Mid-Atlantic Neurology Consultants

8021 Ritchie Hwy
Pasadena, MD 21122

7226 Lee Deforest Dr, Suite 102
Columbia, MD 21046

20 Crossroads Drive, Suite 106
Owings Mills, MD 21117

Phone: 410-590-4616 **Fax: 410-590-4618**
www.midatlanticneurology.com

Patient Information

Name:_____ Date of Birth: _____
Address:_____ Home Phone: _____
_____ Cell Phone: _____
Sex: Male Female Age: _____
Marital Status: _____ Social Security Number _____
E-mail: _____ Occupation: _____

Who is your Primary Care Physician (PCP)? _____
Who is your Referring Physician (if different than your PCP)?_____

List of people who you authorize our physicians to discuss your medical conditions with:
Name/Relationship/Phone#
_____
_____

In case of Emergency, who should we contact? _____
Relationship to Patient _____ Phone number _____

Are we able to leave a message on your voicemail regarding medical results? YES NO

Local Pharmacy Name: _____ Location: _____
Mail Order Pharmacy Name (If applicable)? _____

Which laboratory do you use for blood draws? _____
Which diagnostic imaging facility do you use? _____
(i.e. for MRIs, CT, X-rays)

Insurance Information

Primary Insurance Company: _____
Policy Number: _____ Group Number: _____
Policy Holder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____
Policy Number: _____ Group Number: _____
Policy Holder Name: _____ DOB: _____ Relationship: _____

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Insurance and Payment Policy

We are committed to providing you with high quality medical care. We will facilitate the handling of your medical claims by completing insurance forms for you and accepting direct payment from your insurance carrier. In order to service your insurance needs, we require your understanding of our payment policy.

Please realize that:

1) We cannot guarantee that your insurance company will pay your claims. It is your responsibility to know your coverage based on your insurance plan**.** If your plan requires a referral from your primary, it is your responsibility to provide the referral or payment must be made at the time of the visit.
2) You are expected to provide complete and accurate information; this includes your full name, address, home telephone number, date of birth, social security number, email address, photo ID and your most up to date insurance card. Our staff is fully compliant with all the Health Information Portability and Accountability Act (HIPPA) regulations.
3) If you receive a monthly billing statement from our office, all outstanding balances are due within **30 days** of receiving your statement.
4) We require that you pay your co-pay at the time of your appointment.
5) We reserve the right to charge the guarantor a **$50.00** fee for missed appointments and **$75.00** fee for studies canceled with less than 24 hour notice. There will be a **$35.00** charge for all returned checks

Credit Card On File

All patients are required to keep a credit card on file for any outstanding deductible, co-pays or not covered amounts from your insurance carrier. Your credit card will be securely saved in our electronic health record system and no physical copy of your card information will be kept in the office for your protection. You will notified 5 days in advance (via email) for any charges that would be made from our office. If you would elect to pay these charges via another payment method simply call our billing department and we can make those arrangements immediately.

Initials _____

Patient Consent Form

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct healthcare operations such as quality assessments and physician certifications

I have the right to review the *Notice of Privacy Practices* documentation for a complete description of the uses and disclosures of my health information prior to signing this consent. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature:_____ Date:_____

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Name:_____ Reason for Visit:_____

Past Medical History

Current medications - Doses and Frequency

Surgical History

Year	Procedures	

Family History

Whom	Health Problems	
Mother		
Father		
Brothers		
Sisters		
Grandparents		
Children		

Allergies: _____

Social History:

Which hand do you write with? Right Left Both

Tobacco history: Current smoker?_____ Age Started?_____ Year Quit?_____
How many packs/cigarettes per day?_____

Alcohol history: Do you drink alcohol? Y / N If yes, how much? _____
Did you ever drink heavily in the past? Y / N If yes, when did you quit?_____

Drug history: Do you use recreational drugs? Y / N
If yes, what type and frequency?_____

Review of Symptoms

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fevers
- ☐ Exercise intolerance
- ☐ Pallor

Eyes
- ☐ Vision Changes
- ☐ Dry eyes

Ear, Nose & Throat
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Sinus problem
- ☐ Bleeding gums

GI
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Vomiting

GU
- ☐ Difficulty w/ urination
- ☐ Bladder incontinence

Musculoskeletal
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Low back pain
- ☐ Muscle aches/pains
- ☐ Muscle tenderness

Psychiatric
- ☐ Depression
- ☐ Anxiety

Neuro
- ☐ Headaches
- ☐ Numbness / Tingling
- ☐ Arm or leg weakness
- ☐ Loss of balance
- ☐ Vertigo
- ☐ Dizziness
- ☐ Tremors
- ☐ Loss of consciousness
- ☐ Restless legs

Lymph/Blood
- ☐ Easy bruising

Cardiac / Pulmonary
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Cough / Wheezing

Sleep
- ☐ Dry mouth on waking
- ☐ Side sleeping
- ☐ Morning headaches
- ☐ Non-refreshing sleep
- ☐ Snoring
- ☐ Stop breathing at night
- ☐ Daytime sleepiness
- ☐ Wake up choking
- ☐ Nightmares
- ☐ Violent dreams
- ☐ Hallucinations
- ☐ Kicking / Punching
- ☐ Limb movements

Endocrine
- ☐ Fatigue

Skin
- ☐ Rashes

General Questions:

1) Do you have a Pacemaker/Defibrillator? YES NO
2) Are you currently pregnant? YES NO
3) Do you have metal implants? YES NO

Previous Testing:

Have you ever had an:	MRI Brain / MRA?	YES	NO	_____
(If yes, where and when)	MRI Spine?	YES	NO	_____
	Nerve Conduction / EMG?	YES	NO	_____
	Lumbar Puncture?	YES	NO	_____
	Carotid Doppler?	YES	NO	_____
	Cerebral Angiogram?	YES	NO	_____
	Sleep studies?	YES	NO	_____
	EEG?	YES	NO	_____

Additional Relevant Information: _____

_____
_____
_____
_____

Patient Portal Agreement

Through our Electronic Health Record (EHR), I will have access to the 'Patient Portal' for obtaining my medical data. Information provided on the 'Patient Portal' is provided "AS-IS" and without any warranty as to its reliability, accuracy, timeliness, usefulness or completeness. The practice assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information supplied on this site, but will endeavor to protect the privacy of all individuals. Please allow up to 3 business days for a reply if a message is sent via the ' Patient Portal'. If you do not get a response in that time frame, please contact the office directly at 410-590-4616.

The data above has been filled out to the best of my knowledge _____

Patient's Signature Date

Are you interested in learning more about clinical trials?

What is a clinical trial?

A type of research study that evaluates the potential bene ts and risks of new medications or interventions for treating disease.

Who is SiteRx?

As part of our commitment to providing you with as many care options as possible, we are offering enhanced access to clinical trials using a company by the name of SiteRx. They help providers identify potential clinical trial matches for their patients. They will help coordinate entry into the clinical trial and can help with transportation if needed with no out of pocket cost to patients.

Potential benefits of a clinical trial

Access potential treatments before they are publicly available.

Your participation may help advance medicine for a specific disease or condition.

During the clinical trial, you will receive medical oversight and testing in addition to the care you receive from your doctor

☐ Yes, I would be interested in hearing from SiteRx for a clinical trial that I may be a candidate to join

They would be calling you to give more information about the clinical trial and answer your questions, at which point you can decide if you would like to explore the option further. You can opt out of the study or decline at any time

☐ No, I do not wish to be contact by SiteRx for any clinical trial information