WILMINGTON NEUROLOGY CONSULTANTS, P.A.

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WELCOME TO WILMINGTON NEUROLOGY CONSULTANTS

We are glad that you have chosen one of our physicians to attend to your neurological care. As a group, we are dedicated to providing compassionate, ethical, state of the art care through the combined strength of our physicians. These new patient forms will help facilitate your time in the office and ensure we have all the information necessary to process your insurance claims. Please fill them out completely.

CHECKLIST FOR YOUR APPOINTMENT:

1. Please arrive 15 minutes prior to your scheduled time.
2. Bring completed paperwork, **CURRENT INSURANCE CARDS**, and your ID.
3. Bring all relevant imaging studies and reports.
4. Ask your primary care physician (PCP) to forward all relevant medical records and lab results to our fax 302-892-9407
5. Determine if you need an **INSURANCE REFERRAL** to see us. HMOs in particular will need this so look on your insurance card or call the customer service number to determine its requirements. If your insurance needs a referral to see a neurologist, your PCP must request one and you should have this referral with you or the referral number from the insurance carrier to bring to our office. If you have Medicare but opted into a Medicare Advantage Plan, you will need to check to see if our doctors participate with your chosen plan. If you do not have the required referral or authorization to see us, your insurance company will not pay for the visit and you will be responsible for the visit, or be forced to reschedule to get the referral incurring a late cancellation charge. Unfortunately, we cannot get this paperwork after the appointment.
6. Be prepared to pay any copay at the time of the visit, as well as other outstanding balances from prior appointments.

CANCELLATION POLICY

We require a minimum of 24 hours' notice (business days) of cancellation for all appointments. Both late cancellations, and missed appointments will incur the charge. You will be charged $75.00 for any missed new patient appointment (1 hour set aside for your care) and missed EMG appointments (1 ½ hours set aside for your care). There is a $35.00 charge for missed follow up and EEG appointments.

If you have any questions, please call our office at 302-892-9400 and we will be happy to address your concerns. We look forward to seeing you soon.

William Sommers, D.O.
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ADULT NEUROLOGY · ELECTROENCEPHALOGRAPHY · ELECTROMYOGRAPHY · SLEEP MEDICINE
Suite 407, Medical Office Building
701 North Clayton Street, Wilmington, DE 10805
302.892-9400 phone * 302.892.9407 fax

PATIENT INFORMATION
PLEASE FILL OUT THIS FORM COMPLETELY

Name_____ Date of Birth_____
(First) (M.I.) (Last)
Address:_____ City_____ State_____ ZIP_____

Home Phone_____ Cell Phone_____
Preferred Phone is Home/ Cell (Circle One)

May we leave detailed message? Circle: Yes/No Email_____

SSN_____ Age_____ Gender_____ Marital Status (Circle) S, M, D

Occupation:_____ Student Y/N____ Full/Pt Time_____ School_____

Spouse/Parent (Name)_____ DOB_____ SSN_____
(Circle one)

Spouse/Parent/Employer_____ Phone_____ Ext._____
(Circle One)

Address (if different)_____

Person Responsible for Payment_____

Emergency Contact_____ Relationship_____ Phone_____

Primary Care or Family Physician _____ MD, DO

Primary Care/Family Physician Address_____

City_____ State_____ Zip_____ Phone_____

Preferred Pharmancy_____ Phone_____

Preferred Pharmacy Address_____

INSURANCE INFORMATION

Primary Insurance Company_____
(Present Card for Copying)

SecondaryInsurance Company_____
(Present Card for Copying)

Is this visit related to AUTO ACCIDENT? Circle: Yes/No WORKMAN'S COMPENSATION? Circle Yes/No

Name of Insurance Carrier_____ Address_____

Date of Accident or Loss_____ Claim #_____

Contact Person_____ Phone_____

Name: _____ **D.O.B:** _____

Briefly Describe Reason for Visit: _____

_____

Medical History Review of Systems

Please **CIRCLE ALL** conditions that apply. Please check NO if none of the conditions apply.

System Review	Circle all that apply (Presently)	No	Comments/Other
Body/General	Recent weight loss? Recent Change in Appetite? Fever? Easily Fatigued?		
Sleep	Poorly Refreshing Sleep? Loud Snoring? Noted to Stop Breathing while Sleeping?		
Gastrointestinal	Frequent Diarrhea? Frequent Constipation? Abdominal Pain? Frequent Nausea? Heartburn? Dry Mouth?		
Respiratory	Shortness of breath? Frequent Coughing? Nasal Discharge?		
Urinary System	Trouble emptying bladder? Burning when Emptying Bladder?		
Skin	Rashes? Itching? Swollen Lymph Nodes? Bruise Easily?		
Psychiatric	Feeling Distressed? Feeling Anxious? Hallucinations?		
Musculoskeletal	Muscle Aches? Joint Pain? Joint Swelling? Arm or hand Pain? Leg Pain?		
Cardiovascular	Chest Pain? Feel Heart Racing or Beating Irregular?		
Eyes, Ears, Nose and Throat	Eye Pain? Sore Throat? Ear Pain? Ringing in the Ears? Sinus Pain or Pressure? Recent Changes in Hearing? Recent Change in Sense of Smell? Change in Taste?		
Endocrinology	Diabetes, intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue		
Reproductive (as Applicable)	Change in Menstrual Periods? Problems with Sexual Function?		
Neurological	Headache? Memory Loss? Trouble Talking? Blurred Vision? Double Vision? Weakness? Trouble Walking? Clumsiness? Trouble Swallowing		
Other Medical Problems	Cancer, infectious disease, HIV, autoimmune disease?		

My medication and dosages:_____

_____

_____

Allergies to Medicine?_____

Have you had the flu shot? Y/N If yes, date of shot: _____-

Have you had the covid shot? Y/N, if yes what type and date: _____

Are you pregnant or nursing? Y/N, if yes due date: _____

Berlin Questionnaire©
Sleep Apnea

Height _____ Weight _____ Age _____ Male / Female

Please choose the correct response to each question.

Category 1

1. Do you snore?
□ a. Yes
□ b. No
□ c. Don't know

If you answered 'yes':

2. You snoring is:
□ a. Slightly louder than breathing
□ b. As loud as talking
□ c. Louder than talking

3. How often do you snore?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

4. Has your snoring ever bothered other people?
□ a. Yes
□ b. No
□ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ □ e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
□ a. Yes
□ b. No

If you answered 'yes':

9. How often does this occur?
□ a. Almost every day
□ b. 3-4 times per week
□ c. 1-2 times per week
□ d. 1-2 times per month
□ e. Rarely or never

Category 3

10. Do you have high blood pressure?
□ Yes
□ No
□ Don't know

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

_____ _____

Signature Date

AUTHORIZATION

RELEASE OF INFORMATION: I hereby authorize Wilmington Neurology Consultants, P.A. to release any information required to process insurance claims on my behalf. I understand that I am financially responsible for charges that are not covered by my insurance policy.

_____ _____

Signature Date

Print Name (Indicate if Guardian/POA)_____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance carrier, including Medicare and Medicaid, to send payments of benefits directly to Wilmington Neurology Consultants, P.A. for services rendered to me.

_____ _____

Signature Date

Print Name (Indicate if Guardian/POA)_____

WILMINGTON NEUROLOGY CONSULTANTS, P.A. FINANCIAL POLICY (8/21)

INSURANCE WE CURRENTLY TAKE:

We currently take Medicare, Delaware Medicaid, including Health Options and Amerihealth Caritas of Delaware, Aetna, and Blue Cross Blue Shield. We do not take out of state Medicaid. We are out of network for United Health Care, Cigna and Humana. We take only some Medicare advantage plans.

There are frequent changes in the area of insurance, with new insurance products being introduced all the time. Please call the customer service number on your insurance card to see if we are in your network. You are responsible for obtaining any necessary referrals from your primary care physician or insurance company. Anyone who does not have the required referral or cannot present a valid insurance card to the receptionist will be responsible for payment in full at the time of the service or will be subject to rescheduling. Co-payments must be paid upon arrival in the office. Insurance is a contract between you and your insurance company. Our office files claims as a courtesy to our patients and will assist when we can in getting the claims paid. Your insurance company may need information from you directly and it is your responsibility to cooperate with their request.

PAYMENTS FOR SERVICES: Our office accepts credit cards, checks and cash. Invoiced balances are due upon receipt. We use the billing service, Arete Healthcare Services, who can discuss your balance at any time (302-456-5725). Delinquent balances, past 90 days, will be sent by the billing company to a collections agency which will incur additional fees. Payment in full of overdue past balances is expected prior to future appointments. In case of hardship, payment plans can be arranged with our billing company.

MISSED APPOINTMENTS: We require a minimum of **24 hours' notice** to cancel an appointment to avoid cancellation charges. Monday appointments cancelled during the weekend will be considered late. As a specialty practice, all appointments are reserved for you alone. When you make an appointment and: 1) fail to show up; 2) cancel your appointment with less than 24 hours' notice; or 3) arrive too late to be seen on the day of the appointment, you will be billed **$75.00** for new patient and EMG appointments, and **$35.00** for follow up and EEG appointments. Appointments will not be rescheduled until the fees are paid. A patient with multiple no shows and late cancellations may be discharged from the practice.

RETURNED CHECKS: A fee of $35.00 will be charged for returned checks.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for charges to my account for all professional services rendered to me. I have read the above document and agree to the office policies stated therein.

SIGNATURE: _____ DATE: _____

PATIENT CONSENT FORM AND HIPAA COMPLIANCE
WILMINGTON NEUROLOGY CONSULTANTS, P.A.

The Department of Health and Human Services has established a privacy rule for personal health care information under the Health Insurance Portability and Accountability Act (HIPAA). As our patient, we want you to know that we respect the privacy of your medical records. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations.

We want you to know we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purpose of treatment, payment, or health care operations. These entities are usually not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information as described above, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI) in a way needed to properly care for you and operate our health care office. If you choose to give your consent in this document, at some future time you may withdraw consent to the disclosure of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA compliance officer. To indicate your consent to our policy, please sign below.

Print Name: _____

Signature: _____ Date:_____

Compliance Assurance Notification for Our Patients

We want our valued patients to know that all of our employees, manager, and health care providers undergo training so that they may understand and comply with HIPAA with an emphasis on the privacy rule. We strive to achieve the very highest standard of ethics and integrity in performing services for our patients.