River City Neurological Associates

Covid-19

Due to the current Covid-19 pandemic, our practice has undergone changes in order to comply with safety guidelines and practices to further prevent the spread of the virus. These changes include the following;

Our providers are conducting patient visits through telemedicine. This type of appointment will either be performed virtually through a secure connection via Doxy application or over the phone. When you are given a telemedicine appointment you should expect to be contacted in steps that include the process of being checked in, speaking with a medical assistant followed by a provider and ending the visit with a call back from a front staff member in regards to orders that were placed and scheduling your follow up visit.

1. When you are scheduled for a telemedicine visit and you are a New patient, you will be sent and/or asked to pick up new patient paper work and consent forms that need to be filled out prior to your appointment as well as you providing our office with copies of your ID and insurance cards. Without these items, your appointment will need to be rescheduled.
2. For telemedicine visits, you are given an appointment time. This is the time you should expect the first step of the appointment to begin with the check in process. Your time to see a provider will occur within a 2 hour window after the first step has been completed. Please make sure you allow for this timeframe when making your appointment. If you are being seen virtually through the Doxy application you will need to make sure you are at a location in which you have an adequate internet connection to allow for a successful visit. Telemedicine appointments cannot be conducted with patients while they are driving.
3. In order to provide service for patients that are unable to participate in telemedicine appointments or for those who need to be seen in office due to certain conditions, we have opened the clinic on Wednesdays and limited appointments on Fridays to accommodate this need. However, only having minimum days and times for in person visits while continuing to follow covid-19 safety precautions there are some things we ask our patients to take into consideration: A. You will be screened prior to entering the building by answering a questionnaire regarding symptoms and exposure to covid-19 as well as a temperature check. Any patient that has the following will be asked to reschedule to a later time: a temperature of 99.0 or higher, recent exposure to covid-19, a positive covid-19 test and has not been retested and given a negative result. B. Patients are to wear a mask or face covering to their appointment and keep said mask or covering on through the duration of his/her appointment. C. Patient appointments are limited to patient only unless prior approval of accompanying caregiver is given due to mobility and/or comprehension conditions. In these circumstances, the caregiver will also undergo screening as described in letter B. D. Patients may experience longer than usual wait times. Please understand this when making an in person appointment. Due to the limited days and hours our practice is allowing in office visits and the number of patients that require in office visits, an appointment wait time that is longer than normal is expected and we ask that you plan accordingly. Due to covid-19 safety measures and following social distancing, we can only utilize a number of exam rooms, causing wait times to be extended. This also goes for the number of patients in the waiting areas. We have them arranged to allow for social distancing and if they become full you may be asked to wait in your car until our screener comes and gets you for your appointment.

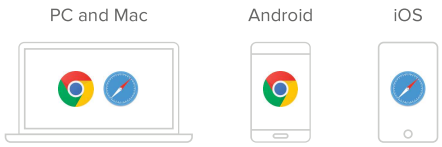
We appreciate your cooperation and patience with us as we work through these conditions to continue to provide care to all of our patients.

doxy.me **PATIENT QUICKSTART**

5 Steps to Check In for Your Video Visit

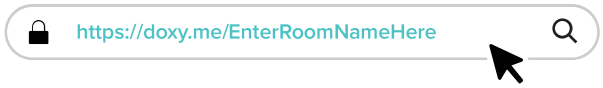
1 Select Device

Use a computer or device with a camera and microphone.



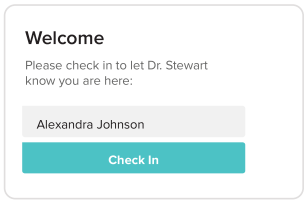
2 Go to Provider's Room

Enter your provider's doxy.me room web address into the browser.



3 Check In

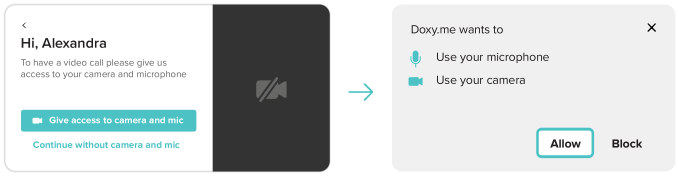
Type in your name and click **Check In**.



- Secure
- No software to download
- No registration needed

4 Enable Webcam and Microphone

Allow your browser to use your webcam and microphone.



Doxy.me is encrypted and HIPAA compliant

5 You're In!

Wait for your provider to start the call.

Tips for a Great Call

- Restart your device before your visit.
- Connect to the internet with an Ethernet cable or strong WiFi signal.
- Ensure your browser is updated to the most recent version.
- If possible, use a newer device and make sure it is fully charged.
- Try disconnecting other devices from the WiFi you're using.
- Click **Pre-call Test** in the waiting room to make sure your system is ready for the call.

Need Help?

If you need more assistance, don't hesitate to contact us!

Call
(844) 436-9963

Send a message
support@doxy.me

RIVER CITY NEUROLOGICAL ASSOCIATES
Mohammed Pathan MD
2101 North Avenue
Columbus GA 31904
Phone: 706 221 8799 Fax: 706 221 8979

Patient Demographic Sheet

Patient Name: _____

Address: _____

_____

Primary Phone: _____ Secondary/Alternate Phone: _____

DOB: _____ Gender: Marital Status: SSN: _____

Email Address: _____ Race: _____

Pharmacy: _____

Do you have a Living Will: _____

EMERGENCY CONTACT(S):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I give permission for Dr. Mohammed Pathan of River City Neurological Associates to speak to the following family members/advocates on my behalf:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ Date

Patient Signature

RIVER CITY NEUROLOGICAL ASSOCIATES
Mohammed Pathan MD
2101 North Avenue
Columbus GA 31904
Phone: 706 221 8799 Fax: 706 221 8979

Medical Records
Release of Information

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Please list below any other physicians or facilities that may have medical information pertaining to your healthcare that would be beneficial in assisting with your care and treatment administered by Dr. Mohammed Pathan.

Physician: _____ Phone: _____

Physician: _____ Phone: _____

Physician: _____ Phone: _____

Facility: _____ Phone: _____

Facility: _____ Phone: _____

Facility: _____ Phone: _____

I authorize Dr. Mohammed Pathan to obtain any and all healthcare information required to assist with my care and treatment.

_____ _____
Patient Signature Date

River City Neurological Associates
Mohammed Pathan, MD
2101 North Avenue
Columbus, GA 31904
Phone: (706) 221-8799 Fax: (706) 221-8979

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF PHI

FOR RCNA STAFF USE ONLY:

To: _____ Fax: _____

PLEASE SEND REQUESTED INFORMATION:

FOR PATIENT USE:

PATIENT NAME: _____ DOB: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclose and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the facility where PHI is being requested from. I understand that my revocation is not effective to the extent that persons or organizations in which I have authorized to use and/or disclose my PHI have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment or eligibility of benefits. I understand that I will be given a copy of this authorization upon my signature, when requested. I hereby authorize the facility where I am requesting PHI to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release the facility where I am requesting PHI from any liability which may result from this disclosure of confidential medical information of which may arise of the result of the use of information contained in the information released. I authorize this information may be faxed when applicable.

PATIENT SIGNATURE : _____

DATE: _____

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted disease; human immunodeficiency (HIV) infection; behavioral health service/psychiatric care and evaluation; treatment for alcohol and or/ drug abuse; or similar conditions.

River City Neurological Associates

Patient Registration, Consent for Treatment

Financial Policy Form

Welcome and thank you for choosing River City Neurological Associates for your medical care. This patient financial policy has been developed to help our patients understand their financial responsibilities regarding their healthcare benefits. Please review and sign our treatment, office and financial policies.

- I hereby give consent for treatment of myself, or the named minor child, by the physician, physician assistants, nurse practitioners, and/or staff of River City Neurological Associates (RCNA).
- I am responsible for providing RCNA with **correct insurance information** at the time of my appointment. If my plan changes, I need to notify the office of these changes. If I fail to do so, I will be responsible for any charges that are not paid in full.
- I am required to obtain a referral from my primary care physician if my insurance requires one. If a referral is required, and I do not have one at the time of service, **I will be financially responsible for the services I received – payment in full.**
- I am responsible for any co-pay, co-insurance, or deductibles required by my insurance. I am responsible to know how much my co-pay is. Payment will be collected at the time of service. Some services may be billed to my insurance company prior to collecting for services. If I owe RCNA it is my responsibility to make prompt payment. I am fully responsible for any unpaid account balances including, but not limited to: co-payments, co-insurances, and deductibles not paid by my insurance carrier. Accounts not paid in full within 30 days will be subject to a finance charge of up to 18% annually. Should my account become delinquent after 90 days I will be referred to the collection agency; I am responsible for the balance owed plus all the cost incurred in collecting the balance. **Please be advised that in the event there are any outstanding balances, we may refuse treatment and/or schedule an appointment for you. We review delinquent accounts for dismissal. Delinquent accounts are defined as accounts with unpaid balances 90 or more days past due.**

SELF-PAY Payment is expected at the time of service. The amount quoted to you is already a discounted rate and due at the time of your visit.

New Patients (including those who have not been seen in over 3 years) - **$205**
Follow up visit - $72
Procedures – Quoted prior to scheduling & due at the time of the procedure

- I understand that the cancellation policy for appointments at RCNA is that I must contact the office **2 business days prior** to my appointment to avoid the **$25 no-show or late cancellation fee.** This fee will be due in full before rescheduling the missed appointment. We have a policy of 3 occurrences and anything over that may result in being dismissed by the practice.
- Returned checks are subject to a $30 service charge and will terminate my privilege to pay by check for future visits.
- I understand that it is my responsibility to call my insurance company to know what **my insurance plan benefits cover or who is in my network.** I will call the insurance company to educate myself on what labs, imaging, hospitals or other practices I am eligible to get services from and the possible co-payments or deductibles that I am financially responsible for.

Assignment of Benefits: I understand that my records in their entirety, regardless of coverage, may be released to any government agencies (Medicare, Medicaid, subpoena) or insurance companies for the purpose of pursuing payment, reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance reviews as requested by law.

We accept Cash, Check and credit Visa, MC, Discover and American Express cards.

By Signing Below: I have read the entire page(s) above which explains my patient financial responsibility. I agree to the above terms, to be financially responsible for the amounts determined by my insurance company and/or RCNA. By signing this I agree to be personally and fully responsible for payment. This form will follow me through the entirety of my treatment with RCNA.

_____

Patient/Legal Representative Print and Sign Relationship to patient Date

QUESTIONNAIRE

Use this document to help facilitate a discussion with your healthcare professional about migraine

ABOUT YOU

How has migraine affected your daily activities? _____

_____

Have you consulted a neurologist or pain specialist during your treatment journey? ☐ Yes ☐ No

ABOUT YOUR MIGRAINE

How many headache days do you experience a month? _____

How many migraine days do you experience a month? _____

How long have you suffered from migraine headaches? _____

Approximately, how old were you when you were diagnosed with migraine headaches? _____

Have you been evaluated for medication overuse headache? ☐ Yes ☐ No

If Yes, do you suffer from medication overuse headache? ☐ Yes ☐ No

ABOUT YOUR MIGRAINE TREATMENT HISTORY

Please place a check mark in the ☐ or write in the medications you have taken if not listed.

TYPE OF MEDICATIONS	MEDICATION CLASS	GENERIC NAME	
Blood Pressure Medications	Beta blockers	☐ Propranolol ☐ Timolol ☐ Atenolol	☐ Metoprolol ☐ Nadolol
	Calcium channel blockers	☐ Verapamil ☐ Diltiazem	☐ Nimodipine
Antidepressants	Tricyclic antidepressants	☐ Amitriptyline ☐ Nortriptyline	☐ Imipramine
	Selective serotonin reuptake inhibitors (SSRI/SSNRI)	☐ Fluoxetine ☐ Paroxetine	☐ Sertraline
Anticonvulsants		☐ Topiramate ☐ Divalproex sodium	☐ Gabapentin
Neuro Toxin	Botulinum toxin	☐ OnabotulinumtoxinA	
Acute Treatments (quick acting)		☐ Triptans	
Other	*Please specify:* _____		

Of the treatments you have taken, have you discontinued any due to:

Efficacy: ☐ Yes ☐ No Side Effects: ☐ Yes ☐ No

How many days a month do you take quick acting medications (prescription or over the counter)? _____

Lilly

HIT-6™ Headache Impact Test

HIT is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36® health assessment tool. This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

When you have headaches, how often is the pain severe?

never rarely sometimes very often always

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

never rarely sometimes very often always

When you have a headache, how often do you wish you could lie down?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

never rarely sometimes very often always

☐	+ ☐	+ ☐	+ ☐	+ ☐
COLUMN 1 6 points each	COLUMN 2 8 points each	COLUMN 3 10 points each	COLUMN 4 11 points each	COLUMN 5 13 points each

To score, add points for answers in each column.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

☐
TOTAL SCORE

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing Score 0 - 3
Sitting and reading	☐
Watching TV	☐
Sitting inactive in a public place (e.g. a theater or a meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
In a car, while stopped for a few minutes in traffic	☐
TOTAL	☐

The higher the score, the greater the chance of a diagnosis of OSA.

ResMed

Toll free: 800 424-0737
www.resmed.com

See Reverse Side for Instructions

Please complete your health questionnaire to the best of your ability

Past Medical History

Anemia

- Yes
- No

Anxiety

- Yes
- No

Heart Problems

- Yes
- No

Cancer

- Yes
- No

Deep vein thrombosis(Blood Clots)

- Yes
- No

Degenerative disease lumbosacral spine

- Yes
- No

Depression

- Yes
- No

Diabetes

- Yes
- No

Neuropathy

- Yes
- No

Fibromyalgia

- Yes
- No

High Blood Pressure

- Yes
- No

Thyroid problems

- Yes
- No

Insomnia

- Yes
- No

Multiple Sclerosis

- Yes
- No

Obesity

- Yes
- No

Seizures

- Yes
- No

Stroke

- Yes
- No

Vertigo

- Yes
- No

Family History

Family History of Health Problems: (Mother, Father, & Siblings Only)

- diabetes
- stroke
- seizures
- heart disease
- dementia
- high blood pressure
- high cholesterol

Tobacco Use:

Non Smoker

- Yes
- No

Did you use to smoke? For how long? When did you quit? How much did you smoke before you quit?

Tobacco Use/Smoking

- Yes
- No
- less than 1 pack per day
- 1 pack per day
- more than 1 pack per day

Used smoke

- Yes
- No

Miscellaneous:

Caffeine:

- Yes
- No
- 1-2 cups
- 2-3 cups
- more than 3

Exercise:

- Yes
- No

Marital status:

- Married
- single
- divorced
- widowed

Are you

- Full-time
- part-time
- disabled
- retired
- none

General/Constitutional

Fever

- Yes

- No

Chills

- Yes
- No

Change in Weight

- Yes
- No

ENT

Ringing in the ears

- Yes
- No

Difficulty swallowing

- Yes
- No

Snoring

- Yes
- No

Genitourinary

Blood in urine

- Yes
- No

Difficulty urinating

- Yes
- No

Cardiovascular

Chest pain

- Yes
- No

Palpitations

- Yes
- No

Shortness of breath

- Yes
- No

Endocrine

Diabetes

- Yes
- No

Difficulty sleeping

- Yes
- No

Thyroid problems

- Yes
- No

Cold intolerance

- Yes
- No

Heat intolerance

- Yes
- No

Hematology

Bleeding problems

- Yes
- No

Skin

Itching

- Yes
- No

Psychiatric

Anxiety

- Yes
- No

Depressed mood

- Yes
- No

Neurologic

Balance difficulty

- Yes
- No

Coordination

- Yes
- No

Difficulty speaking

- Yes
- No

Dizziness

- Yes
- No

Fainting

- Yes
- No

Gait abnormality

- Yes
- No

Headache

- Yes
- No

Loss of strength

- Yes
- No

Low back pain

- Yes
- No

Memory loss

- Yes
- No

Seizures

- Yes
- No

Stroke

- Yes
- No

Tingling/Numbness

- Yes
- No

Yes
No

Transient loss of vision

Yes
No

Weakness

Yes
No

Tremor

Yes
No

Musculoskeletal

Arthritis

Yes
No

Carpal tunnel

Yes
No

History of Gout

Yes
No

Muscle aches