OFFICE POLICIES SHEET **Barry J. McCasland, M.D., P.C.**

In order to provide you with superior care, it is our office policy that initial evaluations are conducted between the physician and the patient ONLY. Family members, care givers, and friends may join subsequently when the diagnosis and plan are discussed if the patient allows.

Office hours are Monday through Friday 8:30 am to 4:30 pm. We are closed for lunch between 12:00 noon and 1:00 pm. For routine inquiries and business, you may call while the office is open. Dr. McCasland or an on-call physician may be reached after hours and on weekends FOR URGENT MATTERS ONLY by calling the office phone number and following the instructions on the recording. This method is not to be used for routine business such as scheduling appointments, obtaining test results, etc. THE ON-CALL PHYSICIAN IS NOT TO BE UTILIZED WHILE THE OFFICE IS CLOSED FOR LUNCH. Prescription refill requests made after hours or on weekends will only be filled if they are of an urgent nature. In general, controlled substances are not refilled after hours or on weekends. **OF COURSE, FOR ANY LIFE- OR LIMB-THREATENING EMERGENCY, CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM.**

As a courtesy to patients on the waiting list, this office attempts to confirm all appointments one or two business days prior to the appointment. If you are unable to keep your appointment or wish to cancel it, please advise us as soon as possible so we may make the appointment time available to another patient in need. Patients who no-show without notice, or who repeatedly reschedule appointments with little or no notice, may be denied further appointments.

This office is not enrolled in all insurance plans. It is the patient's responsibility to verify with his or her insurer that our office is contracted. It is the responsibility of the patient to be familiar with the current terms of his or her insurance policy. All co-pays, by contract, must be paid at the time of your visit. All payments due must be made at the time of service unless alternate arrangements have been made in advance. For your convenience, our office accepts cash, checks, and all major credit cards.

If you participate in an insurance plan that requires you to obtain a referral from your primary care physician, you must obtain that referral prior to your visit. Patients without a valid referral will have to pay the full cost of their visit at the time of service.

This office does NOT file automobile claims or automobile insurance. There are no exceptions. According to Georgia law, it is fraudulent to file health insurance claims for automobile accidents. Patients who have been injured in automobile accidents will be required to pay in full for the visit at the time of service.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

____ ____________________

(Signature) (Date)

5669 Peachtree-Dunwoody Road Suite 275 Atlanta, GA 30342 Phone: 404-531-0334 Fax: 404-531-0494

PATIENT INFORMATION SHEET **Barry J. McCasland, M.D., P.C.**

Name: ____ ____________________
(Last) (First) (M.I.) (Name called)

Address: ____
(Street) (Apt. #) (City) (State) (Zip)

Home phone: (____)____________________ Work phone: (____)____________________ Cell: (____) ____________________

Birthdate: ________/________/________ Age: _____________ Sex: M / F Marital status: ____________________________

Occupation: ____ Employer: ____

Work address: ____

Spouse name: ____ Phone number: ______________________________________

Reason for today's visit: ____

Name of referring physician: ____

Is this work-related? Y / N Is this related to a motor vehicle accident? Y / N Date of injury: ________/_________/________

Emergency contact name and phone number: ____

PRIMARY INSURANCE COVERAGE:

Insurance company name: ___________________________________ Name of policyholder: ____________________________

Date of birth: ____________________ Relationship to patient: ____________________ Employer: ________________________

SECONDARY INSURANCE COVERAGE:

Insurance company name: ___________________________________ Name of policyholder: ____________________________

Date of birth: ____________________ Relationship to patient: ____________________ Employer: ________________________

I understand that regardless of my insurance coverage, I am responsible for my bill. I authorize payment directly to Barry J. McCasland, M.D, P.C. within the terms of my insurance policy. I acknowledge that I am responsible for obtaining all necessary referrals. I authorize all photocopies of this form to be valid as an original.

____ ____________________________
(Signature) (Date)

MEDICAL HISTORY SHEET **Barry J. McCasland, M.D., P.C.**

In order to assist us in obtaining your medical history, please answer the following questions. All information remains confidential.

Major medical illnesses: (such as HYPERTENSION, DIABETES, CANCER, CORONARY ARTERY DISEASE, etc.)

____

____

____

Previous operations (include dates):

____

____

____

Hospitalizations (include dates):

____

____

Medication allergies: ____

Medications currently being taken: ____

____

____

____

Height: ___________________ Weight: ______________________ Handedness (left or right): ___________

Who is your primary care physician? ____

Do any NEUROLOGICAL diseases run in your family? ______________________________________

Do any MEDICAL diseases run in your family? ____

Do you smoke cigarettes or use other tobacco products? _____ Yes _____ No _____ I have in the past, but I quit. (Check one)

I drink alcohol: _____ Never _____ Infrequently _____ Socially _____ 1-2 servings per day _____ 3 or more servings per day

5669 Peachtree-Dunwoody Road Suite 275 Atlanta, GA 30342 Phone: 404-531-0334 Fax: 404-531-0494

REVIEW OF SYSTEMS SHEET

Barry J. McCasland, M.D., P.C.

In order to assist us in obtaining your medical history, please answer the following questions. All information remains confidential. Please circle YES if you have experienced any of the following symptoms currently, recently or in the past. If not, please circle NO.

CONSTITUTIONAL SYMPTOMS:

Fever	YES	NO
Chills	YES	NO
Weight loss	YES	NO
Night sweats	YES	NO

EYES:

Blurred vision	YES	NO
Double vision	YES	NO
Temporary blindness	YES	NO

ALLERGY/IMMUNOLOGY:

Seasonal/environmental allergies	YES	NO
Life-threatening drug allergy	YES	NO

NEUROLOGIC:

Seizures or spells	YES	NO
Tremors or twitches	YES	NO
Dizziness or vertigo	YES	NO
Weakness or paralysis	YES	NO
Loss of balance	YES	NO

ENDOCRINE:

Excessive thirst	YES	NO
Too hot or too cold all the time	YES	NO
Tired/sluggish	YES	NO

GASTROINTESTINAL:

Abdominal pain	YES	NO
Nausea or vomiting	YES	NO
Diarrhea or constipation	YES	NO

CARDIOVASCULAR:

Chest pain	YES	NO
Circulatory problems	YES	NO
Blood clots in legs or lungs	YES	NO

SKIN:

Rashes	YES	NO
Boils or other skin infections	YES	NO

MUSCULOSKELETAL:

Neck pain	YES	NO
Back pain	YES	NO
Muscle pain	YES	NO
Joint pain	YES	NO

EAR/NOSE/THROAT:

Goiter/thyroid nodules	YES	NO
Sinus problems	YES	NO
Recurrent sore throat	YES	NO

GENITOURINARY:

Urinary retention	YES	NO
Urinary frequency	YES	NO
Kidney stones	YES	NO
Kidney failure	YES	NO

RESPIRATORY:

Shortness of breath	YES	NO
Wheezing	YES	NO
Recurrent cough	YES	NO

HEMATOLOGIC/LYMPHATIC:

Swollen lymph nodes	YES	NO
Blood clots	YES	NO
Excessive bleeding	YES	NO

PSYCHIATRIC:

Depression	YES	NO
Anxiety	YES	NO
Suicidal ideation	YES	NO
Are you generally satisfied with life?	YES	NO

____ (Signature)

____________________ (Date)

5669 Peachtree-Dunwoody Road Suite 275 Atlanta, GA 30342 Phone: 404-531-0334 Fax: 404-531-0494

PRIVACY POLICY AND INFORMATION RELEASE SHEET **Barry J. McCasland, M.D., P.C.**

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been given an opportunity to read the Privacy Policy for Barry J. McCasland, M.D., P.C. *(You may request a copy for your records.)*

____ _______________________

(Signature) (Date)

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, ______________________________________, hereby authorize Barry J. McCasland, M.D., P.C., to release my protected health information (including mental health information and the results of HIV and genetic tests) to the following: *(Check all that apply.)*

_____ Spouse (print name) ____

_____ Family members (print names) ____

_____ Employer or school (print name) ______________________________________

_____ Attorney (print name) ____

_____ Physician other than referring physician (print name) ___________________________

_____ Other (print names) ____

This authorization shall expire (print date or enter ‘never’) ___________________________

____ _______________________

(Signature) (Date)

5669 Peachtree-Dunwoody Road Suite 275 Atlanta, GA 30342 Phone: 404-531-0334 Fax: 404-531-0494