AMAC Neurology and Sleep Medicine Associates LLC.

Mushtaque A. Chachar MD
237 State Road. N. Dartmouth, MA 02747
(P)508-717-8903 (F)508-232-7900

New Patient Registration and Assignment Form

Full Name: _____ Date of Birth: _____

Address: _____ City/State/Zip Code: _____

Email: _____ Social Security #: _____

Emergency Contact Information

Name: _____ Phone: _____

*** The following portion of this form is a release of information benefit assignment payment authorization, full disclosure statement, and agreement to pay for professional.

I, _____ authorize AMAC Neurology and Sleep Medicine Associates LLC, to release any information acquired during the course of my examination or treatment for the purpose of processing my insurance/medical claim, and/or referrals, I agreed to allow a photocopy of my signature to be used to process my insurance/medical plan for the period of lifetime. I claim any insurance benefits dues me for services rendered by AMAC Neurology and Sleep Medicine Associates LLC, and authorized and assigned payment directly to AMAC Neurology and Sleep Medicine Associates LLC, regardless of my insurance benefits. I understand that I am financially responsible for any fees incurred, and I agreed to pay such fees in full.

Cancellations require a 24 hour notice if less than 24 hour notice is given you're responsible for administration class of $50.00 for consultation/exam and $250.00 for a schedule procedures. AMAC Neurology and Sleep Medicine Associates LLC, tracks "no notice" of cancellation instances and will terminate patients who have such instance in a calendar year.

I have fully disclose all information concerning the entrance/third-party benefits to which I am entitled. I understand that failure to disclose such information for any and all plans to which I subscribe may cause me to insure full liability for a professional charges as a result of non-payment by any carrier.

Privacy Practices Acknowledgement Form

I have received the notice of privacy practices and I have been provided an opportunity to review it._____(Initial)

I GIVE permission to AMAC Neurology and Sleep Medicine Associates LLC, or it's employee to leave a message regarding my appointment on my cell phone._____(Initial)

AMAC Neurology for Clinic Policies

Your appointments are very important to the us. We respectfully request at least 24 hour notice for cancellations or rescheduling of appointments.
Any appointment missed, late cancelled, or changed without 24 hour notice will be considered as a "no Show". We do not have a reminder system, thus it is patient's responsibility to keep record of follow up. Given that we have limited staff, we do not call to reschedule no show appointments thus after a missed appointment, it is solely patient's responsibility to call our office to reschedule an appointment. Failing to do so will automatically lead to termination of doctor-patient contract and patient will be considered discharged from our service.
The 24 hour cancellation policy gives us time to inform our wait list patients of any availability, as well as keeping our staff schedules filled, thus better serving everyone.

Patient's safety is very important to us. Thus we have a very strict policy for Patient- Physician contract and respectfully expect patient and patient's caretaker to adhere, understand their responsibilities. Any failure of patient's responsibility will automatically (without a written notice as this agreement is considered a notice) lead to termination of doctor-patient relationship..1. Follow Physician (Including MD and APP) instructions to the best of Patient's ability. Our instructions are given to Patient with the intention of maximizing the results of any ministrations we may render. These instructions are for the benefit of the patient and often, when instructions are not followed, a less than desirable treatment outcome often occurs. If patients breach the obligation to participate in their own care by following reasonable instructions will terminate the doctor-patient relationship. 2. Scheduled appointments must be kept.3. Patient is responsible of paying there part of deduction amount as notified by insurance company or paying for service (in case of no insurance and denial from insurance to pay for service provided including office visit and procedure). Failure to settle such balance, for more than 30 calendar day. 5. Patients have a duty to be forthcoming, forthright, and truthful regarding valid administrative and clinical inquiries.6. Patient or legal guardian is expected to maintain a friendly, non-hostile and hospitable behavior during their presence in the healthcare facility.

Controlled substance medication will be discontinued if provider notice, suspect any misuse or abuse of medication without any prior warning and patient will be discharged from our service immediately upon suspicion of such without any warning, grace period , Face to face visit , as it will be considered as breach of patient physician contract from patient side.

Patient's safety is very important to us. Thus we have a very strict policy for medication refill. Any failure of this policy will automatically (without a written notice as this agreement is considered a notice) lead to termination of doctor-patient relationship due to failure to follow instructions.
Instructions of patient's responsibilities: Inform us at least a week ahead of your medication due. For safety of patient, we do not adjust dosages of medication over phone, refill medication for more than 6 months without physically follow up patient. It is patient's responsibility to schedule an appointment before patient run out of medication. Patient need to schedule next follow up visit before leaving our office.
Inform physician about change of any medication you are taking.
Controlled substance cannot be refilled before due (no exceptions), or over the phone, email request. Inform Us if any other provider has filled or started Patient on a control substance (failure of such will lead to breach of physician and doctor relationship).

Dr Chachar's/ Melissa Borges (NP) has explained to me that I have the following condition(s) in a simple terms which I was able to understand: Diagnosis, Prognosis, Treatment options, test ordered. The following have been explained to me about the Treatment and medication (mentioned above): a. Its purpose and nature. b. The potential benefits and risks. c. The likely result if I do not have the recommended treatment. d. The available alternative treatments and their benefits and risks. I am aware that there may be other risks or complications not discussed that may occur. I also understand that during the course of the proposed treatment, unforeseen conditions may be revealed requiring the further change in management, and I authorize such treatment and prescription to be given to me. I acknowledge that no guarantees or promises have been made to me concerning the results of this treatment or any treatment that may be required as a result of this management plan. I understand what has been discussed with me as well as the contents of this form. I have been given the opportunity to ask questions and have received satisfactory answers.

I voluntarily consent to treatment plan and taking prescribed medication described above by my clinician or those who work with him.
In case of side effect from medication, I will call this office, and in case of worsening of symptoms, I will go to ER.
By Signing below, I attest that I read above policies and contracts and agree with all terms of these Policies.

Patient's Name: _____

Patient's signature: _____

Today's Date: _____