Bridgemill Neurological Associates P.C.

Stephanie A. Riemann, M.D., Mary Bedingfield, MSN, NP-C, Marsha A. Alexander, F.N.P. BC

980 Woodstock Parkway, Suite 300, Woodstock, Georgia 30188 Ph# 678-494-9545 Fax 678-494-9559 http://www.bridgemillneurological.com

Appointment Information

Patient Name:_____

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Scheduled Appointment Date/Time: _____/_____/_____, _____ a.m./p.m.

☐ Stephanie A. Riemann, M.D. ☐ Marsha A. Alexander, F.N.P., B.C.

Please arrive at least 20 minutes prior to your appointment time with your new patient information completed. More time will be needed if this is not done. If you arrive later than 15 minutes past your appointment time, unfortunately we will have to reschedule it, so please arrive early so we can provide you with the best service possible. If your insurance requires a referral from your Primary Care Physician, please bring it with you or confirm it is in the office prior to your appointment.

Thank you for choosing Bridgemill Neurological Associates, PC for your medical care. We are committed to providing you with the highest quality medical care possible. Please visit our website at http://www.bridgemillneurological.com for more information and access to our patient portal. Our portal allows you to schedule/cancel appointments, send messages to our staff and access your medical records, or make online payments on your account once you have registered. Copayments are due in full at the time services are rendered. As a courtesy to our patients we accept cash, personal check, money order, Visa and MasterCard.

Office Hours

Monday through Thursday – 8:30 - 4:30; Friday – 8:30 – 12:30; *(closed for lunch from 12:30-1:30pm)*

Directions

From the North

Take I-575 South to exit 8 (Towne Lake Parkway), turn left at the end of the exit ramp. Go to the 2nd traffic light and turn left (Woodstock Parkway). Go approx. ½ mile. We are in the 3rd medical building on the right.

From the South

Take I-575 North to exit 8 (Towne Lake Parkway), turn right at the end of the exit ramp. Go to the next traffic light and turn left (Woodstock Parkway). Go approx. ½ mile. We are in the 3rd medical building on the right.

From Cartersville

Take I-75 South to exit 271 (Chastain Road). Turn left onto Chastain Road and travel until arriving at I-575. Take I-575 North to exit 8 (Towne Lake Parkway), turn right at the end of the exit ramp. Go to the next traffic light and turn left (Woodstock Parkway). Go approx. ½ mile. We are in the 3rd medical building on the right.

From Cumming

Take Hwy 20 West toward Canton. Take I-575 South to exit 8 (Towne Lake Parkway), turn left at the end of the exit ramp. Go to the 2nd traffic light and turn left (Woodstock Parkway). Go approx. ½ mile. We are in the 3rd medical building on the right.

Your Financial Responsibility

Insurance

Your insurance coverage and benefits are a contract between you and your insurance company therefore all disputes must be handled by you with your insurance company. If you are insured under a plan which we do not have a contract, you will be considered a self-pay patient.

All copays, co-insurances and non-covered charges are due at the time of service.

All balances on your account from previous services are due prior to any further services being rendered to you by our office.

Cancellation and No show Administrative Fee Policy

Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care. Therefore effective immediately, Bridgemill Neurological Associates, P.C. reserves the right to charge a fee for missed appointments (no shows) and appointments not cancelled with a 48 hour advance notice.

No shows and cancellation fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple no shows and late cancellations in any 12 month period may result in termination from our practice. The fees are as follows:

Non return of ambulatory EEG equipment	**$500.00**
Office visits	**$50.00**
DCATs (Driving Cognitive appointments)	**$50.00**
EMG/NCS tests	**$150.00**
EEG test	**$150.00**
Botox and injection appointments	**$75.00**

A $35.00 service fee will be incurred for any insufficient checks received by our office.

Forms and Medical Records

A $35.00 Medical Record fee will be incurred if records are provided by our office directly to you, although these are accessible free of charge to you through our web portal. This fee does not apply if records are requested by another physician's office.

A per form fee will be assessed at the time the form is completed. These "per form" fees range from $10.00 - $150.00. Examples include but are not limited to the following:

- Parking permits
- FMLA
- Short and Long term disability (These forms will NOT be filled out upon initial visit with our office, only after established patient)
- School / Work Release
- Any notarized forms from our office if not completed during an office visit.

Patient Acknowledgement & Notice of Privacy Practices

I understand the terms of the Financial Policy and that it may be amended at any time without prior notification to me the patient of Bridgemill Neurological Associates. I have also been provided with a copy of the Notice of Privacy Practices Act disclosure via provider website or upon asking the office, or on display at the front desk.

_____ _____

Patient name Date

_____

Patient signature

Patient Information

Social Security # :_____ Date: _____

Patient Name:_____ DOB :_____/_____/_____

Sex: M F Marital Status: S / M / D / W Race:_____ Language: _____

Address:_____ City:_____ State:____ Zip:_____

Email address: _____

Home Ph#:_____ Cell Ph#:_____ Work Ph# _____

Referring (or Primary Care) Physician

Physician's Name:_____ Ph#: _____
Address:_____ Fax #:_____

Insurance Information

Primary Insurance Company:_____ Ph#: _____
Subscriber's Name:_____ Subscriber's DOB: ____/____/____
Group #:_____ Member ID:_____ Effective Date:_____/_____/_____

Secondary Insurance Company:_____ Phone Number:_____
Subscriber's Name:_____ Subscriber's DOB:_____/_____/_____
Group #:_____ Member ID:_____ Effective Date:_____/_____/_____

Emergency Contact

Name:_____Phone:_____Relation:_____

Pharmacy Information

Local Pharmacy Name:_____ Phone:_____

Mail In Pharmacy Name: _____ Phone #_____

I, hereby make assignment of all medical insurance benefits payable to Bridgemill Neurological Associates, PC. I understand that payment is expected at the time services are rendered unless prior arrangements have been made. I also hereby made Authorization for BNA, PC to release any medical information necessary to execute an assignment of benefit. I understand that regardless of any insurance coverage I may have, I am personally responsible for all charges to this account. I further agree that in the event of non-payment I agree to pay all attorney fees and collection costs and or court cost required. I authorize release of my medical records if necessary. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Signature:_____ Date:_____

Request for Release of Medical Records

Authorization for Physician Release of Medical Information to Bridgemill Neurological Associates, P.C.

Today's Date: _____

I hereby authorize and request that a copy of my medical records be released to:

Bridgemill Neurological Associates, PC
980 Woodstock Parkway, Suite 300
Woodstock, Georgia 30188
Fax 678-494-9559

Patient Signature: _____

Printed Name: _____

Date of Birth: _____ *SSN#* _____

(You may be required to complete a medical records release form from the other physician/facility)

OFFICE USE ONLY:

Physician or Medical Facility Providing Records:

Name of Physician/Facility: _____

Address: _____

City, State, Zip: _____

Ph#: _____ Fax#: _____

Patient Information Release Form

Patient Name: _____ Date of Birth: _____

May we leave a telephone message on recorder or voicemail concerning the following?

	YES	NO
Prescriptions		
Test Results		
Referrals		
Appointments		

Please list phone numbers that you grant us permission to leave voicemail or messages on:

Home: _____ Work: _____ Cell #_____

Medical Information and/or test results can be given over the telephone to:

Check One:

_____ NO ONE except for myself

_____ The following person (s):

Name: _____ Relationship to Patient: _____

Home #: _____ Work #: _____ Cell #: _____

Name: _____ Relationship to Patient: _____

Home #: _____ Work #: _____ Cell #: _____

Patient Signature: _____ Date: _____

Medications

Patient Name: _____ Date of Birth:_____ Date:_____

Please List any Medication Allergies:

_____

_____

Prescription Medications:

Name:	Strength (mg):	# of times taken per day

Over the Counter Medications/Supplements:

Name:	**Strength (mg):**	**# of times taken per day**

Patient: _____

Referring Physician: _____

Primary Care Physician: _____

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

Have you seen any providers for the issue you're being seen for today? If so, who and when?

_____

_____

Have you had recent brain or spine CT's or MRI's? *If yes, when & where were the studies performed:*

_____

_____

Social History:
Check the Appropriate Box:

	Yes	No	How long:	How much/How often:	When did you quit:
Tobacco:					
Alcohol:			***Circle one:*** Beer Wine Liquor		
Caffeine					
Other Substances:					

Family: (Circle one) *Single Married Divorced Widowed*
Children: How Many: What are their ages:
Occupation:
Education level:
Who do you currently live with? Relationship:

Family History:
Check the Appropriate Box:

Relative:	*Father:*	*Mother:*	*Sister:*	*Brother:*	*Children:*
Ages (if living):					
Cause & Age at time of Death:					
Cancer (What type)					
Seizures					
Stroke					
Heart Attack					
Migraines					
Dementia					
Neuropathy					
Glaucoma					

High Blood Pressure					

Patient:_____

Medical History:

Please check any disease or condition you have had in the past or have now:

Heart Disease		Stroke	
Atrial Fibrillation		Cerebral Aneurysm	
Chronic Heart Failure		Dementia	
High Blood Pressure		Vitamin B12 Deficiency	
High Cholesterol		Vitamin D Deficiency	
Diabetes Mellitus		Cubital Tunnel Syndrome	
Thyroid Disorder		Carpal Tunnel Syndrome	
Chronic Obstructive Pulmonary Disease		Vertigo	
Asthma		Restless Leg Syndrome	
Cancer		Sleep Apnea (Obstructive) *Use a CPAP? Circle: YES or NO*	
GI Disorder		Tremor	
Kidney Disorder		Osteoporosis	
Polyneuropathy		Parkinson's Disease	
AutoImmune Disease		Rheumatoid Arthritis	
Osteoarthritis		Multiple Sclerosis	
Depression		Myasthenia Gravis	
Anxiety		Degenerative Disc Disease	
Migraines		Fibromyalgia	
Epilepsy		Obesity	

___ Cancer*: Where?*_____ *When?*_____ *Treatment?*_____

Please list any other health problems that are not described above or describe any above condition further:

_____

_____

Surgical History:
Please list any surgeries you have had and the approximate dates:

_____

_____

_____

_____

CONTROLLED SUBSTANCE AGREEMENT

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. No prescriptions will be written unless you accept the following agreement:

- I understand that all prescription requests require a 48 hour notice and that prescription requests received after 4:00 PM will not be worked on until the next business day.
- I will never share, sell or exchange my medication with anyone for any reason.
- I understand that I am solely responsible for the safekeeping of my medications.
- I know that Bridgemill Neurological does not replace lost or stolen medications.
- I understand that I should not drive or operate heavy machinery while taking medications that cause drowsiness or impaired cognitive function.
- I agree to notify Bridgemill Neurological if I experience any adverse effects or dosage problems with prescriptions.
- My provider may ask me to bring any unused medications to Bridgemill Neurological.
- I agree that if I receive a controlled substance prescription from Bridgemill Neurological, I am not allowed to accept controlled substance prescriptions from other physicians without my doctor's consent.
- I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.
- I know that I cannot be seen in the office without a scheduled appointment for ANY reason.
- I understand that Bridgemill Neurological may dispense and write controlled substance prescriptions on a 30-day basis.
- I understand that abusive behavior or harassment towards any Bridgemill Neurological staff member cannot be tolerated. The Physicians will determine which actions can be considered harassment on a case-by-case basis, and if warranted I can be dismissed from the practice.
- I understand that Bridgemill Neurological is required to perform random urine drug screening while I am being treated with a controlled substance in accordance with Georgia Rule 360-3-06. I understand that this testing may be performed during scheduled appointments or when I pick up requests for written prescriptions.
- I understand that failure to comply with drug screening requirements may result in dismissal from the Practice. Refusal to submit to a drug screen is considered to be admission of improper medication self-management. I understand that I also may be dismissed from the practice for refusal to submit or failure to comply with required appointments.
- If the results of the drug screen do not match my current medication prescribed by my physician or they test positive for illegal drugs, I understand that I can be dismissed immediately from Bridgemill Neurological.
- I understand that should my physician believe I have misused or abused a controlled substance; an appropriate referral for substance abuse will be made in accordance with Georgia Rule 360-3-06.

I have read and understood Bridgemill Neurological Associates policies regarding controlled substances. I agree to the terms involved in the Controlled Substance Agreement and have received a copy of this policy. I understand that if any of the above policies are violated or I choose not to adhere to these policies, I will be dismissed from this office and will not receive any refills from the providers.

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth

_____ _____
Pharmacy Name Pharmacy Phone Number

_____
Pharmacy Address

Patient Controlled Substance Informed Consent Form

I acknowledge that this is an explanation of issues related to the treatment of disorders through the use of controlled substances including opioids (such as Morphine, Vicodin, Hydrocodone) between Bridgemill Neurological and me, the patient, should it be determined by the physician that I am a candidate for this type of therapy.

Side Effects and Risks:

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you now and may be discussed later. Side effects and/or risks include, but are not limited to allergic reactions, sedation, sleepiness, respiratory depression (slowed breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, decreased libido, dependence, tolerance, addiction, or death.

Caution:

Opioid medications may cause drowsiness. Alcoholic beverages should not be taken concurrently. You should not drive, operate machinery, or make important decisions whilst experiencing side effects of these medications.

I _____ have read this agreement very carefully. I understand while there are side effects and risks associated with the use of controlled substances including addiction, my provider has determined that I am a candidate for this type of therapy. My provider reserves the right to discontinue my medication(s) at any time.

_____ _____

Patient Signature Date

_____

Date of Birth