



Thomas S. Hughes, M.D.
Robert Bolen, M.D.
Madison Bondura, NP
Katelyn Scott, PA-C
Kaitlin Mostoller, PA-C

We would like to welcome you to our practice and are excited that you have chosen one of our providers, Dr. Thomas S. Hughes, Dr. Robert Bolen, Madison Bondura, NP, Kaitlin Mostoller, PA-C, and Katelyn Scott, PA-C, to care for you.

We ask that you fill out the attached documents prior to coming to your appointment.

This helps 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 waiting times may be longer at times than most other offices you have been to.

We ask that you arrive 30 minutes prior to your appointment time.

There are a few things that we need you to bring with you to your appointment: **your insurance card(s), photo ID, and records/imaging that your referring provider may have had done, and a list of all current medications.**

PLEASE ARRIVE 30 MINUTES EARLY TO YOUR FIRST APPOINTMENT

PLEASE BRING INSURANCE CARDS(S) AND A VALID PHOTO ID TO YOUR FIRST APPOINTMENT, PAST MEDICAL RECORDS, ANY IMAGING THAT YOU HAVE HAD DONE AND A LIST OF YOUR CURRENT MEDICATIONS

ALL DEDUCTIBLES, CO-PAYMENTS AND/OR CO-INSURANCES ARE DUE AT THE TIME OF SERVICES BASED ON YOUR BENEFITS.

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

Sincerely,

The Tidewater Neurology Staff

**913 Bowman Road, Suite 105, Mount Pleasant, SC 29464 Office (843) 856-9530 Fax (843) 971-1345
7 S. Alliance Drive Ste. 201 A, Goose Creek, SC 29445 Office (843) 553-0997 Fax (843) 553-0919**

Today's Date: _____

New Patient Demographic

First Name: _____ MI: ___ Last Name: _____

Birth date: ___/___/___ Social Security Number (SSN): ___-___-___

Marital status: ___ Single ___ Married ___ Divorced ___ Widowed

Race: _____ Gender: ___M ___F Language: _____ Ethnicity: _____

Responsible party name (if different from patient due to them being a minor child): _____

Address: _____

City: _____ St: ___ ZIP Code: _____ Date of Birth: ___/___/___ SSN: ___-___-___

Patient's Address: _____ City: _____ St: ___ ZIP Code: _____

Home phone: (____) ___-____ Cell phone: (____) ___-____ Work phone: (____) ___-____

Primary Care Physician (PCM): _____ PCM phone number: (____) ___-____

Primary policy plan name: _____

Policy holder DOB: ___/___/___ Patient's relation to policy holder: ___Self ___Spouse ___Child

Policy ID Number: _____ Group #: _____ Policy holder SSN: ___-___-___

Secondary policy plan name: _____

Policy holder DOB: ___/___/___ Patient's relation to policy holder: ___Self ___Spouse ___Child

Policy ID Number: _____ Group #: _____ Policy holder SSN: ___-___-___

Employer: _____ Employment Status: ___F/T ___P/T ___Retired ___N/A

School: _____ Status: ___F/T ___P/T ___N/A

Email Address: _____

Emergency Contact: _____ Number: (____) ___-____ Relationship: _____

A copy of your insurance card(s) is required once a year for verification of information. If you are without a card, you must have all the required information available when you present it to the office. Payment for services is due on the day and time of appointment. We will attempt to bill charges to your insurance company if you provide valid insurance information. Payment may be made by check, cash, or debit/credit card. ** Notice: An additional fee for certain administrative services such as disability forms, letters of medical necessity, and returned checks along with copies of your records will be billed as patient responsibility. Missed appointments fees will also be billed as patient responsibility. ** Patient-Physician agreement: I, the undersigned, authorize Tidewater Neurology, PA to release any information acquired during my examination or treatment to my insurance company(s) or other physicians and medical facilities. I understand that the medical insurance I have may or may 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 photocopy here forth shall be valid as the original. I am aware that I may inquire with my physician about the fee(s) for any professional services required and/ or rendered.

Date: ___/___/___ Signature of Patient/Guardian: _____

PAST MEDICAL HISTORY

(Please check all that apply)

CONDITION	SELF	FAMILY	CONDITION	SELF	FAMILY
STROKE			REFLUX		
CEREBRAL HEMORRHAGE			HIATAL HERNIA		
SEIZURE DISORDER			PEPTIC ULCER		
MIGRAINE/HEADACHE			IBS		
MULTIPLE SCLEROSIS			CHRON'S		
PARKINSON DISEASE			ULCERATIVE COLITIS		
ALZHEIMER DISEASE			HEPATITIS		
DEMENTIA			PANCREATITIS		
ESSENTIAL TREMOR			DIABETES		
PERIPHERAL NEUROPATHY			HYPERTHYROID		
CARPAL TUNNEL			HYPOTHYROID		
TRIGEMINAL NEURALGIA			RENAL FAILURE		
BRAIN TUMOR			PUL. ASTHMA		
HYPERTENSION			COPD/EMPHYSEMA		
HYPERLIPIDEMIA			SLEEP APNEA		
CORONARY ARTERY DISEASE			SARCOIDOSIS		
HEART ATTACK			ASBETOSIS		
CONGESTIVE HEART FAILURE			RHEM. ARTHRITIS		
ATRIAL FIBRILLATION			LUPUS		
PACEMAKER			ANEMIA		
ARRHYTHMIAS			MYELOMA		
DEGENERATIVE DISC/JOINT			DEPRESSION/ANX		
SCOLIOSIS			BIPOLAR		
PROSTATIC HYPERTROPHY			PANIC DISORDER		
INCONTINENCE			ADD/ADHD		
CHRONIC UTIs			ANY OTHER CONDITIONS		
CHRONIC NECK PAIN					
SCIATICA					
LOW BACK PAIN					

Any additional diagnosis or cancers:

- .
- .
- .
- .
- .
- .
- .
- .

Social History

NUMBER OF CHILDREN: _____ sons _____ daughters

SMOKE: ___Y ___N packs per day: _____ Quit _____ years ago

ALCOHOL: ___Y ___N per day/week: _____

CAFFEINE: ___Y ___N per day/week: _____

LIST OF ANY SURGERIES AND THE YEAR:



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MEDICAL RECORDS RELEASE

I, _____, authorize Tidewater Neurology to obtain any and all of my medical records that they may need for my healthcare treatment.
This includes any prior authorizations and appeals on my behalf.

PRINT NAME: _____

SIGNATURE AND DATE: _____

Please fax completed form to: 843-553-0919



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Notice of Privacy Practice (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 (“HIPAA”) 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. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by

“HIPAA”, we have prepared this explanation 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 reference 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 interest 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 reauthorization. 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 rights to obtain a paper copy of this notice form 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 November 22, 2017, until further notice, 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 from the office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: To file a HIPPA complaint or find out more:

The US Dept of Health and Human Services
Office of Civil Rights
200 Independence AVE, SW
Washington, D.C., 20201- Toll Free: 877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

TIDEWATER NEUROLOGY

I understand that under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 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 health care 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 Neurology at the addresses 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: _____



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NOTICE OF PRIVACY PRACTICES
TIDEWATER NEUROLOGY

I understand that under the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), 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: _____ PHONE #: _____

Relationship to patient: _____

Name: _____ PHONE #: _____

Relationship to patient: _____

Name: _____ PHONE #: _____

Relationship to patient: _____

Name: _____ PHONE #: _____

Relationship to patient: _____

Patient signature and date: _____

**WAIVER FOR WORKMAN'S COMPENSATION &
MOTOR VEHICLE ACCIDENTS (MVA).**

(WE UNDERSTAND YOU ARE NOT HERE FOR THESE WE NEED YOU TO SIGN SAYING YOU UNDERSTAND WE DO NOT BILL OR ACCEPT THESE CASES.)

If you are coming to Tidewater Neurology to be treated for a work-related injury/illness or MVA. Please be aware that we DO NOT accept patients under the Worker's Compensation claims or third-party liability claims. We will be happy to see you; however, we will not be able to file any insurance or third-party payers. 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 and date: _____

“No show” Fee Policy for Procedures

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Tidewater Neurology reserves the right to charge a fee of \$50.00 for all missed appointment time. You must cancel within 24 hours prior to the scheduled appointment time.

“No Show” fees are billed directly to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “no shows” in a 12- month period may result in termination from our practice.

By signing below, you acknowledge that you have received this notice and understand this policy:

Patient Name (please print): _____

Sign and date: _____

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