Dr. V. Sharma M.D.
NEUROLOGY & SLEEP SERVICES CENTER

2841 Hartland Road, Suite 402
Falls Church, VA 22043

Phone: 703-778-1800
Fax: 703-778-1803
Website: www.vsharmaneurology.com

PATIENT REGISTRATION

Print

Patient's Chart | Date

PATIENT INFO

First Name | Middle Name | Last Name

Date of Birth | Gender ( ) Male ( ) Female | Social Security Number

Address

Phone (Home) | Mobile

Email | Marital Status: Choose Marital Status

EMERGENCY CONTACT

Full Name | Relationship to Patient: Choose Relationship

Phone (Home) | Mobile | Email

ATTORNEY / WORKER'S COMP. INFORMATION

Mark One ( ) Car Accident ( ) State (•) Worker's Compensation | Date of Injury

Attorney's Name | Address

Phone# | Fax #

Worker's Comp Insurance Name | Worker's Comp Insurance Address

Car Accident—3rd Party Auto Insurance name:

Auto Insurance Address | Policy/ Claim Number

Adjuster Name | Adjuster's Phone | Adjuster Fax

PREFFERRED PHARMACY

Pharmacy Name | Address | Phone #

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician for the services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize Dr. Sharma or insurance company to release any medical information required to either process my claims or for medical care

Patient / Guardian Signature | Date

ALLERGIES TO DRUG OR OTHER SUBSTANCES

Allergy to	Reaction type:

MEDICATIONS

Name	Dose

DESCRIBE INJURY EVENTS (How did it occur? Were you taken to the hospital?)

(Women) are you pregnant? ◉ Yes ○ No — If yes, how long?

Do you experience any hearing difficulties? ◉ Yes ○ No

Do you exercise? ◉ Yes ○ No — If yes, how often?

Do you smoke? ◉ Yes ○ No — If yes, how often?

Do you experience anxiety? ◉ Yes ○ No

Do you experience any numbness? ◉ Yes ○ No — If yes, what part of the body?

Do you experience any dizziness? ◉ Yes ○ No

Do you experience any concentration or memory difficulties? ◉ Yes ○ No

Do you have blurred vision? ◉ Yes ○ No

Do you experience and sleeping difficulties? ◉ Yes ○ No

Do you experience headaches? ◉ Yes ○ No

Intensity (1- 10 ; 10 being the worst)

Duration (How long does it last?)

Location ○ Top ○ Back ○ All Round ○ Fore Head

Quality ◉ Pressure ○ Throbbing

Do you experience neck pain? ○ Yes ○ No

Intensity (1- 10 ; 10 being the worst)

Duration (How long does it last?)

Any pain down to the arms? Which arms? ◉ Yes ○ No

Do you experience back pain? ◉ Yes ○ No

Intensity (1- 10 ; 10 being the worst)

Duration (How long does it last?)

Any pain down to the legs? Which legs? ◉ Yes ○ No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that the Notice describes certain rights I have under federal and state law and discusses how my medical information may be used by Dr. Sharma. If I have questions or complaints regarding my privacy rights, I will be given an opportunity to ask.

Patient / Guardian Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (Please Specify):

FINANCEIAL POLICY STATEMENT

It is the patient's responsibility to know their insurance policy and its limitations. Although we check your insurance benefits as a courtesy to you, it is crucial that you are personally aware of your insurance benefits. We will not become involved in disputes between you and your medical insurance company regarding eligibility, deductible, co-payments, co-insurance payments, covered charges, etc., other than to supply factual information as necessary. If there are any changes to your insurance, you are responsible to advise us of those changes and present the new card for your records. These fees include, but are not limited to, collection agency fees and attorney fees.

MEDICARE

Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CMS (Medicare system). If your secondary insurance does not crossover, it is the patient's responsibility to contact Medicare or file these claims themselves. Any outstanding balances and deductibles are due prior to your appointments. Any coinsurance and non-covered service will be due as service is rendered.

METHODS OF PAYMENT

Our office accepts the following payment methods: cash, personal checks, VISA & MasterCard credit cards. We will assess a $35.00 NSF charge on all returned checks.

CANCELLATIONS/NO SHOW POLICY

The appointments made represent time set aside specifically for you. All cancellations should be made at least 24 hours prior to the scheduled visit. By law, all cancellations and no-shows involving worker's compensation claims must be reported to your physician and your claims adjuster.

All no-show appointments will be charged a $25.00 fee for follow ups ,$30 for Quotient $50.00 fee for tests PSG, CPAP, MSLT, EEG and EMG

The patient is ultimately responsible for all fees or services. I understand and agree to the financial policy statement above.

Patient / Guardian Signature

Date

NOTICE OF DOCTOR'S LIEN

I, _____ [PRINT NAME] hereby authorize and direct _____ [INSURANCE COMPANY] and _____ ATTORNEY] to pay to V Sharma M.D. PC, such sums as may be due and owing services rendered me by reason of the accident [DATE OF INJURY] _____ . I hereby further request that payment be made directly to the Doctor. This agreement is made solely for the Doctor's additional protection and in consideration of the Doctor's awaiting payment.

(Claim #): _____

Please acknowledge this letter by signing below and returning to the doctor's office.

NOTE: Balance is due to change because patient is still in treatment.

Patient's Name (Print) _____ **Patient / Guardian Signature** _____

Patient Telephone _____ **Mobile** _____

FOR OFFICE USE ONLY

CHART #

ASSIGNMENT AND AUTHORIZATION

I, (PATIENT'S NAME) ,

hereby authorize my physician, V. SHARMA M.D to furnish my attorney (LAWYER)

. Any medical records which they request in reference to the injuries sustained by me, my spouse and/or children on (DATE OF INJURY) .

I further authorize and direct said attorney or insurance company to deduct and pay from the proceeds of any recovery in my case, or any money which he may receive on my behalf, including but not limited to medical payments benefits, in connection with my claim for damages from personal injury to the above named physician for her professional services to myself, my spouse and/or my children, as a result of the above referenced injuries. I authorize this sum of money to be paid to the above mentioned physician at the time compensation is received. I understand that this in no way relieves me or my spouse of my personal responsibility to pay my physician for such services when a statement is rendered. It is understood that the signing of this form does not prohibit customary billing.

I also understand that if favorable legal settlement does not occur, I and/or my spouse remain liable for payment of the total bill for services rendered to me by the above names physician.

I and/or my spouse hereby agree to waive the defense of statute of limitations in the event a claim is filed against me or my spouse by reason of an unpaid bill. I and/or my spouse will not raise the defense of the statute of limitations.

I, the undersigned Attorney for the above named patient hereby agree to comply fully with the foregoing assignment and authorization and agree to advice the named doctor within ten days of his request for information regarding the status of the claim of the foresaid patient. I also agree to notify the doctor immediately of any changes in status of this case which may prelude payment of his professional fee by this office.

Signature Date

Attorney: Please sign, date and return this agreement to the doctor's office. Medical and financial reports will be forwarded upon its receipt. Please return original to us and keep a copy for your records.

Signature **Attorney at Law** Date

Print Name Date

Submit

Print