Integrated Sleep Services

Integrated Neurology Services, PLLC

The Infusion Suites

Patient Information

Patient Name: _____
Last First MI

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Preferred method of contact (may check more than one): ☐ Home Phone ☐ Cell Phone ☐ Email

Date of Birth: _____ Age: _____ Gender: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ White ☐ Pacific Islander or Native Hawaiian.

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Language/s: _____

Employer: _____

Occupation: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Referring Provider: _____

Specialty: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Preferred Pharmacy: _____
Name City Zip

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The Infusion Suites

Insurance Information

Primary Insurance: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____
Last First MI

Policy Holder's DOB: _____ Sex: _____ Social Security #: _____

Policy Holder's Employer: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Do you have a Secondary Insurance? ☐ Yes ☐ No If Yes, please provide the following info below.

Secondary Insurance: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____
Last First MI

Policy Holder's DOB: _____ Sex: _____ Social Security #: _____

Policy Holder's Employer: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

_____ _____
Signature Date

_____
Print Name

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Release of Medical Records to Integrated Neurology Services

By signing this form, I authorize the release of confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to Integrated Neurology Services.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

☐ Progress Notes ☐ Lab Reports ☐ EMG Report
☐ Radiology Reports ☐ Medication Records ☐ EEG Report
☐ Sleep Study Results ☐ Other (please specify): _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Integrated Neurology Services
Dr. Simon Fishman; Dr. Neal Maru; Dr. Natalia Kayloe; Dr. Tracy Fulton; Dr. Daniel Kline.;
Shikha Duwady, FNP; Harleen Bath PA-C
6355 Walker Lane Suite 313 Alexandria, VA 22310
Phone: 703-313-9111
Fax: 703-313-4945

The purpose/reason for this release of information is as follows:

☐ At the Request of the Individual for continuity of care.

_____ _____
Patient Name Signature of Patient of Personal Representative

_____ _____
Date Printed Name of Patient/Personal Representative

_____
Relationship to Patient

By signing this form, I authorize Integrated Neurology Services to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

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Integrated Neurology Services, PLLC

The Infusion Suites

General Consent for Treatment and Guaranty of Payment

Consent for Examination and Treatment
I have a condition that requires outpatient care, including diagnostic and laboratory procedures and medical treatment by my physician, physician extenders and office personnel. I understand that the practice of medicine is not an exact science and I know that treatment results cannot be guaranteed. **Patient Initials:** _____

Responsibility for Payment
In consideration of the services provided by Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites, I understand and acknowledge that: (1) I am financially responsible for the charges for all goods and services provided that are not covered by third party payor; (2) I acknowledge that if payment is not received on any patient responsible balance over 90 days I will be sent to a collection agency to recover any outstanding debt and the debt may be reported to the credit bureaus;.(4) I shall not assert any claim that I was relieved of this responsibility in the absence of an express written agreement to the contrary; and (6) in the event litigation is filed for nonpayment for charges, I agree to pay all expenses incurred by Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites because of such litigation, including reasonable attorney's fees and medical expert witness fees. I agree to not hold Integrated neurology Services **Patient Initials**: _____

Worker's Compensation & HMO Patients
If my healthcare insurance payor requires an authorization or referral for treatment and I fail to obtain or verify it has been received prior to my appointment at Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites my appointment will be rescheduled. I understand that for Worker's Compensation payors Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites will need to be given active referral from the payor's claim adjuster, if I fail to obtain or verify it has been received prior to my appointment at Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites my appointment will be rescheduled. **Patient Initials**: _____

Cancellation Agreement:
I understand there are times when I must miss an appointment due to emergencies or obligations to work and family. However, if I do not cancel my appointment at least 48 hours in advance, I acknowledge that I will be charged a $25.00 cancellation fee.
An additional $100 cancellation fee will apply for failure to cancel an Interventional Procedures at least 48 hours in advance. If I should fail to show up for an appointment or call, I acknowledge that I will be charged a $50.00 no-show fee. If I should fail to show up for a scheduled Interventional Procedure appointment, I acknowledge that I will be charged a $200.00 no-show fee. If I should fail to show up for an EMG/Nerve test, I acknowledge that I will be charged a $200.00 no-show fee. If I should fail to show up for a Sleep Lab or Infusion appointment, I acknowledge that I will be charged a $200.00 no-show fee. If I pick up a home sleep testing device and do not return it within 48 hours I acknowledge that I will be charged $50.00 dollars a day until it is returned. If not returned within 2 weeks I acknowledge that I will be charged $2,500.00 for the machine. **Patient Initials**: _____

Deemed Consent and Prescription Monitoring
I understand that under Virginia law if, while examining or treating me, any person employed by or under the direction and control of Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites or any other healthcare provider is directly exposed to my body fluids in a manner which may transmit HIV, Hepatitis B or Hepatitis C, I will be deemed to have consented to testing for HIV, Hepatitis B or Hepatitis C infection and to the release of the test results to the exposed person. I understand that Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites participate in the Virginia Prescription Monitoring Program. This means that prescribers in this office may request information from the Program regarding prescriptions previously dispensed to me. I may ask my healthcare provider for more information about the program, or visit the website at https://www.dhp.virginia.gov/dhp_programs/pmp/. **Patient Initials:** _____

Business Communications
I authorize Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites to contact me for performance improvement purposes such as conducting patient satisfaction surveys. Further, by providing Integrated Neurology Services, PLLC, Integrated Sleep Services and The Infusion Suites with my residential, cellular or wireless telephone number and electronic mail address, I authorize the use of an automatic telephone dialing system to contact my residential, cellular or wireless telephone number, electronic mail address for normal business communications such as appointment reminders, billing inquires or debt collection efforts. **Patient Initials:** _____

Patient Name Date Relation to patient

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Past Medical History

Patient Name: _____ Date: _____

Reason(s) for neurological consultation: _____

Current Symptoms (Review of Systems):

- ❑ Fever
- ❑ Chills
- ❑ Weight Up/Down
- ❑ Visual Changes, Eye Pain
- ❑ Hearing Loss, Ringing in Ears, Ear pain
- ❑ Sinus Congestion, Runny Nose, Sneezing
- ❑ Chest Pain, Palpitations
- ❑ Shortness of Breath, Wheezing
- ❑ Diarrhea, Constipation, Vomiting
- ❑ Abdominal Pain
- ❑ Acid Reflux
- ❑ Leg Swelling
- ❑ Bruising, Bleeding
- ❑ Heat/Cold Intolerance
- ❑ Urinary Frequency/Urgency
- ❑ Rash
- ❑ Headache
- ❑ Dizziness
- ❑ Numbness/Tingling (Where? _____)
- ❑ Pain (Where? _____)
- ❑ Confusion/Memory Loss
- ❑ Tremors/Shaking (Where? _____)
- ❑ Trouble Chewing/Swallowing
- ❑ Speech Changes
- ❑ Imbalance
- ❑ Weakness (Where? _____)
- ❑ Bowel/Bladder Incontinence
- ❑ Joint Pain/Muscle Pain
- ❑ Sleeping Problems, Snoring
- ❑ Anxiety/Depression
- ❑ Other (please specify):

Past Medical History (check all that apply):

- ❑ Acid Reflux/GERD
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Alzheimer's/Dementia
- ❑ Anemia
- ❑ Aneurysm
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Autoimmune Deficiency
- ❑ Back Problems/Pain
- ❑ Bleeding Disorder
- ❑ Blood Clot
- ❑ Blood Transfusion
- ❑ Cancer (Type? _____)
- ❑ Carotid Artery Surgery
- ❑ Cataracts
- ❑ Chronic Fatigue
- ❑ Chronic Pain (Where? _____)
- ❑ Concussion
- ❑ Congenital Heart Disorder/Defects
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Erectile Dysfunction
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Gout
- ❑ Head Injury
- ❑ Heart Disease
- ❑ Heart Valve Problem
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Joint Disorder
- ❑ Kidney Disorder
- ❑ Liver Disorder
- ❑ Lupus
- ❑ Migraines
- ❑ Mild Cognitive Impairment
- ❑ Multiple Sclerosis
- ❑ Muscle Disease
- ❑ Neuropathy
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Peripheral Vascular Disease
- ❑ Pneumonia
- ❑ Post-Traumatic Stress Disorder
- ❑ Shingles
- ❑ Skin Disorder
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Substance Abuse
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Other

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Past Medical History Continued

Past Surgeries (include date/year):

1. _____
2. _____
3. _____
4. _____
5. _____

Family History: Has anyone in your family (**Please specify family member)** ever had any of the following conditions?

- ❑ Alcoholism- Relation: _____
- ❑ Alzheimer's/Dementia-R elation: _____
- ❑ Aneurysm – Relation: _____
- ❑ Anxiety – Relation: _____
- ❑ Blood clots – Relation: _____
- ❑ Brain Tumor – Relation: _____
- ❑ Depression – Relation: _____
- ❑ Diabetes – Relation: _____
- ❑ Heart Attack – Relation:_____
- ❑ High Blood Pressure – Relation: _____
- ❑ High Cholesterol – Relation: _____
- ❑ Migraines – Relation: _____
- ❑ Multiple Sclerosis – Relation: _____
- ❑ Muscle Disease – Relation: _____
- ❑ Neuropathy – Relation: _____
- ❑ Parkinson's Disease – Relation: _____
- ❑ Seizures – Relation: _____
- ❑ Stroke – Relation: _____
- ❑ Thyroid Disease – Relation: _____
- ❑ Other – Relation: _____

_____
_____
_____

Medications

Medication Name	Dose	Time	# Of times taken per day	Prescribing Physician

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Past Medical History Continued

Medication Allergies **(**include type of reaction):

1. _____
2. _____
3. _____
4. _____
5. _____

Social History:

Smoking: ☐ Never

☐ Previous smoker (when did you quit? _____)

☐ Current smoker (amount? _____)

Alcohol: ☐Never

☐ Previous drinker (when did you quit? _____)

☐ Current use (# of drinks per week _____)

Patient Signature: _____

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Do you have any of the following symptoms:

□ Snoring	□ Excessive daytime sleepiness	□ Leg movement during sleep
□ Difficulty falling asleep	□ Difficulty staying asleep	□ Difficulty staying asleep
□ Awaken too early	□ Witnessed apneas	□ High blood pressure

Have you ever had a sleep evaluation or overnight sleep study? □ YES □ NO

If so, where? _____

(If available, please supply a copy of your previous sleep study report)

Were you ever diagnosed with apnea?	□ YES	□ NO
BMI greater than 35?	□ YES	□ NO
Age greater than 50?	□ YES	□ NO
Neck circumference greater than 40?	□ YES	□ NO

EPWORTH SLEEPINESS QUESTIONNAIRE:

How likely are you to doze off or fall asleep in the 8 situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL = _____/24

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The Infusion Suites

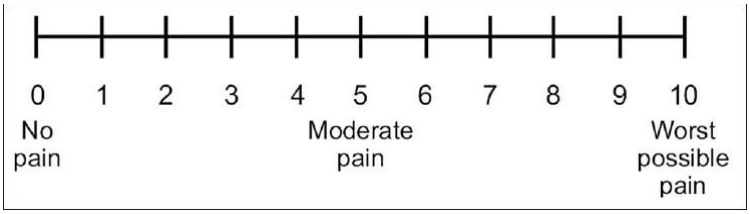
Do you have a painful spine condition? We can help!

Do you have pain that is localized to the area of the neck or back?

Do you have pain that is referred or radiates (shoots) down the arm or the leg?

Have you been previously treated for a painful spine condition but the condition persists or has returned/worsened?

If yes, how severe is your usual pain? Please circle a number on the scale to rate your pain.



If you answered yes to any of these questions, please notify your provider so that they can discuss options with you.

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Integrated Neurology Services, PLLC

The Infusion Suites

HIPAA

Please tell us whom we are allowed to discuss and/or disclose your Personal Health Information.

Print the name(s) you authorize to have your PHI disclosed or released to

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

My signature below authorizes the release of my personal medical information to any specialists I may be referred to and to process insurance claims/applications, prescriptions, and lab work.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can 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 or indirectly
- Obtain payments from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

_____ _____ _____

Patient/Responsible Party Name Date Relationship to Patient

_____ _____

Witness Date

Privacy Practices Statement: Acknowledgement of Receipt

I, _____, acknowledge that I have been offered a copy of the Notice of Privacy Statement from this office, containing a more complete description of the uses and disclosures of my health information and any questions I had have been answered by the office staff. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry treatment, payments or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide such restrictions.

_____

Signature Date Relation to Patient

Integrated Sleep Services

Integrated Neurology Services, PLLC

The Infusion Suites

Notice of Privacy Practices

Please read this notice carefully, as it describes your health information and how it can be used and/or disclosed and how you can be given access to the information.
The privacy of your healthcare information is important to us.

Legal Responsibility of Our Office

Federal and state laws require us to provide you with this notice in regards to the protection of your private healthcare information. We are also required to give you this notice about our privacy policies and procedures, your rights in relation to your healthcare information and our legal responsibilities. This privacy policy takes effect immediately and will remain in place until our office replaces it. We must follow the privacy practices that this notice sets forth.

It is the right of this office to change this policy at any time as long as the changes are in accordance with the applicable laws. Significant changes will result in the replacement of the Notice and the new Notice will be available upon request. If you have questions regarding our privacy policies or if you would like a copy of this notice, please contact our office using the contact information at the end of this Notice, or ask for a copy from the Office.

Protected Health Information (PHI) Uses and Disclosures: Your PHI is used and disclosed for treatment, payment and healthcare operations; for example:

Treatment: Our office may use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you.

Payment: Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you. If you fail to pay your balance your PHI will be disclosed to the firm we use to recover any outstanding debts via a collection agency.

Healthcare Operations: Our office will use and disclose your healthcare information in association with our healthcare operations. These operations include, but are not limited to: evaluation and review of healthcare professionals, quality reviews, assessments, improvement and training activities, licensing and credentialing activities, and certification and accreditation programs.

Your Authorization: In addition to the above uses of your healthcare information, you have the right to give us written authorization to use or disclose your private healthcare information to anyone for any reason. We will not release your private healthcare information without your written authorization. You are allowed to revoke the authorization at any time; however, this revocation will not affect any prior uses or disclosures of this information that may have been released while this authorization was in effect.

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Family and Friends: Your healthcare information will only be released if you have authorized our office to disclose it to a family member, friend or other person. We will only disclose the information necessary to help with your treatment, or payment from your healthcare with your permission.

Minors: We will disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Research: We may use and disclose your PHI for research purposes, we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocol to ensure the privacy of your PHI. We may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of any PHI. We may disclose PHI to be used in collaborative research initiatives amongst Integrated Neurology Services, PPLC, Integrated Sleep Services and The Infusion Suites.

Persons Involved in Your Care: Our office may use or disclose your PHI if it is necessary to notify or aid in the notification of a family member, personal representative or another person responsible for your care of your location, your general condition or death. If you are present and capable of deciding what information and to whom that information should be released, you will be given that option. If you are incapacitated because of an emergency, we will use or disclose only that PHI that is deemed necessary in our professional judgement and experience to make reasonable recommendations of your best interest in allowing another individual to pick up prescriptions, medical supplies, x-rays or other similar forms of healthcare information.

Marketing Health-Related Services: We will not use your PHI for marketing programs without your written authorization.

Required by Law: We will disclose PHI when required to do so by International, Federal, State or Local law.

Abuse or Neglect: Our office will notify the appropriate authorities if we have reason to believe that you have been a victim of abuse, neglect or domestic violence. We may disclose your PHI to the degree necessary to prevent or avert any serious threats to our health or safety or the health or safety of others.

National Security: We may disclose to military officials the health information of Armed Forces personnel under certain circumstances. We my disclose your PHI as required for lawful intelligence, counterintelligence, and other national security activities, for the last 6 years, but not prior to Aril 14, 2003. If you request this more than once in a 12-month period we may charge you a reasonable fee for this request.

Workers Compensation: We my use or disclose PHI for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.

Health Oversight Activities: We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include for example, audits, investigations, inspections, licensure, and similar activities that are necessary the government to monitor the health care system, government programs, and compliance and civil rights laws.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discover request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

Coroners, Medical Examiners, and Funeral Directors: We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary for the institution to provide you with health care; to protect our health and safety or the health and safety of others; the safety and security of the correctional institution.

Disaster Relief: We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure.

Appointment Reminders: We may use or disclose our PHI to provide you with appointment reminders such as voicemail messages, electronic mail, postcards, or letters.

Patient Rights

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You may ask that we provide these copies in a format other than photocopies. We will use the requested format unless that format is unavailable to our office. To obtain access to your healthcare information, you must make the request in writing. You can either send a letter detailing the request or contact our office for a form letter. Contact information is provided at the bottom of this Notice. Please contact us for further information regarding fees or if you need a form to request access to your records.

Disclosure Accounting: You have the right to receive a list of requests that have been made for disclosure of your PHI either from our office or our business associates for purposes other than treatment, payment, healthcare operations and certain other activities for the past 6 years, but not prior to April 14, 2003. If you request this accounting more than once in a 12-month period we may charge you a reasonable fee for this request.

Integrated Sleep Services

Integrated Neurology Services, PLLC

The Infusion Suites

Restriction: You have the right to request that we place restrictions on our use or the disclosure of your PHI. We are not required to abide by these requested restrictions, but if we do, we will accept your request except in emergency situations.

Amendment: You have the right to request that we amend your healthcare information. Again, your request must be made in writing and it must explain why the information should be amended. We have the right to deny this request under certain circumstances as dictated by the federal regulations regarding HIPAA.

Electronic Notice: If you receive this notice via our Web site or via electronic mail, you are also entitled to receive this Notice in written form from our office.

Questions and Complaints

If you need or want more information regarding our privacy practices or if you have any questions or concerns, please contact us.

If you believe your privacy rights have been violated, you may file a complaint with Integrated Neurology Services, PLLC Privacy Officer Kyle Schreiber, 6355 Walker Lane, Suite 201 Alexandria, VA 22310 (703) 313-9111 or with the U.S. Department of Health and Human Services 200 Independence Avenue S.W. Washington, D.C. 20201 (202) 619-0257 or (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hippa/, for more information.

Effective 01/01/2012, Revised 04/01/2019