Neurology Consultants of Arizona

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Gender: □ Male □ Female

Mailing address: _____City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

E-mail address: _____

Marital Status: □ Married □ Partnered □ Single □ Separated □ Divorced □ Widowed

Race/Ethnicity: □ White □ American Indian □ Asian □ Black/African American □ Pacific Islander □ Hispanic/Latino

Emergency contact: _____ Phone number: _____ Relationship: _____

Primary care physician: _____ Previous or referring doctor: _____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____

Employer address: _____ Employer phone number: _____

FINANCIALLY RESPONSIBLE/GUARANTOR (If different than above):

Name: _____ Relationship to patient: _____ DOB: _____

Phone number: _____ Address: _____

Check if patient is self-pay □

PRIMARY INSURANCE:

Name of Insurance: _____ Subscriber: _____ DOB: _____

Patient/Member ID#: _____ Group#: _____ Employer: _____

SECONDARY INSURANCE:

Name of Insurance: _____ Subscriber: _____ DOB: _____

Patient/Member ID#: _____ Group#: _____ Employer: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directed to the physician. I understand that I am financially responsible for any balance. I also authorize Neurology Consultants of Arizona or insurance company to release any information required to process my claims.

I have also had an opportunity to review Neurology Consultants of Arizona's HIPAA patient privacy policies in the waiting room and have been given opportunity to receive a paper copy of these privacy policies should I desire them.

_____ _____

Patient/Guardian Signature Date

7425 E Shea Blvd. Suite 114
Scottsdale, AZ 85260
P: 480-977-6844 F: 480-977-6845

Neurology Consultants of Arizona

Patient name:

HEADACHE QUESTIONNAIRE:

1. At what age did your headaches begin? _____

2. Does anyone in your family have chronic headaches? List below:

_____ _____

_____ _____

3. Have you had any history of head trauma? No / Yes- describe: _____

4. How often do you have headaches on average per week? _____ Per month? _____

5. Where are your headaches typically located? _____

6. What time of day do they usually start (approximately) or does it vary a lot? _____

7. For how many hours per day do your headaches last? _____

8. Rate your pain level on average: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

9. Do you have any symptoms other than pain with your headache? Check any that apply to you:

- □ Nausea
- □ Vomiting
- □ Sensitivity to light
- □ Sensitivity to sound
- □ Visual symptoms just prior to or with your headaches
- □ Pain only on one side of your head (unilateral)
- □ Tingling or weakness in arms
- □ Tingling or weakness in legs
- □ Redness in eyes
- □ Fever
- □ Pulsating
- □ _____

10. Is there anything that usually triggers your headache? Some typical triggers for headache are:

- □ Caffeine
- □ Menstrual period
- □ Sexual intercourse
- □ Skipped meal
- □ Alcoholic beverages esp. beer and wine
- □ Citrus
- □ Too little or too much sleep
- □ Flashing lights
- □ Neck movement
- □ Chocolate

List any not listed here: _____

_____

_____

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HEADACHE MEDICATION HISTORY:

Please check off medications that you have tried in the past and circle the outcome of the medication:

E = Effective C = Contraindicated I = Intolerant F = Failed

Beta Blockers	**Outcome**	**Mixed Analgesics**	**Outcome**
□ Propranolol (Inderal)	E C I F	□ Excedrin	E C I F
□ Atenolol (Tenormin)	E C I F	□ Butalbital (Fioricet)	E C I F
□ Nadolol (Corgard)	E C I F	□ Butalbital w/ Codeine	E C I F
□ Metoprolol (Lopressor)	E C I F	□ Other _____	E C I F
□ Other _____	E C I F		E C I F
Calcium Blockers	**Outcome**	**5HT Antagonists**	**Outcome**
□ Verapamil (Veralan)	E C I F	□ Methesergide (Sansert)	E C I F
□ Diltiazem (Cardizem)	E C I F	□ Cyproheptadine (Periactin)	E C I F
□ Other _____	E C I F		E C I F
Anticonvulsants	**Outcome**	**Antidepressants**	**Outcome**
□ Valproic acid (Depakote)	E C I F	□ Zoloft (Prozac)	E C I F
□ Gabapentin (Neurontin)	E C I F	□ Paxil	E C I F
□ Lamotrigene (Lamictal)	E C I F	□ Celexa	E C I F
□ Topiramate (Topamax)	E C I F	□ Lexapro	E C I F
□ Zonagran	E C I F	□ Fluoxetine	E C I F
□ Keppra	E C I F	□ Amitriptyline	E C I F
□ Pregabalin (Lyrica)	E C I F	□ Nortriptyline	E C I F

Acute Migraine Treatments	**Outcome**
□ Imitrex pill (Sumatriptan)	E C I F
□ Imitrex nasal spray	E C I F
□ Imitrex injection	E C I F
□ Axert (Almotriptan)	E C I F
□ Relpax (Eletriptan)	E C I F
□ Maxalt (Rizatriptan)	E C I F
□ Zomig (Zolmitriptan)	E C I F
□ Zomig nasal spray	E C I F
□ Amerge (Naratriptan)	E C I F
□ Cafergot	E C I F
□ DHE45	E C I F
□ Migranal nasal spray	E C I F
□ Frova (Frovatriptan)	E C I F

Please list any anti-inflammatory medications that you have taken in the past or regularly take (ie: Advil, Aleve, Ibuprofen):

_____

_____

Please list any narcotics or muscle relaxers that you have taken in the past or currently take (ie: methadone, oxycodone, fentanyl, baclofen, cyclobenzaprine, tizanidine, Botox):

_____

_____

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MEDICAL HISTORY:

Main reason for your visit today:

_____

_____

Significant medical conditions you've had, past or present:

_____

_____

SURGICAL HISTORY/HOSPITALIZATIONS:

Year	Reason	Hospital

MEDICATIONS:

Pharmacy name: _____ Address/cross streets: _____

Phone number: _____ Fax Number: _____

List your prescribed drugs and over-the-counter drugs (such as vitamins and inhalers)

NAME	STRENGTH	FREQUENCY TAKEN

ALLERGIES TO MEDICATIONS:

MEDICATION	REACTION

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SOCIAL HISTORY/MENTAL HEALTH:

Exercise- Regular exercise is planned physical activity (e.g. brisk walking, aerobics, jogging, bicycling, swimming, etc.) performed to increase physical fitness. Such activity should be performed 4-5 times per week for 20-60 minutes per session. Exercise does not have to be painful to be effective but should be done at a level that increases your breathing rate and causes you to break a sweat.

Do you exercise according to the above definition?

□ Yes □ No If yes, days per week: _____ Minutes per session: _____

Alcohol-

Do you drink alcohol? □ Yes □ No

If yes, what kind? _____ How many drinks per week? _____

Have you ever felt the need to cut down on drinking? □ Yes □ No

Have you ever been annoyed by criticism of your drinking? □ Yes □ No

Have you ever felt the need for an eye-opener? □ Yes □ No

Have you ever experience black outs? □ Yes □ No

Nicotine/Tobacco-

Do you use or have you ever used nicotine products? □ Yes □ No

If yes, how much? _____pk/day Year quit: _____ Number of years: _____

Indicate type (cigarettes, chew, cigar, vaping. etc.)_____

Safety-

Do you have any concerns about physical, mental, or sexual abuse that you'd like to discuss with the physician? □ Yes □ No

Mental-

Do you feel depressed? □ Yes □ No

Have you ever seriously thought of hurting yourself? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No

Have you ever been to a counselor? □ Yes □ No If yes, for what problem? _____

FAMILY HISTORY:

Does your family have a history of any of the following conditions?

Condition	Relationship	Condition	Relationship
Diabetes disease		Cancer (please indicate type)	
High blood pressure		Migraines	
High cholesterol		Alzheimer's/Dementia	
Kidney disease		Obesity	
Heart disease		Kidney disease	
Thyroid		Asthma	
Psychiatric disorder		Drug and/or alcohol abuse	

***Please indicate if there is any other family or medical history that is not listed above you may feel is pertinent:

_____

_____

_____

_____

_____

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SYMPTOMS (now or in the recent past):		
Constitutional □ Insomnia □ Loss of appetite □ fevers □ Significant weight gain □ Significant weight loss **Neurologic** □ Vision changes □ Headaches □ Memory loss □ Dizziness or vertigo □ Numbness □ Tingling **Ear, Nose, Throat** □ Ringing in the ears □ Hoarseness □ Sinus- nose bleeds □ Oral lesions □ Neck or jaw pain □ Lumps in neck **Respiratory** □ Shortness of breath □ Cough □ Sputum □ Coughed up blood □ Wheezing □ Snoring	**Gastrointestinal** □ Swallowing problem □ Heartburn □ Bloating □ Abdominal pain □ Ulcers □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Irregular bowels □ Blood in stool □ Black stool □ Jaundice □ Hemorrhoids **Genitourinary** □ Menstrual trouble □ Menopause □ Incontinence □ Frequent urination □ Urge to urinate □ Painful urinate □ Blood in urine □ Discharge □ Awaking to urinate □ Change in stream □ Lumps in testicles	**Cardiovascular** □ Chest pain or pressure □ Palpitations □ Wake up breathless □ Ankle swelling □ Leg cramping □ Varicose veins □ Cold feet or hands □ Passing out **Musculoskeletal** □ Joint pain □ Joint swelling □ Muscle aches □ Low back pain **Skin** □ Change in moles □ Rash **Hematology/Blood** □ Easy bruising □ Gums bleeding

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Neurology Consultants of Arizona

Patient name:

OFFICE AND FINANCIAL POLICIES

Welcome to Neurology Consultants of Arizona! It is our pleasure to provide you with excellent health care! Please take a few moments to read the following policies that will help us serve you better and make your visits more enjoyable.

DEMOGRAPHICS/INSURANCE/PAYMENTS- If your address, telephone number, or insurance changes, please notify us immediately. If your insurance changes it is your responsibility to verify that we are contracted with your new plan. Copays, deductibles, and coinsurances are due at the time of service and NO EXCEPTIONS will be made. There will be a $40.00 fee for all NSF checks. If your account is sent to collections for failure to pay account balance when due, you will be charged a collection fee by our billing company in addition to the amount you owe on your account.

APPOINTMENTS- Please arrive 15 minutes prior to the time of your appointment. If you are more than 15 minutes late, we may ask you to reschedule (which may result in a charge) so that other patients are seen at their scheduled appointment times. You may be charged $25.00 for office visits and $150 for procedures if you miss an appointment or do not cancel or reschedule 24 hours prior to your appointment. If you miss three appointments in a 12-month period, you may be DISCHARGED from the practice.

MEDICATIONS- It is your responsibility to keep track of your medication supply. If you need an existing prescription refilled, please contact your pharmacy at least 3 DAYS ahead of time and they will contact us. Prescriptions will not be refilled after-hours or on weekends. PLEASE NOTE, many medications and all controlled substances require an appointment with your provider for refills so scheduling routine visits will be necessary if you are prescribed any of these medications. If it has been longer than one year since your appointment, you will need to schedule for medication refill.

LABS AND REFERRALS- Please allow 7-10 business days for most lab results. Labs take a few days to process at the labs themselves then the doctor must review the labs before signing off to the medical assistant. Please allow 7-10 business days for referrals but know that sometimes it may take longer due to getting approval on an authorized provider.

MESSAGES- Messages left for the doctors and/or medical assistants after 3:00pm and on weekends may not be returned until the next business day.

FORMS- An office visit is required for filling out forms by third parties such as disability insurance, worker's comp, FMLA, life insurance, motor vehicle accidents, etc to ensure accurate information.

MEDICAL RECORDS- There is an administrative fee of $25 if you request a copy of your medical records, although faxing to another medical doctor is waived for continuation of care.

GENERAL- No food or drink, other than water, is to be consumed in the waiting or exam rooms. Minor children must be accompanied by a parent or legal guardian.

Thank you for your understanding; please acknowledge your acceptance of these policies by signing and dating below.

Signature: _____ Date: _____

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Neurology Consultants of Arizona

Patient name:

HIPAA:

Patient name: _____ DOB: _____

Notice to patient:

We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I hereby acknowledge that I have been presented with a copy of Neurology Consultants of Arizona's Notice of Privacy Practices. I authorize Neurology Consultants of Arizona and/or its employees to relay any and all communications regarding my lab results, medical testing, referral information, billing/account information, and any other pertinent health information in the following matter and to the following people:

Phone number: _____ May we leave a detailed message? □ Yes □ No
Phone number: _____ May we leave a detailed message? □ Yes □ No

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Neurology Consultants of Arizona uses a secure HIPAA compliant email system to send confidential medical information. In addition, there is a secure internet e-mail portal; the web address is https://patientportal.advancedmd.com/142331/account/logon. The portal allows a secure two-way communication between clinical staff and patients. To access the portal, an e-mail address is required to sign up.

Email: _____

By signing below, I agree to the above and know that I may revoke this at any time by giving written notification to this provider.

Signature: _____ Date: _____

For office use only: We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because
□ The patient refused to sign
□ Due to an emergency situation, it was impossible to obtain acknowledgement
□ We weren't able to communicate with the patient
□ Other: _____
Employee signature: _____ Date: _____

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Neurology Consultants of Arizona

Patient name:

Authorization for the Release of Medical Records:

Patient Name: _____ DOB: _____

The above named patient is hereby authorizing the release of medical information

□ To

□ From

Neurology Consultants of Arizona
7425 E Shea Blvd. Suite 114
Scottsdale, AZ 85260
Phone: 480-977-6844 Fax: 480-977-6845

□ To

□ From

Facility or doctor name: _____
Facility address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Reason: _____

The type of information to be disclosed is:

□ Complete medical records x 2 years
□ Progress note(s)
□ Lab report(s)
□ Pathology report(s)/Operative report(s)
□ Ancillary report(s) - imaging
□ Other: _____

Release and Waiver:

If the health information that I have requested Neurology Consultants of Arizona to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), Venereal disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Neurology Consultants of Arizona and their provider and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

This authorization shall be considered invalid after 60 days. I may revoke this authorization at any time by providing Neurology Consultants of Arizona written notice or revocation. However, I may not revoke the authorization retroactively for information already released. I hereby waive all provisions of law and privilege relation to the disclosure hereby authorized.

_____ _____

Patient Signature Date

Neurology Consultants of Arizona

Patient name:

HIPAA Notice of Privacy Practices

Effective as of 6/1/2019

Neurology Consultants of Arizona
7425 E Shea Blvd. Suite 114, Scottsdale, AZ 85260
P-480-977-6844 F-480-977-6845

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

Neurology Consultants of Arizona

Patient name:

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint**.

Luay Shayya, MD	480-977-6844	info@ncaz.org
HIPAA COMPLIANCE OFFICER	Phone	Email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI– Revised June 2019

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