 SETH TUWINER, M.D.

##  Riverside Office Park

 19490 Sandridge Way• Suite 260 • Lansdowne, VA 20176

 Office 703.293.5244 • Fax 703.858.5323

 [WWW.VANEUROLOGY.COM](http://WWW.VANEUROLOGY.COM)

## DATE:

CO-PAY:

NAME: DATE OF BIRTH:

ADDRESS

MARITAL STATUS: SS#:

HOME#: WORK PHONE#: CELL#:

PLACE OF EMPLOYMENT:

ADDRESS OF EMPLOYER:

## SPOUSE/PARENT NAME:

SPOUSE/PARENT PLACE OF EMPLOYMENT:

ADDRESS OF EMPLOYER:

PHONE NUMBER:

EMERGENCY CONTACT:

PHONE NUMBER:

 **PRIMARY INSURANCE COMPANY**

NAME OF SUBSCRIBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:

 SUBSCRIBER'S DOB:

 MEMBER ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 INSURANCE CO. ADDRESS:

INSURANCE CO. PHONE #:

**SECONDARY INSURANCE COMPANY**:

NAME OF SUBSCRIBER: SS#:

## SUBSCRIBER'S DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  MEMBER ID # GROUP#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE CO. ADDRESS:

INSURANCE CO. PHONE #:

**FOR WORK RELATED INJURIES**

DATE OF INJURY: REPORTED TO SUPERVISOR 🞏YES 🞏 NO

## NAME OF SUPERVISOR: PHONE#:

WORKERS COMPENSATION INSURANCE CARRIER

MAILING ADDRESS

PHONE #: CLAIM#

CASE MANAGER NAME: PHONE#: FAX#:

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**Please answer ALL questions** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name How did you hear about this practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician’s name:

Birth date:\_\_ Age Height Weight

🞏 Right-handed 🞏 Left-handed

 Current Medications (list: Name, Dose, Frequency) or 🞏 None

Allergies 🞏Yes 🞏No

Reason for visit

Date of symptom onset

Medical/Surgical History

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### Social History

Marital Status Occupation

Number of children

 If yes, how much**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/**day

Do you smoke? 🞏Yes 🞏No

If yes, how much**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

🞏No

 Do you consume alcohol? 🞏Yes

🞏Yes 🞏No If yes, what type?

 Do you use Drugs?

 Have you recently traveled? (Dates/location):

### Family History

Mother’s side Father’s side

YES NO YES NO

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Hypertension

Diabetes Mellitus

High Cholesterol Heart Disease

Stroke

Cancer

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Neurological Conditions

Parkinson's disease

Multiple Sclerosis

Epileptic

Other

(If other, and/or neurological condition(s) exist, please specify)

Additional relevant medical history/information

Patient Signature Date

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Dear Patient,

HIPAA regulations prohibit your physician from sharing information regarding your medical care with other family members or friends unless prior authorization by the patient is given.

I, authorize Dr. Seth Tuwiner and his staff to disclose my medical information to the following family members or close friends who assist in my care.

NAME: RELATIONSHIP:

Please check all that apply for calls that are made to you from Dr. Tuwiner or staff:

 Messages may be left on my cell phone

 Messages may be left on my home phone

 Do not leave messages on any phone number

Patient signature Date

Please be advised, it is your responsibility to keep this information up to date regarding adding or removing names from your disclosure list.

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# ASSIGNMENT OF BENEFITS

As the patient whose name appears below, I hereby authorize Seth Tuwiner, M.D., Neurology Consultant Services, P.C to file on my behalf for payment for any medical benefits arising out of any insurance covering me and hereby assigning the benefits to Seth Tuwiner, M.D., Neurology Consultant Services,

P.C. for application on the patient's bill. I certify that the information reported with regard to my insurance coverage and medical history is accurate and complete and further authorize the release of necessary information, including medical information, for this or any related claim or medical benefits. I permit photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Seth Tuwiner, M.D., Virginia Center for Neuroscience, for all co-insurance, co-pays, and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Seth Tuwiner, M.D., Virginia Center for Neuroscience Furthermore, I will be responsible for payment of charges not covered by my insurance plan.

Payment is requested at the time of services are rendered. If expensive or extended treatment is anticipated, arrangements may be made for a payment plan. All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of the insurance carrier. Seth Tuwiner, M.D., Virginia Center for Neuroscience will bill charges to the primary and/or secondary insurance carrier. Seth Tuwiner, M.D., Virginia Center for Neuroscience will bill the remaining amount to the patient. Any balance due, for whatever reason, i.e. co-payments, failure to have proper referral, denial of workers compensation benefits, is the patient's responsibility. Payments for charges which are the patient's responsibility are to be paid within 30 days. The patient/guarantor signing below accepts responsibility for payment. Should the patient's account be turned over for collection/and or an attorney for payment due, the patient and/or guarantor shall pay any collection costs and/or reasonable attorney fees. The staff will gladly assist you with any aspect of this policy.

Patient Signature Guarantor Signature

# CANCELLATION POLICY

**IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, WE REQUIRE 24 HOURS NOTIFICATION IN ORDER TO AVOID**

**A $75.00 FEE.**