Neurology Center of Wichita

Dr. Subhash Shah, M.D and Kathryn Welch, PA-C

220 S. Hillside Wichita, KS 67211· Phone: 316-686-6866· Fax: 316-686-9797-website: www.pedsbrain.com

In order for the doctor to better provide you with a complete and thorough evaluation, the enclosed forms should be completely filled out prior to your appointment. If something does not apply to the patient or you do not know the answer please state so by writing "unknown" or "n/a". Do not leave any questions or requested information blank. If you have any questions or need clarification on any of these forms please call our office at 316-686-6866 and we will be happy to help you.

We are committed to providing you with the best possible care. Your clear understanding of our office and financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Check list of what we will need prior to or at time of appointments and Financial policy

Please initial the spaces provided on 1-11 that you agree and understand.

1. _____You **MUST** bring your child/patient to all appointments. Most insurance companies will not pay for the visit if the patient is not present for the appointment. If the patient is under the age of 18 they must have a parent or legal guardian with them at every appointment.
2. _____Please bring all insurance cards or a clear copy of the front and back of cards.
3. _____ If your insurance policy requires a referral it must come from the PCP you are locked in with. Please request a referral from your physician BEFORE your appointment. If we do not have the referral at the time of check in, you must sign a waiver accepting financial responsibility for the appointment or choose to reschedule.
4. _____Has the patient had an **EEG, Video EEG, MRI or CT, Head ultrasound?** If so, the doctor will need a CD of actual films, not just the report. If **EMG/NCT, lab work or genetic testing done; if you have seen a specialist such as another neurologist, psychologist, geneticist or developmental pediatrician; if you have had any hospitalizations or ER visits related to this visit PLEASE INFORM US BEFORE THE DAY OF YOUR APPOINTMENT SO WE CAN GET THOSE RECORDS BEFORE YOU ARE SEEN.**
5. _____Please bring a list of all current medications from all providers.
6. _____Bring any legal documentation regarding custody situations and/or legal guardianship. **We will not get involved in divorce situations**. If one parent is legally not to have information regarding a patient, we must have documentation supporting that.
7. _____ **CO-PAY, CO-INSURANCE & DEDUCTIBALE** are **due at the time of service** unless payment arrangements are made prior to appointment. **Patients without insurance will be expected to pay half of the cost at the time of the appointment.** We accept cash, check, MasterCard, Visa.
8. _____Financial arrangements/ payment plan options are available if needed. Please call and speak with billing department at 316-686-6866X216 to make arrangements prior to appointment. Services must be paid promptly in accordance with terms and agreements. In the event of default to pay, by insurance or myself, I agree to pay collection charges, and/or attorney fees. I hereby assign payment directly to Neurology Center of Wichita for the medical benefits, if any, for services as described.
9. _____ Patients with **Kancare/Medicaid** must keep our office informed of **ALL insurance coverage**. You must inform KS Medicaid and managed care plan (Sunflower, Amerigroup, United Health Community Plan) of all insurance policies that cover the patient. Failure to do so will result in responsible party owing the full balance**. All claims legally must be filed with primary coverage before it can be filed to secondary Kancare/Medicaid.**
10. _____**You will be charged a $25 fee** if you do not show up for your appointment or the appointment is not cancelled/rescheduled **24 hours PRIOR** to appointment time
11. _____All concerns/questions need to be directed to the office by phone. Please do not communicate by email as it is not always reliable and your concerns may not be addressed in a timely manner.

Insurance is a contract between you and your insurance company. We WLL NOT become involved in disputes between you and your insurance regarding deductible, co-payments, covered charges, coordination of benefits or other matters regarding reimbursement**. IF YOUR INSURANCE HAS NOT PAID IN 120 DAYS, THE AMOUNT DUE WILL BECOME YOUR RESPONSIBILITY.**

Primary Insurance: _____
Card holders name as shown on card
_____
Policy ID # _____
Group # _____
Insurance requires referral YES or NO
Locked in provider name_____
Effective date _____/_____/_____
Date of Birth of card holder_____/_____/_____
Relationship to patient_____
SS #_____-_____-_____
Employer_____

Secondary Insurance _____
Card holders name as shown on card
_____
Policy ID # _____
Group # _____
Insurance requires referral YES or NO
Locked in provider name_____
Effective date _____/_____/_____
Date of Birth of card holder_____/_____/_____
Relationship to patient_____
SS # _____-_____-_____
Employer_____

****Tips to help your claims process smoothly****

*Always respond to information requested from your insurance company even if you are sure it is information they already have.

*Most insurance companies will request that you update COB-coordination of benefits one or more times per year. Most insurance companies will not process your claims without this information.

*All insurance companies have their own Timely Filing Limit in which claims must be submitted. If we don't have all the needed information to submit your claim with in their specific time limit the insurance company will not pay the claim.

*Always bring the most current copy of insurance card to all appointments even if nothing has changed. Sometimes there are minor changes that don't affect you but it affects the way medical offices have to process your claims.

*Know your policy. We do not decide what or how much your policy pays for or covers. Please call us at 316-686-6866 X 216 if you receive a statement and feel that your claims were not processed or paid correctly.
Thank you!

***By signing below**, I acknowledge that I have read the above information on page 1 and 2 and agree to the terms/conditions. I understand I am responsible for all costs of medical treatment regardless of what my insurance carrier may or may not pay. This signature will also serve as signature on file for assignment of insurance benefits. I hereby authorize the Neurology Center of Wichita to release any information acquired in the course of my child's examination or treatment to insurance companies as required for claims processing.

***By signing below**, I also acknowledge that I have the right to a copy of the Neurology Center of Wichita's Notice of Privacy Practices. This handout states how we will always protect you/your child's personal health information and will not release any information without your consent.

_____I was offered but declined a copy of the Privacy Policy_____ I would like a copy of the Privacy Policy

Guardian Printed name_____

Parent/Guardian Signature_____

Relationship to patient_____
Please be specific about relationship to patient, i.e. biological/step/foster/adoptive parent, aunt/uncle, legal guardian, etc.

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NEW PATIENT EVALUATION

Patient Name: _____ Today's Date: ___/_____/_____
DOB: _____/_____/_____ Sex:_____
Referred by:_____
Mothers name_____ Age____
Fathers name _____ Age____
Parents are (please circle) Married Divorced Single
Widowed Other _____

Chief Complaint:_____

BIRTH HISTORY

Birth Weight: _____ LBS. _____ Oz. Gestational Age (weeks in Womb): _____
Delivery: ☐ Normal ☐ C-Section ☐ Forceps ☐ Anesthesia
Left Hospital on Day # _____ of life.
Major Problems during the newborn period:_____
_____

Maternal History: Use of drugs during pregnancy: Y / N if yes explain _____
Use of alcohol during pregnancy: Y / N if yes explain _____
Use of tobacco during pregnancy: Y / N if yes explain _____
Use of medication during pregnancy: Y/N if yes explain_____

Complications: Excessive Morning sickness YES or NO

Dehydration: YES or NO Bleeding: YES or NO Diabetes: YES or NO

DEVELOPMENTAL HISTORY

(if you are unsure of exact date, please put delayed, normal or advanced)

Social Smile: _____ Rolled Over: _____
Sat without Support : _____ Walked: _____
Spoke 1st words other than "Mama" or "Dada": _____
Spoke short sentence: _____

PAST MEDICAL HISTORY

Immunizations current: yes no

Hospitalizations or surgeries: _____

Serious Illnesses or Head Injury: _____

Seizures

Onset: _____

Characteristics: _____

Known Triggers:_____

Medical Allergies: _____

Medications: _____

_____

_____

_____

Testing and previous medical visits--please circle all that apply:

EEG Video EEG MRI CT Head ultrasound EMG/NCT Lab work

Neurologist Psychologist Geneticist Developmental pediatrician

FAMILY HISTORY

☐ Seizures ☐ Mental Retardation ☐ Migraines

☐ Cerebral Palsy ☐ Muscular Dystrophy ☐ Depression

☐ Other Psychiatric Disorders

Name of Siblings	Age of Siblings
1. _____	_____
2. _____	_____
3. _____	_____
4._____	_____
5. _____	_____

Miscarriages: _____ Still Births: _____

SOCIAL HISTORY

Parents: ☐ Natural ☐ Adoptive ☐ Foster ☐ Guardian

Fathers Education: _____ Type of Work: _____

Mothers Education: _____ Type of Work: _____

PATIENT INFORMATION RECORD

Patient's Name _____ **Pt DOB**_____ **SS #**_____
Primary Phone# _____- ____-_____ Alternate Phone # _____-_____-_____
Email address for Patient Portal_____
Sex_____ **Age**_____ **Student** YES / NO
Mailing Address _____**City**_____ **State**_____
Zip_____
Primary care physician_____ Referring physician_____
Parents are (please circle) *Married Divorced Single Widowed Other-*_____
Patient lives with (circle all that apply) *Mother Father Step-mother Step-father*
Foster mother Foster father Legal guardian(s)
Other - please specify_____
Legal Guardian Name_____
Please SPECIFY RELATIONSHIP to patient (i.e. biological/step/foster/adoptive)_____
SS#_____-_____-_____ **DOB**_____/_____/_____
Home # _____- _____-_____ **Cell #** _____-_____-_____ **Work #** _____-_____-_____
Do you give permission to leave messages with appointment info and test results to above numbers? YES NO
Mailing Address _____**City**_____ **State**_____ **Zip**_____

Secondary Contact Name_____
Please SPECIFY RELATIONSHIP to patient (i.e. biological/step/foster/adoptive)_____
SSN#_____-_____-_____ **DOB**_____/_____/_____
Home # _____- _____-_____ **Cell #** _____-_____-_____ **Work #** _____-_____-_____
Do you give permission to leave messages with appointment info and test results to above numbers? YES NO
Mailing Address _____**City**_____ **State**_____ **Zip**_____

Emergency Contact (please list contact other than mom or dad)_____
Relationship to patient_____ **Phone number**_____

Emergency Contact (please list contact other than mom or dad)_____
Relationship to patient_____ **Phone number**_____

Patient's race--please check all that apply
_____American Indian or Alaska Native
_____Asian
_____Black or African American
_____Hispanic
_____White
_____Other (please specify)_____
_____Unreported/Refused to Report

Ethnicity—please check all that apply
_____Hispanic or Latino
_____Not Hispanic or Latino
_____Unreported/Refused to report