

Dear Prospective Patient,

Your appointment is on _____ with an ARRIVAL TIME of _____ with Dr. _____. You do not need to come earlier than the above stated arrival time if you have already filled out the attached paperwork.

We will be very thorough in our evaluation of your neurological problem. Please read/sign the attached office policies carefully and fill out the following forms to help us get to know you and further explore what problems you are having. These forms must be completed in advance and brought to your initial visit. We may request that your appointment be rescheduled if you arrive more than 10 minutes late for your appointment.

In addition to this paperwork please bring the following to your first appointment:

- All health insurance cards
- Driver's License or current government issued ID
- All of your medications or a list of medications and dosage

Amelia Caraway, a Physician Assistant, is a vital part of our team at NAR. After our initial consultation, she may be seeing you at your follow up visits.

Before your consultation, we invite you to visit our website at www.neuroroc.com to get to know us better. We look forward to meeting you in person and helping you with your healthcare needs.

Sincerely,

Ashanthi Gajaweera, MD

Ryan Evans, MD

Erica Patrick, MD

Today's date _____

Patient Name _____		
Date of Birth _____	Current Age _____	
Address _____	City _____	Zipcode _____
Primary Phone # _____		
Secondary Phone # _____		
Primary Care Doctor _____		
Referring Physician _____		
Pharmacy you use: Name _____ Location _____		

Gender: How do you identify? (circle) man / woman / non-binary / self-describe _____
Occupation: _____ If retired, former occupation: _____
Please list anyone who lives at home with you _____
Marital Status _____ Spouse's name _____
Are you right or left-handed? _____
Have you been vaccinated against COVID 19? yes / no

Briefly state the reason you were referred for neurological evaluation: _____ _____
Please be aware that we DON'T accept No Fault related Motor Vehicle Accident cases.
Is this a work-related injury? (circle) yes / no
We DO accept Worker's Compensation claims but it is imperative that we have all the necessary authorizations for your visit PRIOR TO BEING SEEN. Your visit will need to be rescheduled or cancelled if authorizations are not in place.

Have you RECENTLY experienced any of the following symptom? (select all that apply):

- | | | |
|---|---|--|
| <input type="radio"/> Weight loss | <input type="radio"/> Chest Pain | <input type="radio"/> Seizures |
| <input type="radio"/> Weight gain | <input type="radio"/> Palpitations | <input type="radio"/> Vertigo/dizziness |
| <input type="radio"/> Fever | <input type="radio"/> Swelling of limbs | <input type="radio"/> Slurred speech |
| <input type="radio"/> Chills | <input type="radio"/> Urinary incontinence | <input type="radio"/> Weakness |
| <input type="radio"/> Rash | <input type="radio"/> Abdominal pain | <input type="radio"/> Numbness |
| <input type="radio"/> Double vision | <input type="radio"/> Heartburn | <input type="radio"/> Incoordination |
| <input type="radio"/> Nasal drip/congestion | <input type="radio"/> Nausea/Vomiting | <input type="radio"/> Balance trouble |
| <input type="radio"/> Ear ache/infection | <input type="radio"/> Diarrhea | <input type="radio"/> Tremors |
| <input type="radio"/> Dental problems | <input type="radio"/> Constipation | <input type="radio"/> Trouble sleeping |
| <input type="radio"/> Trouble swallowing | <input type="radio"/> Back pain | <input type="radio"/> Falls |
| <input type="radio"/> Ringing in ears | <input type="radio"/> Neck pain | <input type="radio"/> Restless dream sleep |
| <input type="radio"/> Hearing loss | <input type="radio"/> Joint Pain / Swelling | <input type="radio"/> Anxiety |
| <input type="radio"/> Loss of taste/smell | <input type="radio"/> Muscle Pain / Cramps | <input type="radio"/> Depression |
| <input type="radio"/> Shortness of breath | <input type="radio"/> Headaches | <input type="radio"/> Hallucinations |
| <input type="radio"/> Cough | <input type="radio"/> Snoring | <input type="radio"/> blackouts / fainting |

Medications: attach separate list if needed

Medication Allergies: _____

How tall are you? _____ How much do you weigh? _____

Please check the following tests you have had and when/where they were done:

- MRI Scan of the head _____
- EEG (Brain wave recording) _____
- EMG and Nerve Conduction _____
- Lumbar puncture (spinal tap) _____

Have you seen a neurologist before? yes /no ? If so, who and when?

Is there any **family history** of brothers/sisters/parents with any of the following?

List brother/sister/parents

- Stroke prior to age 60 _____
- Parkinsons disease _____
- Dementia _____
- Seizures or epilepsy _____
- Migraine _____
- Cerebral Aneurysm _____
- Multiple Sclerosis _____
- Neuropathy _____
- Huntington’s Disease _____

Do you drink alcohol? Yes / No

If so, what (beer/wine etc.)? _____ #drinks _____ per day/week

I currently smoke ____ packs/day.

Do you want to quit?

Have you ever smoked? Yes/No Quite date _____(year)

Caffeine intake _____ cups / oz /day of coffee / soda / tea (select all that apply)

Please list any other recreational drugs or supplements? _____

<p>Have you been diagnosed with any of the following conditions?: circle all that apply</p>		
<ul style="list-style-type: none"> <input type="radio"/> Migraine Headaches <input type="radio"/> Seizures/Epilepsy <input type="radio"/> Stroke <input type="radio"/> Carotid stenosis <input type="radio"/> Restless Leg Syndrome <input type="radio"/> Concussion <input type="radio"/> Depression <input type="radio"/> Anxiety <input type="radio"/> Bipolar Disorder <input type="radio"/> Anemia <input type="radio"/> Clotting disorder <input type="radio"/> Diabetes <input type="radio"/> Thyroid Disorder 	<ul style="list-style-type: none"> <input type="radio"/> Obesity <input type="radio"/> Sleep Apnea <input type="radio"/> Asthma <input type="radio"/> Emphysema/COPD <input type="radio"/> High Cholesterol <input type="radio"/> High Blood Pressure <input type="radio"/> Heart Disease <input type="radio"/> Atrial Fibrillation <input type="radio"/> Valvular disorder <input type="radio"/> Pacemaker/Defibrillator <input type="radio"/> Peripheral vascular disease <input type="radio"/> Kidney Failure <input type="radio"/> Liver Disease/Hepatitis 	<ul style="list-style-type: none"> <input type="radio"/> Bariatric Surgery <input type="radio"/> Celiac Disease <input type="radio"/> Crohns/UC <input type="radio"/> Reflux (GERD) <input type="radio"/> Gout <input type="radio"/> Lupus <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Fibromyalgia <input type="radio"/> Sarcoidosis <input type="radio"/> Tuberculosis <input type="radio"/> HIV/AIDS <input type="radio"/> Cancer (please specify): Other: _____

Please list any surgeries/hospitalizations/pregnancies along with date/year:

Illness/surgery

If menstruating, are your periods regular? yes / no

If postmenopausal, what year was your last period _____

Any personal history of miscarriage / stillbirth? yes / no

Number of pregnancies _____ Number of miscarriages _____

Are you on any type of hormone therapy? If so, what _____

What type of contraception do you use? _____

Neurology Associates of Rochester, PC Telemedicine Consent Form

We are defining Telemedicine to include communication via phone, video or using a patient portal for providers to communicate with patients to review their results, address their concerns, questions and medication management etc. Telemedicine also includes our providers using electronic interfaces such as phone discussions or video conferencing with your PCP and other specialists when deemed medically necessary.

I give Neurology Associates of Rochester permission to utilize Telemedicine services including video visit, phone visits, patient portal communications. I also give Neurology Associates of Rochester permission to bill my insurance for these services.

Printed Name of Patient

Date

Signature of Patient or Legal Guardian

Neurology Associates of Rochester PC, HIPAA PRIVACY NOTICE

This practice is obligated under HIPAA to protect the privacy of your protected health information (PHI) and to provide you with a notice of our privacy practice (Privacy Notice).

Acknowledgement of Receipt: I acknowledge that I have received a copy of the Privacy Notice bearing an effective date of 9/13/2013.

Verbal Disclosure of PHI to Designated Individuals: As stated in our Privacy Notice, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We request that you designate the individual with whom we may discuss and/or release your protected health information. I understand that I may rescind or modify this consent at any time. Such change must be in writing.

Name

Relationship

Can we leave medical information on:

Patient Portal	yes___	no__
your home phone	yes___	no__
your cell phone	yes___	no__
your answering machine	yes___	no__
with another person	yes___	no__

Name of Patient

Signature

Date

Neurology Associates of Rochester, PC Medical Services Financial Agreement**INSURANCE COVERAGE**

This office makes no claim that your insurance policy will cover all services provided. Insurance policies may vary greatly in terms of deductible and percentage of coverage for neurology consultation and testing. We require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances to this office. After verification of your insurance coverage, we will bill your insurance provider for the services that you receive.

PAYMENT ARRANGEMENTS

If you have a contracted amount for copayment, that amount is due at the time of each visit. If you have a deductible, we require that you pay 50% in advance towards each visit. Your full portion of the bill is expected to be paid after payment is received from your insurance provider. Any unpaid balance will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 2% applied per month. Any positive balances will be refunded to you within 30 days of receiving your insurance explanation of benefits (EOB).

ASSIGNMENT OF BENEFITS

By signing this form, you authorize payment of medical benefits to be made directly to this office. If your insurance provider sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

RELEASE OF INFORMATION

By signing this form, you were also authorizing this office, upon request from your health insurance provider, to release any medical or other necessary information necessary to process your insurance claim. You also acknowledge and requests payment of government medical benefits to this office.

TERMINATION OF CARE

If you are discharged from this practice or voluntarily suspend or terminate your care at any time, all charges for professional services are immediately due and payable to this office. All services rendered by this office will be charged directly to you. You are personally responsible for payment regardless of your health insurance coverage.

REFERRALS & CONTRACTED FACILITIES

If you have an insurance plan that requires a referral (e.g., an HMO plan), it is your responsibility to obtain a referral from your primary care provider prior to your first scheduled appointment and keep it current for every visit thereafter. If we do not have a referral, services can only be rendered if you sign an "Advanced Beneficiary Notice," stating that you understand that a referral was not obtained and payment in full is expected the day of service. If you require the use of a specific lab or x-ray facility, you must notify the nurse to ensure the proper facility is used.

CANCELLED APPOINTMENTS

Missed appointments represent a cost to us and to other patients who could have been seen in the time that was set aside for you. Therefore, cancellations must be requested at least 48 hours prior to the scheduled appointment time. Failure to cancel or to not show for a scheduled follow up appointment may result in a \$40 fee. Failure to cancel or to not show for a scheduled New Patient visit or procedure may result in a \$100 fee. These fees are not billable to your insurance.

FEE FOR FORMS AND LETTERS

There will be a fee of \$20-50 for completion of forms and letter for use outside of the patient's medical record. This may include forms such as those used for DMV, employment, life insurance, disability insurance, FMLA.

This fee range will depend on the complexity and time required for completion of the form as well as the time constraints requested. You will be notified of the fee due prior to completion and all forms and paperwork will be released once payment is received. We accept credit card or cash for these fees.

GENERAL

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage or benefits, please do not hesitate to speak to one of our receptionists about your concerns.

Acceptance of the Medical Services Financial Agreement

I have received, read, and understand the “Medical Services Financial Agreement” of Neurology Associates of Rochester, PC. All questions that I have concerning the Financial Agreement have been answered to my satisfaction. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified that I am responsible for all charges incurred.

Printed Name of Patient

Date

Signature of Patient or Legal Guardian