New Patient Registration

Neurological Institute of Northern Virginia, PC

Name: _____ DOB: _____

1.) What symptoms do you have?_____

2.) When did this problem begin? _____

3.) Has it worsened over time? _____

4.) Do you have any associated symptoms? _____

5.) What medicines have you taken for this problem?_____

6.) What other physicians have you seen for this problem?_____

7.) Have you seen a neurologist before? _____

If yes, specify the name of the physician. _____

8.) Have you had any surgeries related to this problem? _____

9.) Have you had any imaging related to this problem? Yes / No

If yes, specify imaging type and where it was done:_____

*I understand that Dr. Haideh Sabet does **NOT** see any Workers' Compensation, active legal cases, or Motor Vehicle Accident cases. She also does **NOT** prescribe any controlled substances, such as narcotics or sleep medicines. I understand that Dr. Haideh Sabet does **NOT** take Medicaid, and that I may be responsible for any payment if I have this insurance. I understand that all patient visits are in-person only, and televists will only be conducted in a nationwide emergency. I hereby consent to the scanning and storage of my identification card and insurance card in my secure electronic medical record for purposes of verification, billing, and treatment at this practice. I understand that this information will be maintained in accordance with all applicable privacy and security regulations, including but not limited to HIPAA. I acknowledge that if I do not consent to the aforementioned policies, including but not limited to the scanning and storage of my identification and insurance cards, this practice reserves the right to deny care or services in accordance with applicable laws and regulations.*

I understand that I must contact the office via phone, fax, or patient portal message for any appointment rescheduling. I understand that I cannot reply to automated appointment reminder texts or emails as these messages are not received by the office.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

CONDITIONS OF REGISTRATION

THE PRACTICE

Neurological Institute of Northern Virginia, P.C. and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child (ren) under Medicaid, Medicare, or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, the Health Care Financing Administration or The Centers for Medicare and Medicaid Services (CMS), needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Such charges for records do not exceed **$.50** per page for the first 50 pages and **$.25** per page thereafter in addition to a **$10.00** regular postage/handling fee. I further agree to pay a **$60.00** form fee for each form I require to be completed by The Practice.

REFERRALS AND AUTHORIZATIONS

If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not The Practice's to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself, my children, step children or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or confirmation. I agree to pay a **$25.00 no show fee for non-surgical appointments and a $50 no show fee for electromyography (EMG) appointments** that are not canceled at least 24 hours in advance. I also agree to pay a **$25.00 no show fee for non-surgical appointments and a $50 no show fee for surgical procedures if I arrive more than 15 minutes** late. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a **$25.00 returned check fee** in addition to the original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

HAIDEH Y. SABET, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individual 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. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, 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 healthcare operations.

- ✓ **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a physical exam.
- ✓ **Payment** means such activities 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.
- ✓ **Healthcare 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 references 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 be of interest to 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 your authorization. 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 restrictions 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 identified by you. We are, however, not required to agree to 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 at 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 disclosures of protected health information.
- ✓ The right to obtain a paper copy of this notice from 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 June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change 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 the revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries:
Haideh Y. Sabet, M.D., Attn: Privacy Officer, 5130 Duke St. Ste 9, Alexandria, VA 22304, 703-370-9411

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Service
Office of Civil Rights, 200 Independence Ave, S.W, Washington, D.C. 20201, 202-619-0257, Toll Free: 877-696-6775

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

I have received and/or reviewed your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may at any time request, in writing from the Privacy Office, a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my protected health information is used or discussed to carry out treatment, payment or healthcare operation. 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.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

PATIENT REGISTRATION

5130 Duke Street, Suite 9
Alexandria, VA 22304
Tel: 703-370-9411 Fax: 703-370-9417

PATIENT INFORMATION

Date: _____ Gender: ☐ Female ☐ Male

Last Name: _____ M.I: _____

First Name: _____

Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ ext. _____

The best way to contact me is by (circle one):
Home phone / Work phone / Cell

Email Address: _____

Would Like To Sign Up For The Patient Portal? Yes or No
In the patient portal you can see test results, future appointments, office notes and pay bills or copay

Social Security Number (Optional): _____

Marital Status (circle one):

Student ☐ Single ☐ Married ☐ Widowed ☐

Divorced ☐ Engaged

Primary Care Physician: _____
Phone Number: (_____)_____
Fax Number: (_____)_____

Emergency Contact Information
First Name: _____
Last Name: _____
Relationship: _____
Home Number: (_____)_____
Cell Number: (_____)_____

Who do we thank for referring you?
_____

Patients must attach a copy (front and back) of their primary and secondary insurance cards.

RESPONSIBLE PARTY INSURANCE INFORMATION

Primary Insurance Company_____
Policy Holder's Name: _____
SSN#:_____ Date of Birth _____
Member ID: _____ Group Number: _____
DO YOU HAVE ANY ADDITIONAL INSURANCE?
Yes or No IF YES, COMPLETE THE FOLLOWING
Secondary Insurance Company_____
ID#_____ Group Number: _____
Policy Holder's Name: _____
SSN#:_____ Date of Birth: _____

PHARMACY PREFERENCE

Primary Pharmacy _____
Address: _____
City: _____ State: _____
Zip: _____ Phone Number: (_____) _____

LANGUAGE / RACE / ETHNICITY

Primary Language (circle one):
Arabic ☐ Chinese ☐ English ☐ French ☐
Italian ☐ Japanese ☐ Portuguese ☐ Russian
Spanish ☐ Other _____

Race (circle one): American Indian or Alaskan Native
Asian ☐ Black or African American
Native Hawaiian or Pacific Islander
White ☐ Other _____

Ethnicity (circle one): ☐ Hispanic or Latino
Not Hispanic or Latino

Do you live alone? ☐ Yes ☐ No
Planning Pregnancy? ☐ Yes ☐ No

_____ _____ _____/_____/_____
Print Name **Signature** **Date**

Neurological Institute of Northern Virginia
5130 DUKE STREET, SUITE 9
ALEXANDRIA, VA, 22304

THIS FORM IS DESIGNED TO COMPLY WITH HIPAA REQUIREMENTS
"NOTICE OF PRIVACY PRACTICES"

Date: _____/_____/_____

I, _____ give Dr. Haideh Sabet, M.D. and/ or their staff permission to release
Print Name

any medical information or schedule appointments for to the following person

First and Last Name	Phone Number	Relationship to the Patient
First and Last Name	Phone Number	Relationship to the Patient
First and Last Name	Phone Number	Relationship to the Patient

PRINT PATIENT NAME	**PATIENT SIGNATURE (or authorized to sign)**	**DATE**
_____	_____	_____/_____/_____

Print Name	**Signature**	**Date**
_____	_____	_____/_____/_____

Neurological Institute of Northern Virginia
5130 DUKE STREET, SUITE 9
ALEXANDRIA, VA, 22304

Patient's Responsibility

It is the patient's responsibility to know their insurance policy. Patients should be aware of their benefit coverage including which physicians, laboratories, and facilities are contracted with their insurance plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and copays. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier directly.

Print Name: _____

Patient's Signature: _____

Date: _____/_____/_____

_____	_____	_____/_____/_____
Print Name	**Signature**	**Date**

Neurological Institute of Northern Virginia
5130 DUKE STREET, SUITE 9
ALEXANDRIA, VA, 22304

PATIENT HEALTH HISTORY FORM

Please answer the following questions to the best of your ability

1. Medical Conditions

- ☐ Arthritis
- ☐ Asthma
- ☐ Cataracts
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Pacemaker/Defibrillator
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ STD
- ☐ Ulcers
- ☐ Thyroid Disorder
- ☐ TIA
- ☐ Valvular Problems

2. Medications and Doses

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

3. Allergies/Medication Allergies

_____
_____
_____
_____

4. Surgical History (please provide surgical dates)

_____
_____
_____
_____
_____
_____
_____
_____

5. Smoking Status

- ☐ Current smoker every day
- ☐ Current some days
- ☐ Former smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Never smoked

If yes, how many years have you smoked tobacco? _____
At what age did you start smoking tobacco? _____

6. Alcohol Consumption

Do you drink alcohol?

- ☐ Yes
- ☐ No

_____ drinks per day / month / year

7. Caffeine Consumption

Do you drink caffeine?

- ☐ Yes
- ☐ No

_____ servings per day / month / year

8. Family History

Please list any family medical history, especially diabetes, high blood, heart pressure heart disease, type of cancer
Mother: _____
Father: _____
Other (specify relation): _____
_____

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

Neurological Institute of Northern Virginia
5130 DUKE STREET, SUITE 9
ALEXANDRIA, VA, 22304

REVIEW OF SYSTEMS

(Circle Yes or No)

Psychiatric:
N/Y Depression
N/Y Sleep Disturbances
N/Y Anxiety
N/Y Hallucinations
N/Y Mood Swings
N/Y Memory Loss
N/Y Agitation
N/Y Feeling unsafe in a relationship
N/Y Alcohol abuse

Constitutional:
N/Y Fever
N/Y Night Sweats
N/Y Significant weight gain (_____ lbs)
N/Y Significant weight loss (_____ lbs)
N/Y Fatigue
N/Y Exercise Intolerance

Hematologic:
N/Y Bruising
N/Y Anemia
N/Y Swollen glands

Genitourinary:
N/Y Bladder control issues

ENMT:
N/Y Difficulty hearing
N/Y Ear pain
N/Y Frequent nosebleeds
N/Y Sinus problems
N/Y Sore throat
N/Y Bleeding gums
N/Y Snoring
N/Y Dry mouth
N/Y Mouth ulcers
N/Y Oral abnormalities

Cardiovascular:
N/Y Chest pain
N/Y Shortness of breath when walking
N/Y Shortness of breath when lying down
N/Y Palpitations
N/Y Arm pain on exertion
N/Y Known heart murmur

Immunologic:
N/Y Runny nose
N/Y Sinus pressure

Integumentary:
N/Y Rashes

Neurologic:
N/Y Loss of consciousness
N/Y Weakness
N/Y Seizures
N/Y Dizziness
N/Y Headaches
N/Y Involuntary movements
N/Y Gait dysfunction
N/Y Bladder symptoms
N/Y Bowel symptoms
N/Y Confusion
N/Y Speech disorder
N/Y Syncope
N/Y Blackout
N/Y Muscle twitching
N/Y Vertigo
N/Y Tinnitus
N/Y Imbalance or falling
N/Y Blurred vision
N/Y Visual loss
N/Y Double vision
N/Y Numbness
N/Y Tingling

Endocrine:
N/Y Fatigue

Musculoskeletal:
N/Y Muscles aches
N/Y Back pain
N/Y Neck pain
N/Y Cramps
N/Y Muscle weakness
N/Y Joint pain
N/Y Swelling in extremities

Gastrointestinal:
N/Y Abdominal pain
N/Y Nausea
N/Y Vomiting
N/Y Constipation
N/Y Change in appetite
N/Y Diarrhea

Respiratory:
N/Y Cough
N/Y Shortness of breath
N/Y Wheezing
N/Y Coughing blood
N/Y Sleep apnea

Eyes:
N/Y Dry eyes
N/Y Vision changes

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

Neurological Institute of Northern Virginia
5130 DUKE STREET, SUITE 9
ALEXANDRIA, VA, 22304

TELEMEDICINE PATIENT CONSENT/REFUSAL FORM: FOR NATIONWIDE EMERGENCIES ONLY

PATIENT NAME: _____

DATE OF BIRTH: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine consultations which includes both phone calls and/or video calls.

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
a. Details of your medical history, examinations, and tests will be discussed with Dr. Sabet through the use of interactive video, audio and telecommunication technology
b. A physical examination of you may take place
c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to these telemedicine consultations

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Virginia state law apply to information disclosed during this telemedicine consultation.

5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care of treatment.

6. RISKS, CONSEQUENCES & BENEFITS: You have been advised of the potential risks, consequences and benefits of telemedicine. You have had the opportunity to ask questions about the information presented in this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

☐ **I agree** to participate in telemedicine consultations (including both phone calls and/or video calls) as they arise and I understand that there are limitations to this method of communication which include the absence of a neurological exam. **I understand** that I must be located in either the state of **Virginia or the District of Columbia** at the time of the telemedicine consultation.

OR

☐ **I refuse** to participate in a telemedicine consultation for the procedure(s) described above.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**