BALANCE AND DIZZINESS CENTER
MEMORY CENTER / TMS HEALTH CENTER

MICHAEL HEUBLUM, MD (NEUROLOGY)
JEFF SHENFELD, MD (INTERNAL & SLEEP)

401 S VAN BRUNT STREET, SUITE 302, ENGLEWOOD, NJ 07631
TEL. (201) 947-4777 FAX. (201) 461-6160

Patient Demographic Form

Today's Date: _____ /_____ /_____

Name: _____

Date of Birth: _____ Age: _____ Sex: M / F

Right/Left Handed Height _____'_____" Weight_____lbs

Address: _____

Phone#: _____ E-mail: _____

Primary Care Doctor: _____

Emergency Contact: _____ (_____)
Name *Relationship*

Emergency Phone#: _____

How did you find us?: _____

Check what best applies to your symptoms/conditions.

[ ] Dizziness [ ] Balance Problem [ ] Sleep Issue

[ ] Memory Concern [ ] Other (_____)

Signature: _____

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1. When did symptoms **first** begin?: _____

Section A. Dizziness, Balance & Fall Questionnaire

**** If you are NOT DIZZY, please skip this box and go to the Question 6. ****

2. Duration of episodes:

[ ] Seconds
[ ] Minutes
[ ] Hour

[ ] Constant
[ ] Periodical

3. My dizziness is best described as…

[ ] I feel like I am spinning/moving
[ ] I see the world around me spinning/moving
[ ] Lightheadedness or "swimming" sensation
* Symptoms present with - Nausea [ ] and/or Vomiting [ ]

4.These positions make me dizzy.

[ ] Sitting [ ] Getting up [ ] Standing [ ] Lying in bed [ ] Turning [ ] Bending

5. When was your **last** dizziness episode?:

_____

6. Have you seen other Healthcare Providers for your current condition?

[ ] Yes - [ ] Primary Care Doctor
[ ] Neurologist
[ ] Cardiologist
[ ] ENT/HNS
[ ] Emergency Room
[ ] Other: _____

[ ] No

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Section B. Medical History

1. Mark all that apply.

[ ] Ringing in the ear (Tinnitus)
[ ] Hearing Loss
[ ] Fullness of ear
[ ] Motion Sickness
[ ] Staggered Gait
[ ] Head trauma / Injury
[ ] Loss of consciousness
[ ] History of fall

[ ] Shortness of breath
[ ] Chest pain
[ ] Irregular heartbeat
[ ] High blood pressure
[ ] Low blood pressure
[ ] Orthostatic hypotension

[ ] Double/Blurry vision
[ ] Low vision
[ ] Glaucoma
[ ] Cataracts

[ ] Anxiety
[ ] Depression
[ ] Panic Attack

[ ] Headache/Migraine
[ ] Facial Numbness
[ ] Numbness of the leg
[ ] Pain in the leg
[ ] Numbness of the arm
[ ] Pain in the leg
[ ] Neck pain
[ ] Back pain
[ ] Arthritis / Rheumatism
[ ] Shingles
[ ] Cold sores / Fever blisters

[ ] Seizure
[ ] Stroke
[ ] Slurred speech
[ ] Asthma
[ ] Thyroid problem
[ ] Kidney problem
[ ] Liver problem
[ ] Diabetes
[ ] Cancer / Chemotherapy
[ ] Excessive weight loss or gain
[ ] Excessive bleeding with previous surgery

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2. Major surgeries you had.

3. Medications you are taking.

4. Is there anything else you would like to make sure to tell your physician about?

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Notice of Privacy Practices Consent Form

DIAGNOSTIC ULTRASOUND PLUS, INC.

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

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your *Notice of Privacy Practices Consent Form* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices Consent Form.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

INSURANCE AUTHORIZATION, FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims, provided verification of your insurance policy(s) allows assigned benefits and coverage for the services rendered. I hereby authorize payment directly from my insurance carrier to the rehabilitation agency for the benefits due to me in my pending claim. I further authorize the release of any medical information required by my insurance carrier.

I, the undersigned, understand that the rehabilitation agency will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make complete payment for services rendered, I am responsible for complete payment of physical therapy services, including any and all deductibles, coinsurance amounts. I am responsible for payments that are denied for lack of medical necessity as determined by your health insurance payer. The charges incurred are not subject to any fee schedule or reductions unless the rehabilitation agency is a contracted managed care provider for my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand the payments of the fee are not contingent upon a settlement of litigations; however, I hereby instruct my attorney to pay the rehab agency in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS

Accepting the assignment means that the provider of services agrees to accept the “allowable” charges as determined by Medicare as full payment. However, you much remember Medicare generally pays 80% of the allowable charges. Therefore, you are still responsible for the 20% balance. In addition to the 20% you are responsible for any amounts applied toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT

A rehab agency representative has explained to me that under the Medicare guidelines, I will be responsible for 20% of the allowable charge. The rehab agency has agreed to accept assignment of the benefits on this portion of the charges; I also understand that should the supplemental insurance company fail to pay for these charges with a “reasonable length of time”, or send payment directly to me, I will become responsible for payment in full.

The above Patient Financial Policy and Agreement has been read and/or explained to me:

Patient’s Signature:_____

Name:_____Date: _____