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

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

New Patient Form

Date: _____

Name:_____DOB:_____Age:_____

Height:_____Weight: _____

Handedness: Right_____Left _____

Referring Physician:_____Date symptoms began: _____

Primary Care Physician:_____Pharmacy: _____

Briefly describe your present symptoms (problems):_____

_____

_____

Advanced Directive (DNR/Living Will/POA):_____

Any Recent Falls_____Yes____No

Staff Use ONLY:
Height_____ Weight_____ BP: _____

MEDICATIONS:

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

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

Patient Number_____

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More Info at www.NeurologyandSleepClinic.com

PAST MEDICAL HISTORY:

Do you have or have you had these medical conditions:

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

Other: _____

_____

PREVIOUS OPERATIONS:

____	Carotid artery surgery	____	Hysterectomy
____	Heart Valve replacement	____	Appendectomy
____	Carpal tunnel release	____	Back Surgery
____	Knee replacement	____	Brain surgery
____	Hip Replacement	____	Tonsillectomy
____	Gall bladder removal	____	Pacemaker

Other surgery:

_____

_____

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SLEEP HISTORY:

Have you ever been diagnosed with Sleep Apnea?____Yes____No

If yes, what is your current treatment?____CPAP____Bi-Pap____Oral Appliance

Do you snore loudly?____Yes____No

Do you often feel tired, fatigued, or sleepy during the daytime?____Yes____No

Has anyone observed you stop breathing during your sleep?____Yes____No

Do you have or are you being treated for high blood pressure?____Yes____No

SOCIAL HISTORY:

Marital status: (circle) Never married Married Divorced Separated Widowed

Do you smoke? (circle) yes no

How much?_____cigarettes/ packs a day (circle one)

Given counsel to abstain? (circle) yes no.

How much alcohol do you drink?_____per day_____per month

Illicit drug use (circle): yes no.

If yes, what, and how often: _____

Occupation:_____

Do you live alone? (circle) yes no.

FAMILY HISTORY:

Please check if a member of your family has been diagnosed with:

Coronary artery disease	_____	Migraine/headache	_____
Congestive heart failure	_____	Epilepsy	_____
Hypertension	_____	Stroke Syndrome	_____
High cholesterol	_____	Dementia	_____
Diabetes	_____	Parkinson's Disease	_____
COPD	_____	Restless leg syndrome	_____
Cancer	_____	Obstructive sleep apnea	_____
Depression	_____	Tremor	_____

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REVIEW OF SYSTEMS: (CURRENT COMPLAINTS)

Systemic Symptoms **___ Weight Change** **___ Chills** **___ Fever** **___ Night Sweats** **___ Other constitutional**	**Pulmonary Symptoms** **___ Shortness of breath** **___ Cough** **___ Coughing up blood** **___ Night sweats** **___ Wheezing**
HEENT Symptoms **___ Headache** **___ Eyesight problems** **___ Nosebleeds** **___ Other head-related symptoms**	**Cardiovascular Symptoms** **___ Chest pain or discomfort** **___ Fast heart rate** **___ Palpitations** **___ Other cardiovascular symptoms**
Neck Symptoms **___ Neck pain** **___ Neck stiffness** **___ Lump or swelling in the neck** **___ Other neck symptoms**	**Gastrointestinal Symptoms** **___ Difficulty swallowing** **___ Heartburn** **___ Nausea** **___ Vomiting** **___ Abdominal pain** **___ Diarrhea**
Genitourinary Symptoms **___ Blood in urine** **___ Difficulty/pain with urination** **___ Increased urinary frequency**	**Hematological Symptoms** **___ Easy bleeding** **___ Easy bruising**
Skin Symptoms **___ Itching** **___ Skin lesions** **___ Rashes** **___ Other skin symptoms**	**Psychological Symptoms** **___ Sleep disturbance** **___ Depression** **___ Anxiety**
Other symptoms: **_____** **_____**	**Endocrine Symptoms** **___ Excessive sweating** **___ Excessive thirst** **___ Other**

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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 #: _____

Patient Number _____

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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

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Consent to Participate in Telemedicine Services

Telemedicine allows health care providers to evaluate, diagnose and treat patients at a distance using telecommunications technology. It requires sharing information to help improve your health care.

This information may be used for diagnosis, therapy, follow-up or education, scheduling, and billing purposes. It may include:

- Details of your medical history, examinations, and diagnostic test results. These may be communicated by the use of interactive video, audio, and telecommunication technology.
- You may receive a physical examination from onsite staff at your visit.
- Video, audio and/or photo recordings may be taken of you during the telemedicine visit and stored in your electronic medical record.
- A technical specialist may be present if needed for communication services.
- Individuals involved will be announced and are expected to maintain confidentiality or information obtained or observed.

Expected benefits

- Improved access to medical care by enabling you to remain at your local health care site (your home, for example) while the health care provider collects and reviews test results at another site, which may be in another state
- More efficient evaluation and management for your medical needs
- Obtaining the expertise of a specialist without having to travel

Possible risks

As with any medical procedure, there are possible risks associated with the use of telemedicine. These risks may include, but are not limited to:

- Medical evaluation or treatment may be delayed because of failure of equipment or technical services.
- The provider may decide the transmitted information is of poor quality, requiring the telemedicine visit to be rescheduled or a face-to-face visit with your local provider be scheduled.
- Security processes could fail, causing a breach in the security of personal information.
- Not having access to your complete medical record may result in adverse drug interactions, allergic reactions or other errors.

I understand my participation in telemedicine is voluntary. I may refuse to participate or decide to end my participation at any time. I understand that my refusal to participate, or my decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of withdrawing my consent to participate in telemedicine services.
I understand providers at the remote site and the local site may have access to relevant clinical information including mental health information, and alcohol and drug abuse information.
I understand Neurology & Sleep Clinic, PLC will use electronic systems that include network and software security protocols to protect my personal health information.
I have read this document and received information about the process and telemedicine providers. I hereby consent to participate in services using telemedicine under the terms described above. I understand this document will become a part of my medical record.

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Consent to Participate in Telemedicine Services

Please check the appropriate box:

_____I want to participate in and receive services through telemedicine.
_____I do not want to participate in telemedicine sessions, and I understand the consequences.

_____ _____
Patient signature Date

- ☐ **It has been determined the patient is unable to sign and, with attempt made, a legal guardian or personal representative is not available or accessible.**

- ☐ **It has been determined the patient is medically unable to give informed consent and a legal guardian or personal representative is available. Please complete:**

The above consent is accepted and given on behalf of _____
because it has been determined the patient is medically unable to give informed consent.

_____ _____
Legal guardian or personal representative Date

_____
Relationship to patient

Check if applicable: ☐ **telephone/verbal consent (witnessed by two staff members)**

_____ _____
Witness Date

_____ _____
Witness Date

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