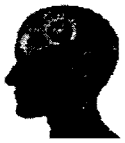


Neurological
Services, P.C.

NEUROLOGICAL SERVICES, P.C.
463 WORCESTER ROAD
FRAMINGHAM, MA 01701

ZAHRA AYUB, M.D.
MARTIN BIELAWSKI, M.D.
JOSEPH D'ALTON, M.D.
LUDMILA FRIDMAN, M.D.

JANE LOUIE, M.D.
FLAVIA MACHADO, M.D.
LINA ZASLAVSKY, M.D.

PATIENT NAME_____ **DATE**_____

Thank you for calling for an appointment for a neurological consultation.
It is scheduled on _____, **20**_____ **at** _____ **AM/PM**

Framingham Office
463 Worcester Road, Suite 101
Framingham, MA 01701

Marlborough Office
65 Fremont Street, Suite 8
Marlborough, MA 01752

The following information may be helpful to you:

Directions to our office are on the back of this form. All offices are wheelchair accessible. We try to run the office on schedule, but occasionally are delayed by medical emergencies. If you have a tight schedule, call an hour ahead of time to find out how we are doing. Please give 24 hours notice if you are unable to keep this appointment. A fee will be charged, $35.00 for a follow up visit or $100.00 for a new patient visit, if you do not cancel the appointment (with 24 hours notice).

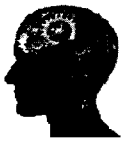
You may want to come with someone to help you explain the problem. Some people find it helpful to write out a brief summary of the symptoms. Please bring your reading glasses, list of all current medications, and your insurance card(s).

For most insurances, we will bill directly to your insurance company. If you are not covered by insurance, we will allow you to spread your payments out over a comfortable period of time. If you are a member of an HMO (ex. Harvard Pilgrim, Tufts, Fallon, BC/BS HMOs), you are required to obtain a referral from your primary care physician. Your co-payment is due at the time of your visit. If your visit here is the result of an auto accident or worker's compensation injury, all information regarding your claim is required prior to booking an appointment (including claim number, insurance agent, authorization, etc). You will receive a bill until the claim is paid.

You may find it useful to keep this information for future reference. We look forward to seeing you and will try to be of help.

IF YOU DO NOT RECEIVE A CONFIRMATION PHONE CALL PRIOR TO YOUR SCHEDULED APPOINTMENT, PLEASE CALL OUR OFFICE

Zahra Ayub, M.D.	**508-879-6016**	**Jane Louie, M.D.**	**508-879-1911**
Martin Bielawski, M.D.	**508-879-0888**	**Flavia Machado, M.D.**	**508-879-5081**
Joseph D'Alton, M.D.	**508-820-0431**	**Lina Zaslavsky, M.D.**	**508-620-9350**
Ludmila Fridman, M.D.	**508-872-0360**		



Neurological
Services, P.C.

Patient Registration Form

Patient Name: _____
(Last) (First) (M.I.)

Primary Phone: _____ Secondary Phone: _____
Do you give permission to leave a message on these numbers?: □ Yes / □ No

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Sex: □M / □F Social Security #: _____

Marital Status: □ M / □ S / □ D / □ W Height: _____ Weight: _____

E-Mail Address: _____
Would you like to sign up for our patient portal?: □ Yes / □ No

Employer: _____ □ Retired / □ Student

Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Insurance Information
Primary Insurance: _____ ID: _____
Subscriber/Policyholder: _____ Relationship: _____
Subscriber Date of Birth: ___/_____/_____ Subscriber Social Security #: _____
Employer: _____ Phone: _____
Secondary Insurance: _____ ID: _____

☐ **Workman's Compensation or** ☐ **Automobile Accident?**
If yes, please provide us with a copy of the claim information and ask for the appropriate form.

Release of Information
I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.
Name(s): _____ Relationship to Patient: _____

Please provide 24-hours notice when canceling a scheduled appointment to avoid a cancellation fee.
Cancellation Fee schedule: New Patient: $100.00; Established Patient: $35.00

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits directly to the physician. I understand that I am responsible for payment for these services if I have not obtained the proper referral.

Patient Signature: Date:

Disclosures, Consents & Patient Responsibility Acknowledgment
Provider: NEUROLOGICAL SERVICES, P.C.

I CONSENT TO MEDICAL TREATMENT AND TO THE DISCLOSURE OF MY HEALTH INFORMATION AS NEEDED FOR MY TREATMENT AND THE SUBMISSION OF CLAIMS TO MY INSURANCE COMPANY OR OTHER RESPONSIBLE PARTIES TO PAY FOR THIS TREATMENT.

I ACCEPT THE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED TO ME IF MY INSURANCE CARRIER DENIES OR DOES NOT COVER THE CLAIM FOR THESE SERVICES UNDER MY INSURANCE PLAN OR REMITS THE PAYMENT DIRECTLY TO ME.

If any of my insurance plans requires me to have a **REFERRAL AUTHORIZATION** to be seen and treated by the provider, I am responsible for obtaining the proper and necessary referral and insurance authorization as required from my insurance companies and from my referring providers prior to receiving medical treatment now and in the future. If I receive medical services without having obtained the proper referral and insurance authorization and insurance coverage is denied for lack of such authorization from any of my insurance plans, I agree to be financially responsible for the unauthorized medical services I have received from the provider.

I waive my right not to be billed by the provider if any claim is denied by my insurance companies for lack of **REFERRAL AUTHORIZATION** or if I fail to obtain the necessary and required **REFERRAL AUTHORIZATION** in order to be treated by the provider.

I AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE PROVIDER FOR CLAIMS SUBMITTED ON MY BEHALF FROM ALL MY INSURANCE COMPANIES.

I WILL PAY ALL CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES WHICH MY INSURANCE PLAN DECLARES AND DESIGNATES AS THE RESPONSIBILITY OF THE PATIENT. THE PROVIDER MAY TAKE WHATEVER LEGAL STEPS NECESSARY TO COLLECT PAYMENT IN FULL FROM ME.

I WILL PAY LATE FEES, IF ANY, ON CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES THAT ARE MY RESPONSIBILITY IF I DO NOT PAY THESE BALANCES IN FULL WHEN DUE AND BILLED TO ME.

MY UNPAID BALANCES MAY RESULT IN MY ACCOUNT BEING REFERRED FOR COLLECTION OR CREDIT REPORTING. I WILL BE RESPONSIBLE FOR RESULTING COLLECTION FEES TO COLLECT MY UNPAID BALANCES.

I AUTHORIZE THE USE OF THIS SIGNATURE, CONSENT, AND WAIVER FORM FOR ANY AND ALL CLAIMS SUBMITTED BY THE PROVIDER AND I ACKNOWLEDGE HAVING RECEIVED A COPY OF THIS SIGNED FORM FOR MY RECORDS.

THIS FORM SHALL BE IN EFFECT FOR ANY AND ALL MEDICAL CARE AND TESTS RENDERED BY THE PROVIDER LISTED ABOVE BEGINNING ON THIS SIGNATURE DATE AND UNTIL THE DATE I STOP RECEIVING MEDICAL SERVICES FROM THIS PROVIDER.

I certify that I have been made aware of the Neurological Services P.C. Notice of Privacy Practices and that I have a right to receive a copy upon request. I certify that I understand that Neurological Services, P.C. reserves the right to change the privacy practices and I may receive an updated copy upon request. I hereby authorize Neurological Services, P.C. or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

I certify that I understand the privacy risks of mail, phone calls, and e-mail and I hereby authorize Neurological Services, P.C. to utilize these delivery services as needed.

Patient Signature: _____ Print Name_____ Date: _____

Guarantor Signature: _____ Print Name_____ Date: _____
(Guarantor signature required if patient requires guarantor to ensure coverage or payment for medical services rendered to the patient).

Neurological
Services, P.C.

Confidential Patient Questionnaire

Patient Name:_____ DOB:_____

Reason for visit (please state specific concerns: _____

_____

In-patient Hospital Admissions (in order):

Location	Date	Reason

Current Medications (or provide a list):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Medication Allergies and Reactions:

Other illnesses/medical conditions:

Family History:	**Age**	**Health**	**Age at Death**	**Cause**	**Other Issues**
Father					
Mother					
Siblings					
Children					

Do you smoke? □ Yes / □ No How Much? _____ When quit? _____

Do you drink alcohol? □ Yes / □ No How much/how often? _____

Occupation? _____

PLEASE COMPLETE BACK SIDE OF FORM

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	YES	NO		YES	NO
Chest Pain			Irregular periods		
Shortness of breath			Painful periods		
Ankle swelling			Date of last period		
Cough			Frequent urination		
Sputum			Painful urination		
Asthma			Poor stream		
Angina			Blood in urine		
Loss of appetite			Impotence/sexual dysfunction		
Weight gain			Depression		
Weight loss			Anxiety		
Heartburn			Panic attacks		
Nausea			Claustrophobia		
Vomiting			Snoring		
Diarrhea			Headache		
Constipation			Visual difficulty		
Abdominal Pain			Double vision		
Peptic ulcer			Speech problem		
Rectal bleeding			Swallowing problem		
Joint pain			Limb weakness		
Joint swelling			Numbness		
Neck pain			Tingling		
Back pain			Vertigo		
Skin rash			Dizziness		
Tick bite			Memory problem		
Fever			Walking problem		
Loss of energy			Blackouts		
Shivering			Balance Problem		

Signature of patient

Date