5673 Peachtree Dunwoody Rd, Suite 300
Atlanta, GA 30342
Phone 404.255.2670 • Fax 404.255.2654

GERALD SILVERBOARD, MD
ATLANTA CHILD NEUROLOGY
SPECIALIST IN CHILD AND ADOLESCENT NEUROLOGY

3400-A Old Milton Pkwy, Suite 210
Alpharetta, GA 30005
www.AtlantaFamilyNeurology.com

PATIENT INFORMATION: - *Please Fill Out* COMPLETELY

FOR OFFICE USE ONLY

Date	Account#	Referral Provider Email

Last Name	First Name	Middle Initial	Date of Birth

Street Address	City	State	Zip
Billing Address (If different from above)	City	State	Zip
Employer	Occupation		
Home Phone	Work Phone	Cell Phone	
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated	❒ Male ❒ Female	Social Security #	Email Address
Pharmacy Name	Pharmacy Phone		
Pharmacy Address	City	State	Zip

PRESENT RESPONSIBLE PARTY/GUARANTOR (see financial policy) ❒ Check if self and skip to next section

Name	Date of Birth	Social Security #

Billing Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Employer	Relationship to Patient		

IN CASE OF AN EMERGENCY, NEAREST RELATIVE / FRIEND NOT RESIDING AT THE SAME RESIDENCE

Name	Relation	Phone

Street Address	City	State	Zip

INSURANCE INFORMATION

Primary Insurance Company	Policy Number	Group Number

Insurance Phone	Policy Holder Name	
Relationship to Patient	Policy Holder SSN	Policy Holder Date of Birth

Secondary Insurance Company	Policy Number	Group Number

Insurance Phone	Policy Holder Name	
Relationship to Patient	Policy Holder SSN	Policy Holder Date of Birth

Referring Physician	Phone		
Address	City	State	Zip
Primary Care Physician (if different from above)	Phone		

I hereby authorize Atlanta Child Neurology and affiliates to release any medical information necessary to process any and all claims filed by them. I understand that I am financially responsible for all charges incurred, regardless of what insurance coverage I may currently have.

I hereby authorize payment directly to Atlanta Child Neurology and affiliates for all insurance services performed as specified on the attached insurance claims.

I hereby authorize any hospital and / or physician to disclose and release to Atlanta Child Neurology and affiliates any and all information that may have been obtained in connection with physical examination or surgical and / or medical treatment with the understanding that any information obtained will be treated as confidential.

I have read and received a copy of Atlanta Child Neurology's *Notice of Privacy Practices*. This notice describes how health information about you (as a patient of this practice) may be used and disclosed. This notice also explains how you can get access to your individually identifiable health information.

Signature:_____ Date:_____

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FINANCIAL POLICY

Thank you for choosing Atlanta Child Neurology as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship. *It is your responsibility to keep us informed of any insurance carrier changes before your appointment date and to make any necessary payments at the time of service or you may be asked to reschedule your appointment.*

Co-pays

The patient is expected to present the insurance card and a form of identification at each visit. All co-payments, co-insurances, deductibles and past due balances are due at the time of check-in unless previous arrangements have been made with the Financial Department. Absolutely no post-dated checks will be accepted. Although we estimate what your insurance company may pay as well as estimate your patient liability, it is the insurance company that makes the final determination of your eligibility and benefits. Any other balances deemed the patient responsibility by your insurance company after the processing of your claim will be billed to you. *Payment is due within 30 days of receipt of the bill.*

Returned Checks

The Bank Fee for a returned check is $50 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. Please make immediate financial arrangements prior to your appointment, if there is a possibility of insufficient funds. You may be placed on a cash only basis following any returned check.

Coordination of Benefits (COB)

COB is a provision used to establish the order in which health insurance plans pay claims when more than one plan exists. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance. It is imperative to keep both your insurance company and your physician updated on any COB changes. Failure to report any changes to us or to your insurance carrier may result in a re-filling fee of $25 or may result in patient responsibility for the entire bill.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your insurance company as a courtesy to you. We are members of most insurance plans but not all of them and we are required per our agreement with insurance carriers to collect all patient's cost share, deductibles, co-pays and co-insurances. We are not allowed to write them off. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. Should your insurance fail to pay for any reason, you are responsible for the balance. We make every attempt to know the specifications of your policy, however, it is ultimately your responsibility to understand your insurance policy. Atlanta Child Neurology expects you to be interactive and responsible for communicating with your insurance carrier on any open claims. We will transfer liability of the claim to you if your insurance does not pay properly within 45 days.

Outstanding Balance Policy

It is our policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections cost including attorney fees and court costs. If you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service.

Minors

The parent(s) or guardian(s) present in the office and signing this financial policy and/or the release to treat is the guarantor, and therefore responsible for full payments and billing statements.

Refund Policy

It is the guarantor's responsibility to initiate a written request for a refund on an overpayment. Refunds are only released to the guarantor on the account or the issuant of the payment in excess. Before an overpayment check can be issued, all open claims must be closed. Please allow at least 30 days for processing and the issuance of a refund check.

Referrals
Most insurance plans require a referral from your primary care physician or pediatrician to see a specialist. If your plan requires a referral, it is your responsibility to obtain the referral and make sure we are in receipt of it two business days before your appointmen.t. If not, your appointment may be rescheduled.

Appointments & Cancellations
If you miss your appointment and did not cancel your appointment at least 24 hours before the appointment time, you may be charged a $50.00 Cancellation/No-show fee. In order to provide continuity of care and to best assess effectiveness of medications, follow-up visits are typically required for prescription refills. Consequently, keep your designated follow-up appointments in order to avoid running out of medications. For a routine prescription refill, please contact your pharmacy, and, if necessary, the pharmacist will call our office. For other requests, please note that prescriptions and refills for medications are issued weekdays during office hours. Prescription refills must be requested before 3:00 PM Monday – Thursday and before 12:00 noon on Fridays. Otherwise, the request will be fulfilled on the following business day. No narcotics will be filled on weekends. Please have your prescription and pharmacy phone number available when requesting refills.

Administrative Services
Our goal is to provide the best medical care possible in a supportive and caring environment. However, some of our services are not covered by insurance. To continue these essential services we have developed a fee schedule which represents the cost of each service to our office. As a courtesy to our valued patients, we offer an optional umbrella benefit which covers all services for a single fee of $97.00, due at the time of your first visit and then annually. If you do not wish to pay the annual fee before requiring any of the listed services, you will be charged for administrative services individually as you request them. **You cannot pay the annual Administrative Services Fee at the time you request one of these services.**

Form Completion:

- Disability forms - $75.00
- Letter of Medical Necessity - $35.00
- Family Medical Leave Act (FMLA) forms - $50.00
- Life insurance forms - $75.00
- School and work excuse/absence forms:
  - Free when requested at the time of your appointment.
  - After leaving our office, a $10.00 fee may be assessed.

Medical Records:

- Copy of medical records - $35.00 minimum. If record is in excess of 25 pages, additional fees may be required.
- Other Reports: extra claims, statements, payment histories, etc. (generally used for flex benefit plans and/or yearly tax needs) - $20.00
- Requests must be submitted in writing and received in our office **one business week** prior to the date that records are needed.
- When records are sent to healthcare providers you have been referred FROM or TO, no fees are assessed.

Other administrative services not covered under your insurance plan: *Fee determined at time of request.*

❒ *I wish to pay the annual Administrative Services Fee of $97.00 at this time.*

❒ *I choose NOT to pay the annual Administrative Services Fee.*
I understand that I will pay for the services listed above as I request them.

I, _____ , hereby acknowledge I have read and fully understand the financial policy of this office. I also understand that my signature authorizes employees and physicians of ATLANTA CHILD NEUROLOGY, PC to provide treatment to me. My original signature shall be valid as the Release, Assignment and responsibility for my insurance company including MEDIGAP for the purpose of billing.

_____ _____ _____
Signature Date Patient Name (Print)

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. **Please review it carefully.**

Protected Health Information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with Atlanta Family Neurology. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Atlanta Family Neurology is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Our practice is now participating in the Emory Health Information Exchange (HIE). When it comes to your healthcare, it is important for all members of your care delivery team to have details about your current and past medical information. This is why Emory Healthcare has made it easy for you to get this information to your providers through the HIE, an electronic network that allows approved providers within the Emory HIE network to securely share and view your health information. For more information, visit emoryhealthcare.org/ehealthexchange

Your Health Information Rights

Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making any decision about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. We will respond in writing within 60 days of your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment;
- The information is not part of the record which you are permitted to inspect and copy:
- The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

We will respond within 60 days, in writing, explaining of the request was accepted or denied.

Request an alternative means of confidential communication: You have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, {using a form provided by our practice}, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

Request a restriction of your PHI: This means you have the right to ask us, in writing, not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction

An accounting of Disclosure: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will accommodate all reasonable requests.

A Paper copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit by calling and asking us to mail you a copy.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us, or directly to the Secretary of Health and Human services.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints/

Authorize other use and disclosure: You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization.

We may contact you to provide information about health related benefits and services offered by our office, for fundraising activities, share information in a disaster relief situation, include your information in a hospital directory, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Ways in Which We May use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health Information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example - we should disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Health care operations: We will use and disclose your protected health information to support the business activities of our practice. For example we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third-party business associates who perform billing, consulting, or transcription services for our practice.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example - we may include information with a bill to a third- party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Other Ways We May Use and Disclose Your Protected Health Information

Public health: We will use and disclose your protected health information in certain situations to help with public health and safety issues. Some of the situations include:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law: We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

Other Permitted and Required Uses and Disclosures: We are also permitted to use or disclose your PHI without your written authorization for the following purposes:

- To comply with Food and Drug Administration requirements
- Legal proceedings
- Coroners
- Funeral directors
- Organ donation
- Criminal activity
- Military activity
- National security
- Worker's compensation
- When an inmate is in a correctional facility
- If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form you acknowledge you were advised of the HIPAA Notice of Privacy Practices. Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.

Signature of Responsible Party

Date

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Last Name	First Name	Middle Initial	Date of Birth
Referring Physician		Primary Physician, if different from Referring Physician	
❒ Male ❒ Female	Form completed by(print name):	❒ Mother ❒ Father ❒ Other	Handedness: ❒ Right ❒ Left

WHAT IS THE MAIN REASON YOU ARE SEEING A NEUROLOGIST? Describe onset, when, where, frequency, duration. What makes it worse or better?

Review of Systems - Check if your child has had any of the following symptoms and explain.

System	Symptom	Explain
Constitutional	❒ Fever ❒ Weight Loss ❒ Fatigue ❒ Recurrent Infection ❒ Unusual Odors Of Body Fluids	
Eyes	❒ Double Vision ❒ Loss Of Visual Acuity ❒ Blurring ❒ Cataracts ❒ Strabismus ❒ Need For Glasses	
Ears, nose and throat	❒ Hearing Loss ❒ Ringing In The Ears ❒ Vertigo ❒ Aural (Ear) Discharge ❒ Infections ❒ Congestion ❒ Hoarse Voice ❒ Difficulty Swallowing ❒ Dental Symptoms	
Respiratory	❒ Shortness Of Breath ❒ Wheeze ❒ Cough ❒ Coughing Up Blood ❒ Blue Discoloration ❒ Altered Pattern Or Breathing	
Cardiovascular	❒ Chest Pain ❒ Abnormal Rate Or Rhythm ❒ Abnormal Blood Pressure ❒ Shortness Of Breath ❒ Swelling Of Ankles	
Gastrointestinal	❒ Diarrhea ❒ Constipation ❒ Nausea ❒ Vomiting ❒ Rectal Bleeding ❒ Black Tarry Bowel Motions ❒ Weight Loss Or Gain ❒ Jaundice ❒ Specific Food Intolerance Or Aversion	
Genitourinary	❒ Blood In The Urine ❒ Pain On Urination ❒ Loin Pain ❒ Impotence	
Skin, hair, nails	❒ Dark Or Light Patches On The Skin ❒ Rash ❒ Changes In Hair Or Nails	
Musculoskeletal	❒ Joint Pain Or Swelling ❒ Small Lumps Under Skin ❒ Skeletal Deformities	
Psychiatric	❒ Mood Changes ❒ Delusions ❒ Hallucinations	
Endocrine	❒ Symptoms Of Thyroid ❒ Adrenal ❒ Islet Cell ❒ Parathyroid Disease	
Hematological and lymphatic	❒ Pale Appearance ❒ Enlargement Of Lymph Nodes ❒ Loss Of Energy ❒ Abnormal Bleeding Or Clotting	
Allergic	❒ Running Nose ❒ Eyes, Or Skin Redness Or Swelling	
Neurological	❒ Abnormalities Of Higher Function (Including Speech And Language) ❒ Strength ❒ Coordination ❒ Sensation ❒ Development ❒ Headaches ❒ Seizures Or Other Spells	

List all surgeries and recent hospitalizations, include date

Major accidents or injuries

Allergies to Medications – List medications and reactions

Medications, Supplements

Name	Dose	Frequency	Name	Dose	Frequency
1			4		
2			5		
3			6		

Family History – Check and list relationship (i.e. mother, father, paternal aunt or uncle, maternal grandfather, etc) if any blood relative has had the following:

☑		Relative	☑		Relative
❒	Similar type of illness that your child has now		❒	Parkinson's disease	
❒	Stroke		❒	Anxiety, Depression, Panic Attacks or OCD	
❒	Alzheimer's or dementia		❒	High Blood Pressure	
❒	Migraines		❒	Diabetes	
❒	Seizure disorder or epilepsy		❒	Cancer	
❒	Muscle disease		❒	Blood Clotting Disorder	
❒	Nerve disease or neuropathy		❒	Brain aneurysm (brain bleeding)	
❒	Tremor, Dystonia, Tics		❒	Other:_____	

Birth History

Did you carry your child for the full 9 months? ❒ Yes ❒ No If no, how long?		
Child's birth weight?	Birth length?	Delivery ❒ Vaginal ❒ C-Section
If C-Section, why		
Medications during pregnancy ❒ Yes ❒ No If yes, specify: ie. prescription meds, alcohol, tobacco etc		
Problems during pregnancy, labor/delivery or following the birth? ❒ Yes ❒ No If yes, specify		

Developmental History – At what age did your child

Roll over		Sit		Crawl	
Stand		Walk		Jump	
Pick up object with 2 finger grasp		Use spoon		Cut with scissors	
Say first words		Speak in sentences		Learn colors	
Count 1 - 10		Toilet Train			

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Release of Medical Records

Please allow 7-10 business days to receive records.		For questions, please call 404-255-2670	
Patient Name		**Date of Birth**	

❒ Release of records FROM:

Physician Name		**Practice Name**	
Physician Address			
Physician Phone		**Fax**	

❒ OR Release of records FROM:

Atlanta Family Neurology
5673 Peachtree Dunwoody Rd, Suite 300
Atlanta, GA 30342
404/255-2654 (fax)

Please release the following information:

❒ **MRI**	❒ **Office Notes**	❒ **CT**	❒ **EKG Report**
❒ **Hospital Notes**	❒ **EEG Report**	❒ **Labs**	
❒ **Other (specify):**			

❒ **I do**	❒ **I do not**	**Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus.)**
❒ **I do**	❒ **I do not**	**Authorize release of information related to psychological assessment and treatment for alcohol and/or drug abuse.**

❒ Release of records TO: ❒ Physician ❒ Other (specify):

Name		**Practice Name (If Applicable)**	
Address			
Phone		**Fax**	

❒ OR Release of records TO:

Atlanta Family Neurology
5673 Peachtree Dunwoody Rd, Suite 300
Atlanta, GA 30342
404/255-2654 (fax)

This authorization will expire on	

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Atlanta Family Neurology, PC has acted in reliance upon this authorization. My written revocation must be submitted to Atlanta Family Neurology's Privacy Officer at 5673 Peachtree Dunwoody Rd, Suite 300, Atlanta, GA 30342. Some releases may be subject to a fee as allowed under GA State Law 0.C.G.A. 31-33-3.

Patient or Guardian Signature _____ Date _____ Patient Name (Print) _____

ATLANTA FAMILY NEUROLOGY
GERALD SILVERBOARD, M.D.

TEST RESULTS

Any and all test & labs will not be discussed over the phone. It is your responsibility to call the office to schedule a follow-up appointment to review your results

ATLANTA FAMILY NEUROLOGY
ATLANTA CHILD NEUROLOGY

Discharge Checklist

Patients are expected to return for a follow-up visit as directed by the physician to discuss results.

- Genetic test results generally are available within 10-12 weeks.
- Routine drug level studies may take 3 to 5 days.
- Routine medical problems are responded to within 24 to 48 hours.
- MRI results are available by follow-up appointment 48 to 72 hours after test has been performed to allow for receipt and physician review.
- EEG results are available by follow-up appointment in 5 days.

FOR OFFICE USE ONLY

Test	**Referrals**
☐ EEG	☐ Neuropsychology
☐ MRI	☐ Ophthalmology
☐ NCV	☐ Genetics
☐ EMG	☐ PT, OT, SP
☐ LABS	

A follow-up visit for formulation of a care plan is **still expected**.

Please allow 10 business days for test authorization and scheduling. If you have not been contacted within 10 days by our office, please call the office to:

- ✓ Verify the tests were ordered and authorized by your insurance company.
- ✓ Schedule a follow-up appointment to discuss test results.

Please Note: Authorizations do expire. Any diagnostic testing not performed within the allotted authorization window will not be reauthorized and rescheduled, which will delay your diagnosis.

Our office requires 24 hour notice when canceling or rescheduling appointments or you will incur a $50.00 cancellation fee (NO EXCEPTIONS)
For EEG appointments, we require 72 hours notice when cancelling or rescheduling or you may incur a $100.00 fee (NO EXCEPTIONS)

Atlanta Family Neurology is always available to discuss emergency medical concerns in a timely fashion.

Patient/Guardian Signature: _____ Date _____

Print Name: _____

Print Form Clear Form Save Form

www.AtlantaFamilyNeurology.com Phone (404) 255-2670 Fax (404) 255-2654