TRI-CITY NEUROLOGY, LLC

200 EAST BATTLE STREET • TALLADEGA, AL 35160
(256) 362-9677

PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Cell Phone: _____

Sex: _____ Race: _____ Marital Status: _____ Birthdate: _____

Retired: _____ Employed: _____ Full time student: _____ Part time student: _____

Employer: _____ Phone: _____

Social Security: [Can provide in person during visit] _____ Drivers License: _____

Person responsible for account: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Phone: _____

Social Security: _____ Drivers License: _____

Spouse's Name: _____ Employer: _____ Phone: _____

Person to notify in case of emergency: _____ (Outside Your Home) Phone: _____ (Other Than Your Number)

Relatives or friends that are patients: _____

Drug Allergies: _____

Major Medical Problems:: _____

Have you arranged for a Living Will? (Advanced Directives) ☐ Yes ☐ No Have you appointed a durable power of attorney? ☐ Yes ☐ No

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____

Policy holder's name: _____ Birthdate: _____ / _____ / _____

Employer: _____

Contract or group: _____

Relationship of patient to policy holder: _____

Insurance Company (Secondary): _____

Policy holder's name: _____ Birthdate: _____ / _____ / _____

Employer: _____

Contract or group: _____

Relationship of patient to policy holder:

Referred by: _____

CONSENT FOR TREATMENT: - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize TRI-CITY NEUROLOGY LLC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to TRI-CITY NEUROLOGY LLC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the TRI-CITY NEUROLOGY LLC charges for these services. I understand that I am financially responsible to TRI-CITY NEUROLOGY LLC for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by TRI-CITY NEUROLOGY LLC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE: _____ DATE: _____

REORDER FORM MBF PERRY CO. • 800-304-7008 • TRI CITY (7-09)

Tri-city neurology LLC
200 Battle St East, Talladega , AL, 35160

Health history questions

The health related questions are to help understand your medical problems. All questions are OPTIONAL and confidential.

Date of Visit: _____
Main reason for today's visit: _____
Other concerns:_____

ALLERGIES

List any allergies to medications

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

_____

PREFERRED PHARMACY

_____

MEDICATIONS

List current medications: OR provide a separate.

DRUG NAME	DOSE
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____

PAST MEDICAL HISTORY

☐ Diabetes	☐ Head trauma	☐ Numbness/tingling
☐ Hypertension	☐ Heart disease	☐ Back pain
☐ Cholesterol problems	☐ Brain aneurysm	☐ Neck pain
☐ Strokes/TIA	☐ Depression	☐ Tremor
☐ Seizures	☐ Fibromyalgia	☐ Parkinson's Disease
☐ Anxiety	☐ Arthritis	☐ _____
☐ Migraines	☐ Cancer	☐ _____
☐ Headaches	☐ Sleep problems	☐ _____
☐ _____	☐ _____	☐

SURGICAL HISTORY

_____
_____
_____
_____

SOCIAL HISTORY

Smoking status ☐Never ☐Used to ☐ Somedays ☐ Unknown
☐ Daily _____Packs/day. _____Cig/day _____Years of smoking

Dominant Hand ☐RIGHT ☐LEFT ☐BOTH ☐Unknown

Marital status ☐Married ☐Divorced ☐Single ☐Widow
☐Domestic partner ☐Separated

Caffeine use ☐None ☐Some ☐Moderate ☐Heavy

Alcohol use ☐None ☐Some ☐Moderate ☐Heavy

Chewing tobacco ☐None ☐Some ☐Moderate ☐Heavy

Exercise ☐None ☐Some ☐Moderate ☐Heavy

Street Drugs ☐None ☐Weed ☐Cocaine ☐Meth ☐Other

Living Situation ☐Alone ☐With others ☐Other_____

Occupation ☐None ☐Disabled ☐Retired ☐_____

FAMILY HISTORY ☐Adopted

☐Diabetes ☐Blood pressure ☐Cholesterol problems
☐Stroke ☐TIA ☐Brain Aneurysm
☐Seizure ☐Tremor ☐Parkinson's
☐Migraines ☐Headaches ☐Multiple Sclerosis
☐Dementia ☐Alzheimer's ☐Bleeding problems
☐Heart disease ☐Brain cancer ☐Spine problems.
☐Depression ☐Anxiety ☐Other_____
☐Unknown ☐_____ ☐_____

Review of systems [✓ all that applies to you]

General
- ☐Fever
- ☐Chills
- ☐Fatigue
- ☐Weight gain
- ☐Weight loss

Ear/Nose/Throat
- ☐Ear pain
- ☐Difficulty hearing
- ☐Dry mouth
- ☐Nose bleeds
- ☐Mouth ulcers
- ☐Sinus pressure
- ☐Ear ringing
- ☐_____

Respiratory
- ☐Cough
- ☐Shortness of breath
- ☐Bloody cough
- ☐Wheezing
- ☐Snoring
- ☐Sleep apnea

Cardiovascular
- ☐Chest pain with exertion
- ☐Chest pressure/heaviness
- ☐Palpitation
- ☐Light-headed on standing
- ☐Breathing problem lying
- ☐Breathing problems walking
- ☐Leg swelling
- ☐_____
- ☐_____
- ☐_____
- ☐_____

Musculo-skeletal
- ☐Back pain
- ☐Neck pain
- ☐Muscle aches
- ☐Joint pain
- ☐Shoulder pain

Psychiatric
- ☐Depression/mania
- ☐Anxiety
- ☐Insomnia
- ☐Panic attack
- ☐Personality problems
- ☐Fear for safety
- ☐Schizophrenia
- ☐_____

Eyes
- ☐Vision change
- ☐Double vision
- ☐Droopy eyes
- ☐Color vision problems
- ☐Eye redness/dry eyes
- ☐Blindness

Skin
- ☐Skin rash
- ☐Itching
- ☐Skin growth
- ☐Eczema
- ☐Easy bruising

Endocrine
- ☐Appetite change
- ☐Increased thirst
- ☐Hot flashes
- ☐Increased sweating

Neurological
- ☐Seizures ☐Tremor
- ☐Weakness
- ☐Headaches/Migraines
- ☐Memory problems
- ☐Dizziness
- ☐Vertigo
- ☐Restless leg
- ☐Sleep problems
- ☐Fainting
- ☐Numbness/tingling
- ☐Stroke symptoms/TIA
- ☐Attention problems.
- ☐Confusion
- ☐Problem speaking

GI
- ☐Abdominal pain.
- ☐Difficulty swallowing
- ☐Bloody stool.
- ☐Indigestion.
- ☐Nausea
- ☐Vomiting.

GU/OBGYN
- ☐Loss of bladder control
- ☐Difficulty urinating
- ☐Blood in urine
- ☐Prostate problems.
- ☐_____

Allergy/Immunology.
- ☐Frequent sneezing
- ☐Itching
- ☐Hives
- ☐Immune deficiency

Other comments:_____

_____
Patient/guardian signature

Medication History Authorization Form

Authorization to Access Medication History

I hereby authorize **Tri city neurology**, its physicians, and authorized clinical staff to access and review my **medication history** from external sources, including but not limited to:

Pharmacies, Pharmacy Benefit Managers (PBMs) , Health Information Exchanges (HIEs) Health Plans and Insurance Companies Other treating providers and healthcare organizations

This may include information regarding: Prescription medications filled in the past, Dosage, frequency, and duration of medications, Medication adherence and refill history, Over-the-counter medications if recorded

This access is provided for the purpose of: Assisting in medical diagnosis and treatment planning, Preventing harmful drug interactions or duplicate prescriptions, Maintaining an accurate and up-to-date medication list, Improving the safety, quality, and coordination of my care

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Acknowledgment of Rights and Privacy

I understand that: This authorization is voluntary, and I may revoke it in writing at any time. Revocation will not affect any information already obtained or used before the revocation date. This information is protected by federal and state privacy laws, including the **Health Insurance Portability and Accountability Act (HIPAA)**. Tri city neurology is committed to maintaining the privacy and confidentiality of my health information.

Expiration

This authorization remains in effect **until revoked in writing**

Patient/Authorized Representative Signature

Signature: _____
Printed Name: _____
Date: _____

If signed by someone other than the patient:
Relationship to Patient: _____
Legal authority to act (e.g., parent, guardian, POA): _____

COMMUNICATION AUTHORIZATION FORM/ NEW PATIENT PAPERWORK

TRI-CITY NEUROLOGY LLC
ALTERNATIVE PEOPLE COMMUNICATION
AUTHORIZATION FORM

PATIENT NAME:	
PATIENT PHONE NUMBER:	

WHEN IT COMES TO YOUR MEDICAL TREATMENT, WE STRIVE TO COMMUNICATE WITH YOU IN AS TIMELY AND PROFESSIONAL MANNER AS POSSIBLE. THERE ARE CERTAIN OCCASIONS WHEN FAMILY MEMBERS, FRIENDS OR OTHERS MIGHT BE INVOLVED IN YOUR CARE AS A PATIENT AND YOU WILL WANT OUR OFFICE TO BE ABLE TO COMMUNICATE DIRECTLY WITH THEM. IN ORDER TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION, PLEASE SHARE WITH US THE NAMES OF ANY OF THE OTHER PEOPLE WITH WHOM WE CAN DISCUSS YOU CARE AND SHARE YOUR PROTECTED HEALTH INFORMATION.

PLEASE LIST ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS ASPECTS RELATED TO YOUR CARE:

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

Are there any other numbers you would like to be contacted at? _____

Home Phone: _____ **Work Phone:** _____

_____ **Okay to leave message on machine?** _____ **Okay to leave message?**

_____ **Leave message to call us back?**

_____ **Leave detailed message (re: tests results, appointment times, ect)**

PATIENT SIGNATURE: _____ DATE: _____

Controlled Substance Agreement:

This agreement is applicable and made between the provider Fazal Rahim M.D and YOU for the responsible use of controlled substances **IF PRESCRIBED** for you. Controlled substances include pain medications, anxiety medications, sleep medications, ADHD medications, narcolepsy medications, certain seizure & migraine medications.

Purpose

I acknowledge that controlled substances are prescribed to manage specific medical conditions and must be used responsibly to avoid misuse, dependency, or diversion.

Patient Responsibilities

I will take medications exactly as prescribed.
I will not increase or decrease the dosage without prior approval from my provider.
I will not obtain duplicate controlled medications from any other provider, unless authorized.
I will not share, sell, or divert or give my medication to anyone.
I will keep medications secure and understand that lost/stolen prescriptions will not be replaced.
I agree to random urine or blood drug screens **[at my cost]** and/or pill counts as required.
I understand that misuse may result in dependence, withdrawal, and serious harm.
I will cooperate with pharmacy, practice or law enforcement if an investigation is required.
I will not use Illegal drugs including Cocaine, heroin, ECT, speed, crystal meth, THC etc.
I will follow practice policies in regards to refill requests, and required follow-up visits.

Clinic Responsibilities

The provider will explain risks, benefits, and alternatives to using controlled substances.

The provider may discontinue medications if:

1. I **violate** this agreement.
2. My condition no longer requires them.
3. There is evidence of misuse or diversion.

Termination of Treatment

Violation of this agreement may result in discontinuation of controlled substances and possible discharge from the clinic.

Consent to Alabama PDMP Review and historical data:

I authorize my provider to access my prescription history through the Alabama Prescription Drug Monitoring Program **(PDMP).** & permit to contact previous pharmacies or physicians to obtain information if needed.

_____ _____

Name of patient: **Date:**

Assignment of Benefits & Financial Responsibility Agreement

Assignment of Benefits

I hereby assign and authorize direct payment of all applicable insurance benefits to Tri city neurology , including any major medical benefits otherwise payable to me under the terms of my insurance. This assignment applies to all services provided to me including but not limited to medical evaluation, treatment, diagnostic testing, and procedures.

I understand that: This assignment of benefits will remain in effect until I revoke it in writing.

A photocopy or digital copy of this authorization shall be considered as valid as the original.

Financial Responsibility

I acknowledge and agree that:

I am financially responsible for deductibles, co-insurance, co-payments. Non covered or unauthorized services need to be discussed before hand as these will be billed to me directly. If my insurance company fails to pay Tri city neurology within a reasonable period , I may be billed directly and may be responsible for payment. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees, court costs, and interest, as permitted by law.

Patient Certification

I certify that the information I have provided regarding my insurance coverage is accurate and current. I understand and agree to the terms of this Assignment of Benefits and Financial Responsibility Agreement.

Patient's Signature: _____

Date: _____

If Patient is a Minor or Unable to Sign:

Authorized Representative Name: _____

Relationship to Patient: _____

Signature of Representative: _____

Authorization to Receive SMS/Text Messages

By signing this document, you authorize Tri city neurology to send you text messages (SMS and MMS) for purposes including

Acknowledging receipts

Appointment reminders

Billing and payment notifications

Prescription or treatment updates

Service or account alerts

Consent and Disclosures

By providing your mobile phone number, you agree and consent to receive such messages using automated systems or manual text communication. You understand and acknowledge the following Message & data rates may apply depending on your wireless carrier plan.

Consent is not a condition of purchase or service.

You may opt out of SMS communications at any time by replying "STOP" to any message.

If you need assistance or more information, reply "HELP" to any message or contact us directly at 256 362 9677

Text messaging is not guaranteed to be secure; you assume responsibility for any risks involved in receiving sensitive information by text.

Authorization Information

Full Name: _____

Mobile Number: (_____) _____ – _____

Date of Birth (if applicable): _____

Consent to Receive SMS: □ Yes □ No

Signature

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Tri city neurology is committed to protecting your health information. We are required by law to maintain the privacy of your protected health information (PHI) and to provide you with this notice of our legal duties and privacy practices.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and share your information for the following purposes without your written authorization: To provide and coordinate your healthcare and other services. To bill and receive payment from health plans or other entities. For quality assessment, training, licensing, audits, and general operations. To comply with laws, court orders, or government regulations. To prevent disease, report adverse events, or for public health investigations. To respond to legal actions, subpoenas, or law enforcement inquiries. Coroners, To assist in identifying deceased persons or determining causes of death. To comply with laws related to work-related injuries.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: We will not use or share your information without your written authorization for marketing, or Sale of your health information,

You may revoke your authorization at any time in writing.

YOUR RIGHTS: You have the right to get a copy of your medical record [Fees may apply to cover costs] . Request corrections to medical record, request confidential communications and to contact you in a specific way or place. You can ask us not to share certain health information, though we are not required to agree. Get a list of disclosures. Receive a copy of this notice. If you believe your privacy rights have been violated, you can file a complaint with us or with the U.S. Department of Health and Human Services.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy of your health information. We will let you know promptly if a breach occurs that may compromise the privacy or security of your information. We must follow the duties and privacy practices described in this notice.

CHANGES TO THIS NOTICE: We reserve the right to change the terms of this Notice at any time. The updated Notice will be available in our office and on our website, if applicable.

CONTACT US : If you have any questions about this notice or wish to file a complaint, please contact: Tri City neurology

200 Battle street East, Talladega, AL 35160 , TEL : 256 362 9677 FAX: 256 362 9676