Columbus Memory=MC² Center

Jonathan L. Liss, M.D.

Appointment Date: _____ Time: _____ Arrival Time: _____

REGISTRATION INFORMATION
*****FORMS ARE FRONT AND BACK*****

Date: _____

Last Name: _____ First Name: _____ Initial: _____

Responsible Party (if minor): _____Birth date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Gender:_____ Age: _____ Race: _____ Status: Single / Married / Widowed / Divorced

E-Mail Address: _____ Social Security #: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____

Spouse(or responsible party) Name: _____

Birth Date: _____ Spouse (or responsible party's) Social Security #: _____

Employed by: _____ Business Phone #: _____

Business Address: _____

Who is responsible for this account? _____ Relationship to Patient: _____

In case of emergency, who should be notified? _____ Phone: _____

Pharmacy Name & Address (LIST ONLY ONE): _____

How did you learn of our Practice? _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though undersigned had personally signed the particular claim.

I_____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

To pay and hereby assign directly to _____JONATHAN L. LISS M.D._____ all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____JONATHAN L. LISS M.D._____ will be credited to my account, in accordance with the above said statement.

_____ _____
(Authorized Signature of Subscriber) (Date)

7196 North Lake Drive, Suite A | Columbus, GA 31909
Phone: 706-327-4000 | Fax: 706-324-2557 | columbusmemorycenter.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ Date: _____

Reason for today's appointment: _____

What doctor referred you? _____

What other doctor(s) should we send letters to? _____

Medication Allergies:

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Current Medications:

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

7)_____ 8)_____ 9)_____

10)_____ 11)_____ 12)_____

Medical Illnesses (Please circle all that apply):

Diabetes	Heart Attack	Ulcer	Glaucoma	Irritable Bowel
Hypertension	Heart Disease	Emphysema	Macular Degeneration	Alcohol Dependence
Stroke (Brain Attack)	Seizures	Asthma	Thyroid Dysfunction	Drug Dependence
Gout	Sleep Apnea	Depression	Renal Insufficiency	Lupus
Arthritis	Sexually Transmited Disease	Hepatitis	Fibromyalgia	

Cancer Type: _____

Other: (Please list)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Past Surgical History (please list all surgeries): Do you have a pacemaker: _____ Do you have a stent: _____

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

7)_____ 8)_____ 9)_____

Social History (circle one below):

Marital Status: Single / Married / Divorced / Widowed / Separated

Alcohol Intake: Never / Occasionally / Daily / Social

Tobacco Use: Never / Occasionally / Smokeless Daily, how many packs? ____ I quit in: _____(Year)

Recreational Drug Use: No / Yes

Occupation: Homemaker / Retired / Disabled / Other: _____

Family History:	Diseases	(Please Circle)
Father:	_____	Living / Deceased
Mother:	_____	Living / Deceased
Siblings:	_____	Living / Deceased
Children:	_____	Living / Deceased

SYSTEM REVIEW

Please only circle current or active problems

Constitutional Symptoms
- Unexplained weight loss or gain
- Fever
- Fatigue
- Weight gain/Obesity
- Weight Loss

Eyes
- Blurred Vision
- Double Vision
- Cataracts
- Vision Change
- Eye Pain
- Visual Disturbance

Ears/Nose/Mouth/Throat
- Ear Ringing
- Frequent Nosebleed
- Mouth Sores
- Bad Breath
- Swollen Glands in Neck

Cardiovascular
- Chest Pain/Pressure
- Palpitations
- Shortness of breath while walking or lying flat
- Swelling of feet, ankles, or hands

Respiratory
- Frequent Cough
- Spitting-up blood
- Shortness of breath

Sleep
- Excessive daytime sleepiness
- Insomnia
- Suddenly fall asleep without warning
- Sudden fall while awake without warning
- Irresistible urge to move legs

Gastrointestinal
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Rectal Bleeding
- Heart Burn
- Abdominal Pain
- Peptic Ulcer

Psychiatric
- Nervousness
- Depression
- Confusion
- Alcohol Abuse
- Drug Abuse
- Hallucination
- Psychosis
- Suicidal

Integumentary
- Rash
- Itching
- Change in Skin Color
- Change in hair or nails

Neurological
- Headache
- Numbness
- Dizziness
- Tremors
- Lightheaded
- Tingling
- Weakness
- Hearing Loss
- Memory Loss
- Mental Status Change
- Seizure
- Speech Difficulties

Musculoskeletal
- Joint Stiffness
- Muscle Cramps
- Muscle Pain
- Joint Pain
- Back Pain

Endocrine
- Cold Tolerance
- Excessive Thirst
- Hormone problems
- Change in hat or glove size
- Glandular Problems
- Heat Tolerance

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Diplomat, American Board of Sleep Medicine / Diplomat, American Board of Psychiatry & Neurology

Acknowledgement of Office and Financial Policies

By signing below, I acknowledge and agree to the items listed below:

- This office charges a $50.00 no-show fee per missed appointment.
- I may obtain a copy of Notice of Privacy Practices upon request.
- No medication refills will occur on weekends or holidays.
- Telephone requests for medication refills require a 72-hour notice.
- Dr. Jonathan L. Liss does not provide hospital coverage, after-hours care, or weekend coverage. However, community-based neurologists remain on-call for emergency room coverage at St. Francis or Piedmont Columbus Regional.
- There is a $40.00 form fee for all requested forms. Forms require 7-14 business days to complete.
- There is a $10.00 fee for fax services.
- This office does not do pre-authorizations for medications. If your insurance company requests/ requires this, please provide us with a copy of authorized medications.
- I authorize payment to Columbus Memory Center, P.C. of all charges for services provided. I understand that I am personally responsible for all charges not covered by my insurance company. I authorize payment of medical benefits, which would otherwise be payable to me, Columbus Memory Center, P.C. for services rendered by Dr. Jonathan L. Liss.
- Dr. Jonathan L. Liss would like to share some of his office notes about your care with the Chattahoochee sleep Center. This is a sleep center that he directs. It complies with all HIPPA privacy standards. With great effort, he is helping this center achieve full accreditation. It will be the first sleep center in the history of this region that has attained this lofty goal. In order to fulfill one of the many standards involved, he must share patient charts that involve sleep related diagnoses.
- If the assistance of a collection agency becomes necessary to collect an outstanding balance, I understand that my account balance will be increased by 35 percent to help recover the cost of collections.
- There will be a fee of $40.00 for any checks that are returned.

Pharmacy: _____

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

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Patient Consent
Use and Disclosure of Protected Health Information (PHI)

With my consent, Jonathan L. Liss, M.D., Columbus Memory Center may use and disclose protected health information (PHI) **about me to carry out treatment, payment and healthcare operations (TPO).** Please refer to Jonathan L. Liss, M.D., Columbus Memory Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jonathan L. Liss, M.D., Columbus Memory Center reserves their Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jonathan L. Liss, M.D., Columbus Memory Center's Privacy Officer at 7196 North Lake Drive, Suite A, Columbus Georgia, 31909.

With my consent, Jonathan L. Liss, M.D., Columbus Memory Center **may call, mail, e-mail or fax my home or designated location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO**, such as appointment reminders, patient statements, insurance items and any call pertaining to my clinical care, including laboratory results, among others, so long as they are marked ***Personal and Confidential.***

I have the right to request that Jonathan L. Liss, M.D., Columbus Memory Center restrict how it uses and discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Jonathan L. Liss, M.D., Columbus Memory Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Jonathan L. Liss, M.D., Columbus Memory Center can exercise the option to decline to provide medical services to me.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name, Relationship to Patient (If applicable)

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PICTURES AND AUDIO/VISUAL RECORDING ACKNOWLEDGEMENT

Thank you for choosing the Columbus Memory Center (CMC) as your healthcare provider. At CMC, we believe the physician-patient relationship is especially important, which includes protecting all communication between you and your treating clinic provider. In order to protect your patient information, CMC prohibits the unauthorized taking of pictures, any audio, and visual recording while recieving care or guidance from CMC. If there are circumstance in which you feel that you may need to record an encounter with your provider, this must be approved by the physician in writing prior to your appointment.

Please sign below acknowledging that you understand this policy.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

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Medication History Consent Form

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources including your pharmacy and health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form, you agree to give our practice, your pharmacy, and your health insurance provider permission to disclose information about prescriptions that have been filled at any pharmacy or covered by any health insurance plan for you. This includes prescription medicines to treat HIV/AIDS and medicines used to treat mental health conditions such as depression or anxiety. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug histories available to use, and the drug history from your health plan may not include medications you purchased without using your health insurance. Your medication history may not include over the counter medicines, supplements or herbal remedies. Still, it is very important for us to take the time to discuss everything you are taking, and for you to share with us any errors you note in your medication history.

I, _____, give permission for Dr. Jonathan L. Liss, M.D./ Columbus Memory Center to obtain a medication history from my pharmacy, health plan provider(s), and any additional healthcare providers.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name, Relationship to Patient (If applicable)

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CONSENT TO DISCLOSE MEDICAL INFORMATION

I, _____, give Dr. Jonathan L. Liss permission to speak about my medical condition with the following people:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I give my Doctor, Dr. Jonathan L. Liss, permission to speak about my medical conditions with my physician and other authorized members of my healthcare team.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name, Relationship to Patient (If applicable)

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