Thomas S. Hughes, M.D.
Charles A. Kelly, M.D.

We would like to welcome you to our practice and are excited that you have chosen Dr. Thomas S. Hughes, Dr. Charles A. Kelly, Dr. Robert Bolen, Cynthia A. Davis-PA-C, and Angela F. Finlayson, NP as your providers. We ask that you fill out the attached documents prior to coming to your appointment. This will help with the waiting period so that you may be seen as quickly as possible.

Please be advised that due to the nature of our practice our wait times may be longer at times than other offices.

We have enclosed directions to our office. Please feel free to call us if you need us to further explain these directions.

There are a few things that we need you to bring with you to your appointment. Those are, your insurance cards, and records/imaging that your referring provider may have had done, and a list of current medications.

Again, we thank you and look forward to meeting you at your appointment.

Sincerely,

The Tidewater Neurology Staff

Tidewater Neurology, PA

New Patient Registration
Welcome to Our Practice

Today's Date: _____

First Name: _____ MI: ____ Last Name: _____

Birthdate: ____/____/____ Social Security Number: ____-____-____ Marital Status: Single Married Divorced Widowed

Race_____ Gender_____ Language _____ Ethnicity _____

**********This section must be completed ONLY if different from the patient (such as a minor child) **********

Responsible Party Name (if different than patient): _____ Address: _____

Zip Code: _____ Date of Birth: ____/____/____ Social Security Number: ____-____-____

****

Patient's Street Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: ( )____-____ Cell Phone: ( )____-____Work Phone: ( )____-____

Primary Care Physician: _____ Primary Care Phone: ( ) _____-_____

Policy Holder DOB: ____/____/____ Patients Relation to Policy Holder: ____self ____spouse ____child ____other

Policy ID: _____ Group # : _____ Policy Holder SSN: _____-_____-_____

Secondary Policy Information: Plan Name: _____ Policy Holder Name: _____

Policy Holder DOB: ____/____/____ Patients Relation to Policy Holder: ____self ____spouse ____child ____other

Policy ID: _____ Group # : _____ Policy Holder SSN: _____-_____-_____

**********Extended Patient Information**********

Employer: _____ Employment Status: ____Full Time ____Part Time ____Retired ____N/A

School: _____ Student Status: ____Full Time ____Part Time ____N/A

Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone ( ) ____-____ Relationship _____

A COPY OF YOUR INSURANCE CARD(S) IS REQUIRED AT EACH VISIT FOR VERIFICAITON OF INFORMATION. IF YOU ARE WITHOUT A CARD, YOU MUST HAVE ALL REQUIRED INFORMATION AVAILABLE WHEN YOU PRESENT TO THE OFFICE.

PAYMENT FOR OFFICE SERVICES IS DUE ON THE DAY OF THE VISIT. WE WILL ATTEMPT TO BILL CHARGES TO YOUR INSURANCE COMPANY IF YOU PROVIDE VAILD INSURANCE INFORMATION. PAYMENT MAY BE MADE BY CHECK, CASH OR DEBIT/CREDIT CARE. **NOTICE: AN ADDITIONAL FEE FOR CERTAIN ADMINISTRATIVE SERVICES SUCH AS DISABILITY FORMS, LETTERS OF MEDICAL NECESSITY AND RETURNED CHECKS WILL BE BILLED AS PATIENT RESPONSIBILITY. MISSED APPOINTMENT FEES WILL ALSO BE BILLED AS PATIENT RESPONSIBILITY.**

PATIENT-PHYSICIAN AGREEMENT: I, the undersigned, authorize Tidewater Neurology, PA to release any information acquired in the course of my examination or treatment to my insurance company(s) or other physicians and medical facilities. I understand that the medical insurance I have may not or not completely cover the fee(s) for professional services rendered to me, and I agree that I am responsible for said fee(s). I authorize payment directly to and assign to intuition, the surgical/medical benefits for their services. A photo copy here forth shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

DATE: ____/____/____ SIGNATURE OF PATIENT/GUARDIAN: _____

MEDICATION NAME	STRENGTH	FREQUENCY (TIMES A DAY)	HOW LONG ON MEDICATION (days,months,years)

Allergies: _____

Pharmacy Name: _____ Phone Number: ( ) _____-_____

Generic Preferred ? Y or N
Brand Name Only ? Y or N
Mail Order Pharmacy ? Y or N
90 Day Supply ? Y or N

MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

NEUROLOGIC

Stroke

Cerebral Hemorrhage

Seizure Disorder

Migraine/Chronic Headaches

Multiple Sclerosis

Parkinson's

Alzheimer's

Dementia

Essential Tremor

Peripheral Neuropathy

Carpal Tunnel Syndrome

Trigeminal Neuralgia

Brian Tumor

Myasthenia Gravis

CARDIOVASCULAR

Hypertension (Blood Pressure)

Hyperlipidemia (Cholesterol)

Coronary Artery Disease

Myocardial Infarction (Heart Attack)

Congestive Heart Failure

Arterial Fibrillation

Pacemaker

Implanted Defibrillator

Arrhythmias

ORTHOPEDIC

Degenerative Disc Disease

Scoliosis

Degenerative Joint Disease

UROLOGIC

Prostatic Hypertrophy (BPH)

Incontinence

Chronic Urinary Tract Infections

PAIN

Low Back Pain

Chronic Neck Pain

Fibromyalgia

Reflex Sympathetic Dystrophy

Chronic Radiculopathy

Sciatica

GASTROINTESTINAL

Reflux

Hiatal Hernia

Peptic Ulcer

Irritable Bowel

Crohn's

Ulcerative Colitis

Hepatitis

pancreatitis

METABOLIC/ENDOCRINE

Diabetes, Adult Onset

Diabetes, Childhood Onset

Hyperthyroid (High)

Hypothyroid (Low)

Chronic Renal Failure

Dialysis

Pulmonary

Asthma

Copd/Emphysema

Sleep Apnea

Sarcoidosis

Asbestosis

RHEUMATOLOGIC

Rheumatoid Arthritis

Systemic Lupus Erythematosus

Polymyalgia Rheumatic

HEMATOLOGIC

Anemia

Myeloma

Thrombocytopenia

Leukopenia

PSYCHOLOGICAL

Depression

Anxiety

Panic Disorder

Bipolar

ADD/ADHD

List Any Other Conditions

List Any Cancers, Past or Present

List Any Surgeries

FAMILY MEDICAL HISTORY (CIRCLE ALL THAT APPLY) PAGE 2

NEUROLOGIC

Stroke

Cerebral Hemorrhage

Seizure Disorder

Migraine/Chronic Headaches

Multiple Sclerosis

Parkinson's

Alzheimer's

Dementia

Essential Tremor

Peripheral Neuropathy

Carpal Tunnel Syndrome

Trigeminal Neuralgia

Brian Tumor

Myasthenia Gravis

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Hyperlipidemia (Cholesterol)

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Congestive Heart Failure

Arterial Fibrillation

Pacemaker

Implanted Defibrillator

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Orthopedic

Degenerative Disc Disease

Scoliosis

Degenerative Joint Disease

Urologic

Prostatic Hypertrophy (BPH)

Incontinence

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Asbestosis

Rheumatologic

Rheumatoid Arthritis

Systemic Lupus Erythematosus

Polymyalgia Rheumatic

HEMATOLOGIC

Anemia

Myeloma

Thrombocytopenia

Leukopenia

PSYCHOLOGICAL

Depression

Anxiety

Panic Disorder

Bipolar

ADD/ADHD

List Any Other Conditions

Your Personal Information:

Right Handed Left Handed

Married Divorced Single Widowed

Number Of Children ___Sons ___Daughters

Smoke Y/N

_____ Packs Per Day

Alcohol Y/N

____ Per Day ____ Per Week ____ Per Month

Caffeine Y/N

____ Per Day ____ Per Week ____ Per Month

Education Level: Grade School High School
College Post Graduate

Current Employment Status:
Employed Retired
Disabled Unemployed

Have you had any of the following:

Please bubble in your answer:

Weight change	O Yes	O No
Fatigue	O Yes	O No
Hearing loss	O Yes	O No
Change in voice	O Yes	O No
Change in bowel habits	O Yes	O No
Leg cramps	O Yes	O No
Depression	O Yes	O No
Excessive sweating	O Yes	O No
Headache	O Yes	O No
Memory problems	O Yes	O No
Numbness	O Yes	O No
Double vision	O Yes	O No
Sexual problems	O Yes	O No
Shortness of breath	O Yes	O No
Daytime Sleepiness	O Yes	O No
Easy bruising	O Yes	O No

Fever	O yes	O No
Night Sweats	O Yes	O No
Drooling	O Yes	O No
Nausea	O Yes	O No
Joint Pain	O Yes	O No
Back Pain	O Yes	O No
Anxiety	O Yes	O No
Diabetes	O Yes	O No
Seizure	O Yes	O No
Tremors	O Yes	O No
Diminished vision	O Yes	O No
Incontinence	O Yes	O No
Chest pain	O Yes	O No
Snoring	O Yes	O No
Insomnia	O Yes	O No

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explaination of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not

required to agree with a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA or to File a complaint:

The US Dept of Health & Human Services
Office of Civil Rights
200Independence Avenue, S.W.
Washington, D.C., 20201
(202)619-0257
Toll Free: 877-696-6775

NOTICE OF PRIVACY PRACTICES

Tidewater Neurology

913 Bowman Rd Ste. 105
Mt Pleasant, SC 29464
(843) 856-9530

118-B Springhall Dr.
Goose Creek, SC 29445
(843) 553-0997

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I authorize Tidewater Neurology to discuss my health information with the following people. I understand that at any time I can request a change in the list below.

Name _____

Relationship to the patient _____

Name _____

Relationship to the patient _____

Name _____

Relationship to the patient _____

Patient signature/ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Tidewater Neurology

913 Bowman Road Ste.105
Mt Pleasant, SC 29464
(843)856-9530

118-B Springhall Dr.
Goose Creek, SC 29445
(843) 553-0997

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Tidewater Neurology has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Tidewater Nuerology at the address above to obtain a current copy of the *Notice of Privacy Practices.*

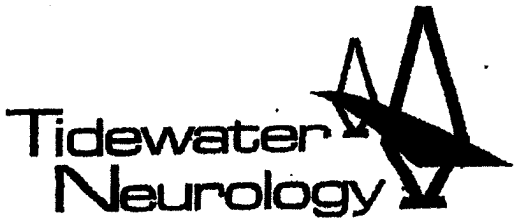
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____



Thomas S. Hughes, M.D.
Charles A. Kelly, M.D.

I, _____ authorize Tidewater Neurology to obtain any and all medical records that we may need for your healthcare treatment.

_____
Print Name

_____
Sign & Date

Tidewater Neurology

Thomas S. Hughes, M.D.
Charles A. Kelly, M.D.

Motor Vehicle Accident Waiver

If you are coming to Tidewater Neurology to be treated for a motor vehicle accident related injury/illness, please be aware that we do not accept patients under third party liability claims. We will be happy to see you; however we will not be able to file any insurances or third party payors. The balance of any visits or tests will be the sole responsibility of the patient on the date of service.

Thank you for your understanding.

Sincerely,

Tidewater Neurology

_____ _____

Patient Signature Date

Tidewater Neurology ~ 913 Bowman Rd. Ste. 105 ~ Mt. Pleasant, 29464 ~ Office (843) 856-9530 ~ Fax (843) 971-1345
118-B Springhall Dr. ~ Goose Creek, SC 29445 ~ Office (843) 553-0997 ~ Fax (843) 553-0919

Tidewater Neurology

Thomas S. Hughes, M.D.
Charles A. Kelly, M.D.

Worker's Compensation Waiver

If you are coming to Tidewater Neurology to be treated for a work related injury/illness, please be aware that we do not accept patients under Worker's Compensation claims. We will be happy to see you; however we will only bill your Private Insurance. Any balance that your carrier leaves as your portion, will be billed directly to you.

Thank you for your understanding.

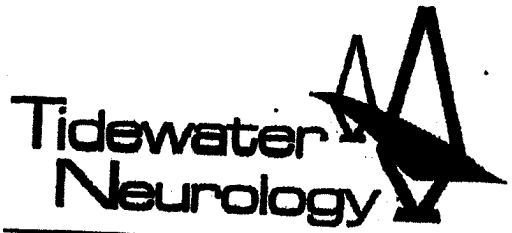
Sincerely,

Tidewater Neurology

_____ _____

Patient Signature Date

Tidewater Neurology ~ 913 Bowman Rd. Ste. 105 ~ Mt. Pleasant, 29464 ~ Office (843) 856-9530 ~ Fax (843) 971-1345
118-B Springhall Dr. ~ Goose Creek, SC 29445 ~ Office (843) 553-0997 ~ Fax (843) 553-0919



Thomas S. Hughes, M.D.
Charles A. Kelly, M.D.

CANCELLATION POLICY

WE REQUIRE A 24 HOUR CANCELLATION NOTICE FOR ALL APPOINTMENTS.

OUR POLICY IS AS FOLLOWS:

- **FIRST MISSED APPOINTMENT: $40.00 FEE**
- **SECOND MISSED APPOINTMENT: $100.00 FEE**
- **THIRD MISSED APPOINTMENT YOU MAY BE DISMISSED FROM OUR PRACTICE.**

THIS POLICY WILL BE ENFORCED SO THAT WE CAN CONTINUE TO HAVE AVAILABLE APPOINTMENTS FOR OUR PATIENTS.

WE WILL MAKE EVERY ATTEMPT TO REMIND YOU OF YOUR APPOINTMENT. PLEASE MAKE SURE WE HAVE UP TO DATE CONTACT INFORMATION.

PATIENT SIGNATURE: _____
DATE: _____

THANK YOU,

THOMAS S. HUGHES, MD
CHARLES A. KELLY, MD