



Thomas S. Hughes, M.D.  
Charles A. Kelly, M.D.  
Robert Bolen, M.D.  
Heather Norton, ACNPBC  
Kaitlin Roper, PA-C  
Kendall Bowler-PA-C

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We would like to welcome you to our practice and are excited that you have chosen one of our providers to care for you;

Dr. Thomas S. Hughes, Dr. Charles A. Kelly, Dr. Robert Bolen, Heather Norton, ACNP-BC, Kaitlin Roper, PA-C and Kendall Bowler, PA-C as one of your providers. **We ask that you keep in mind throughout your relationship with our practice you will see our mid-level Kaitlin and Heather.**

We ask that you fill out the attached documents prior to coming to your appointment. This helps with the waiting period so that you may be seen as quickly as possible.

**Please be advised that due to the nature of our practice our wait times may be longer at times than most other offices you have been to.**

There are a few things that we need you to bring with you to your appointment: **your insurance cards, and records/imaging that your referring provider may have had done, and a list of all current medications.**

**\*\*\*\*\*PLEASE BRING INSURANCE CARD(S) TO YOUR FIRST APPOINTMENT. IF YOU FAIL TO BRING THESE, THEN IT WILL RESULT IN YOU BEING ASKED TO RESCHEDULE TO A DIFFERENT DATE.**

**\*\*\*\*\* PLEASE HAVE IN HAND ALL DEDUCTIBLES IF NOT MET, CO-PAYMENTS, AND OR CO-INSURANCES THAT ARE DUE AT TIME OF CHECK IN. \*\*\*\*\***

Again, we thank you and look forward to meeting you at your appointment.

Sincerely,

The Tidewater Neurology Staff

913 Bowman Road, Suite 105, Mount Pleasant, SC 29464 Office (843) 856-9530 Fax (843) 971-1345  
7 S. Alliance Drive Ste. 201 A, Goose Creek, SC 29445 Office (843) 553-0997 Fax (843) 553-0919  
1483 Tobias Gadson Blvd, Suite 103, Charleston, SC 29407 Office (843) 410-1583 Fax (843) 793-3104

Tidewater Neurology

**New Patient Paperwork**  
**Welcome to our practice**

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number (SSN): \_\_\_\_-\_\_\_\_-\_\_\_\_

Marital status: Single; married; divorced; widowed

Race: \_\_\_\_\_ Gender: M or F, Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Responsible party name (if different from patient due to them being a minor child): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_.

Primary Care Physician (PCM): \_\_\_\_\_ PCM number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Primary policy plan name: \_\_\_\_\_

Policy holder DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patients relation to policy holder: \_\_\_\_\_self \_\_\_\_\_spouse \_\_\_\_\_child

Policy ID number: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy holder SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Secondary policy information: Plan Name: \_\_\_\_\_ Policy holder name: \_\_\_\_\_

Policy holder DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patients relation to policy holder: \_\_\_\_\_self \_\_\_\_\_spouse \_\_\_\_\_child

Policy ID: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy holder SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Employer: \_\_\_\_\_ Employment Status: \_\_\_\_\_F/T \_\_\_\_\_P/T \_\_\_\_\_Retired \_\_\_\_\_N/A

School: \_\_\_\_\_ Status: \_\_\_\_\_F/T \_\_\_\_\_P/T \_\_\_\_\_N/A Email address: \_\_\_\_\_@

Gmail, Yahoo, Outlook, Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Relationship: \_\_\_\_\_

A copy of your insurance card(s) is required at each visit for verification of information. If you are without card, you must have all required information available when you present to the office.

Payment for services is due on the day and time of appointment. We will attempt to bill charges to your insurance company if you provide valid insurance information. Payment may be made by check, cash, or debit/credit card. \*\* Notice: An additional fee for certain administrative services such as disability forms, letters of medical necessity, and returned checks along with copies of your records will be billed as patient responsibility. Missed appointment fees will also be billed as patient responsibility. \*\* Patient-Physician agreement: I, the undersigned, authorize Tidewater Neurology, PA to release any information acquired in the course of my examination or treatment to my insurance company(s) or other physicians and medical facilities. I understand that the medical insurance I have may or may not completely cover the fee(s) for professional services rendered to me, and I agree that I am responsible for said fee(s). I authorize payment directly to and assign to intuition, the surgical/medical benefits for their services. A photo copy here forth shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/ or rendered.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of Patient/Guardian: \_\_\_\_\_

Medication/supplement	Strength/mg/mcg	Number of times a day taken	Length of time taken (days, weeks, months, years.)

\*\*\*\* Allergies (Meds, Food, Plants, Insects): \_\_\_\_\_

Pharmacy Names and Number: \_\_\_\_\_

Generic Preferred? Y/N, Brand Name Only? Y/N, Mail order pharmacy? Y/N, 90day supply? Y/N

### **MEDICAL HISTORY**

*(Please check all that apply)*

CONDITION	SELF	FAMILY	CONDITIONS	SELF	FAMILY
STROKE			REFLUX		

CEREBRAL HEMORRAGE			HIATAL HERNIA		
SEIZURE DISORDER			PEPTIC ULCER		
MIGRAINE/HEADACHE			IBS		
MULTIPLE SCLEROSIS			CROHN'S		
PARKINSON DISEASE			ULCERATIVE COLITIS		
ALZHEIMER DISEASE			HEPATITIS		
DEMENTIA			PANCREATITIS		
ESSENTIAL TREMOR			DIABETES		
PERIPHERAL NEUROPATHY			HYPERTHYROID		
CARPAL TUNNEL			HYPOTHYROID		
TRIGEMINAL NEURALGIA			RENAL FAILURE		
BRAIN TUMOR			PUL. ASTHMA		
HYPERTENSION			COPD/EMPHYSEMA		
HYPERLIPIDEMIA			SLEEP APNEA		
CORONARY ARTERY DISEASE			SARCOIDOSIS		
HEART ATTACK			ASBESTOSIS		
CONGESTIVE HEART FAILURE			RHEUM. ARTHRITIS		
ATRIAL FIBRILLATION			LUPUS		
PACEMAKER			ANEMIA		
ARRHYTHMIAS			MYELOMA		
DEGENERATIVE DISC/JOINT			DEPRESSION/ANX		
SCOLIOSIS			BIPOLAR		
PROSTATIC HYPERTROPHY			PANIC DISORDER		
INCONTINENCE			ADD/ADHD		
CHRONIC UTIs			ANY OTHER CONDITIONS:		
CHRONIC NECK PAIN					
SCIATICA					
LOW BACK PAIN					

Any additional diagnosis or cancers:

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## PERSONAL INFORMATION

RIGHT or LEFT HANDED: \_\_\_\_\_

STATUS:

- ☐ MARRIED
- ☐ DIVORCED
- ☐ SINGLE
- ☐ WIDOWED

NUMBER OF CHILDREN: \_\_\_\_\_ sons \_\_\_\_\_ daughters

SMOKE: Y/N \_\_\_\_\_ packs per day \_\_\_\_\_ quit, years ago

ALCOHOL: Y/N \_\_\_\_\_ per day/week

CAFFIENE: Y/N \_\_\_\_\_ per day/week

EDUCATION LEVEL:

- ☐ GRADE SCHOOL
- ☐ HIGH SCHOOL
- ☐ COLLEGE
- ☐ POST GRADUATE

CURRENT EMPLOYMENT STATUS:

- ☐ EMPLOYED
- ☐ UNEMPLOYED
- ☐ RETIRED
- ☐ DISABLED

LIST ANY SURGERIES AND THE YEAR:

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*I, \_\_\_\_\_, authorize Tidewater  
Neurology to obtain any and all of my medical records that they  
may need for my healthcare treatment.*

\_\_\_\_\_  
*PRINT NAME*

\_\_\_\_\_  
*SIGNATURE AND DATE*

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**this information please review it carefully.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment-** Means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment-** Means such activates as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care operations-** Include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on you reauthorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person indetified by you. WE are however, not required to agree with a requested restriction. IF we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of discloses of protected health information.
- The rights to obtain a paper copy of this notice form us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 22, 2017 until further notice, and we are required to abide by the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised notice from the office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: To file a HIPPA complaint or find out more:

The US Dept of Health and Human Services  
Office of Civil Rights  
200 Independence AVE, SW  
Washington, D.C., 20201  
Toll Free: 877-696-6775



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#### NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

TIDEWATER NEUROLOGY		
913 Bowman RD Ste. 105 Mt. Pleasant, SC 29464 (843) 856-9530	1483 Tobias Gadson BLVD. Ste. 103 Charleston, SC 29407 (843) 410-1583	7 S. Alliance Drive Ste. 201A Goose Creek, SC 29445 (843) 553-0997

*I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal health care operations such as quality assessments and physician certifications.*

*I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Tidewater Neurology has the right to change its Notice of Privacy Practices from time to time and that I may contact Tidewater Neurology at the addresses above to obtain a current copy of the Notice of Privacy Practices.*

*I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.*

*Patient Name:* \_\_\_\_\_

*Relationship to patient:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES

### TIDEWATER NEUROLOGY

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Goose Creek, SC 29445  
(843) 553-0997

*I understand that under the Health Insurance Portability and Accountability Act of 1996, ("HIPPA"), I have certain rights to privacy regarding my protected health information. I authorize Tidewater Neurology to discuss my health information with the following people. I understand that at any time I can request a change in the list below.*

Name: \_\_\_\_\_ PHONE# \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ PHONE# \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ PHONE# \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ PHONE# \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

Patient signature and date: \_\_\_\_\_

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## ***WAIVER'S FOR WORKMENS COMPENSATION & MOTOR VEHICLE ACCIDENTS (MVA).***

***(WE UNDERSTAND YOU ARE NOT HERE FOR THESE WE NEED YOU TO  
SIGN SAYING YOU UNDERSTAND WE DO NOT BILL OR ACCEPT THESE  
CASES.)***

***If you are coming to Tidewater Neurology to be treated for a work related injury/illness or  
MVA, Please be aware that we do not accept patients under the Worker's Compensation  
claims or third party liability claims. We will be happy to see you; however, we will not be  
able to file any insurance or third-party payers. The balance of any visits or tests will be the  
sole responsibility of the patient on the date of service.***

***Thank you for your understanding.***

***Sincerely,  
Tidewater Neurology***

***Patient signature and date: \_\_\_\_\_***

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### **“No show” Fee Policy for Procedures**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Tidewater Neurology reserves the right to charge a fee of \$50.00 for all missed appointment time. You must cancel within 24 hours prior to the scheduled appointment time.

“**No Show**” fees are billed directly to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “no shows” in a 12- month period may result in termination from our practice.

\*Equipment return for home sleep tests and ambulatory EEG’s: Patients who are set up with this equipment are given an appointment for a return date and time. If you fail to return this equipment to our office by your scheduled appointment date and time, you will be charged a \$50.00 “equipment non-return fee” for everyday you fail to return this equipment to our office. We need this equipment back in time to set up other patients for their tests.

By signing below, you acknowledge that you have received this notice and understand this policy:

Patient Name: \_\_\_\_\_

(Please print)

Sign and date: \_\_\_\_\_

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