980 Woodstock Parkway, Suite 300 (3rd Floor)
Woodstock, GA 30188
www.bridgemillneurological.com
Phone: 678-494-9545 Fax: 678-494-9559

Stephanie Riemann, MD *Marsha Alexander, RN, MSN, FNP-BC* *Mary Bedingfield, MSN, NP-C*

Appointment Date & Time:_____

Please arrive at least 20 minutes prior to your appointment time.

If possible, email your completed paperwork to Newpatient@bridgemillneurological.com prior to your appointment. If you arrive later than 15 minutes past your appointment time, unfortunately we will have to reschedule it. 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.

Office Hours

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

Quest Diagnostics Lab available on premises

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.

New Patient Registration Form

Date: _____

Patient First Name:_____Patient Last Name:_____
Sex: M F DOB:_____/_____/_____Social Security # :_____
Marital Status: S / M / D / W Race:_____ Language: _____
Email address: _____
Street Address:_____
City:_____ State:_____ Zip:_____
Home Phone #:_____ Cell Phone#:_____
Emergency Contact _____ Phone #_____
Relationship to Patient _____

Referring Physician

I am requesting Bridgemill Neurological Associates send my medical records and communicate directly regarding my medical condition and plan of care to: Dr._____.
Phone #: _____ Fax #_____
Referring Physician**:** _____
Primary Care Doctor:_____

Preferred Pharmacy Information

Local Pharmacy Name:_____
Phone:_____ Fax: _____
Address:_____

Mail In Pharmacy Name: _____Phone:_____
Address:_____

Insurance Information

Primary Insurance: _____

Secondary/Supplement:_____

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:_____

Patient Name: _____ Date of Birth:_____

Medications

ALLERGIES

Medications, dyes, tapes, etc:	Reaction:

Prescription Medications AND Over the Counter meds/supplements/herbs:

Medication	Strength (mg):	Frequency (times per day)	Length of time on Medication:

Patient Name: _____ Date of Birth:_____

Past Medical History: *Please check any disease or condition you have or had*

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

Cancer: Where?_____ When?_____ Treatment_____

Surgical History:

Operation/Procedures, reason for procedure	Date:
1.	
2.	
3.	
4.	

Family Medical History: *Check the Appropriate Box:*

Relative:	*Father:*	*Mother:*	*Sister:*	*Brother:*	*Children:*
Ages (if living):					
Cause & Age at time of Death:					
Cancer (What type)					
Dementia					
Glaucoma					
Heart Attack					
High Blood Pressure					
Migraine					
Neuropathy					
Other Neurologic Condition:					
Parkinson's					
Seizures/Epilepsy					
Stroke					

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

COVID19 Vaccination: Vaccinated? ◯Yes or ◯NO If so, what date: _____
Have you had Covid19? ◯Yes or ◯NO If so, what date:_____

Are you currently under the care or follow a neurologist or have you seen another neurologist in the past?

◯Yes or◯NO (Circle One) If yes, please answer the following:

Physician's Name:_____

When?_____ What for?_____

Have you seen any providers for the issue you are being seen for today? ☐Yes ☐ No (If yes, answer below)

Physician's Name:_____

When?_____ What for?_____

Have you had recent brain or spine CT's or MRI's? If so, please fill in the box below.

BRAIN AND SPINE IMAGING (Including x-rays, CT scans, MRIs)

Type of scan	Where	Results	Date:

Social History:

Tobacco Use: ◯Yes ◯No How long?_____ Average packs per day_____ if quit, when?_____
Alcohol Use: ◯Yes ◯No If yes, how much/how often? _____
◯Beer ◯Wine ◯Liquor
Other Substances: ◯Yes ◯No Other Drug/Name_____
Caffeine: ◯Yes ◯No If yes, how much per day_____

Living Situation: ◯Independent in Home ◯In Home with Assistance Other:_____
Marital Status: ◯Married ◯Not Married ◯Divorced ◯Widow/Widower ◯Live with Significant Other
Education: ◯High School ◯Technical School ◯College ◯Graduate School
Occupation (Job): _____ Retired? ◯YES ◯NO
Do you have children? ◯Yes ◯No If yes, How many children? _____

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 Policy

Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care. Our goal is to provide high-quality individualized medical care and in order to do so, we must maintain each patient's appointment as scheduled. We do understand there are times when a patient needs to cancel their appointment. Our practice's policy regarding cancellations or no show appointments is as follows:

- As long as the appointment is cancelled within forty-eight (48) hours, there are no fees charged to the patient.
- Late cancellations (less than 48 hours of your appointment time can result in a charge of 50% of the fee for the scheduled appointment. In order to re-schedule your appointment, the late cancellation/no show fee must be paid in full.
- Multiple no shows and late cancellations in any 12 month period may result in termination from our practice.
- Late appointment arrivals will result in rescheduling of that appointment.
- We do recognize there are rare events and emergencies that make it impossible to cancel your appointment in a timely 48 hour manner. However, these circumstances are at the discretion of Bridgemill Neurological and will rarely be granted.

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.

_____ Date: _____
Patient Name

_____
Patient signature

Request for Release of Medical Records

Date: _____

Patient Name _____ Patient DOB: _____

I authorize _____(Physician/Office/Entity)

to release a copy of my medical records to:

Bridgemill Neurological Associates, PC
Fax 678-494-9559

Attention: _____
980 Woodstock Parkway, Suite 300
Woodstock, Georgia 30188
Phone# 678-494-9545

Specific Records Requested:_____

Patient Signature: _____

OFFICE USE ONLY:

Physician or Medical Facility Providing Records:

Name of Physician/Facility: _____

Address: _____

City, State, Zip: _____

Ph#: _____ Fax#: _____

HIPAA

Test Results Ordered by Bridgemill Neurological:

◯ Leave a detailed voice message on my cell phone _____ (Initials) _____

OR

◯ Leave a detailed voice message on my home phone _____ (Initials) _____

◯ Send detailed notification through the patient portal (Initials) _____

◯ I give my permission to leave detailed message with individual answering the phone (Initials)_____

Sharing of Medical Information:

I give Bridgemill Neurological permission to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Preferred Phone Number: _____

Name:_____ Relationship:_____

Preferred Phone Number: _____

NO ONE EXCEPT MYSELF (Initials)_____

Are there any additional instructions regarding any of the above? _____

_____

_____

_____

Patient signature

Date: _____

Patient Name: _____ Date of Birth:_____

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

Patient Name: _____ Date of Birth:_____

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