Neurology and
Neurosurgery Associates, P.A.
Providing complete neurological and spinal care

NAME:_____ **DOB:**_____ **DATE:**_____

NNA OFFICE POLICIES
NO SHOW/CANCELLATION POLICY
If it is necessary to cancel or reschedule your appointment, please do so at least 24 hours prior to your appointment. If we do not receive the cancellation notice, there is a $50 fee for missed appointments. This charge will be payable by the patient and will not be billed to any insurance company. the fee must be paid by the patient prior to rescheduling the appointment.
FORM COMPLETION POLICY
Neurology & Neurosurgery Associates charges for form completion. This charge is $25 per form and will be payable by the patient and will not be billed to any insurance company. This fee must be paid prior to the form being completed. Requests will be completed within 7 to 10 business days.
MESSAGES
Messages left on voicemail will be answered in the order in which they were received (unless urgent). All messages will be answered within 48 hours of receipt. We ask that you not leave multiple messages within that time frame, as it will only slow down the process. Our staff strives to answer all their messages as quickly as possible and voicemail is checked often throughout each business day.
MEDICATION REFILLS
Please allow 2 to 3 business days for medication refills. Refill requests received after business hours, or on weekends and holidays, will be addressed on the next business day. Any requests for refills received after 3 p.m. will be addressed on the next business day. Please contact your pharmacy and ask that they fax your refill request to our office. **DO NOT WAIT until you are out of your medication before you request refills. Your doctor may not be available to approve your refill on an urgent basis.**
MEDICAL RECORDS RELEASE POLICY
You will need to sign a release form requesting that our office release your medical records to any other doctor or facility. If any attorney or insurance company is requesting your records they must submit a written request with a signed release. Please allow up to 10 business days for the request to be processed. Please note that we can only release the information that was completed by our providers. We cannot release the information from other physicians, hospitals, etc.
FINANCIAL POLICY
As a courtesy we will file all claims directly to your insurance company on your behalf. Please note that you are responsible for providing your complete and correct insurance information at the time of service. Please inform our office of any insurance or billing changes immediately. If we are not provided with the correct information at the time of service, the patient will be held responsible for the bill. The patient is responsible for knowing their own insurance policy benefits and coverage limitations and informing our office of any non-covered services. If your insurance requires a referral and/or authorization, please obtain those prior to your service. All copays are due at the time of service. Self-pay accounts must be paid in full at the time of service. **Is this auto related (Y / N) Is this work related (Y / N)**
By signing, I acknowledge that I have read and agree to the policies set forth above. **SIGNATURE:**_____ **DATE:**_____ Signature of patient or authorized representative **RELATIONSHIP TO PATIENT:**_____

NEUROLOGY AND NEUROSURGERY ASSOCIATES, P.A.
CLINIC SUMMARY OF NOTICE OF PRIVACY PRACTICES

This Summary describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At NNA clinic, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your case.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclose your health information, as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and received a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of the actual Notice of Privacy Practices as well as this Summary.

If we change any of the details of the Notice of Privacy Practices, we will notify you of the changes in writing.

You may file a complaint with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Deborah Schweitzer at 863-293-2107.

The Notice of Privacy Practices and this Summary go into effect as of April 11, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices (the "Notice") and a Summary of the Notice (the "Summary"). The Notice and the Summary describe how my health insurance may be used or disclosed. I understand that I should read the Notice and the Summary carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on this Company's website at www.neurohaven.com, or by requesting one at our Company's offices.

Signature of patient or patient representative:_____ Date:_____

Printed name of patient or patient representative:_____

Relationship to patient:_____

Neurology and Neurosurgery Associates, P.A.

Telephone: (863) 293-2107 Fax: (863) 294-9314

Patient Name:_____ Today's date: _____

Age:_____ Birth date: _____ Date of last physical examination: _____

What is your reason for visit?_____

Date symptoms began?_____

Severity of symptoms: ☐Mild (1-3) ☐Moderate (4-6) ☐Severe (7-9) ☐Incapacitating (10+) **Best / Worse**

Aggravated by :_____

Relieved by:_____

Who is your Medical Doctor?_____

List all doctors seen for this problem:

_____

List all tests or x-rays performed for this problem: (x-ray, CT, MRI, EMG, Bone Scan, Myelogram)

Have you had Physical Therapy for this problem in the last year?_____ If so, where_____

List any medications and treatments done for this problem:

Pregnant : Yes / No Last menstrual period:_____

Symptoms

Check (✓)symptoms you currently have or have had in the past year.

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Edema-Leg Swelling
- ☐ Irregular Heartbeat/Palpitations
- ☐ Fainting

Genitourinary
- ☐ Painful Urination (Dysuria)
- ☐ Frequent Urination
- ☐ Blood in Urine (Hematuria)
- ☐ Urge Incontinence
- ☐ Urinary Incontinence

Neuro/Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Headache
- ☐ Loss of Consciousness
- ☐ Memory Loss
- ☐ Seizure
- ☐ Tremors
- ☐ Vertigo
- ☐ Visual Changes

Hematologic
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Embolism

HEENT
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Facial Pain
- ☐ Nasal Congestion
- ☐ Dysphagia

Vascular
- ☐ Cool Extremities
- ☐ Edema-Leg Swelling
- ☐ Erythema-Redness of Skin
- ☐ Extremity Pain
- ☐ Varicose Veins

Reproductive
Female
- ☐ Postmenopausal
- ☐ Hormone Replacement Therapy
- ☐ Breast Discharge/Pain/Lumps
- ☐ Vaginal Itch

Reproductive (continued)
Male
- ☐ Circumcised
- ☐ Erectile Pain
- ☐ Testicular Pain
- ☐ Sexual Dysfunction

Dermatologic
- ☐ Contact Allergy
- ☐ Hair Loss
- ☐ Nail Changes
- ☐ Rash
- ☐ Skin Lesions

Immunologic
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies

Respiratory
- ☐ Chest Pain
- ☐ Cough
- ☐ Dyspnea (Shortness of Breath)
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea/Vomiting

Metabolic/Endocrine
- ☐ Cold Intolerant
- ☐ Excessive Sweating
- ☐ Generalized Weakness
- ☐ Heat Intolerant
- ☐ Numbness

Musculoskeletal
- ☐ Back Pain
- ☐ Bone/Joint Symptoms
- ☐ Muscle Weakness
- ☐ Rheumatoid Arthritis

Other: _____

Conditions Check (✓) conditions you currently have or have had in the past year.

Past Medical History
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Bipolar Disorder
- ☐ Blood Clots
- ☐ Brain Tumor
- ☐ Cancer
- ☐ COPD
- ☐ CVA
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tremors

- ☐ Sleep Apnea

Hospitalizations

Past Surgical Histories

	Year		Year		Year
☐ Anesthesia Reaction	____	☐ CABG	____	☐ Colostomy	____
☐ Aneurysm Resection	____	☐ Carotid Endarterectomy	____	☐ Discectomy	____
☐ Angioplasty with Stent	____	☐ Carpal Tunnel Release	____	☐ Gastric Bypass	____
☐ Appendectomy	____	☐ Cataract Extraction	____	☐ Hernia Repair	____
☐ Arthrodesis	____	☐ Cerebral Shunt	____	☐ Hip Replacement	____
☐ Back Surgery	____	☐ Cholecystectomy	____	☐ Knee Replacement	____
☐ Colectomy	____	☐ Laminectomy	____		
☐ Lasik	____	**Male**		**Female**	
☐ Muscle Biopsy	____	☐ Prostate Biopsy	____	☐ Augmentation Mammo	____
☐ ORIF	____	☐ TURP	____	☐ Bilateral Tubal Ligation	____
☐ Pacemaker	____	☐ Vasectomy	____	☐ Breast Biopsy	____
☐ Small Bowel Resection	____			☐ Cesarean Section	____
☐ Spinal Fusion	____			☐ D and C	____
☐ Thyroidectomy	____			☐ Hysterectomy	____
☐ Tonsillectomy	____			☐ Mastectomy	____
				☐ Myomectomy	____
				☐ Red. Mammoplasty	____
				☐ TAH/BSO	____
				☐ Vaginal Hysterectomy	____

Do you have a pacemaker, aneurysm clip, artificial heart valve, or other implants? ☐ Yes ☐ No

Are you claustrophobic? ☐ Yes ☐ No

Other: _____

Social History

Hand Dominance ☐ Left ☐ Right ☐ Ambidextrous
Changes in sleep patterns? ☐ Yes ☐ No

Occupation:
Employer:_____ Occupation:_____
Employment status:_____ Restrictions: _____

Tobacco Use: ☐ Yes ☐ No ☐ Former
Type: _____
Packs per day:_____
Years smoked: _____
Year Quit: _____

Drinks Alcohol: ☐ Yes ☐ No Formerly Year Quit: _____
Type:_____ Frequency: _____
Amount: _____ Last Drink: _____
Family History of alcoholism? ☐ Yes ☐ No
Street Drugs: ☐ Yes ☐ No Year Quit: _____
Type:_____ Frequency: _____
Family History of Drug Abuse? ☐ Yes ☐ No

Caffeine Use:
Type: _____ Amount daily: _____

Family History

Who:	What Condition	Age of Onset	Cause of Death?

Medications List medications you are currently taking

_____
_____
_____
_____

Allergies

_____
_____
_____
_____

Preferred Pharmacy _____

_____

Phone #:_____

_____

Pain Management Health History Form

If you are here to be evaluated for Pain Management, please complete the following questions:

1. **What was the cause of your symptoms?**

- ☐ Accident at work
- ☐ At work, but not an accident
- ☐ Accident at home
- ☐ Motor vehicle accident
- ☐ Following surgery
- ☐ Following illness
- ☐ Pain just began, no reason
- ☐ Other:_____

2. **Location of Pain:**

- ☐ Head
- ☐ Face/Jaw
- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Elbow
- ☐ Hand/Wrist
- ☐ Chest
- ☐ Abdomen
- ☐ Groin
- ☐ Genitourinary (Bowel, Bladder, Sex organs)
- ☐ Upper Back
- ☐ Mid Back
- ☐ Lower Back
- ☐ Thigh
- ☐ Buttock
- ☐ Knee
- ☐ Calf
- ☐ Ankle/Foot
- ☐ Multiple Joints
- ☐ Other:_____
- ☐ Left side
- ☐ Right side
- ☐ Both sides
- ☐ In the middle

Duration of Pain:_____ weeks/months/years.

Quality: Would you describe your pain as:

☐ Burning ☐ Sharp ☐ Aching ☐ Throbbing ☐ Shooting ☐ Other:_____

Timing:

☐ Always Present ☐ Often Present ☐ Rarely Present

Context: What time of day is your pain worse?

☐ Morning, on arising ☐ Later in the morning ☐ Afternoon ☐ Evening ☐ Bedtime
☐ Night (when sleeping) ☐ Other:_____

What parts of life can you not do due to pain?_____
What makes your pain worse?_____
What makes your pain better?_____

Associated Signs and Symptoms
Do you have any of the following symptoms associated with your pain?

- ☐ Numbness (Location:)_____
- ☐ Tingling (Location:)_____
- ☐ Pins and needles (Location:)_____
- ☐ Weakness (Location:)_____
- ☐ Coldness
- ☐ Increased Swelling
- ☐ Muscle Spasm
- ☐ Muscle Tightness
- ☐ Skin Discoloration
- ☐ Bowel or Bladder problems

Previous Pain Management Procedures

- ☐ Epidural
- ☐ Facet Blocks
- ☐ Trigger Point Injections
- ☐ Medication Pump
- ☐ SCS
- ☐ Intrathecal Pump

To the best of my knowledge the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

Signature of patient, parent, guardian, or personal representative _____ Date _____

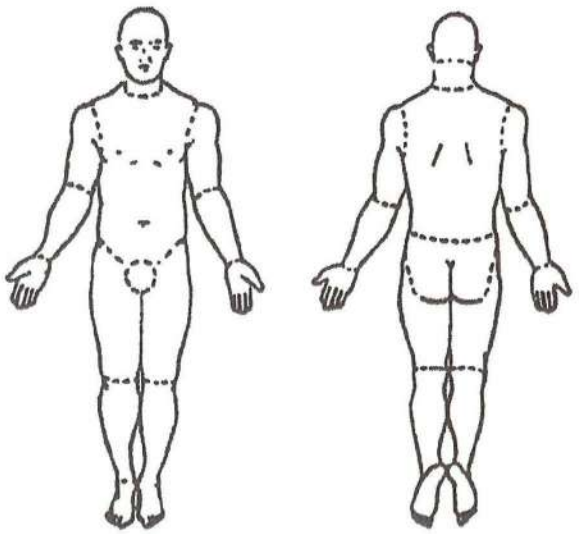
Please print name of patient, parent, guardian, or personal representative _____ Date _____

Reviewed by _____ Date _____

Height: _____

Weight: _____

Show on the diagram below the areas that are painful, numb, or weak.



Patient Health Questionnaire

Name:_____ DOB:_____

Over the last 2 weeks how often have you been

Bothered by any of the following problems?

Please Circle Answer

1. Little interest or pleasure In doing things	Not At All	Several Days	More Than Half The Days	Nearly Everyday
2. Feeling down, depressed, or hopeless	Not At All	Several Days	More Than Half The Days	Nearly Everyday
3. Trouble falling or staying asleep, or sleeping too much	Not At All	Several Days	More Than Half The Days	Nearly Everyday
4. Feeling tired or having little energy	Not at All	Several Days	More Than Half The Days	Nearly Everyday
5. Poor appetite or overeating	Not at All	Several Days	More Than Half The Days	Nearly Everyday
6. Feeling bad about yourself or that you're a failure or have let your family down	Not at All	Several Days	More Than Half The Days	Nearly Everyday
7. Trouble concentrating on things, such as reading the newspaper or watching television	Not at All	Several Days	More Than Half The Days	Nearly Everyday
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	Not at All	Several Days	More Than Half The Days	Nearly Everyday
9. Thoughts that you would be better off dead, or hurting yourself in some way	Not at All	Several Days	More Than Half The Days	Nearly Everyday

Name:_____ Date of birth:_____Date:_____

STOP BANG Questionnaire

Height ___ inches/cm Weight lb/kg
Age ___
Male/Female
BMI ___

Collar size of shirt: S, M, L, XL, or _____ inches/cm
Neck circumference* _____ cm

1. *S*noring
Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes No

2. *T*ired
Do you often feel *t*ired, fatigued, or sleepy during daytime?
Yes No

3. *O*bserved
Has anyone *o*bserved you stop breathing during your sleep?
Yes No

4. Blood *p*ressure
Do you have or are you being treated for high blood *p*ressure?
Yes No

5. *B*MI
*B*MI more than 35 kg/m2?
Yes No

6. *A*ge
*A*ge over 50 yr old?
Yes No

7. *N*eck circumference
*N*eck circumference greater than 40 cm?
Yes No

8. *G*ender
*G*ender male?
Yes No

* Neck circumference is measured by staff
High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
Frances Chung, F.R.C.P.C., Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.#*
Anesthesiology 2008; 108:812-21