Indiana Neuroscience Associates

♦ **Patient Name:** **Medical Record #:**

Social Security #:	**Date of Birth**: **Sex**:

Address One:
Address Two:
City: **State**: **Zip**:

Home Phone#: **Work Phone#**: **Cell Phone#**:

Employer: **Emp. Phone#:**

Email: ____

Would you like to receive information from us through email (excluding protected health information)? **Yes** ☐ **No** ☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Employed: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Military Duty
Student: ☐ Full Time ☐ Part Time ☐ Not a Student
Race: ☐ Black/African American ☐ White ☐ Asian ☐ More than 1 race ☐ Other _______________
Ethnicity: ☐ Hispanic ☐ Not Hispanic
Language Spoken: ☐ English ☐ Spanish ☐ Other: ___________________________________

Referring Doctor: **Ref. Dr. Phone**:	**Primary Care Doctor**: **PCP Phone**:

Emergency Contact: Relationship: ___________________________________
Address:
City: **State**: **Zip**:
Home Phone#: **Cell Phone#:** **Work Phone#:**

♦ **RESPONSIBLE PARTY** ☐ Self ☐ **Please complete this section if Responsible Party is different than patient.**

Name:	**SSN#**: **Date of Birth**: **Sex**:

Address:: **City**: **State**: **Zip**:

Home Phone#: **Work Phone#**: **Cell Phone#**:

Employer: **Emp. Phone#:**

♦ **INSURANCE INFORMATION**

Primary Insurance: **Relationship to Patient**: _______________
Subscriber Name: **Subscriber DOB**:
Policy/ID#:
Group Number: **Group Name**:

Secondary Insurance: **Relationship to Patient**: _________________
Subscriber Name: **Subscriber DOB**:
Policy/ID#:
Group Number: **Group Name**:

Please continue to other side

Patient Name: **Date of Birth**: **MRN**:

NO SHOW / LATE CANCELLED APPOINTMENTS

It is our office policy to charge $25.00 (at the discretion of the provider) for EACH follow-up appointment missed or not cancelled with at least 24 hours advance notice. There is a $50.00 charge for new patients, procedure, or test appointments missed or not cancelled with at least 24 hour advanced notice. Payment will be due within 10 days of the missed/late-cancelled appointment or at your next visit whichever occurs first. Multiple missed or late-cancelled appointments may result discharge from our practice.

PAYMENT / FINANCIAL POLICY

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my insurance company to pay Indiana Neuroscience Associates directly. I authorize Indiana Neuroscience Associates to release medical information to my insurance carrier to the extent needed to receive payment for services.

Payment for services is expected and due at the time of service. Co-pays, deductibles, co-insurance, non-covered services and/or past balances on my account are due at check in. There is a $5.00 billing fee for co-pays not paid at the time of service. I understand that I may not be able to schedule an appointment until past due balances are paid.

Any and all checks returned for non-sufficient funds will result in a $20.00 processing fee. The original check amount plus the processing fee must be paid within 10 days or prior to scheduling your next appointment, whichever occurs first. Indiana Neuroscience Associates reserves the right of check refusal.

It is patient responsibility to ensure that Indiana Neuroscience Associates is provided with complete and current billing and insurance information.

It is the patient responsibility to confirm that any/all providers with whom they are scheduled are participating in their insurance network. Patients will be responsible for charges incurred as a result of services rendered with an out-of-network provider.

It is the patient responsibility to obtain an initial authorization for services if required by insurance.

Indiana Neuroscience Associates will file secondary insurance claims, for contracted insurance carriers, one time as a courtesy to the patient.

Should it be necessary to turn my account to a collection company, I understand that I will be responsible for any additional collection, court or attorney costs.

A fee of $65.00 is required to complete paperwork (including but not limited to work, disability, life insurance, etc.) and $25.00 for FMLA forms will be charged for all forms completed by the office. Payment in full is required prior to the release of the completed paperwork.

Indiana Neuroscience Associates does not accept or bill third party carriers or attorneys for services.

PATIENT RESPONSIBILITY

I agree to provide (to the extent possible) my treating physician information needed in order to receive appropriate care.
I understand that it is my responsibility to understand my health problems and participate, to the degree possible, in developing, with my treating physician, agreed up on treatment goals.

I understand that it is my responsibility to follow plans and instructions for care that I have agreed upon with my treating physician.

FACILITY OWNERSHIP

In compliance with Indiana State Law, we would like to inform you that we have a financial interest in Proscan Imaging. If you require imaging studies you may choose to be referred to a health care facility other than ProScan Imaging for you studies. Ownership interests by physicians in commercial ventures can provide important benefits in patient care.

HIPAA

- ♦ ________ I authorize Indiana Neuroscience Associates to discuss information regarding my treatment with _______________________

  Relationship ___________________________ Phone # _____________________________

- ♦ ________ I authorize messages to be left on my answering machine/voice mail from physicians, nurses or staff members of Indiana Neuroscience Associates.

- ♦ ________ Indiana Neuroscience Associates is compliant with HIPPA privacy laws. A copy of this policy can be provided at your request.

Patient or Responsible Party (if patient is a minor) Signature Date

Patient Name: **Date of Birth**: **MRN**:

PHARMACY INFORMATION

PRIMARY RETAIL PHARMACY:

NAME: ____

PHONE: ____

ADDRESS: ____

Street City State Zip

Please provide complete address

MAIL ORDER PHARMACY:

NAME: ______________________________

PHONE: ______________________________

ADDRESS: ______________________________

Indiana Neuroscience Associates

Patient Health History for Electronic Health Record

We are currently implementing an Electronic Health Record. Please complete this form in its entirety. You must include a written list of Medications including strength and dosage.

Name: ____ **Date of Birth**: ____________ Male ☐ Female ☐

Name of Primary Care Physician: ____ Phone # ________________

Name of referral physician or other referral source: ___________________________ Phone # _________________
(if not primary care physician):

PAST MEDICAL HISTORY

Prior Neurological Problems:

Other medical problems (check all that apply):

Diabetes: ☐ High B/P: ☐ Heart Disease: ☐ Lung Disease: ☐

Arthritis: ☐ Ulcers: ☐ Thyroid Disease: ☐

ALLERGIES: ☐ **No Known Drug Allergies** ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ IV Contrast ☐ Latex

☐ Other: ____________________________ _______________________________

____________________________ _______________________________

CURRENT MEDICATIONS: (Complete or attach separate list)

Medication	Dosage	Taken for How long?	

Over the counter medications:

VACCINATIONS :

☐ Chicken Pox - Date: ____________ ☐ Flu - Date: ____________ ☐ Pneumonia - Date: __________

FAMILY HISTORY (mother, father, siblings)

	Living	If Living, Medical Problems	If Deceased At What Age	Cause of death
Father	YES ☐ NO ☐	____________	____________	____________
Mother	YES ☐ NO ☐	____________	____________	____________
Brother	YES ☐ NO ☐	____________	____________	____________
Brother	YES ☐ NO ☐	____________	____________	____________
Sister	YES ☐ NO ☐	____________	____________	____________
Sister	YES ☐ NO ☐	____________	____________	____________

			Person with disorder			
Diabetes	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heart Disease	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
High Blood Pressure	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Stroke	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Obesity	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Snoring	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Sleep Apnea	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Narcolepsy	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Daytime Sleepiness	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Other: ____________	NO ☐	YES ☐	☐ Father	☐ Mother	☐ Brother	☐ Sister

SOCIAL HISTORY

Have you ever smoked? NO ☐ YES ☐, how long? ______ Packs per day? _____ Date quit? ____________

Do you drink alcohol of any kind? NO ☐ YES ☐ How much and what kind? ________________________

Do you drink coffee, tea, or soft drinks? NO ☐ YES ☐ Caffeinated ☐ Decaffeinated ☐ Amount Daily ____________

Have you ever used marijuana, cocaine or other drugs? NO ☐ YES ☐, which drug and how often? ________________________

How many meals do you eat daily? ________

How often so you exercise? Daily ☐ Weekly – 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x ☐ Infrequently ☐

What time of day do you exercise? Morning ☐ Afternoon ☐ Evening ☐

For how long? Minutes – 5-10 ☐ 10-15 ☐ 15-20 ☐ 20-30 ☐ 30-45 ☐ 45-60 ☐ Great than 1 hour ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐

Do you live alone? YES ☐ NO ☐ With Spouse ☐ With Caregiver ☐

Female Only

Are you pregnant NO ☐ YES ☐

Are you or have you experienced pregnancy complications? NO ☐ YES ☐ Type ___________________________

PAST SURGICAL HISTORY:

Have you had any surgeries? If yes, what year?

Head or neck: _________________ Brain or nerve: _________________ Neck or back: _________________
Tonsillectomy: ________________ Hand, arm, leg or foot: ___________ Nasal surgery:_________________
Cardiac surgery: _______________ Cardiac Cath: __________________ Appendectomy: _______________
GI surgery: ___________________ Hernia: ________________________ Hysterectomy:_________________

Other:

REVIEW OF SYSTEMS

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

Skin:
- ☐ Excessive Sweating
- ☐ Rash

HEENT:
- ☐ Sleep Apnea
- ☐ Facial numbness/tingling

Neck:
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Swelling

Respiratory:
- ☐ Difficulty Breathing
- ☐ Snoring
- ☐ Wakes up from Sleep Wheezing or Short of Breath

Cardiovascular:
- ☐ Chest Pain
- ☐ Fainting/Blacking Out
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Swelling of Extremities

Gastrointestinal:
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Vomiting

Male Genitourinary:
- ☐ Incontinence
- ☐ Painful Urination

Female Genitourinary:
- ☐ Difficulty Emptying Bladder
- ☐ Dyspareunia
- ☐ Frequency
- ☐ Incontinence
- ☐ Painful Urination

Musculoskeletal:
- ☐ Back Pain
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness

Neurological:
- ☐ Auras
- ☐ Decreased Memory
- ☐ Difficulty Speaking
- ☐ Dizziness

Neurological (cont'd)
- ☐ Headaches
- ☐ Incoordination
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Syncope
- ☐ Stroke
- ☐ Tremor
- ☐ Trouble Walking
- ☐ Vertigo
- ☐ Visual Changes
- ☐ Weakness

Psychiatric:
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Nervousness
- ☐ Panic Attacks
- ☐ Trouble Falling Asleep

Endocrine/Glands:
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Sexual Dysfunction
- ☐ Thyroid Problem

Hematology:
- ☐ Abnormal Bleeding
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Painful Lymph Nodes

PHARMACY INFORMATION

Name: ____ Date of Birth : ___________________

PRIMARY RETAIL PHARMACY:

NAME: ____

PHONE: ____

ADDRESS: ______________________________________

MAIL ORDER PHARMACY:

NAME: ____

PHONE: ____

ADDRESS: ______________________________________

____ ___________________________

Patient Signature Date

____ ___________________________

Person Completing Form (Other than patient) Date