CENTER NEUROLOGY, P.C.

JOSEPH N. SABA, M.D.

Neurology, EEG, EMG,, Evoked Potentials

Certified Diplomate, American Board of Neurology and Psychiatry (Neurology)
Certified Diplomate, American Board of Neurology of CLinical Neurophysiology and Qualification in EEG
Certified Diplomate, American Board of Independent Medical Examiners (ABIME)
Certified Diplomate and Senior Disability Analyst, American Board of Disability Analysts
Fellow, American Academy of Disability Evaluating Physicans
Fellow for Life, Royal Society of Medicine (Great Britain)

PLEASE FILL IN ALL FORMS COMPLETELY BEFORE YOUR SCHEDULED APPOINTMENT
PLEASE PRINT CLEARLY. You are welcome to bring one adult with you to the exam room. However, children are not allowed unless they are being treated. Please bring all Meds on each visit and previous Records including Xrays.

Picture I.D. is required. Copays are due at time of service.

If your health insurance requires prior authorization, please obtain the authorization prior to your appointment.

If you were in an automobile accident, be sure to bring your insurance card along with the adjuster's name, phone number, claim number and police report.

If this is a worker's compensation injury, we will need the name of your worker's comp insurance company, adjuster's name, phone number and claim number before appointment time for approval or denial to treat. We will verify all information in the office. Please remember that your insurance company has a list of approved physicians for worker's compensation injuries and we may not be one of them. You may want to check ahead of time to make sure we are an approved physician with your insurance company.

If you are represented by an attorney, fill in all blanks on the 5th page and have your attorney sign the forbearance agreement BEFORE your first visit.

You are scheduled to see Dr. Saba on _____ at _____. Please arrive by _____.

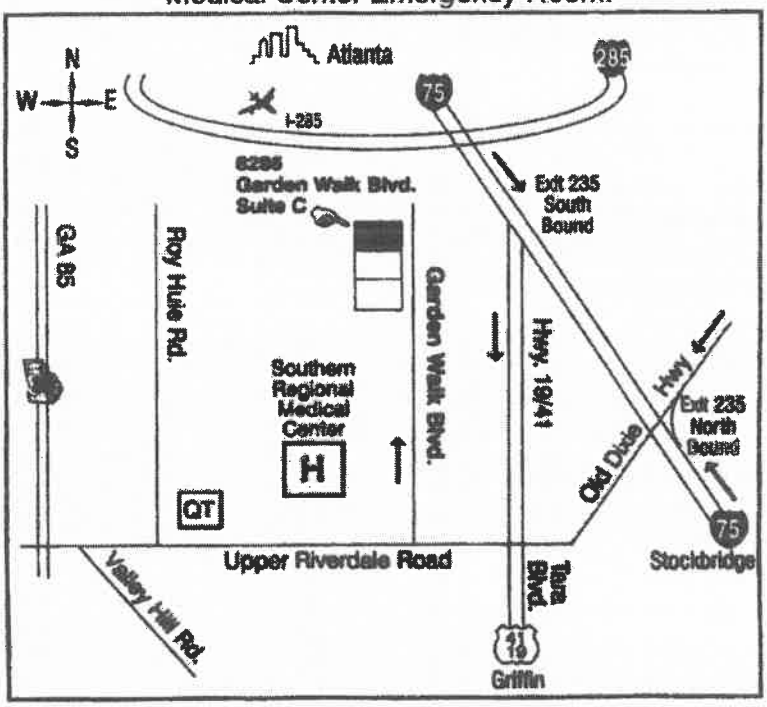
Please be on time. If you need to reschedule your appointment, would you please call at least 24 hours in advance. (Phone: 770-996-1352). No calling and no showing for an appointment will result in a $74.00 rescheduling fee. Please note that insurance verification can be time consuming. You may want to allow 1 to 2 hours for your first visit. If you are more than 15 mins late we may have to reschedule your appointment.

DIRECTIONS • *Use only these directions*

South on I-75, take Jonesboro/Griffin exit 235. Turn right at the 1st traffic light onto Upper Riverdale Road. Go to the 3rd traffic light and turn right onto Garden Walk Blvd. We are 1/2 mile down the street on the left, past Southern Regional Hospital Emergency Room.

North on I-75, take the Old Dixie Hwy. exit 235. Turn left off exit then turn right at the first traffic light crossing over Tara Blvd. onto Upper Riverdale Road. Go to the 3rd traffic light and turn right onto Garden Walk Blvd. We are 1/2 mile down the street on the left.

We are located in Clayton County, South of the Airport and I-285 loop, and very close to Southern Regional Medical Center Emergency Room.



6285 Garden Walk Blvd., Suite C • Riverdale, GA 30274 • Phone: (770) 996 -1352 • Fax: (770) 991-0850

Please fill in completely

PATIENT'S NAME	MARITAL STATUS S / M / W / *D / *SEP	DATE OF BIRTH	AGE	SS#
MAILING ADDRESS	CITY AND STATE		ZIP CODE	HOME PHONE# ( )
ADDRESS OF RESIDENCE IF DIFFERENT FROM ABOVE	CITY AND STATE		ZIP CODE	CELL # ( )
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?		BUS PHONE # ( )
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
SPOUSE OR PARENT'S NAME	SS#		DATE OF BIRTH	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?		BUS PHONE # ( )
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
NAME AND ADDRESS NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU	CITY AND STATE		ZIP CODE	HOME PHONE # ( )

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE & ZIP CODE	HOME PHONE# ( )
MEDICAL INSURANCE (SUCH AS BC BS - MEDICARE, ETC.) PRIMARY INSURANCE:		
ADDRESS:	CONTRACT #	GROUP#
SECONDARY INSURANCE:		
ADDRESS:	CONTRACT #	GROUP#
WERE YOU INJURED ON THE JOB?_____ DATE _____ INSURANCE COMPANY:	ADJUSTER NAME:	ADJUSTER'S PHONE # ( )
ADDRESS:	CLAIM #	
WAS THIS AN AUTO ACCIDENT?_____ DATE OF ACCIDENT_____ YOUR AUTO INSURANCE CARRIER:	ADJUSTER NAME:	ADJUSTER'S PHONE # ( )
AUTO INSURANCE ADDRESS:	CLAIM #	
ATTORNEY'S NAME (IF ANY)	ADDRESS:	PHONE # ( )
REFERRING PHYSICIAN'S NAME	ADDRESS:	PHONE # ( )

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Center Neurology to submit claims and to furnish complete information to insurance carriers concerning my condition, treatments and services rendered.
I hereby instruct, request and direct my insurance carrier or its intermediaries to issue payment directly to Center Neurology.
I understand that I am personally and fully responsible for any amount not covered by insurance.
I hereby authorize photocopies of this form to be valid as the original.
I hereby acknowledge having been informed of my privacy rights.
I hereby acknowledge having reviewed the Notice of Center Neurology's Privacy Policy prior to signing this consent.

Date _____ Signature _____

JB215

CENTER NEUROLOGY, P.C.

NEW PATIENT MEDICAL HISTORY

Name _____ Date of Birth _____

Do You Have Any of the Following:	Yes	Some	No
A) Headaches			
B) Neck Pain			
C) Shoulder Joint Pain and Which Side is Worse			
D) Arm or Finger Numbness, Tingling or Weakness and Which Side is Worse			
E) Upper or Mid Back Pain			
F) Low Back Pain			
G) Leg Pain or Numbness and Which Side is Worse			
H) Knee Joint Pain and Which Side is Worse			
I) Loss of Bowel or Bladder Control			
J) Any Sexual Difficulties			

K) Family History (Circle correct answer please):

Diabetes:	Y	N
High Blood Pressure:	Y	N
Stroke:	Y	N
Seizures:	Y	N
Heart Disease:	Y	N
Migraine:	Y	N
Alzheimers:	Y	N

Are you here for a traumatic injury? _____ Date of injury? _____

Any Other Signficant Neck or Back Conditions Requiring Treatment (before or since the traumatic injury in question?)

_____

Did You See a Doctor? _____ Who _____ What Year _____

PLEASE ANSWER THE FOLLOWING:

1. If Accident or Injury, Please Give Date and Describe: _____

_____

_____

_____

_____

_____

2. Were You Taken to the Emergency Room? _____ Where? _____ By Car or Ambulance?
3. Have You Been Hospitalized for This Injury? _____
4. What Kind of Work Do You Perform? _____
5. Give Date(s) Out of Work or Disabled as a Result of This Injury? _____
6. How Many Days or Weeks in Total Have You Lost from Work? _____

5. **HAVE YOU EVER HAD ANY OF THE FOLLOWING DONE?**

A) Myelogram _____

B) CAT Scan or MRI _____

C) Back or Neck Surgery _____ When _____ Where _____

D). Epidural Nerve Block _____

E) Tens Unit Used and does it help? _____

F) Physical Therapy or Chiropractic _____

6. **MEDICAL/SURGICAL HISTORY:**

A) Please Bring with You All of Your Medicine Bottles on Every Visit and Please List Here All of Your Medicine:

_____

_____

_____

_____

B) Please Describe Any Medical Problems Such as Diabetes, High Blood Pressure, Migraines, Ulcers, Heart Condition, Asthma, Seizures, Strokes, Cancer, Anemia, Prostate, Surgery, Etc. _____

_____

_____

_____

_____

C) Please List Any Medication Allergies or Intolerance: _____

_____

D) Average Amount You Smoke in a Day or a Week _____

E) Average Amount of Alcohol - Beer You Drink in a Week or Month _____

D) Estimated Height _____ Estimated Weight _____

FOR FEMALES ONLY

A) Are You on Birth Control? _____ Hormones? _____

B) Could you possibly be pregnant? _____

C) Have You Had a Hysterectomy? _____ Partial _____ Complete _____

D) Have You Had a Tubal Ligation? _____

E) Are You Breast Feeding? _____

REVIEW OF SYMPTOMS:
(Circle any symptoms that you have had)

- weak and tired • fevers • chills • night sweats • weight loss • weight gain #lbs_____
- headaches • blurred vision • halos around lights • ear pain • ear discharge • nosebleeds
- sore throat • difficulty swallowing • stiff neck • decreased motion to neck • thyroid trouble
- chest pains (they feel like _____and _____makes the come on.)
- ankle swelling • shortness of breath • cough • coughing up blood • wheezing • nausea
- vomiting • diarrhea • constipation • black or bloody stool • bright red blood per rectum
- pain on urination • discharge • female trouble • muscle pains • weakness • wasting
- joint pains • swelling • stiffness • seizures • fainting spells • tics • weakness • dizziness
- Any bleeding tendencies/disorders? • Do you urinate too much? YES/NO
- Are you thirsty too often? YES/NO • Does cold weather bother you? YES/NO
- Does hot weather bother you? YES/NO

HEMATOLOGY:
- Easy bruising Y / N

GENITOURINARY:
- Urinary incontinence Y / N • Difficulty Urinating Y / N

GENERAL:
- Weight change Y / N • Loss of appetite Y / N • Recurrent fevers Y / N • Fatigue Y / N
- Night Sweats Y / N

DERMATOLOGY:
- Rash Y / N

NEUROLOGY:
- Headache Y / N • Tingling Y / N • Seizures Y / N • Dizziness Y / N • Tremors Y / N
- Weakness Y / N • Back Pain Y / N • Neck Pain Y/ N • Snoring/Daytime Sleepiness Y / N
- Gait/Balance Problems Y / N • Memory Problems Y / N • History of Sleep Apnea Y / N

OPTHALMOLOGY:
- Blurring of Vision Y / N

ENT/RESPIRATORY:
- Hearing Loss Y / N

CARDIOLOGY:
- Chest Pain Y / N • Palpitations Y / N • Leg Swelling Y / N • Dizziness Y / N
- Shortness of Breath Y / N

GASTROENTEROLOGY:
- Nausea/Vomiting Y / N • Difficulty Swallowing Y / N

PSYCHOLOGY:
- Depression Y / N • Sleep Disturbances Y / N • Anxiety Y / N

SURGICAL HISTORY:

_____

_____

_____

_____

_____

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Authorization for Use/Disclosure of Protected Health Information

I hereby request and authorize **Center Neurology, P.C.** to receive medical records as described below.

Patient's Full Name _____ SSN: _____

Maiden/Other Name: _____ Telephone Number (Home): _____

Date of Birth: _____ Telephone Number (Work): _____

Current Address: _____

I further request and authorize use or disclosure of the medical records checked below to (please provide name and address or class of persons):

_____

_____

This Authorization applies to the information checked below for the following date or dates of service: _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information. HIV/AIDS information and/or information regarding alcohol or substance abuse.

- ❑ History and Physical Report
- ❑ Consultation Reports
- ❑ Discharge Summary Reports
- ❑ Radiology Reports
- ❑ Operative Report
- ❑ Laboratory Test Results
- ❑ Emergency Room Record
- ❑ **Entire Medical Record***

* Entire Medical Record includes all items not in bold print.
** An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. You may pick up a revocation form from Medical Records and return it there after you have completed and signed it. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Center Neurology shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third part (for example, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and will **expire at that time unless another date is written here:**

_____

_____	_____	_____
Patient's or Legal Representative's Signature	**Please Print Name**	**Today's Date**

As Legal Representative, my relationship to the patient is _____. Any document outlining such authority should be attached. The patient is unable to sign because _____

There may be fees for provision of any or all requested information.

❑ This use or disclosure is for marketing function for which Center Neurology receives direct or indirect remuneration from a third party.

DISCLAIMER: WE DO NOT PROVIDE CHRONIC NARCOTICS PRESCRIPTIONS OR CHRONIC PAIN MANAGEMENT.

Patient Name:_____ **Date of Birth:**_____

Pharmacy Name:_____

Pharmacy Address:_____

_____

Pharmacy Telephone:_____

Should you change your pharmacy in the future, please notify this office.

Thank you.