Dear Prospective Patient,

Your appointment is on _______________ with an ARRIVAL TIME of __________ with Dr. _________________________. You do not need to come earlier than the above stated arrival time if you have already filled out the attached paperwork.

We will be very thorough in our evaluation of your neurological problem. Please read/sign the attached office policies carefully and fill out the following forms to help us get to know you and further explore what problems you are having. These forms must be completed in advance and brought to your initial visit. We may request that your appointment be rescheduled if you arrive more than 10 minutes late for your appointment.

In addition to this paperwork please bring the following to your first appointment:

- All health insurance cards
- Driver's License or current government issued ID
- All of your medications or a list of medications and dosage

Our Physician Assistant, Amelia Caraway and Nurse Practitioner, Caterine Garcia-Ruderman are a vital part of our team at NAR. After our initial consultation, they may be seeing you at your follow up visits.

Before your consultation, we invite you to visit our website at www.neuroroc.com to get to know us better. We look forward to meeting you in person and helping you with your healthcare needs.

Sincerely,

Ashanthi Gajaweera, MD

Ryan Evans, MD

Erica Patrick, MD

Today's date___________________________

Patient Name____

Date of Birth____________________________ Current Age__________________________

Address ______________________ City_________________________ Zipcode__________

Primary Phone # ____

Secondary Phone # ____

Primary Care Doctor ____

Referring Physician ____

Pharmacy you use: Name ______________________Location__________________________

Gender: How do you identify? (circle) man / woman / non-binary / self-describe__________

Occupation: ____________________If retired, former occupation: _____________________

Please list anyone who lives at home with you____________________________________

Marital Status _____________Spouse's name ____________________________________

Are you right or left-handed? ____

Have you been vaccinated against COVID 19? yes / no

Briefly state the reason you were referred for neurological evaluation:

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Please be aware that we DO NOT accept No Fault related Motor Vehicle Accident Cases or Worker's Compensation claims.

Have you RECENTLY experienced any of the following symptom? (select all that apply):

- Weight loss
- Weight gain
- Fever
- Chills
- Rash
- Double vision
- Nasal drip/congestion
- Ear ache/infection
- Dental problems
- Trouble swallowing
- Ringing in ears
- Hearing loss
- Loss of taste/smell
- Shortness of breath
- Cough
- Chest Pain
- Palpitations
- Swelling of limbs
- Urinary incontinence
- Abdominal pain
- Heartburn
- Nausea/Vomiting
- Diarrhea
- Constipation
- Back pain
- Neck pain
- Joint Pain / Swelling
- Muscle Pain / Cramps
- Headaches
- Snoring
- Seizures
- Vertigo/dizziness
- Slurred speech
- Weakness
- Numbness
- Incoordination
- Balance trouble
- Tremors
- Trouble sleeping
- Falls
- Restless dream sleep
- Anxiety
- Depression
- Hallucinations
- blackouts / fainting

Medications: attach separate list if needed

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Medication Allergies: ____

How tall are you?____________________How much do you weigh?__________________

Please check the following tests you have had and when/where they were done:

- MRI Scan of the head ____
- EEG (Brain wave recording) ____
- EMG and Nerve Conduction ____
- Lumbar puncture (spinal tap) ____

Have you seen a neurologist before? yes /no ? If so, who and when?

____

Is there any **family history** of brothers/sisters/parents with any of the following?

List brother/sister/parents

- Stroke prior to age 60 ____
- Parkinsons disease ____
- Dementia ____
- Seizures or epilepsy ____
- Migraine ____
- Cerebral Aneurysm ____
- Multiple Sclerosis ____
- Neuropathy ____
- Huntington's Disease ____

Do you drink alcohol? Yes / No

If so, what (beer/wine etc.)? ________________#drinks__________ per day/week

I currently smoke ____ packs/day.

Do you want to quit?

Have you ever smoked? Yes/No Quite date _______(year)

Caffeine intake _______________cups / oz /day of coffee / soda / tea (select all that apply)

Please list any other recreational drugs or supplements? ___________________________________

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Have you been diagnosed with any of the following conditions?: circle all that apply

Migraine Headaches	Obesity	Bariatric Surgery
Seizures/Epilepsy	Sleep Apnea	Celiac Disease
Stroke	Asthma	Crohns/UC
Carotid stenosis	Emphysema/COPD	Reflux (GERD)
Restless Leg Syndrome	High Cholesterol	Gout
Concussion	High Blood Pressure	Lupus
Depression	Heart Disease	Rheumatoid Arthritis
Anxiety	Atrial Fibrillation	Fibromyalgia
Bipolar Disorder	Valvular disorder	Sarcoidosis
Anemia	Pacemaker/Defibrillator	Tuberculosis
Clotting disorder	Peripheral vascular disease	HIV/AIDS
Diabetes	Kidney Failure	Cancer (please specify):
Thyroid Disorder	Liver Disease/Hepatitis	Other: ________________

Please list any surgeries/hospitalizations/pregnancies along with date/year:

Illness/surgery

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If menstruating, are your periods regular? yes / no

If postmenopausal, what year was your last period ___________

Any personal history of miscarriage / stillbirth? yes / no

Number of pregnancies ________________ Number of miscarriages ____________

Are you on any type of hormone therapy? If so, what _________________________

What type of contraception do you use? __________________________

Neurology Associates of Rochester, PC Telemedicine Consent Form

We are defining Telemedicine to include communication via phone, video or using a patient portal for providers to communicate with patients to review their results, address their concerns, questions and medication management etc. Telemedicine also includes our providers using electronic interfaces such as phone discussions or video conferencing with your PCP and other specialists when deemed medically necessary.

I give Neurology Associates of Rochester permission to utilize Telemedicine services including video visit, phone visits, patient portal communications. I also give Neurology Associates of Rochester permission to bill my insurance for these services.

_______________________________________ ______________________

Printed Name of Patient Date

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Signature of Patient or Legal Guardian

Neurology Associates of Rochester PC, HIPAA PRIVACY NOTICE

This practice is obligated under HIPAA to protect the privacy of your protected health information (PHI) and to provide you with a notice of our privacy practice (Privacy Notice).

Acknowledgement of Receipt: I acknowledge that I have received a copy of the Privacy Notice bearing an effective date of 9/13/2013.

Verbal Disclosure of PHI to Designated Individuals: As stated in our Privacy Notice, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We request that you designate the individual with whom we may discuss and/or release your protected health information. I understand that I may rescind or modify this consent at any time. Such change must be in writing.

Name	Relationship
______________________________	____
______________________________	____
______________________________	____

Can we leave medical information on:

Patient Portal	yes___	no__
your home phone	yes___	no__
your cell phone	yes___	no__
your answering machine	yes___	no__
with another person	yes___	no__

______________________________ ____

Name of Patient Signature Date

Neurology Associates of Rochester, PC Medical Services Financial Agreement

INSURANCE COVERAGE

This office makes no claim that your insurance policy will cover all services provided. Insurance policies may vary greatly in terms of deductible and percentage of coverage for neurology consultation and testing. We require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances to this office. After verification of your insurance coverage, we will bill your insurance provider for the services that you receive.

PAYMENT ARRANGEMENTS

If you have a contracted amount for copayment, that amount is due at the time of each visit. If you have a deductible, we require that you pay 50% in advance towards each visit. Your full portion of the bill is expected to be paid after payment is received from your insurance provider. Any unpaid balance will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 2% applied per month. Any positive balances will be refunded to you within 30 days of receiving your insurance explanation of benefits (EOB).

ASSIGNMENT OF BENEFITS

By signing this form, you authorize payment of medical benefits to be made directly to this office. If your insurance provider sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

RELEASE OF INFORMATION

By signing this form, you were also authorizing this office, upon request from your health insurance provider, to release any medical or other necessary information necessary to process your insurance claim. You also acknowledge and requests payment of government medical benefits to this office.

TERMINATION OF CARE

If you are discharged from this practice or voluntarily suspend or terminate your care at any time, all charges for professional services are immediately due and payable to this office. All services rendered by this office will be charged directly to you. You are personally responsible for payment regardless of your health insurance coverage.

REFERRALS & CONTRACTED FACILITIES

If you have an insurance plan that requires a referral (e.g., an HMO plan), it is your responsibility to obtain a referral from your primary care provider prior to your first scheduled appointment and keep it current for every visit thereafter. If we do not have a referral, services can only be rendered if you sign an "Advanced
Beneficiary Notice," stating that you understand that a referral was not obtained and payment in full is expected the day of service. If you require the use of a specific lab or x-ray facility, you must notify the nurse to ensure the proper facility is used.

CANCELLED APPOINTMENTS

Missed appointments represent a cost to us and to other patients who could have been seen in the time that was set aside for you. Therefore, cancellations must be requested at least 48 hours prior to the scheduled appointment time. Failure to cancel or to not show for a scheduled follow up appointment may result in a $40 fee. Failure to cancel or to not show for a scheduled New Patient visit or procedure may result in a $100 fee. These fees are not billable to your insurance.

FEE FOR FORMS AND LETTERS

There will be a fee of $20-50 for completion of forms and letter for use outside of the patient's medical record. This may include forms such as those used for DMV, employment, life insurance, disability insurance, FMLA.

This fee range will depend on the complexity and time required for completion of the form as well as the time constraints requested. You will be notified of the fee due prior to completion and all forms and paperwork will be released once payment is received. We accept credit card or cash for these fees.

GENERAL

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage or benefits, please do not hesitate to speak to one of our receptionists about your concerns.

Acceptance of the Medical Services Financial Agreement

I have received, read, and understand the “Medical Services Financial Agreement” of Neurology Associates of Rochester, PC. All questions that I have concerning the Financial Agreement have been answered to my satisfaction. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified that I am responsible for all charges incurred.

_______________________________________ _____________________

Printed Name of Patient Date

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Signature of Patient or Legal Guardian