



# NEUROLOGY & SLEEP CLINIC PLC.

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**TREATMENT OF:**

- Alzheimer's
- Chronic Migraines
- Epilepsy
- Headaches
- Memory Disorders
- Multiple Sclerosis
- Neuropathy
- Parkinson's disease
- Sleep Disorders
- Stroke

## EMG Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Handedness: Right \_\_\_\_\_ Left \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date symptoms began: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Describe briefly your present symptoms (problems): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Advanced Directive (DNR/Living Will/POA): \_\_\_\_\_

Any Recent Falls \_\_\_ Yes \_\_\_ No

**PROCEDURES**

**PERFORMED:**

- Botox Injection
- Deep Brain Stimulator (DBS)
- EEG & Video EEG
- EMG & NCV
- Independent Medical Exams
- Rehab
- Sleep Studies
- Vagal Nerve Stimulator (VNS)
- Telemedicine

**MEDICATIONS:**

Name of Drug	Dose	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:	Drug	What reaction?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Number \_\_\_\_\_

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**PAST MEDICAL HISTORY:**

Do you have or have you had these medical conditions:

- |  |  |
|--|--|
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Diabetic Retinopathy    |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Tremor                  |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Autoimmune disease      |
| <input type="checkbox"/> CHF                 | <input type="checkbox"/> Osteoarthritis          |
| <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Anxiety disorder        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Migraine/headache       |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> Stroke syndrome         |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Peripheral Neuropathy   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Dementia                |
| <input type="checkbox"/> GI Disorder         | <input type="checkbox"/> Restless Legs Syndrome  |
| <input type="checkbox"/> Kidney disorder     | <input type="checkbox"/> Obstructive sleep apnea |

Other: \_\_\_\_\_

\_\_\_\_\_

**PREVIOUS OPERATIONS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Carotid artery surgery  | <input type="checkbox"/> Hysterectomy  |
| <input type="checkbox"/> Heart Valve replacement | <input type="checkbox"/> Appendectomy  |
| <input type="checkbox"/> Carpal tunnel release   | <input type="checkbox"/> Back Surgery  |
| <input type="checkbox"/> Knee replacement        | <input type="checkbox"/> Brain surgery |
| <input type="checkbox"/> Hip Replacement         | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gall bladder removal    | <input type="checkbox"/> Pacemaker     |

Other surgery:

\_\_\_\_\_  
\_\_\_\_\_

Patient Number \_\_\_\_\_



## **PATIENT REGISTRATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Marital status:  Single  Married  Widowed  Divorced

Pharmacy: \_\_\_\_\_ Race: \_\_\_\_\_

Personal E-mail: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_

POA (Power of Attorney): \_\_\_\_\_ Phone: \_\_\_\_\_

Name of spouse/next of kin that we may contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### **INSURANCE INFORMATION:**

(Patient is responsible for completion of insurance information below.)

Is today's visit the result of a motor vehicle accident?  Yes  No: Date of injury: \_\_\_\_\_

Is today's visit the result of a personal injury?  Yes  No: Date of injury: \_\_\_\_\_

Is today's visit the result of a work injury?  Yes  No Date of Injury: \_\_\_\_\_ Claim # \_\_\_\_\_

**Primary Ins.** \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Ins Address: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Secondary Ins:** \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Ins Address: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_



**DISCLOSURE:**

I authorize the following means to communicate my health and/or account information:

Persons: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_

Voicemail and/ or Text messages can be left at: (\_\_\_\_\_) \_\_\_\_\_

E-mails may be sent to the address on file, or \_\_\_\_\_

\_\_\_\_\_  
Patient (or representative) Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES:**

I have seen and understand the Burlington Neurology & Sleep Clinic, PLC's Notice of Privacy Practices.

**ASSIGNMENT AND RELEASE:**

I, the undersigned, certify that I or my dependent assign directly to Burlington Neurology & Sleep Clinic, PLC all insurance benefits, if any, otherwise payable to me for services rendered. As a courtesy, Burlington Neurology & Sleep Clinic, PLC will bill my insurance, and it is my responsibility to ensure timely payment. Acceptance of my insurance card in no way constitutes the clinic's participation with my carrier. I understand that it is my responsibility to verify insurance coverage, eligibility and participation of this clinic and/or its doctors with my insurance carrier. I also understand that I am financial responsible for all charges whether paid or not by insurance, plus any finance charges which accrue at 18% annually on the balance not paid within 30 days of the statement date. There will be a charge of \$25.00 for all returned checks. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and communications.

**I acknowledge that failure to sign this form does not release me from financial responsibility, as outlined below, for services I receive from this clinic and its physicians.**

**CONTINUITY OF CARE:**

I give my permission to Burlington Neurology & Sleep Clinic, PLC to release my records for the continuity of my care and/or to refer me for further treatment.

**I, the undersigned, have read and understand the above information.**

\_\_\_\_\_  
Patient (or representative) Signature

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION:**

I request that payment of authorized Medicare or Medicare Advantage (any plan) benefits be made either to me or on my behalf to BN&SC, PLC and all its providers, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 on the CMS-1500 form, or else on other approved claim forms or electrically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charges and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all insurance submissions, including Medicare and all of my secondary insurances.

\_\_\_\_\_  
Beneficiary (policy holder) Signature

\_\_\_\_\_  
Date