

NCF Patient Information

Appointment Date:	Appointment Time:	Marital Status: S M D W Sex: M F
Last Name	First Name	Middle Name
Birth Date (Mo/Day/Yr)	Social Security Number	
Home Address—Street	City, State, Zip Code	Email Address
Home Phone	Cell Phone	Business Phone
Employer Name	Employer Address	
	Employer Phone:	
With whom is your appointment?	Date of Onset of Condition	Appointment Reason
Referring MD Name		**Referring MD Phone Number**
Primary Care Doctor Name		**Primary Care Doctor Phone Number**

Primary Insurance Company	Primary Ins. Phone	Primary Ins. Policy #	Primary Ins. Group Number
Name of Insured Person—Primary Ins.	Birth Date of Insured-Primary	Social Security # of Insured Person-Primary	Relationship to Insured-Primary
Secondary Insurance Company	Secondary Ins. Phone	Secondary Ins. Policy #	Secondary Ins. Group Number
Name of Insured Person—Secondary Ins.	Birth Date of Insured-Secondary	Social Security # of Insured—Secondary	Relationship to Insured-Secondary
Nearest Relative Contact in Emergency	Address		Phone

****IS THIS AN ACCIDENT/AUTO ACCIDENT/LEGAL CASE? YES NO**

****IS THIS A WORKERS COMPENSATION CASE? YES NO**

I certify the above information is correct. I understand I am responsible to notify the Neurology Center of Fairfax, LTD if my insurance coverage changes, if benefits change, or if the coverage I have reported is incorrect. I understand and agree that I am ultimately responsible for payment in full for services I receive from the Neurology Center of Fairfax LTD.

Patient Signature	Today's Date
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REVIEW OF SYSTEMS

(Please circle any symptoms that are now present.)

1. Constitutional Symptoms

Weight loss
Weight gain
Appetite Change
Fever
Severe fatigue
Sleep disturbance

2. Eyes

Glaucoma
Cataracts
Changing Vision
Eye pain or redness
Double vision
Visual loss
Flashing lights
Other

3. Ears/Nose/Mouth/Throat

Hearing loss
Ear pain
Ringing in ears
Sinus disease
Loss of smell or taste
Vertigo (spinning)
Swallowing difficulty
Hoarseness or change in voice
Swollen glands
Sore throat or mouth sores
TMJ Disorder
Other

4. Cardiovascular

Hypertension
High Cholesterol
Chest pain or angina
Heart murmur
Irregular heartbeat (palpitations)/racing heart
Faintness/lightheadedness
Heart failure
Other

5. Respiratory

Shortness of breath
Cough
Coughing up blood
Asthma/wheezing
Other

6. Gastrointestinal

Abdominal pain
Ulcer disease
Gastric reflux disorder
Hepatitis
Liver failure
Blood in stool
History of GI bleeding
Constipation
Diarrhea
Loss of bowel control
Nausea/vomiting
Other

7. Genitourinary

Pain on urination
Frequent bladder infections
Problem controlling bladder function
Kidney stones
Sexual dysfunction
Other
FEMALE # of pregnancies _____ miscarriages _____
Last menstrual period _____
Birth control pills _____
Hormone replacement therapy _____
Other

8. Neurological

Headaches
Confusion
Memory loss
Change in speech
Difficulty in walking
Weakness all over
Weakness in part of body (where)
Difficulty with coordination
Muscle pain
Muscle spasms or cramps
Tremor
Convulsions/seizures
Numbness/tingling (where)
Stroke or "TIA"
Head injury ("knocked unconscious")
Other

9. Sleep Disturbances

Snoring/stops breathing
Morning dry mouth/choking
Morning headache
Difficulty falling asleep/nighttime walking
Worried about not sleeping
Urge to move legs at night/restless leg
Nightmares/bad dreams/sleep walking
Wake up confused or in a panic
Punching/kicking while sleeping
Awake, but not able to move body
Daytime sleepiness or fatigue
Sounds of images when falling asleep or waking up

10. Psychiatric

Nervousness/worry
Depression
Mood swings
Panic attacks
Hallucinations
Learning disabilities
Attention Deficit Disorder
History of drug/alcohol abuse
History of mental/physical abuse
History of counseling
Other

11. Bones and Joints

Arthritis/Gout
Swollen joints
Back pain
Neck pain
Radiating pain into arm
Radiating pain into leg
Other

12. Skin

Rash
Easy bruising
Varicose veins
Other

13. Endocrine

Diabetes
Thyroid disease
Excessive or decreased sweating
Breast discharge
Other

14. Hematologic

Anemia
History of blood clots (phlebitis)
Past transfusions
Bleeding disorder
Other

15. Allergy

List food allergies/reactions
List environmental allergies/reactions
Allergy shots?

NCF New Patient Visit

To improve your visit with the doctor, please prepare a summary (or chronology) of your illness (one page or less) to include:

- ✧ When did symptoms begin? What symptoms did you have at the beginning?

- ✧ What brought on the symptoms or made them worse?

- ✧ What other symptoms have occurred? When did they occur?

- ✧ What tests have been done? What were the results?

- ✧ What medications have you taken? What were the results of the treatment?

- ✧ List all current medications and the dose you are currently taking on the reverse side (or attach a list).

Patient Name _____ **NCF Number**_____

Date_____
(3/10/10)

Tremor/Parkinson's Clinical Symptoms Checklist Form
(Complete Both Sides Prior to Scheduled appointment Time)

Patient Name _____ Date _____

Date of Birth _____

Current Tremor/Parkinson's Medications:

Name of Medication	Strength	Time of dose and # of tablets
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Side Effects (Yes/No) _____

Does your medication last from one dose to the next? (Yes/No)

Compulsive behaviors: (i.e. excessive spending, gambling, or hypersexual behaviors)? (Yes/No) _____

History of: Glaucoma (Yes/No)
Melanoma (Yes/No)

Other Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Additional Medications

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

CONTINUE ON REVERSE SIDE

Motor Symptoms

Tremor (Yes/No)	mild	moderate	severe
Rigidity (Yes/No)	mild	moderate	severe
Slowness (Yes/No)	mild	moderate	severe
Dyskinesia/Involuntary Movement (Yes/No)	mild	moderate	severe
Abnormal Hand/Foot Posturing (Yes/No)	mild	moderate	severe

Walking

Shuffling (Yes/No)	mild	moderate	severe
Start Hesitation (Yes/No)	mild	moderate	severe
Freezing (Yes/No)	mild	moderate	severe
Imbalance (Yes/No)	mild	moderate	severe
Use of assistive devices	(Yes/No)	_____	
Any falls	(Yes/No)	_____	

Activities of Daily Living/Dressing and Showering:

(Independent/Needs help) _____
Difficulty with Swallowing, Eating, or Drooling (Yes/No) _____

Associated Symptoms

Constipation/Diarrhea	(Yes/No)	_____
Urinary Symptoms	(Yes/No)	_____
Sexual Dysfunction	(Yes/No)	_____
Lightheadedness (orthostasis)	(Yes/No)	_____
Double Vision	(Yes/No)	_____
Depression	(Yes/No)	_____
Anxiety	(Yes/No)	_____
Sleep Disturbances	(Yes/No)	_____
Hallucinations	(Yes/No)	_____
Confusion	(Yes/No)	_____
Memory Loss	(Yes/No)	_____
Speech Difficulty	(Yes/No)	_____
Slowness in Processing Information	(Yes/No)	_____

Other symptoms? _____

**NEUROLOGY CENTER OF FAIRFAX, LTD.
Patient Authorizations**

Patient Name: _____

Social Security

Date of Birth: _____ **Number** _____

(Please read carefully. You are authorizing these actions.)

I hereby authorize the Neurology Center of Fairfax, Ltd. (NCF) to apply for benefits on my behalf for covered services rendered by NCF, to myself or to my dependent. Authorization is effective as of today. I request payment from my insurance carrier be made directly to NCF, or in case of Medicare Part B benefits to NCF.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any other related claim, to my insurance carrier or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of an original. It is possible that services provided to me by NCF may not be covered by Medicare or by my insurance. I agree to assume responsibility for full payment of all services if Medicare or other insurance payment is denied. I further agree to be responsible for the outstanding balance on this account and to pay all reasonable costs of collection including attorney's fees at 40% of the outstanding balance and monthly interest at 1.5% should this account become overdue.

I understand that payment for all services is due and payable in full at the time of service and that payment for services may be required at the time of service. This includes, but is not limited to, my co-payment, co-insurance and deductibles. I agree to provide NCF with my current insurance card and a valid referral (if required) at the time services are rendered.

I hereby authorize release of my records to and discussion of my care with my treating physicians, and other healthcare providers. I hereby authorize NCF to contact the people whom I list as emergency contacts in the event of an emergency. I authorize NCF to obtain contact information from my health insurer or other providers, if NCF is unable to contact me directly for any reason. I authorize my treating NCF physician to provide information to my caregiver or to a family member if my treating NCF physician judges this disclosure to be important for my well being. I authorize NCF to leave messages for me on answering devices attached to my telephones. These authorizations may be revoked by me at any time in writing.

I have read, understand, and agree to the terms and conditions above. I acknowledge that I have received a copy of the Neurology Center of Fairfax, Ltd.'s Notice of Privacy Practices.

I understand that although my insurance may pay part or all of the charges I incur, I am still ultimately liable and responsible for all charges. I understand that it is my responsibility to know the correct amount of my co-payment. I understand my co-payment, co-insurance and any deductibles are due at the time of service. I understand there is a \$10 administrative fee if I do not pay my co-payment and co-insurance at the time of service, and a separate \$10 fee each time a bill is generated for co-payments not paid at the time of service.

Signature: _____ **Date:** _____ at Fairfax, VA

****If the patient is under the age of 18, please complete the following:**

The undersigned is a parent/guardian of the patient and executes this form on behalf of the patient.

Name: _____ Relationship
To patient: _____

Signature: _____ Date: _____

FOR PATIENTS WHO DO NOT HAVE THEIR INSURANCE CARD AND/OR REFERRAL IF REQUIRED.

I acknowledge that I did not bring a referral as required by my insurance company and/or do not have my insurance card. I am electing to be seen today and agree to pay in full today for the services rendered today since I do not have a valid referral and/or insurance card.

Signature: _____ **Date:** _____

NEUROLOGY CENTER OF FAIRFAX, LTD. NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer, 3020 Hamaker Court, Suite 400, Fairfax, VA 22031, 703-876-0800

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

- 1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IM to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
- 2. Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your HHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
- 4. Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
- 5. Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
- 6. Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
- 7. Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
- 8. Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- 1. Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
 - maintaining vital records, such as births and deaths
 - reporting child abuse or neglect
 - preventing or controlling disease, injury or disability
 - notifying a person regarding potential exposure to a communicable disease
 - notifying a person regarding a potential risk for spreading or contracting a disease or condition
 - reporting reactions to drugs or problems with products or devices
 - notifying individuals if a product or device they may be using has been recalled
 - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
 - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- 2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- 4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IHHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IHHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IHHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IHHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IHHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IHHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IHHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IHHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IHHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR IHHI

You have the following rights regarding the IHHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, Neurology Center of Fairfax, Ltd.** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your UHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IHHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IHHI, you must make your request in writing to **Privacy Officer, Neurology Center of Fairfax, Ltd.** Your request must describe in a clear and concise fashion:

- a) the information you wish restricted;
- b) whether you are requesting to limit our practice's use, disclosure or both; and
- c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IHHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, Neurology Center of Fairfax, Ltd.** in order to inspect and/or obtain a copy of your IHHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Privacy Officer, Neurology Center of Fairfax, Ltd.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IHHI kept by or for the practice; (c) not part of the IHHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IHHI for non-treatment, non-payment or non-operations purposes. Use of your IHHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Privacy Officer, Neurology Center of Fairfax, Ltd.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Officer, Neurology Center of Fairfax, Ltd.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Privacy Officer Neurology Center of Fairfax, Ltd.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHHI for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Privacy Officer, Neurology Center of Fairfax, Ltd.**

New Appointment Reminder System

As we continue to improve our services, we are pleased to inform you that we are implementing a personalized appointment reminder system called HouseCalls. This system will provide our patients with the courtesy of a timely reminder for upcoming appointments.

Our appointment reminder system will call you at home prior to your scheduled appointment to confirm the day, date, and time of your next appointment.

You will be prompted to confirm this appointment by pressing the *1* on your touch-tone telephone keypad. You will also have the option to cancel the appointment by pressing *2* on your telephone keypad. If you are not available, the system will leave a message on your answering machine.

If your home telephone system blocks calls from unknown numbers, does not allow automated calls, or if you do not have an answering machine, HouseCalls will not be able to leave you an appointment reminder message.

Our goal is to place a timely reminder call to you for upcoming appointments. However, this is a courtesy call. It is your responsibility to keep your scheduled appointment. If you do not cancel your appointment at least 24 hours in advance, or if you miss your appointment, you will be charged up to a \$75.00 cancellation fee.