



COMMUNITY
NEUROSCIENCE
SERVICES

33 Lyman St. Suite 400
Westborough, MA. 01581

Phone: 508-898-0055
Fax: 508-898-0035

Patient Registration Form

Patient Name: _____ **Date of Birth:** _____

Mailing Address: _____

**We will send Billing Statements, Lab Results and all other correspondence to this address.*

Home Phone# _____ **Cell Phone#** _____

Gender Male Female Transgender **Social Security #:** _____

Primary Care Provider _____ **phone#** _____

Email Address: (Please print legibly)

By providing your email, you agree to be enabled for our Online Patient Portal

Marital Status: Single Married Divorced Widowed Separated

Who may we discuss your medical information including, account/billing information with?

Name _____ contact # _____

Name _____ contact # _____

Emergency Contact:

Name: _____ Phone #: _____ Relation: _____

Race: White Asian Black Native Hawaiian American Indian Other: _____

Ethnicity: Non-Hispanic Hispanic Origin Unknown

Preferred Language: English Spanish Chinese Russian Indian Other: _____

Preferred Pharmacies:

Local Pharmacy _____ **Phone:** _____

Mail Order: _____ **Phone:** _____

Do you give us permission to run prescription eligibility? Yes No

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY

I authorize CNS and my insurance company to release any PHI information required for processing any insurance claims(s). I also authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for the full amount of the charges which are not covered by insurance benefits. I also understand that CNS submit claims to my insurance company using the information that I have provided for this purpose, and I agree that I will be responsible for the charges if the insurance company indicates that coverage was not in effect. I understand it is my responsibility to verify benefits and coverage with my insurance plan. If being signed by a parent, these provisions apply to the patient named below. If CNS sends me a Billing Statement, payment of the full balance is due within 30 days of the statement date unless I make other formal arrangements with the Billing Department.

Signature _____

Printed Name: _____ **Date:** _____

PATIENT HISTORY FORM

NAME _____ DATE OF BIRTH _____

Social History

Tobacco Use: Never Current Smoker Former Smoker
Drink alcohol: Never
Substance abuse: Never Currently Former
How much and how often? _____

Please \checkmark each problem that applies to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nerve/Muscle Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer: state what type
_____ | <input type="checkbox"/> GERD | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disease |
| | <input type="checkbox"/> Kidney Disease | |

Please List Previous Surgery:

Please list current Medications below: Indicate Strength and number of times taken daily.

Please describe any Allergies: Including reaction

NAME _____ DATE OF BIRTH _____

Please indicate Family History:

	Mother	Father	sibling	child	Grandmother (maternal/paternal) M/P	Grandfather (maternal/paternal) M/P
Alcohol abuse						
Aneurysm						
Asthma						
Arthritis						
Birth defect						
Breast Cancer						
Colon Cancer						
Other Cancers						
COPD						
Depression						
Diabetes						
Drug Abuse						
Early Death						
Glaucoma						
Heart disease						
Hyperlipidemia						
Hypertension						
Kidney disease						
Seizures						
Mental Illness						
Stroke						
Thyroid disease						
Other						

Please List any other Medical Problems not addressed in this form:



COMMUNITY
NEUROSCIENCE
SERVICES

33 Lyman St. Suite 400
Westborough, MA. 01581

Phone: 508-898-0055
Fax: 508-898-0035

**CNS
ACKNOWLEDGEMENT OF RECEIPT OF PRIVATE PRACTICES**

I, _____ acknowledge that I have received a copy
(Name of Patient)

of CNS's Notice of Practices. This notice describes how CNS may use and disclose my protected health information, certain restrictions on the use of disclosure of health information and rights I may have regarding my protected health information.

Signature of Patient or Personal Representative

Date

Relationship to patient



COMMUNITY
NEUROSCIENCE
SERVICES

PATIENT RESPONSIBILITY FORM

Name (Print): _____ DOB: _____

Thank you for choosing Community Neuroscience Services as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

If your insurance plan has a designated primary care physician (PRIMARY CARE PHYSICIAN) and you are required to obtain a written referral from that doctor, you must provide the office with that referral at the time of check-in. Please also be aware, there are also insurance plans we accept that deem our services as Out-Of-Network. Out-Of-Network benefits may be subject to an Out-Of-Network deductible and will require an out of network referral from your insurance carrier.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know your coverage and benefits.** You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services without a referral in place, you will be responsible for your balance in full.

It is ultimately the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at CNS. CNS staff will work on your behalf to obtain a referral from your primary care provider prior to your appointment.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian

Date



Welcome to
Community neuroscience services

In order to provide the best care to our patient population, we do ask that you read and agree to these terms prior to being seen by your scheduled physician. In this way, if you are unable to keep your appointment for any reason, we're able to reschedule your appointment and also provide care for someone else in need.

Missed appointments and late cancellations

- Cancellations, no shows, or missed appointments within less than 48 hours' notice are sent as a notification per year assigned preference from CNS
- Please know it is up to the discretion of the physician whether you'll be seen if you arrive late to your scheduled appointment
- If you are more than 10 minutes late, it may be necessary for your visit to be scheduled to another date and time.
- If you receive three notifications in one calendar year, you will be discharged from the practice we'd recommend you consult your insurance provider for a list of new physicians in the community that can meet your needs.

I have read and understand these office policies and agreed to the policies provided to me. I'm aware that I can ask for a copy of the signed agreement.

Signature: _____ Date: _____

HCP /guardian signature: _____ Date: _____