NEUROLOGICAL ASSOCIATES

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PHILADELPHIA, PA 19152
(in Arthritis Group Office)

STOP!!!

Please read this page in its entirety before you continue to the next page!!!!

Appointment Date : _____ **Time:** _____

Attention All Patients:

To help our physicians better evaluate you at the time of your visit please either bring or have faxed to our office any and all tests that were performed and would be relevant to your visit.

EX: MRI, MRA, EEG, CAT SCAN, BONE SCAN, BLOOD WORK AND ALL MEDICATIONS. IF YOU HAVE IMAGING RESULTS ON CD/DVD PLEASE BRING IT WITH YOU.

Call us at least one day in advance if you cannot make your appointment. Should you need to cancel or reschedule your appointment, we ask that you contact us at least 24 hours in advance at 610-825-0610 and leave us a message with our answering service or send us an email at robert.sacks@531neurologicalassociates.com. Failure to do so will result in a $100.00 no show fee for EMG/NCS visits and $50.00 no-show fee for all other visits. This policy is in place to ensure that we can offer open appointments to patients on our waiting list.

Come Prepared: Please bring insurance cards(s)/prescription card

Payments: We accept cash, checks or credit cards. Co-payments/Co-insurance/deductible amounts are contractually required and must be paid at the time of the visit.

Referral (if applicable). If your insurance requires an electronic referral, you must obtain it from your primary care physician or other physician referring you, prior to your appointment.

PATIENT INFORMATION (Please Print In Black Ink Only)

Name:_____ Age: _____ Date of Birth ____/_____/_____
Last **First** **M**

Address:_____
Street **City/State** **Zip Code**

Home Phone (___)_____ Marital Status: _____ Sex: ____ SS#:_____

Cell Phone(___)_____ **E-Mail**: _____
(Must be filled in)

Employer's Name & Address:_____

Family Physician: _____ Phone#:(____)_____

Address:_____
Street **City/State** **Zip Code**

Referring Physician:_____Phone#:(____)_____

Address:_____
Street **City/State** Zip Code

HEALTH INSURANCE INFORMATION

PRIMARY Insurance Carrier:_____ ID#:_____

Subscriber's Name: _____ Date of Birth _____ Relationship _____

SECONDARY Insurance Carrier:_____ ID#:_____

Subscriber's Name: _____ Date of Birth _____ Relationship _____

ACCIDENT INFORMATION (if applicable)

Type of Accident: Car __ Work __ Fall __ Other _____ Date of Accident: _____/_____/_____

State Accident Occurred: _____ If Car: Driver __ Passenger __ Pedestrian ___

Insurance Company _____ Claim # _____

Insurance Company Address _____

Adjuster's Name: _____ Phone Number: (____)_____

Attorney Name: _____ Full Address: _____

Attorney Phone Number: (___)

I request that payment of authorized insurance benefits be made on my behalf to Neurological Associates only for services furnished to me by them. I authorize Neurological Assoc. to release to my insurance company any medical information needed to determine the benefits payable to related services. I understand I am financially responsible for any amount denied or partially paid by a third party payer. I understand there is a $30.00 fee for returned checks. If my account goes to collections I will be responsible for collection costs (30% of balance).

SIGNATURE:_____ **DATE:**_____

Patient Name: _____ **Today's Date:** ___/___/____

Date of Birth: _____

PLEASE LIST ALL CURRENT MEDICATIONS
OR GIVE SECRETARY YOUR LIST OF MEDICATIONS

	Name of Medicine	Strength/mg.	How Taken (ex. 1 a day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Local Pharmacy Name: _____

Address: _____

Phone #: _____ Fax #: _____

Speciality Pharmacy Name: _____

Address: _____

Phone #: _____ Fax #: _____

NEUROLOGICAL ASSOCIATES

HISTORY & PHYSICAL

NAME: _____ **REFERRING DOCTOR** _____

Reason for Today's Visit

_____

History of Present Problem

_____

_____

Have you had any of the following tests performed recently that pertain to today's visit

CT Scans _____ **MRI** _____ **Blood Tests** _____

If so the location they were performed _____

_____

Weight _____ **Height** _____ **Blood Pressure** _____

_____

Past Medical History - **Please check Yes or No to below listed symptoms**

Yes	No		Yes	No	
☐	☐	Headache/Migraine	☐	☐	Anemia
☐	☐	Headache/Tension	☐	☐	Diabetes
☐	☐	Epilepsy/Seizures	☐	☐	Thyroid Disease
☐	☐	Vascular Problems	☐	☐	Menstrual/Sexual Dysfunction
☐	☐	Other Neuromuscular	☐	☐	Other Hormone Problems
☐	☐	Head Injury	☐	☐	Liver Disease/Hepatitis
☐	☐	Spinal Cord Injury	☐	☐	Renal Disease
☐	☐	Spine Disease	☐	☐	Urinary Problems/Disease
☐	☐	Stroke	☐	☐	Venereal Disease
☐	☐	Malignancy of Brain/Spine	☐	☐	Arthritis
☐	☐	Depression	☐	☐	Cancer
☐	☐	Heart Problems	☐	☐	HIV
☐	☐	Blood Pressure Problems (Low/High)	☐	☐	Alcohol Abuse
☐	☐	Difficulty Breathing	☐	☐	Smoking
☐	☐	Lung Disease	☐	☐	Drug Use
☐	☐	Ulcers	☐	☐	Other _____
☐	☐	Polyps			_____
☐	☐	Bleeding Disorder			_____

ALLERGIES

_____

_____

PRIOR SURGERIES/HOSPITALIZATIONS

_____

_____

REVIEW OF SYSTEMS – GENERAL

Are you experiencing any difficulties with the following

Yes	No		Yes	No	
☐	☐	Fatigue	☐	☐	Problems with heat or cold
☐	☐	Weight change	☐	☐	Stomach / Intestinal
☐	☐	Fevers	☐	☐	Sexual / Urinary Dysfunction
☐	☐	Depression	☐	☐	Muscle / Skeletal Problems
☐	☐	Ear / Nose/ Throat	☐	☐	Skin Problems
☐	☐	Cardiac	☐	☐	Blood Disorders
☐	☐	Respiratory	☐	☐	Hormone / Thyroid / Diabetes

REVIEW OF SYSTEMS – NEUROLOGIC

Are you experiencing any difficulties with the following

Yes	No		Yes	No	
☐	☐	Headache	☐	☐	Ringing in ears
☐	☐	Dizziness	☐	☐	Vertigo
☐	☐	Fainting	☐	☐	Decreased hearing R / L
☐	☐	Confusion	☐	☐	Swallowing difficulties
☐	☐	Concentration	☐	☐	Hoarseness
☐	☐	Memory	☐	☐	Choking
☐	☐	Lethargy	☐	☐	Weakness - arms
☐	☐	Personality change	☐	☐	Weakness - legs
☐	☐	Hallucinations	☐	☐	Numbness - arms
☐	☐	Speech Difficulty	☐	☐	Numbness - legs
☐	☐	Spells	☐	☐	Prickling/ tingling
☐	☐	Nausea	☐	☐	Stiffness
☐	☐	Vomiting	☐	☐	Clumsiness
☐	☐	Trouble with smell	☐	☐	Pain
☐	☐	Blurred vision	☐	☐	Poor balance
☐	☐	Loss of vision	☐	☐	Poor coordination
☐	☐	Other visual changes	☐	☐	Trouble walking
☐	☐	Difficulty chewing	☐	☐	Incontinence - bladder
☐	☐	Facial numbness/tingling	☐	☐	Incontinence - bowel
☐	☐	Difficulty tasting			

FAMILY HISTORY

Yes	No	
☐	☐	Alzheimer's Disease
☐	☐	Seizures
☐	☐	Migraines
☐	☐	Multiple Sclerosis
☐	☐	Parkinson's Disease
☐	☐	Diabetes
☐	☐	Hypertension
☐	☐	Muscle / Nerve Disease

SOCIAL HISTORY

Yes	No	
☐	☐	Do you currently smoke How many packs a day _____
☐	☐	Do you drink alcohol How many drinks a day _____
☐	☐	Do you use illicit drugs What kind _____

FINANCIAL DISCLOSURES

We, the staff of Neurological Associates, thank you for choosing us as your neurologist. We believe that it is important for patients to understand their financial responsibility. Please read the following information and sign below acknowledging your understanding. Thank you.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will gladly submit the claim to your insurance carrier on your behalf for insurances that we are in-network with. Please note that any copays, deductibles or non-covered services are your responsibility and will be collected on the day of your appointment. We accept cash, check or credit cards.

Missed Appointments: We require notice of cancellation 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance or are 15 minutes late for your appointment, a no-show fee will apply. This fee is $100.00 for EMG/NCS visits and $50.00 for all other visits.

I understand that I am financially responsible for all charges not covered by my insurance. This includes deductibles, co-payments, co-insurance and non-covered services.

I have read and understand the above financial policy.

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

Patient or Authorized Representative: _____

Neurological Associates – HIPAA Privacy Form 1

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. FEDERAL LAW REQUIRES US TO PROVIDE YOU WITH THIS NOTICE AND TO REQUEST YOUR SIGNATURE ACKNOWLEDGING IT. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO USE.

We are required by applicable Federal Law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time providing the change is permitted by applicable law. You may request a copy of our Notice at any time.

We use and disclose health information about you for: treatment, payment and healthcare operations.
Your Authorization: In addition, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
If you give us an authorization you may revoke it in writing at any time.
We must disclose your health information to you, as described in the Patient Rights section of this Notice.
We may use or disclose health information to notify a family member or another person responsible for your care, of your location, your general condition or death.
We may use or disclose your health information when we are required to do so by law.
We may use or disclose your health information to provide you with appointment reminders (such as voicemail message, postcards, letters or treatment reminders).

You have the right to look at or get copies of your health information. Fees may be applied for copies of records.

You have the right to receive a list of instances in which we disclosed your health information for the last 7 years.

We are committed to safe quality care. If you have a specific privacy need or want more information about the privacy policy, please contact our HIPAA Compliance Officer:

Patient Acknowledgement: _____ Date: _____

Refused to Sign (Employee Initials here): _____ Patient Name: _____

I authorize disclosure of my health information to the following person(s) other than my Physicians.

Name: _____ Relationship/Phone#: _____

_____ _____

Patient Signature for Authorization of Disclosure: _____ Date: _____

Patient Signature for Revocation of Disclosure: _____ Date: _____