GARDENS NEUROLOGY – NEW PATIENT INFORMATION PACKET (PLEASE PRINT CLEARLY)

First name:_____ Middle initial:____ Last name:_____ Date of Birth:_____

Occupation_____ Email (in all caps please):_____

Gender: M F X* U** Race:_____ Ethnicity:_____ Language: English Other:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Primary phone #:_____ Cell phone #:_____ Alt. phone #:_____

Primary care physician:_____ Referring physician:_____

Spouse/Other name:_____ Phone #:_____ Email:_____

Emergency contact person name:_____ Phone #:_____

Is this visit due to an auto accident/work related injury/worker's comp case? Y N Is there any litigation involved? Y N

Have you seen a neurologist before? If so, who and when:_____

Primary insurance name:_____ Secondary insurance name:_____

Policy holder name:_____ DOB:_____ Relationship:_____

Pharmacy Name:_____ Address:_____ Phone #:_____

By signing below, I certify that the insurance information above is correct and I will update it as it changes. I understand that the APRN accepts only traditional Medicare and visits with Dr. Silvers are private pay only. I authorize the release of any medical information to my insurance on file for the purpose of submitting and billing my claim. Any physician that I list as my primary care provider and/or referring physician will receive a copy of the office visit note by fax once it is locked.

I hereby consent to medical treatment for myself. I authorize insurance payments to be paid directly to Gardens Neurology. I understand that I am financially responsible for any services deemed not covered (partially or in full) by my insurance for any reason. Any payments (self-pay, deductibles, co-insurance, copays) are due at time of service and a credit card number, or deposit, must be on file. If I fail to make payments for services rendered, I am financially responsible for any and all costs and fees related to the collection of my debt. For out of network advantage plan claims, I will pay up front and then submit to my plan and collect on my own, unless Gardens Neurology offers the courtesy of submitting such claims once on my behalf where the payer will reimburse the providers directly. I understand that I am NOT guaranteed a reimbursement after my submission of the claim and I will cover all balances due when they occur. Payment plans are not available.

Any established patient will be considered a new patient again after a gap of not being seen **by the doctor** more than 18 months from the previous visit. A new patient appointment is scheduled as 50 minutes face-to-face, a follow up is 25 minutes face-to-face and some appointments will need to be extended and charged accordingly (at the doctor's medical discretion). Scheduled appointment times may be adjusted and moved up or down by up to 30 minutes without notice so please check your final confirmation message for your precise arrival time and scheduled appointment times.

By signing below, I agree to all of the above as well as the attached packet.

Signature:_____ Date:_____

If needed, Guardian name:_____ Signature:_____Date:_____

*Intersex/unspecified **Undisclosed/Prefer not to disclose

Gardens Neurology - Patient Questionnaire Form

Patient Name:_____ Chief Complaint:_____ Date:_____

Medication List; attach or write below – (Include Medical Marijuana, Supplements, Dosage and Instructions):

_____

_____

_____

Past Medical History: (please check all that apply)

☐ Diabetes mellitus ☐ Glucose intolerance ☐ Hypertension ☐ Hyperlipidemia
☐ Atrial fibrillation ☐ Coronary artery disease ☐ Coronary angioplasty ☐ Stenting
☐ Coronary bypass surgery ☐ Cardiac valve disease ☐ Pacemaker
☐ CHF ☐ Other cardiac _____
☐ HIV/AIDS ☐ COPD ☐ Asthma ☐ Kidney stones
☐ Hyperthyroidism ☐ Hypothyroidism ☐ Multiple sclerosis ☐ Epilepsy
☐ Stroke(s) ☐ Pulmonary emboli ☐ DVT
☐ Other clotting condition_____
☐ Obstructive sleep apnea: using CPAP Y N ☐ Migraine without aura ☐ Migraine with aura
☐ Parkinson disease ☐ Other movement disorder(s) _____
☐ Brain tumor ☐ Peripheral neuropathy ☐ Other neuromuscular condition_____
☐ Mild cognitive impairment ☐ Alzheimer disease ☐ Other cognitive disorder_____
☐ RLS ☐ Depression ☐ Anxiety ☐ Other neurological/psychiatric condition_____
☐ Cancer (Type[s])_____ ☐ Treatments: (circle) radiation / chemotherapy
☐ Other major medical conditions_____

Allergies:_____

Past Surgeries_____

Social History: (please circle all that apply below)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Alcohol Use:	Never	Rarely	Moderate	Daily	
Tobacco Use:	Never	Previously, but quit		Current packs/day _____	
Recreational Drug Use:	Never	Type/Frequency:_____			

Patient Family History: (please check all that apply)

	Father	Mother	Siblings	Children
Stroke	☐	☐	☐	☐
Migraine	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Dementia	☐	☐	☐	☐
Parkinson's/Movement disorders	☐	☐	☐	☐
Neuromuscular condition	☐	☐	☐	☐
If deceased, cause of death	_____	_____	_____	_____

Gardens Neurology - Review of Systems

DOB:_____Date: _____

Patient Name:_____

Weight:_____Height:_____

Hypertension	Y	N
Smoking	Y	N
Any falls in the last 12 months?	Y	N
↳ If yes to falls, how many falls?	_____	
were the falls with injury?	Y	N

Cardiovascular

Lightheaded or dizziness	Yes
Chest pain or angina	Yes
Palpitations	Yes
Anemia	Yes
Bleeding tendencies	Yes
Shortness of breath	Yes

Constitutional Symptoms

Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Rash or itching	Yes
Thyroid disease	Yes
Change in libido	Yes

Gastrointestinal/Urinary

Rectal bleeding/blood in stool	Yes
Abdominal pain/heartburn	Yes
Painful urination	Yes
Frequent urination	Yes
Incontinence	Yes

Psychiatric

Depression Y N

↳ If yes, answer questions below

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself, being a failure, let yourself/your family down	☐	☐	☐	☐
7. Trouble concentrating on things such as reading or watching TV	☐	☐	☐	☐
8. Moving/speaking slowly or being fidgety/restless moving more than usual	☐	☐	☐	☐
9. Thoughts of being better off dead or hurting yourself in some way	☐	☐	☐	☐

Musculoskeletal

Joint pain or swelling	Yes
Muscle weakness	Yes
Muscle pain or cramps	Yes
Low back pain	Yes
Neck pain	Yes

Neurological

Frequent headaches	Yes
Convulsions/seizures	Yes
Numbness or tingling	Yes
Tremors	Yes
Weakness and paralysis	Yes
Stroke	Yes
Traumatic brain injury	Yes
Difficulty walking	Yes
Memory loss	Yes
Daytime sleepiness	Yes
Anxious	Yes

Eyes/ENT

Visual loss	Yes
Double vision	Yes
Hearing loss/ringing in the ears	Yes

Other

_____

_____

_____

GARDENS NEUROLOGY – CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I authorize Gardens Neurology, in accordance with HIPAA, the use and disclosure of all individual, identifiable, personal health, financial and demographic information (known as Protected Health Information or PHI) for the purpose of: Providing medical treatment, obtaining payment and reimbursement, obtaining authorization for tests, requesting medical information from, and cooperating with, other providers, and all other necessary transactions related to providing my care. Any doctors I list (PCP and/or referring physicians) will automatically receive a copy of the office visit note once it is locked.

The purpose and all other uses are known collectively as Treatment, Payment and Other healthcare options. (TPO). I authorize any physician or healthcare facility to provide upon request any PHI to Gardens Neurology for the TPO. I consent to Gardens Neurology discussing any or all of my medical care, including evaluation, treatment, diagnosis, even if related to psychiatric or psychosocial impairments, substance abuse, AIDS, HIV related infections or pregnancy with:

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Person(s) listed above are allowed to have conversations with the office and are not automatically provided with records.

I have been given the opportunity to review Gardens Neurology's Privacy Notice which is posted in the waiting room.

By signing below, I consent to Gardens Neurology leaving messages on my phone and sending me emails and texts.

I understand my rights to restrict the use and discloser of PHI and may revoke this consent in writing at any time.

I understand that should I choose not to consent to the terms & conditions of Garden Neurology's privacy notice, I will provide a written request and the practice has the right to withhold treatment except where required by law.

IMPORTANT GUIDELINES AND NOTICE TO PATIENTS REGARDING ALL FUTURE INTERACTIONS WITH OUR PROVIDERS

I understand that the doctor has opted out of Medicare on 01/01/2025 and will be only a private pay type provider until further notice. I am aware that I will sign a mandatory private pay contract directly with Dr. Silvers and agree to follow up with him at least once a year and pay his appropriate visit type fees. I also understand that as a traditional Medicare policy holder coming in as a private pay patient, I will **NOT** submit a claim to Medicare for reimbursement (advantage plans may partially reimburse). I accept that any follow up conversation or email exchange that could potentially last more than 5 minutes, and/or any interactions that would require any input, interpretation of results, medication changes, evaluations, discussions or recommendations from the providers, will require setting up another appointment. All appointment types except cognitive tests, care plan visits and routine follow ups, will be set up with Dr. Silvers. The doctor has the final say on whether appointments are needed, and will continue to make his medical decisions as he has consistently done in the past.

CCM type visits will be set up separately between me and the office and I shall sign a separate form if I wish to enlist.

Patient's name (please print):_____ Signature:_____ Date:_____

Guardian's name and signature (if needed):_____ Date:_____

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 prohibits the use and discloser of protective health information for the treatments, payments and other healthcare operations without a signed consent and prohibits the use and discloser of protective health information for non-healthcare related activities without specific and explicit authorization. The signature above allows Gardens Neurology, with your permission, to use this information for the sole purpose of medical treatment in our facility. In the case of an EMR migration, this signature will authorize the transfer of information from one carrier to another.

GARDENS NEUROLOGY – STATEMENT OF PATIENT'S FINANCIAL RESPONSIBILITY

Patient name:_____ DOB:_____

While Dr. Silvers is seeing only private pay patients, Frances will continue to accept traditional Medicare for most of her appointment types. Gardens Neurology will verify your Medicare coverage only, not your secondary. Due to this credentialing setup, you are in charge of ensuring that you are covered for any visit type and aware of copays/coinsurance and deductibles. You should definitely verify benefits (in and out-of-network) and you will be responsible for payment in full if services are denied, or down paid, by Medicare or your secondary, for any reason whatsoever. If you have a Medicare advantage plan, you will be a self-pay patient for all your visits with our providers, and we will gladly provide you with the paperwork to submit for reimbursement since we do not bill directly. We cannot guarantee that you will be reimbursed, but we will do our best to assist you with documentation. Billing for in-office testing will be done as a courtesy to you, but following any denials, full payment by you is expected. We will attempt to collect once, and beyond such attempt, payment will be put through on your credit card number which we will keep on file. This is a requirement for full coverage of any balances due after reimbursements have been processed, or denied, by your insurance. For any balance due which is over 90 days, your account will be sent to collections. Agency fees will be added to your account's total when submitted for collections. All balances must be settled prior to any upcoming appointments. Payments can be made by check, cash or credit card (processing fees may apply). Any returned checks are subject to a $30 fee. Signing this form authorizes Medicare to pay any in-network benefits directly to Gardens Neurology. At this time, we cannot offer any payment plans.

Deductibles, Co-pays and Co-insurance Policies

Some policies, including Medicare, require the patient to pay a deductible, a co-pay or co-insurance. It is expected that those payments will be made upon arrival in the office prior to your appointment. As a specialist, some diagnostic procedures are not considered part of your office visit co-pay and may be applied towards your deductible and/or co-insurance. Please check with your payer ahead of time to ensure coverage for all visit types including CCM, it will save you out-of-pocket expenses. Your credit card number on file, or your paid credit, will be used for any outstanding balances due.

Cancellation and/or No-Show Policy

With the escalating costs of running a medical practice, we have no choice but to institute this policy. As your appointment approaches, you must notify the office **MORE THAN 2 BUSINESS DAYS** in advance of any changes to your appointment date and time (reschedule or cancel). Failure to do so will result in full payment for the visit with Dr. Silvers, and a $75 fee for any APRN appointments. We always attempt to confirm with you by phone, email and text, therefore we ask that you contact us IN-PERSON, during business hours, to either confirm, cancel or reschedule. If we are unable to reach you to confirm your appointment within the 2 days, we may assume you are not coming and might assign your time slot to another patient. In that case, you will be bumped to the next available opening. Remember, the appointment was YOUR choice of date and time. If you no-showed after confirming an appointment, this fee must be paid in order to reschedule any future appointments and continue care. If you show up more than 10 minutes late it disrupts the entire day and you will need to reschedule AS WELL AS pay the no-show fee. All visits are long and complicated and need the entire time allotted.

Self-Pay

By signing below, you understand that Dr. Silvers does not participate and is not contracted with any insurances, while Frances accepts Government issued Medicare only (NO Medicare advantage plans either). The self-pay rate is collected prior to each visit and the prices are displayed in our waiting room. You agree to pay the full amount for the consultations and treatments at the time of your visit. Forms for self-pay patients will be provided at each visit per state and federal laws. Any advantage plan reimbursements from your out-of-network payers will not cover the entire cost of the visit if at all.

As the patient, I understand that sometimes imaging, bloodwork, therapies and/or medications may not be covered as I expected. I understand that Gardens Neurology will do their best to submit all necessary information to ensure coverage, however any unpaid portions of such medications and tests are the patient's responsibility. This financial responsibility form supersedes any prior signed documents which are now null and void and are no longer in effect.

Patient/Guarantor Signature:_____ Date:_____

GARDENS NEUROLOGY – CONTACTING DOCTORS OUTSIDE OF REGULAR BUSINESS HOURS

Our providers and staff are here to assist you during business hours. During the regular workweek the office is staffed from 9 am – 4 pm on Mondays through Thursdays, and 9 am – 2 pm on Fridays, however providers' working days and hours vary, and the office is closed during some federal holidays. Patients are encouraged to contact the office at any time, during business hours, with any questions and/or concerns that they may have. We recommend that all patients monitor their medications to ensure that they do not run out. For any refills, please allow 24 hours to process. You may use our email to reach out to us during the weekend or leave a message on our voicemail. A link to your portal should have already been sent although access will provide you with minimal information. All messages left on our phone will be handled the next business day. The office email address is a good option to keep in touch with us. Feel free to email us 24/7 at info@gardensneurology.com and someone should get back to you within 24 hours. Please note that depending on your issues, some responses from our providers may instruct you to come in for an in-person visit. Any conversations regarding changes in medications, changes in your condition, or any extended discussions and reviews will require a visit with the appropriate provider who is designated to take care of your specific issue.

Any EMR that Gardens Neurology chooses, will be where my records will be kept in accordance with HIPAA regulations unless instructed differently by me in a written request. In case of my records changing to a different EMR, I give Gardens Neurology permission to transfer my records over.

FOR EMERGENCIES CALL 9-1-1 FIRST AND FAST!!

With any urgent medical concerns that arises outside of our business hours, you may either 1) contact your primary care doctor, 2) go to the nearest urgent care center or 3) go to the nearest hospital/emergency room. Do not hesitate to seek immediate medical care. You should follow up with us upon your discharge if it was recommended that you see a neurologist. If you visited the ER or were admitted to the hospital, you must notify us within 48 hours of your discharge! Dr. Silvers does not round at any local hospitals and the office does not have an answering service during off hours.

IMPORTANT NOTICE TO ALL!

As you choose to maintain an ongoing relationship with us, it is crucial that you understand the guidelines we have implemented regarding behavioral expectations between you (and your representatives) and us. We will always try our best to stay in touch, however we encourage our patients to take an active role in their care and suggest that you call our office any time with any issues, questions or concerns, we are always happy to hear from you. We can not anticipate nor guess your expectations, and find that an open line of communication benefits everyone. With that said, any negative behavior exhibited by you, or anyone representing you, will not be tolerated and will result in the patient being permanently discharged from our practice. Any verbal abuse, threats, inappropriate language, blatant complaints of dissatisfaction, aggressive attitude and outrageous demands, either by phone, in writing or in person, are unacceptable. Any threats of contacting lawyers or complaints/jokes that "you are doing it for the money" will also cause an immediate discharge. More details regarding our office guidelines can be found on our website under the forms tab as Rights and Responsibilities and Office Policies.

I, the undersigned, read this notice and verify that I will follow accordingly as explained above.

Signature:_____ Print name:_____ Date:_____