BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Consent to Treat

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments deemed necessary. The administration of any needed anesthetics and performance of procedures may be deemed necessary or advisable in the treatment of the patient. The use of prescribed medication, the performance of diagnostic procedures, the taking and utilization of cultures and performance of other medically accepted laboratory tests may be considered medically necessary in the judgment of the attending physicians or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing.

MEDICARE PATIENT: I authorize Blue Ridge Associates in Neurology (B.R.A.i.N.) to release medical information about me to the Social Security Administration or its intermediaries for my Medicare Claims. I assign the benefits payable for services to Blue Ridge Associates in Neurology.

In accordance with the provisions of Section 32.1 – 45.1 of the Code of Virginia, whenever any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Center for Disease Control,transmit human immunodeficiency virus, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person(s) exposed, as well as the Virginia Health Department and appropriate counseling will be offered.

I have reviewed and understand my Patients Rights and Responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ Date _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

Rev 3/1/2023

BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Patient Registration Form

Patient _____ _____ _____
Last Name First Name Middle Initial
SSN _____ **Date of Birth** _____ **Sex** ☐M ☐F

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Which contact information would you prefer that we use for the following communication:

	Appointment Reminders	Test Results	Billing Questions	May we leave detailed messages?
Home phone _____	☐	☐	☐	☐
Work phone _____	☐	☐	☐	☐
Cell phone _____	☐	☐	☐	☐
Email _____	☐	☐	☐	☐

Employer Name _____ **Your job title** _____

Emergency Contact Person/Relationship to patient _____
Phone #(s)_____
***Responsible Party (if not patient) Name/ Address/ Phone#(s) for Billing**
_____
_____

Primary Care Physician Name
_____

Referring Physician Name
_____

Do you have Medical Coverage? ☐ yes ☐ no
Primary Cardholder Name(if NOT pt) _____ **Date of Birth** _____
Do you have Prescription Drug Coverage? ☐ yes ☐ no
Please provide copies of your insurance and prescription card(s) at your appointment.

Local Pharmacy Name, Town _____
Mail-in Pharmacy (if applicable) Name _____By signing below, I acknowledge that I understand that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because the amount paid by insurance companies varies, it is ultimately my responsibility to pay the portion of the bill not paid by my insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer). I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I have received notice of this organization's privacy practices.

Signature: _____ **Date:** _____

Name and title if not patient _____

Rev 3/1/2023

2955 Market Street, Suite B, Christiansburg, VA 24073
ph 540 381-6211 fx 540 645-6623 www.swvabrain.com

BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Patient History Form

Patient Name: _____ ☐ Right handed, or ☐ Left handed

Today's Date: _____

If you bring to your appointment medical records and/or medication lists, you may leave blank any portions of this questionnaire that are addressed by the records or medication lists.

If you prefer to fill in your medical history through our online portal at www.swvabrain.com, please provide us with your email address. Once we put your email into the system, you will receive an email with instructions to complete your history online. Please call (540) 381-6211, select option 1, and leave a message with your name and request to add your email address to our online system.

1. Medical History: Please list current and past medical conditions (and approximate date of onset):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

2. Allergies: Please list all medication and food allergies and the type of reaction, if known:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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3. <u>Medications:</u> Please list all current medications, strength, and frequency. If you need extra space, please continue on the back of this page.

Medication name	Pill strength	# Pills with each dose	Frequency of doses

4. Surgical History: Please list surgeries (and approximate dates):

5. Family History: Please list medical conditions in family members:

	Mother	Father	Son	Daughter	Brother	Sister	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other conditions:

_____ _____

_____ _____

6. Social History:

Do you, or have you ever smoked tobacco?

Currently, every day ☐ Currently, some days ☐ In the past but quit ☐ Never ☐

If you smoke or smoked, how many packs per day? _____

If you smoked but quit, when did you quit? _____

Do you drink alcohol?

No ☐

Yes - ☐ Beer ☐ Liquor ☐ Wine ☐

If you drink, how many drinks? _____ How often? _____

Do you, or have you ever, used recreational drugs?

No ☐

Yes - what type? _____

_____ **Date** _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Review of Systems

Patient Name: _____ **Today's Date:** _____

Review of Systems: In the past *month*, have you experienced any of the following:

☐ Fevers	☐ Chills	☐ Sweats	☐ Poor appetite	☐ Fatigue
☐ Too sleepy	☐ Trouble sleeping	☐ Feeling ill	☐ Weight gain	☐ Weight loss
☐ Eye pain	☐ Vision loss	☐ Blurry vision	☐ Double vision	☐ Eye irritation
☐ Eye discharge	☐ Light sensitivity	☐ Ear pain	☐ Ringing in ears	☐ Decreased hearing
☐ Nasal discharge	☐ Nosebleeds	☐ Sore throat	☐ Hoarseness	☐ Trouble swallow
☐ Chest pain	☐ Palpitations	☐ Passing out	☐ Easily winded	☐ Leg swelling
☐ Cough	☐ Bloody sputum	☐ Wheezing	☐ Nausea	☐ Vomiting
☐ Diarrhea	☐ Constipation	☐ Stool incontinence	☐ Abdominal pain	☐ Bloody stool
☐ Pain with urination	☐ Blood in urine	☐ Urine incontinence	☐ Back pain	☐ Joint pain
☐ Joint swelling	☐ Muscle cramps	☐ Muscle pain	☐ Muscle stiffness	☐ Skin rash
☐ Itching	☐ Color change	☐ Hair loss	☐ Dry skin	☐ Weakness
☐ Numbness	☐ Seizures	☐ Tremors	☐ Dizziness	☐ Depression
☐ Anxiety	☐ Memory loss	☐ Suicidal thoughts	☐ Hallucinations	☐ Cold intolerance
☐ Heat intolerance	☐ Excessive thirst	☐ Excessive hunger	☐ Frequent urine	☐ Easy bruising
☐ Easy bleeding	☐ Big lymph nodes	☐ Hives	☐ Hay fever	☐ Ongoing infections

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BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments. Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. For example, your health plan may request and receive information on dates of service, services provided and medical condition being treated. However, you have the right to request restrictions on PHI disclosures for health services or items paid out of pocket in full.

Health care operations. Your health information may be used as necessary to support the daily activities of *Blue Ridge Associates in Neurology*. For example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report some communicable diseases to the state public health department.

Other uses and disclosures requiring authorization. Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information

Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

***Blue Ridge Associates in Neurology* Duties**

We are required by law to maintain the privacy of your protected health information and to make available this notice of privacy practices. We are required to abide by the privacy policies that are outlined in this notice. We are required to notify you of any breach of unsecured PHI.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:
US Department of Health & Human Services
202-619-0257 Toll Free: 1-877-696-6775

I have read and reviewed and, if requested, received a copy of this notice.

_____ Date _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

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BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Medication Policy

I, _____, have read, understand, and agree to the following terms regarding medication prescriptions with Dr. Jill Cramer:

1. While Dr. Cramer tries to accommodate medication refill requests as quickly as possible, be aware medication refills sometimes take several days to process. Please provide at least five (5) business days advance notice for medication refills. The fastest way to process a refill request is to call the pharmacy and ask the pharmacist to forward a faxed or electronic request to Dr. Cramer.

2. If you take controlled substances including, but not limited to: codeine, morphine, oxycodone, hydrocodone, tramadol, methylphenidate, dextroamphetamine, diazepam, lorazepam and alprazolam, note that Dr. Cramer does NOT typically take over the prescribing of these medications from another physician.

3. Be aware that Dr. Cramer participates with the Prescription Monitoring Program. By law, they can review your controlled substance refill habits through this monitoring program. By their policy, Dr. Cramer will review your prescription refill habits periodically. Any patient found to be receiving prescriptions for controlled medications (see above partial list) from more than one provider will NOT receive further controlled substance prescriptions from Dr. Cramer.

4. Early refill requests for controlled medications will NOT be honored.

5. Medication refills cannot be provided for patients who have not been seen in office within 12 months of refill request. Please make sure you have annual appointments with Dr. Cramer if you require ongoing non- controlled prescriptions. For controlled prescriptions, patients must be seen in office a minimum of every six(6) months.

6. For patients who are prescribed controlled substances by Dr. Cramer, random pill counts and urine drug screens may be performed at or between scheduled office visits. The following situations will result in Dr. Cramer no longer prescribing these medications: failure to participate in any requested pill count or urine drug screen; pill count is lower than expected; urine drug screen fails to show the prescribed medications; urine drug screen shows narcotics other than the prescribed medications; or urine drug screen shows any illicit substances.

7. Be sure to update your medication list with Dr. Cramer or Dr. Cramer's assistant, Renee, at each office visit. Also, please advise us of any adverse reactions or allergies to medications you have used previously.

_____ **Date** _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

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BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Disclosure to Family/Friends

I, _____, hereby authorize release of my medical information to the following people and/or companies:

***If you want nobody else to be able to access your medical information, call for appointments, ask questions regarding your account or medical care, please write "NONE" in the top Name box.**

Name	Relationship to Patient	Phone or Fax # or Email

Other Disclosures (Workers Comp, Disability Rep, etc.)

_____ Date _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

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BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Consent to Release/Obtain Medical Information

To release the medical information of:

Patient Name:_____

Date of Birth:_____ ***SS#:*** _____

I, the undersigned do hereby authorize and request records ***from***:

_____

_____

To: **Blue Ridge Associates in Neurology at below address/ fax#**

Records to be released:

	YES	**NO**
Discharge Summary	☐	☐
Lab Reports	☐	☐
Substance Abuse Records	☐	☐
History Physical	☐	☐
Office/ Consult Notes	☐	☐
Radiology Reports / Films or Disc	☐	☐
Psychiatric Records	☐	☐
Operative Reports	☐	☐
Emergency/Outpatient	☐	☐
EKG/EEG/ECHO/EMG/Stress	☐	☐

Other (Specify)_____

Treatment Date (s):_____

This disclosure is for the purpose of: Medical Care ☐ Claims Processing ☐ Legal ☐ Other_____

I understand that:

- By signing this authorization, I am giving the healthcare entity permission to disclose confidential health records.
- My treatment, payment, enrollment or eligibility for benefits will NOT be conditioned on signing this authorization.
- I may withdraw or revoke this authorization in writing at any time. Withdrawal of this authorization does NOT affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- There is potential that information may be re-disclosed by the recipient and no longer protected by law.
- A copy of this authorization and a notation concerning the person or agencies to whom disclosure was made shall be included in the original health records.
- The healthcare entity may impose a reasonable fee for copies of records in accordance federal and state law
- This authorization will automatically expire one year after the day below.

SIGNATURE:_____ **DATE:**_____

(Signature of Patient/Parent/Legal Guardian/Representative)

_____

(Relationship to Patient)

_____ Date:_____

(Signature of Witness)

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BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Assignment of Benefits

Our office is pleased to submit charges for the services you receive through our medical practice to your health insurance company or companies. We submit directly to the company(s) as a courtesy to you.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but insurance does not always pay the entire fee. The insurance company typically allows a certain fee to be paid to the physician for services rendered, and then the insurance company will pay the portion that they have agreed to pay. The amount that the insurance company pays is paid generally at a percentage of the negotiated fee. Remaining fees are the responsibility of the patient, including copays, deductibles, and co-insurances. Once insurance has paid, our practice will forward a bill for the balance directly to the patient.

I assign to Blacksburg Neurology, PC (dba Blue Ridge Associates in Neurology) the authority to accept health insurance benefit payments directly from my health insurance carrier(s) on my behalf.

I agree to pay to Blacksburg Neurology, PC (dba Blue Ridge Associates in Neurology) my portion of the medical bills remaining once my health insurance has rendered initial payment. I understand that the patient responsibility amount for covered or non-covered services is a contractual agreement that I have with my insurance plan and an agreement between Blacksburg Neurology, PC, and my insurance. I am responsible for any amounts the insurance company deems my responsibility.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I acknowledge that I have received notice of this organization's privacy practices. If requested, I have also received a hard copy for my files.

_____ Date _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

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We will do everything we reasonably can to work with you to keep your account with us up to date and to avoid turning your account to an outside agency for collections. In the unlikely event that we need to turn your account over to a collection agency, please review and acknowledge the following statements:

Contingency Fee Agreement For Delinquent Accounts

A Debt placed for collection with Agency and referred to an Attorney to satisfy payment of this account or to obtain judgment on this account, shall be subject to a collection fee of 33.3% of the amount paid if collected by Attorney. Should an account be referred for legal action, this amount shall be in addition to any other costs incurred directly or indirectly by Agency's attorney to collect amounts owed under Agreement such as court costs, sheriffs fees, interest, late fees, investigatory fees, credit reporting fees, etc. (only accounts requested by Creditor will be referred for legal action). Once an account has been assigned for collection, any payments received by the creditor, agency, and/or attorney including, but not limited to consumer payments, insurance payments, attorney payments, shall be subject to the agreed upon contingency fee.

My signature below acknowledges that I am aware of the above Contingency Fee Agreement

_____ _____

'Signature Date

Contact By Phone

You agree, *if your account is turned over to collections for non-payment,* that, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

I/we have ready this disclosure and agree that Blacksburg Neurology d/b/a Blue Ridge Associates in Neurology and Roanoke Area MS Center may contact me/us as described above.

_____ _____

'Signature Date

I do not agree to be contacted by any telephone numbers associated with my billing account.

_____ _____

'Signature Date