In order to provide patients 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 plans are discussed if the patient allows.

Office hours are Monday through Thursday from 8:30 am to 4:30 pm with lunch taken from 12:00 noon to 1:00 pm. Friday hours are from 8:30 am to 12:00 noon. 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 utilized for routine requests such as scheduling or cancelling appointments, obtaining test results, etc. THE ON-CALL PHYSICIAN IS NOT TO BE UTILITEZED 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. **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 several business days prior to the appointment. Appointment confirmation calls, or emails/text messages with your consent, are a courtesy only and should not be relied upon to remember your appointment date and time. 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. 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 their insurer that our office is actively contracted. It is the responsibility of the patient to be familiar with the current terms of their 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 an insurance referral for specialists' visits from your primary care physician, you must obtain that insurance 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.

_____ _____

(Patient Signature) (Date)

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: (____)_____ Cell phone/text messages: (____)_____

E-mail address (please print legibly): _____

Birthdate: _____/_____/_____ Age: _____ Sex: M / F Marital status: _____

Employer: _____ Occupation: _____

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)

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

MEDICAL HISTORY

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

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

Height: _____ (ft/in) Weight: _____ (lbs) Dominant hand: RIGHT LEFT

Medication Allergies:

_____

Current Medications: _____

_____

_____

Major medical illnesses: (such as High Blood Pressure, Diabetes, Cancer, etc.) _____

_____

_____

Previous operations/surgeries (include dates): _____

_____

_____

Hospitalizations (include dates): _____

_____

_____

Primary care physician: _____

Family history of NEUROLOGICAL DISEASE (such as Alzheimer's, Parkinson's, etc.): _____

_____

Family history of any other MAJOR MEDICAL DISEASE: _____

_____

Current tobacco use: YES NO History of tobacco use: YES ____ months ago NO

Alcohol consumption: NEVER INFREQUENT SOCIALLY DAILY (1-2 SERVINGS) (3+ SERVINGS)

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

REVIEW OF SYSTEMS

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 or recently. If not, 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 allergies	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 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?

X _____ **DATE:** _____

Patient Signature

Wireless means of communication (email and text messages) are rapidly becoming a standard means of communication between business and clients and between medical practitioners and patients. In light of this shift in business practices, your consent to participate in wireless communication is needed.

By providing Barry J McCasland, M.D., P.C. with a phone number and/or email address, you or anyone authorized to act on your behalf, are providing express consent authorizing Barry J McCasland, M.D., P.C., as well as its agents, subsidiaries, officers, partners, successors in interest, and any companies acting on its behalf, to contact you at any phone number or email address you provided or have provided to Barry J McCasland, M.D., P.C. at any time with information related to your account.

By providing Barry J McCasland, M.D., P.C. with any phone number or email address, you are confirming you are the owner or are authorized to use the provided phone number or email address. You also confirm that you will notify Barry J McCasland, M.D., P.C. immediately if you no longer own or are no longer authorized to use any phone number or email address you provide to Barry J McCasland, M.D., P.C.

You permit Barry J McCasland, M.D., P.C. to contact you via live operator, automatic telephone dialing systems, prerecorded and artificial voice messages, text messages (SMS or MMS), or email.

Phone numbers and email addresses you authorize Barry J McCasland, M.D., P.C. to contact you include any that you provide to Barry J McCasland, M.D., P.C., and that you contact Barry J McCasland, M.D., P.C. from, and that are provided to Barry J McCasland, M.D., P.C. by someone acting on your behalf, and that Barry J McCasland, M.D., P.C. locates from other lawful sources.

You understand that you are solely responsible for payment of any message rates and data charges associated with communications you receive or send to Barry J McCasland, M.D., P.C..

By providing Barry J McCasland, M.D., P.C. with any phone number or email address, you acknowledge that you have read, fully understand, and will comply with this Wireless Communication Policy and Consent.

☐ I HAVE READ AND UNDERSTAND THE WIRELESS COMMUNICATION POLICY STATED ABOVE AND ***AGREE*** TO ACCEPT RESPONSIBILITY AS DESCRIBED.

☐ I HAVE READ AND UNDERSTAND THE WIRELESS COMMUNICATION POLICY STATED ABOVE AND ***DO NOT AGREE*** TO ACCEPT RESPONSIBILITY AS DESCRIBED.

_____ _____

(Patient Signature) (Date)

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) _____

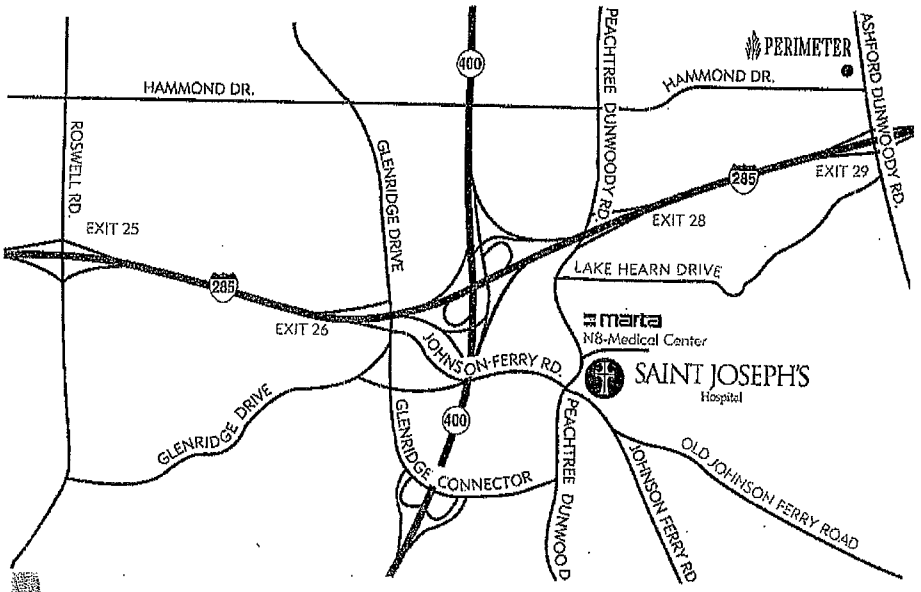
_____ Other (print names) _____

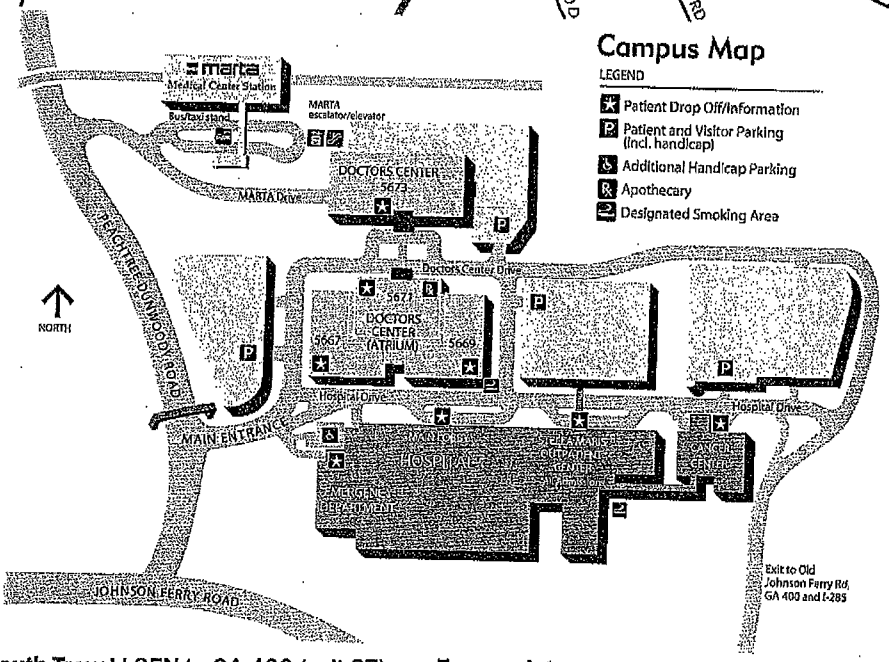
This authorization shall expire (print date or enter 'never') _____

_____ _____

(Signature) (Date)

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





From Points South Travel I-85N to GA 400 (exit 87). Take exit 3 (Glenridge Connector) and turn right onto Glenridge Road. At the second light, turn left onto Peachtree Dunwoody Road. Cross Johnson Ferry Road and immediately enter the right turn lane. Turn right into the hospital campus.

From Roswell/Cumming/Alpharetta Travel GA 400S to exit 3 (Glenridge Connector) and turn right onto Glenridge Road. At the third light, turn left onto Peachtree Dunwoody Road. Cross Johnson Ferry Road and immediately enter the right turn lane. Turn right into the hospital campus.

From points west Travel I-20E to I-285N to exit 26 (Glenridge Connector). Turn right at the end of the ramp onto Glenridge Road and immediately enter the left turn lane to turn left onto Johnson Ferry Road. At the third light, turn left onto Peachtree Dunwoody Road and immediately enter the right turn lane. Turn right into the hospital campus.

From points east Travel I-20W to I-285N. Take exit 28 and turn left onto Peachtree Dunwoody Road. At the third light, just past the MARTA station, turn left into the hospital campus.

From the hospital to GA 400N and GA 400S Turn left out of the main entrance onto Peachtree Dunwoody Road. At the second light, turn right onto the Glenridge Connector. Turn left at second light to the 400N ramp. Turn left at the third light to the 400S ramp.

From the hospital to I-285E Turn right out of the campus onto Peachtree Dunwoody Road. At the second light, turn right onto the ramp.

From the hospital to I-285W Turn left out of the campus onto Peachtree Dunwoody Road. At the first light, turn right onto Johnson Ferry Road. At the third light, turn right onto the Glenridge Connector and immediately enter the far left lane. At the next light, turn left onto the ramp.