ALZHEIMER'S MEMORY CENTER

Cognitive and Behavioral Neurology

WELCOME

We have provided these forms to make this an easy process for you.

Please complete the following forms:

1. Registration Form
2. Acknowledgement of Notice of Privacy Practices
3. Authorization For Treatment
4. History Sheet (Download separately)
5. Permission to Communicate with Caregivers / Compound Release (if needed)
6. Authorization to Disclose Health Information (Download separately if needed)
7. Payment & Cancellation Policy

Please bring the following information to your appointment:

1. Completed forms listed above.
2. Insurance Card
3. A list of medications
4. Radiology films (if applicable)
5. Medical Records

Our goal is to provide our patients with the best customer service. We ask for you to arrive 30 minutes prior to your appointment time. This will allow you more time with Dr. Bolouri. If you are not able to attend this appointment, please contact our office within 24 hours of the scheduled appointment time.

We hope you have a pleasant visit with us.

We are available to answer any questions that you may have. Please feel free to contact our office at 704-364-4000.

The Staff of the Alzheimer's Memory Center

7809 Sardis Road Charlotte, NC 28270 Phone #: 704-364-4000 Fax #: 704-364-4005

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Date _____ Primary Phone (____) _____ Cell Phone (____) _____
Do we have permission to leave a voice message (i.e. appointment reminders) at the contact number? □ Yes □ No
Do we have permission to leave a voice message for normal test results at the contact number? □ Yes □ No

PATIENT INFORMATION

Name _____ SSN # _____
Last Name First Name Middle Initial
Address _____
City _____ State ____ Zip _____ Birthdate: _____
Pharmacy Name: _____ **Telephone** #: _____
Pharmacy Address: _____
Emergency Contact/Caregiver: _____ Phone (____) _____

PRIMARY PHYSICIAN INFORMATION (Information Needed)

DR. Name _____
Address _____
Facility Name _____
City _____ State _____ Zip _____

Telephone Number _____ Fax # _____

INSURANCE INFORMATION

Insurance Name _____Policy #_____
Have you change insurance company since your last visit to our office? ___ yes or ___ no
Are you currently under Hospice care? ____ If yes, please provide the following information:
Facility Name _____
Address_____ Phone#_____
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of insurance company (ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named and Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

_____ _____
Signature of Patient, or Legal/Responsible Party Date

_____ _____
Please Print Name of Patient, or Legal/Responsible Party Relationship to Patient

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, am aware that as part of my health care plan/treatment, Alzheimer's Memory Center maintains paper and electronic copies of my medical records. I am also aware that my medical record serves for:

- ☐ A communication among other health care providers who contribute with my medical care.
- ☐ The purpose of obtaining payment from Third Party payers to determine insurance benefits payable for related services.
- ☐ As a main source of information to third-party payers to verify services.
- ☐ Planning my medical care.

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Alzheimer's Memory Center. I have read and understand my rights.

- ☐ The right to request confidentiality of my medical records.
- ☐ The right to request restriction of how my health information is disclosed.
- ☐ The right to obtain copies of my Professional Health Information (PHI).
- ☐ The right to correct my Professional Health Information.
- ☐ The right to confidential communication with the providers.
- ☐ The right to read the privacy notice prior to signing.

I understand that as part of my medical treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, as described in the notice of privacy practices, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that Alzheimer's Memory Center is not required to agree to the restrictions requested. I agree that I may revoke this consent in writing only, except in the event that the organization has already taken action. I also agree that by refusing to sign this consent or revoking this consent, this provider may refuse to treat me as permitted by Federal regulations. (Code 164.506)

Note:
Alzheimer's Memory Center reserves the right to change the notice of privacy practices policies at any time. However, we will provide you with a copy of any changes via your preferred method such as: email, mail, our web site and at the office. Please indicate preference:
_____

Patient's Signature or Legal/Responsible Party _____

Date_____

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For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____ _____

Prepared By _____

Signature _____

Date _____

7809 SARDIS ROAD, CHARLOTTE, NC 28270 •PHONE 704-364-4000 •FAX 704-364-4005

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AUTHORIZATION FOR TREATMENT

I voluntarily consent to health care treatment/testing from the physician(s) and staff at Alzheimer's Memory Center.
I am aware that I can stop my treatment at any time without written notice.
I understand that I have the right to ask questions regarding my medical care/treatment.

Other Authorization:
I authorize Alzheimer's Memory Center to request medication information from my pharmacy, facilities and other providers if needed for my medical treatment.

NOTE:
Due to a very demanding schedule, Dr. Bolouri will not be available to see you in the hospital. Inpatient physicians will provide you with the medical care needed. Please contact our office if you need to be seen by Dr. Bolouri.

Signature of the patient, or Legal/Responsible Party_____

Date _____

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Alzheimer's Memory Center
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number) (Spouse, Parent, Friend, Relative, Child, Etc) ☐	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

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APPOINTMENT CANCELLATION POLICY & FORMS FEES

I, _____, am aware that I will be charged a fee of $25.00 if I do not show for my appointment as scheduled. However, if I contact the office at least 24 hours prior to the appointment the fee will not be applied.

I, _____, am aware that after the second no show appointment I will automatically be discharged from the facility.

OTHER CHARGES

I, _____, am aware that there will be a fee of $50.00 to complete any Disability Form.

I, _____, am aware that there will be a fee of $ 25.00 for returned checks.

I, _____, am aware that there will be a fee of $ 50.00 for FMLA (Family and Medical Leave Act) form.

NOTE:
Please be aware that Dr. Bolouri is not an immigration physician. Therefore, he is NOT able to complete immigration forms. Please contact the immigration department if you need help finding a physician.

PATIENTS/RESPONSIBLE PARTY:
Payment in full is expected at the time service is rendered, unless the patient is covered by an insurance company with whom we participate. In this case the patient or the responsible party is only required to pay the deductible if not met and/or co-payment/coinsurance dictated by the insurance company at the time of service.

Signature of the Patient or Legal/Responsible Party_____

Date_____

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M. REZA BOLOURI, M.D.

LATE TO APPOINTMENT POLICY

Attention Patients & Caregivers.

If you are an **established patient** and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule your appointment unless the physician's schedule can still accommodate you.

Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule.

Please be aware that when one patient is late can cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

New Patient

Likewise if you are a new patient and you arrive **at** the scheduled appointment time and not 30 minutes early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

"NO-SHOW" POLICY

While we make every effort to provide a reminder call a week and 24 hours prior to your appointment, it is **your responsibility** to contact our office to reschedule your appointment. We charge a $25 missed appointment fee to patients who do not show up to their appointment. If this should happen more than twice, the practice may at its discretion choose to discontinue your care.

_____

Patient Signature Acknowledges Receipt Date

_____

Legal Guardian Signature Acknowledges Receipt Date

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