Noel Brain Center

Patient Name: Date:

Today's Date _____

Name _____ Age _____ Date of Birth_____ Sex: M F

Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place to Reach You (circle one) Home / Work / Cell / Email - May we leave a message for you? ☐Yes ☐No

Employer _____ Occupation/Duties _____

Work Address _____ City _____ State _____ Zip _____

Marital Status: S M W D

In Case Emergency of Emergency Please Contact _____ Phone_____

REFERRED BY/HOW YOU FOUND US: _____

Please allow the front desk to make a copy of your driver's license or alternate ID

In your own words please describe what brings you to our office today?

Noel Brain Center

Patient Name: Date:

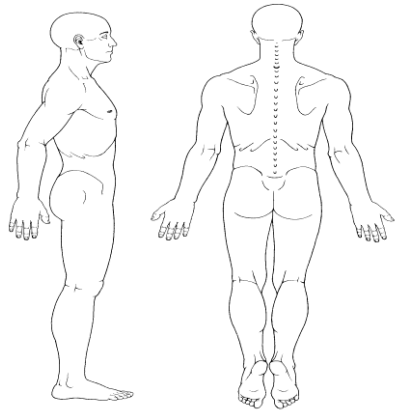
- ***Number One Complaint***: _____
- Date when symptom first appeared _____ • Was the Onset: □ Gradual □ Sudden □ Progressive over Time
- What makes it feel better? _____
- What makes it feel worse? _____
- Type of Pain: □ Sharp □ Dull □ Ache □ Burn □ Throb • Do you experience Numbness or Tingling? □ Yes □ No
- Does the pain radiate or travel into your □ Upper Arm □ Lower Arm □ Upper Leg □ Lower Leg
- How often do you experience these symptoms? □ 100% □ 75% □ 50% □ 25% □ 10%
- Pain Intensity: □ No Pain □ Mild Pain □ Moderate Pain □ Unbearable Pain
- Have you ever been to another doctor for this problem? □ Yes □ No

  Doctor _____ Date _____

- ***Second Complaint***_____
- Date when symptom first appeared _____ • Was the Onset: □ Gradual □ Sudden □ Progressive over Time
- What makes it feel better? _____
- What makes it feel worse? _____
- Type of Pain: □ Sharp □ Dull □ Ache □ Burn □ Throb • Do you experience Numbness or Tingling? □ Yes □ No
- Does the pain radiate or travel into your □ Upper Arm □ Lower Arm □ Upper Leg □ Lower Leg
- How often do you experience these symptoms? □ 100% □ 75% □ 50% □ 25% □ 10%
- Pain Intensity: □ No Pain □ Mild Pain □ Moderate Pain □ Unbearable Pain
- Have you ever been to another doctor for this problem? □ Yes □ No

  Doctor _____ Date _____

Please mark the areas of your complaint on the diagram below. Please use the following symbols on the pain diagram to accurately describe your condition:



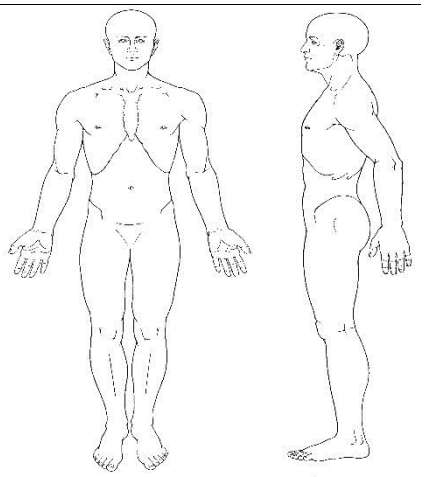
PPP: Where you experience Pain

NNN: Where you experience Numbness

TTT: Where you experience Tingling

BBB: Where you experience Burning

CCC: Where you experience Cramping



3221 S. Cherokee Lane, Suite 1830, Woodstock GA 30188 (770) 587-5844

Noel Brain Center

Patient Name: Date:

Please list all past surgeries or hospitalization:

_____

Please describe and date all previous accidents and falls:

_____

Please list any medications or vitamins you are currently taking and the amount:

_____

Please list all medical conditions that you currently have or have had in the past 6 months:

_____

For Women Only:
Date you started your last menstrual cycle: _____
Is there even a slight chance you are pregnant? YES NO
# of Pregnancies_____ Method of Birth Control_____

Please circle all that apply: Metal Implants, AIDS, Seizures, Pace Maker, Osteoporosis/Penia, Diabetes, MS, Cancer Stroke, Heart Disease, NONE OF THE ABOVE

I have carefully read and completed these forms to the best of my ability.

Patient or legal guardians Signature_____

PRINT NAME: _____

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Noel Brain Center

Patient Name: Date:

Consent for Treatment

I, the undersigned, hereby permit Noel Brain Center to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR ALL PAYMENTS DUE.**

Patient's Signature_____ Date ___/___/___ Witness_____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claims) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ Date ___/___/___ Witness_____

Request For Payment Of Benefits To Provider Of Care

I hereby authorize the Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Noel Brain Center the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date ___/___/___ Witness_____

3rd Party or Attorney Protection of Balance

I, the undersigned patient am directing the responsible parties' insurance company and/or my Attorney, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. Payments for services rendered are to be mailed directly to Noel Brain Center bearing treating doctor as payee**. IF IT IS THE 3RD PARTIES POLICY TO MAKE CHECK PAYABLE TO THE PATIENT ONLY, I HEREBY IRREVOCABLY REQUEST, BOTH THE TREATING DOCTOR AND THE PATIENT BE THE NAMED PAYEE**. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if the responsible party or my attorney does not wish to cooperate in protecting my treating doctor will not await payment but will require me to make payment on a current status. If in the event I move and\or am unreachable, **I hereby authorize my treating doctor and/or Noel Brain Center to contact any local, state or federal government agency and\or private credit-reporting agency for information necessary to secure my outstanding balance.**

Patient's Signature_____ Date ___/___/___ Witness_____

Consent for Treatment of Minor

I hereby authorize my treating doctor and/or Noel Brain Center to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my _____(indicate relationship of child), _____(child's name)

Patient's Signature_____ Date ___/___/___ Witness_____

FOR WOMEN ONLY: Pregnancy Warning and Consent To X-ray

I understand that there are inherent risks to being X-rayed if I am pregnant I am satisfied that I understand what those dangers are. My last menstrual period began on (Date) ___/___/___. I believe that I (circle one) **am**, **am not**, **may be** pregnant. I understand the risks associated with proposed X-ray evaluation and regardless of the risks request that I have X-rays at this time.

Patient's Signature_____ Date ___/___/___ Witness_____

Noel Brain Center

Patient Name: Date:

Health and Medical Information Release Form

I, _____, give permission to Dr. Cedrick Noel, his staff, associates, and employees of Noel Brain Center to share private and medical information with my medical doctor or healthcare practitioner, _____, as well as his or her staff, employees, and associates. Also, my medical doctor/healthcare practitioner, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Noel and his staff.

Signature: _____ Date: _____

Medical Doctor/Healthcare Provider Information

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

Noel Brain Center

Patient Name: Date:

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for Noel Brain Center (Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at any address/phone number/fax number/e-mail address I have supplied to office except:

_____

_____

_____

The Practice may communicate confidential information about me to my spouse, physician, parents and others listed below unless the undesired name above is crossed out initialed and dated by me. The Practice may also disclose to those individuals or entities listed on the line below:

_____

_____

_____

_____ _____/_____/_____

Patient/Patient Representative Date

Noel Brain Center

Patient Name: Date:

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