

Mid-Maryland Neurology, PA

Patient Information

Name		Date of Birth	Age	Social Security Number	
Home Address		City		State	Zip
Mailing Address (if different from above)		City		State	Zip
Home Phone <input type="checkbox"/> Check if preferred for appointment reminders		Work Phone			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Spouse's Name		
E-mail		Cell Phone <input type="checkbox"/> Check if preferred for appointment reminders <input type="checkbox"/> Text reminders			
Primary/Referring Physician's Name (*Required*)		Address		City	State Zip

Employment Information

Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer (Parent's employer if minor)		Position		
Employers Address		City	State	Zip	Phone
Spouse's Employer				Spouse's Social Security Number	
Spouse's Employer's Address		City	State	Zip	Phone

Responsible Party Information

Person Responsible for Medical Expenses		Relationship to Patient		Phone	
Address		City		State	Zip

Primary Insurance Information

Insurance Company		Policy Number		Medicare Number	
Address of Insurance Company		City	State	Zip	
Subscriber's Name		Subscriber' Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:			
Policy Holder's Social Security Number:		Policy Holder's Date of Birth			

Secondary Insurance Information

Insurance Company		Policy Number		Group Number	
Address of Insurance Company		City	State	Zip	
Subscriber's Name		Subscriber' Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:			
Policy Holder's Social Security Number:		Policy Holder's Date of Birth			

Emergency Contact Information

Person to Contact in Case of Emergency (Other than Spouse)		Relationship to the Patient		Phone	
--	--	-----------------------------	--	-------	--

Authorization For the Release Of Information and for Payment to Mid-Maryland Neurology

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also authorize payment of insurance benefits directly to *Mid-Maryland Neurology*. I am responsible for payment if my insurance does not pay for services. I acknowledge the receipt of Mid-Maryland Neurology's privacy practices.

X
Signature of Patient, or Parent if a minor

Date

We reserve the right to charge \$50.00-150.00 for missed appointments if **not given** 48 hours' notice of the cancellation.

NEW PATIENT HISTORY FORM

Please choose one:

- Dr. Boyd Dwyer
 Dr. Richard Leschek

Do you need an interpreter for Sign Language or Foreign Language?

- ASL Foreign Language (specify) _____

Name: _____

Today's Date: _____

Age: _____

Birth Date: _____

Present Illness: Please *briefly* describe your current symptoms:

Past Medical History: Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Asthma <input type="checkbox"/> COPD | <input type="checkbox"/> HIV | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Cancer: type _____ | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sleep apnea <input type="checkbox"/> CPAP |
| <input type="checkbox"/> Concussion/Head Injury | <input type="checkbox"/> Heart Disease/ <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Prediabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> "Reflux" |
| <input type="checkbox"/> Depression | | <input type="checkbox"/> Other _____ |

Any Serious Injuries or Surgeries?

Medications:

<i>Name</i>	<i>Dose</i>	<i>How taken (frequency)</i>

Allergies:

- Aspirin Sulfa Codeine/morphine Penicillin
- Other Drugs: _____

Family History:

	Father	Mother	Brothers(1,2...)	Sisters(1,2...)
Number (of Bro/Sisters)	XXX	XXX		
Age (or age at death)				
Cause of Death				
Health (good/bad)	<input type="checkbox"/> Good <input type="checkbox"/> Bad	<input type="checkbox"/> Good <input type="checkbox"/> Bad		
<i>Conditions (check if yes)</i>				
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/MI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine/headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/shakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:				

Social History:		<i>type</i>		
Tobacco/Vape:	<input type="checkbox"/> Yes <input type="checkbox"/> No		___per day	X ___ years
Alcohol:	<input type="checkbox"/> Yes <input type="checkbox"/> No		___per day/week	X ___ years
Caffeine:	<input type="checkbox"/> Yes <input type="checkbox"/> No		___per day	
Cannabis:	<input type="checkbox"/> Yes <input type="checkbox"/> No			X ___ years

Have you ever been treated for alcoholism? Yes No When? _____

Have you ever been treated for Drug addiction? Yes No When? _____

Occupation: _____

Symptoms Review: Check if *positive*.

General

- Weight Loss >5lb
- Weight Gain >5lb
- Fatigue
- Fever/chills

Eyes

- Loss of vision
- Double vision
- Blurred vision

Ears/Nose/Throat

- Vertigo
- Hearing loss
- Ringing in ears
- Difficulty swallowing
- Loss of taste
- Loss of Smell

Muscles/Joints

- Joint pain
- Muscle pain

Heart and Lungs

- Chest pain
- Palpitations
- Irregular Heart beat
- Shortness of breath

Mood

- Anxiety
- Depression
- Mood swings
- Irritability
- Unexplained/uncontrolled crying
- Unexplained/uncontrolled laughing

Kidney/Urine/Bladder

- Incontinence
- Painful urination
- Frequency
- Urgency
- Blood in urine

Skin

- Rash
- Sun sensitivity
- Hair loss

Sleep

- Insomnia
- Snoring
- Daytime sleepiness
- Nightmares
- Difficulty breathing

Gastrointestinal

- Nausea
- Vomiting
- Heartburn
- Stomach pain
- Constipation
- Diarrhea
- Blood in stools

Neurologic

- Blackouts
- Cramps/ muscle spasms
- Dizziness
- Falls
- Headaches
- Imbalance
- Memory loss
- Mental confusion
- Numbness/tingling
- Speech difficulty
- Tremor/shaking
- Weakness

PRIME-MD PHQ-2

Over the past 2 weeks have you been bothered by any of the following problems?	Yes	No
1. Little interest in doing things	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>

What tests have you had for this problem or over the past year? What are the results?

<i>Test</i>	<i>Date</i>	<i>facility</i>	<i>Results</i>
CT Scan			
EEG (brain wave)			
EMG			
MRI			
Blood Work			
Other			

Mid-Maryland Neurology, PA

172 Thomas Johnson Dr, Suite 202, Frederick, MD 21702
Phone: 301-698-8300 ~ Fax: 301-698-8389

HIPAA AUTHORIZATION ACKNOWLEDGEMENT AND CONSENT FORM

Date: _____

Patient Name: _____

_____(Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the Mid-Maryland Neurology PA's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my Protected Healthcare Information (PHI) for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a questions or complaints. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____(Patient initials) **Release of Information.** I hereby permit Mid-Maryland Neurology PA and the physicians or other health professionals involved in my care to release PHI for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment.
- This authorization permits Mid-Maryland Neurology to use and/or disclose individually identifiable health information to any person or entity liable for payment on the Patient's behalf, in order to verify coverage or payment questions, or for any other purpose related to benefit payment.
- Individually identifiable health information may include DOB, address, phone numbers, insurance information, dates of services, type of service, treatment history, medical history, family history, physical examination, medication history, emergency records, laboratory and radiology reports, operative reports, physician notes, consultations, neuropsychiatric evaluation and drug and alcohol history (i.e. as explained in the HIPAA brochure). I understand that these medical records may contain references to mental health, substance abuse, and/or HIV/AIDS related information along with routine medical dictation and lab work.
- If I am covered by Medicare. I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of Medicare claims.

Disclosures to Family Members and/or Friends

I give permission for Mid-Maryland Neurology, Drs. Boyd Dwyer, and Richard Leschek to discuss and disclose PHI for purposes of communicating results findings and care decisions to the persons listed below. You have the right to revoke this authorization in writing. *This permission must be updated yearly.*

Name (First Last)	Relationship	Phone(if known)

Patient Signature

Date

Parent/Guardian

Date



Boyd A. Dwyer, MD

Richard T. Leschek, DO

Mid-Maryland Neurology, PA

Phone: 301-698-8300 ~ Fax: 301-698-8389

172 Thomas Johnson Dr, Suite 202

Frederick, Maryland 21702

IMPORTANT INFORMATION ABOUT PATIENT E-MAIL

As a patient of *Mid-Maryland Neurology PA*, you may request we communicate with you by electronic mail (e-mail). This Fact Sheet will inform you about the risks of communicating with your health care provider or program via e-mail and how *Mid-Maryland Neurology, PA* will use and disclose provider/patient e-mail.

E-mail communications are a two-way communication. However, responses and replies to e-mails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

E-mail messages on your computer, laptop, or other device have inherent privacy risks especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected. *You should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer's system may be viewed by your employer.*

Unencrypted e-mail provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

E-mail is sent at the touch of a button. Once sent, an e-mail message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. You can also help minimize this risk by using only the e-mail address that you provide to our practice/ program/ provider.

In order to forward or process and respond to your e-mail, individuals at *Mid-Maryland Neurology, PA* other than your health care provider may read your e-mail message. Your e-mail message is not a private communication between you and your treating provider.

Neither you nor the person reading your e-mail can see the facial expressions or gestures or hear the voice of the sender. E-mail can be misinterpreted.

At your health care provider's discretion, your e-mail message and any and all responses to them may become part of your medical record.

Appropriate uses for E-mail

E-mail may be used to request information and ask non-urgent questions. It is not an appropriate place to have long discussions regarding health issues and sensitive medicolegal matters. *It should not be used in emergencies.* If you are experiencing a sudden or severe change in your health or need an immediate response, contact your healthcare provider's office by telephone, call 911, or go to an emergency room. E-mail may be used for:

- General medical advice after an initial face-to-face visit
- Lab or radiology test results
- Patient educational material
- Other non-urgent communication

Communication with your doctor by e-mail is consider a privilege and should not be abused!



Boyd A. Dwyer, MD

Richard T. Leschek, DO

Mid-Maryland Neurology, PA

Phone: 301-698-8300 ~ Fax: 301-698-8389
172 Thomas Johnson Dr, Suite 202
Frederick, Maryland 21702

Patient Request for E-mail Communications

Patient Name: _____ Date of Birth: _____

Email Address: _____ Phone Number: _____

Communications over the Internet and/or using the e-mail system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via e-mail. To request that your provider or *Mid-Maryland Neurology, PA* communicate with you via email you must complete this form and return it to this office.

Please be advised that:

- This request applies only to the healthcare providers of *Mid-Maryland Neurology, PA* including Dr. Dwyer and Dr. Leschek.
- If you would like to request to communicate via e-mail with another health care provider or program, you must complete a separate request for that office.
- *Mid-Maryland Neurology, PA* will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS, substance abuse, mental health information) via e-mail.
- You must provide your email address when registering for your visit with your provider

I understand and agree to the following:

- I certify the e-mail address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the **IMPORTANT INFORMATION ABOUT PATIENT E-MAIL** form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated via e-mail. *If this is of concern to you, you should not communicate with your healthcare provider through e-mail.*
- I understand that all e-mail communications may be forwarded to other physicians for purposes of providing treatment to me.
- I agree to hold *Mid-Maryland Neurology, PA* and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via e-mail.

Signature of Patient

Date

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

We can share health information about you with organ procurement organizations

Work with a medical examiner or funeral director:

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

For workers' compensation claims

For law enforcement purposes or with a law enforcement official
With health oversight agencies for activities authorized by law
For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

KEEP FOR YOUR RECORDS



**Boyd A. Dwyer, MD
Richard T. Leschek, DO**

Mid-Maryland Neurology, PA

172 Thomas Johnson Drive

Suite 202

Frederick, Maryland 21702

Phone: 301-698-8300

Fax: 301-698-8389

When it comes to your health information, you have certain rights.

YOUR RIGHTS

This section explains your rights and some of our responsibilities to help you.

Get paper copy of your medical record:

We will provide a copy or a summary of your health information, usually *within 30 days of your written request*. *We may charge a reasonable, cost-based fee*. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications:

We will say “yes” to all reasonable requests. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share:

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information:

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES**For certain health information, you can tell us your choices about what we share:**

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care

Share information in a disaster relief situation

Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes
Sale of your information

Most sharing of psychotherapy notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES & DISCLOSURES**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

How we run our organization:

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

KEEP FOR YOUR RECORDS

KEEP FOR YOUR RECORDS

Mid-Maryland Neurology, PA

Dr. Boyd Dwyer
&
Dr. Richard Leschek

DIRECTIONS TO:
172 Thomas Johnson Dr.
Suite 202
Frederick, MD 21702

From: 270 North:

Route 270 north to Route 15 north. Follow to Exit for Motter Ave. Make right onto Opossumtown Pike, go 2 lights and make a Right on Thomas Johnson Drive. Go about 0.25 miles on the right you will see the "Ambers Professional Buildings" across from FCN Bank. You will see buildings 174 and 170 from the street. We are in building in 172 (in between and behind 174 and 170), in suite 202.

From: Route 15 South:

Route 15 South exit onto Christophers Crossing in Frederick. Take left onto Thomas Johnson Drive south about 1.8 miles. You will see "Ambers Professional Buildings" on the Left. We are the brown group of buildings across from FCN Bank. You will see buildings 170 and 174 from the street. We are in building in 172 (in between and behind 170 and 174), in suite 202 .

Any problems please call 301-698-8300 option 1.

KEEP FOR YOUR RECORDS