

**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 for this problem?

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 the name of the facility: \_\_\_\_\_

**\*\*\*I UNDERSTAND THAT I SHOULD WEAR SLIP-ON SHOES TO MY NEW PATIENT APPOINTMENT\*\*\***

*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 televisits 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**



# 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**

**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**

## 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**

**PATIENT HEALTH HISTORY FORM**

*Please answer the following questions to the best of your ability*

<p><b>1. <u>Medical Conditions</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Dizziness/Fainting</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Heart Problems</li> <li><input type="checkbox"/> High Cholesterol</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Liver Disease</li> <li><input type="checkbox"/> Lung Disease</li> <li><input type="checkbox"/> Lupus</li> <li><input type="checkbox"/> Lyme Disease</li> <li><input type="checkbox"/> Migraines</li> <li><input type="checkbox"/> Multiple Sclerosis</li> <li><input type="checkbox"/> Pacemaker/Defibrillator</li> <li><input type="checkbox"/> Parkinson's Disease</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Sickle Cell Disease</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> STD</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Thyroid Disorder</li> <li><input type="checkbox"/> TIA</li> <li><input type="checkbox"/> Valvular Problems</li> </ul>	<p><b>2. <u>Medications and Doses</u></b></p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p> <p>8. _____</p> <p>9. _____</p> <p>10. _____</p> <p>11. _____</p> <p><b>3. <u>Allergies/Medication Allergies</u></b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>4. <u>Surgical History (please provide surgical dates)</u></b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>5. <u>Smoking Status</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current smoker every day</li> <li><input type="checkbox"/> Current some days</li> <li><input type="checkbox"/> Former smoker</li> <li><input type="checkbox"/> Heavy tobacco smoker</li> <li><input type="checkbox"/> Light tobacco smoker</li> <li><input type="checkbox"/> Never smoked</li> </ul> <p>If yes, how many years have you smoked tobacco? _____</p> <p>At what age did you start smoking tobacco? _____</p> <p><b>6. <u>Alcohol Consumption</u></b></p> <p>Do you drink alcohol?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p>_____ drinks per day / month / year</p> <p><b>7. <u>Caffeine Consumption</u></b></p> <p>Do you drink caffeine?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p>_____ servings per day / month / year</p>
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**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): \_\_\_\_\_

\_\_\_\_\_

**REVIEW OF SYSTEMS**

*(Circle Yes or No)*

<p><b><u>Psychiatric:</u></b>  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</p> <p><b><u>Constitutional:</u></b>  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</p> <p><b><u>Hematologic:</u></b>  N/Y Bruising  N/Y Anemia  N/Y Swollen glands</p> <p><b><u>Genitourinary:</u></b>  N/Y Bladder control issues</p> <p><b><u>ENMT:</u></b>  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</p>	<p><b><u>Cardiovascular:</u></b>  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</p> <p><b><u>Immunologic:</u></b>  N/Y Runny nose  N/Y Sinus pressure</p> <p><b><u>Integumentary:</u></b>  N/Y Rashes</p> <p><b><u>Neurologic:</u></b>  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</p>	<p><b><u>Endocrine:</u></b>  N/Y Fatigue</p> <p><b><u>Musculoskeletal:</u></b>  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</p> <p><b><u>Gastrointestinal:</u></b>  N/Y Abdominal pain  N/Y Nausea  N/Y Vomiting  N/Y Constipation  N/Y Change in appetite  N/Y Diarrhea</p> <p><b><u>Respiratory:</u></b>  N/Y Cough  N/Y Shortness of breath  N/Y Wheezing  N/Y Coughing blood  N/Y Sleep apnea</p> <p><b><u>Eyes:</u></b>  N/Y Dry eyes  N/Y Vision changes</p>
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\_\_\_\_\_

**Print Name**

\_\_\_\_\_

**Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Date**

**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