Progressive Neurology And Sleep Center

Quality Care You Deserve

Name: _____

Address: _____

City _____ State _____ ZIP _____

Female ❑ Male ❑ Date of Birth: _____ Marital Status Widowed

Telephone #: Home: _____-_____-_____ Cell: _____-_____-_____

Office: _____-_____-_____

Email Address: _____

Please Specify At Which Phone Number To Leave Messages:_____

Please Specify At Which Phone Number To Call for Appointment reminder:_____

Race: ❑Native Hawaiian or other Pacific Islander ❑other race ❑Decline
❑American Indian or Alaska Native ❑Asian
❑Black or African American ❑White/Caucasian

Ethnicity: ❑Not Hispanic or Latino ❑Hispanic or Latino ❑Decline

Preferred Language : _____ ❑Decline

Occupation: _____

Employer: _____

Emergency Contact:_____

Emergency Contact Phone: _____

Responsible Party Name: _____ Self

Address: _____

City _____ State _____ ZIP _____

Telephone #: Home: _____-_____-_____ Cell: _____-_____-_____

HIPPA Acknowledgement: Please initial one option

I hereby acknowledge that I have been provided with a copy of Progressive Neurology and Sleep Center Notice of Privacy Policies

Is it ok to leave a message regarding your health information at your:

❑Home Phone ❑Cell Phone ❑No Voice message Initial: _____

Is it ok to email you about your health information: ❑Yes ❑No Initial: _____

I consent to send you text/email appointment reminders: ❑Yes ❑No Initial: _____

I do not want to give access of my health records to anyone else except the following people:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Consents

Consent for Treatment
I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the treating physician, as well as, testing and/or treatment carried out by Progressive Neurology and Sleep Center PLLC staff under the discretion of the treating physician.

Release of Medical Information
I authorize Progressive Neurology and Sleep PLLC to release information acquired in the course of my examination and treatment to my insurance carriers. I agree that Progressive Neurology and Sleep Center PLLC may request and use my prescription medication history from the other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Deemed Consent
Under Virginia State Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which can transmit human immunodeficiency virus (HIV), or Hepatitis B or Hepatitis C viruses, you should be deemed to have consented to testing for above infectious diseases and consented to release of the test results to the person who was exposed.

Chaperones may be present during certain examinations. Any request for a chaperone by a patient and/or family member will be honored. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam testing or treatment.

Signature of the patient or responsible party: _____

Relationship: _____

Date: _____