSS OF SPEECH
_RINGING IN EARS
_SINUS PROBLEMS

HEME/SKIN
_ANEMIA
_SORES THAT WON'T HEAL
_EASY BRUISING

RESPIRATION
_SHORTNESS OF BREATH
_FREQUENT COUGH
_ASTHMA
_EMPHYSEMA

URINARY
_LACK OF BLADDER CONTROL
_PAINFUL URINATION
_KIDNEY STONES

ENDOCRINE
_HEAT/COLD TOLERANCE
_DIABETES
_THYROID PROBLEMS

PSYCHIATRIC
_PSYCHIATRIC CARE
_SUICIDE ATTEMPT
_CHEMICAL DEPENDENCY

MALE/FEMALE
_ERECTION DIFFICULTIES
_MISCARRIAGES
_CURRENTLY PREGNANT?

Do you have any other signs, symptoms, or problems other than the above?

_____
_____
_____

NAME: _____ DATE: _____

List any medical problems in your family:
Mother: _____
Father: _____
Sister: _____
Brother: _____
Daughter: _____
Son: _____
Other: _____
_____
_____

Smoking Status:
___Never ___Former ___Everyday ___Occasionally
How many packs per day: _____
How many years of smoking: _____
Marital Status: _____
Occupation: _____
Do you use alcohol? ___Yes ___No
If yes, what kind and how much: _____
Do you use illegal drugs? ___Yes ___No ___In the past
If yes, what kind and how much: _____
Do you use chewing tobacco? ___Yes ___No
If yes, how many times per day? _____

This clinic will only give controlled substances in certain instances and for acute reasons. If we decide to prescribe controlled substances (narcotics, sedatives, sleep aids, etc.) then no other controlled substances should be obtained from other physicians, unless we are notified. No controlled substances will be called in after hours. Controlled substance prescriptions that are lost, misplaced, etc. will not be refilled.

_____ *I agree* _____ *I will not ask for controlled substances from this office.*

THANK YOU

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I made in the completion of this form. I understand that I may be seen by a Certified Registered Nurse Practitioner, who has been specially trained by the physician. Periodically, I will be evaluated by the physician. I may request an appointment with the physician at my discretion.

Signature: _____ Date: _____

NEUROLOGY AND NEURODIAGNOSTICS OF ALABAMA, LLC
HEADACHE SPECIALISTS OF ALABAMA

PATIENT INFORMATION

Full Legal Name_____ **Name Normally Used (Nickname)**_____

Street Address (not PO Box)_____**City, State**_____ **Zip Code**_____

Mailing address (if different from above)_____

Home Phone ( )_____ **Work Phone ( )**_____ **Cell Phone ( )**_____

Email _____

Date of Birth____/____/____ **Age**_____ **Sex**_____ **Marital Status**_____

Social Security #____-____-____**Driver's License/State**_____ **Occupation**_____

Employer Name_____

Employer Address_____

Other Physicians you see_____

How did you hear about us?_____

SPOUSE'S INFORMATION

Name_____ **Date of Birth**_____

Address (If different from above)_____

Occupation_____ **Employer Name**_____

Employer Address_____

Home Phone ( )_____ **Work Phone ( )** _____ **Cell Phone ( )**_____

INSURANCE INFORMATION

Responsible Party Name_____ **Phone # ( )**_____**SSN**_____

Responsible Party Address_____

Primary Insurance_____ **Co-Pay $**_____

Contract #_____ **Group #**_____ **Effective Date**_____

Contract Holder's Name_____ **Relationship**_____ **Date of Birth**_____

Secondary Insurance_____ **Co-Pay $**_____

Contract #_____ **Group #** _____ **Effective Date**_____

Contract Holder's Name_____ **Relationship**_____ **Date of Birth**_____

Other Insurance Information_____

Emergency Contact_____ **Phone**_____ **Relation**_____

The Clinic and attending physician are authorized to furnish any medical records requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my care. My signature is also my authorization of assignment of benefits to the Clinic. I understand that I am directly responsible to Neurology and Neurodiagnostics of Alabama, LLC for all charges for medical and procedural services rendered to me, regardless of insurance coverage. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature of Responsible Party_____**Date**_____

FINANCIAL POLICY

Neurology and Neurodiagnostics of AL
1000 Southlake Park, Suite 200
Hoover, AL 35244
205-536-8736

1. Payment for services rendered is expected at the time of treatment unless arrangements are made prior to treatment.

2. Our office will file insurance claims for services rendered, however, the patient is not relieved of responsibility for payment just because the patient has insurance.

3. Patients are responsible for updating all demographic information at every visit. If your insurance is a closed panel, requires a referral or is denied for any reason, you the patient, will be responsible for payment in full of the total visit. Patients are encouraged to call their insurance PRIOR to any visit to inquire if visits and procedures require a referral as well as whether or not they will be covered.

4. Patients must pay co-pays and deductibles due at the time services are rendered. Our office is contractually obligated to the insurance company to collect the patient's portion of the bill.

5. Balances due that are billed for 90 days will automatically be turned over to the collection agency, Amsher. There is a 50% up charge for all accounts that are turned over to collections.

6. Financial arrangements can be made for payment of bills.

7. For questions regarding billing, a billing manager can be reached at: 205-702-6602.

8. Copies of medical records are available for a fee. The fee charged follows the rules of the Alabama Board of Medical Examiners.

9. There is a $50 no-show fee for missed new patient and testing appointments. There is a $25 no-show fee for missed follow-up appointments. If you cannot keep your appointment, we ask that you cancel at least 24 hours in advance.

10. Those who no-show for new patient appointments or cancel more than twice, will not be able to make future appointments.

Signed:_____ Date:_____

NEUROLOGY AND NEURODIAGNOSTICS OF ALABAMA, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

1) I have received a copy of the Notice of Privacy Practices for Neurology and Neurodiagnostics of Alabama, LLC. Dr. Diane Counce reserves the right to modify the privacy practices outlined in this notice.

Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Patient Representative: _____
(If patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient: _____

2) Please list below any persons with whom we can discuss your medical history and problems, i.e. family member, caregiver, etc. If there is no one you want to list, please state "none."

_____

_____

_____

3) Please list the method that you prefer us to use to contact you:

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

4) Do we have permission to leave a message with your lab and test results?

Yes_____ No_____

Signature: _____ **Date:** _____