



NEUROLOGICAL ASSOCIATES OF WASHINGTON, P.L.L.C.

- PATIENT REGISTRATION -



Name: _____ Date of Birth: _____
LAST FIRST M.I.

Address: _____ Sex: ___ Male ___ Female

City: _____ State: _____ Zip: _____ Social Security Number: _____

Employer: _____ Occupation: _____ Student? Yes No

Emergency Contact: _____ Phone# _____ Relation to you: _____

Marital Status: S M W D Pharmacy Name: _____ Phone Number: _____

PHONE MESSAGES MAY BE LEFT FOR ME ON:		
<input type="checkbox"/> Home Voice Mail	<input type="checkbox"/> Cellular Voice Mail	<input type="checkbox"/> Work Voice Mail
HOME NUMBER	CELL NUMBER	WORK NUMBER

Which physician in our clinic are you seeing today? _____

- REFERRING PHYSICIANS -

Referred by: _____ Phone# _____
Last First

Primary Care Physician: _____ Phone# _____
Last First

- INSURANCE INFORMATION -

PLEASE BE SURE TO HAVE US COPY YOUR INSURANCE CARD (S) TODAY TO INSURE PROPER BILLING

Is this a work related condition? L&I? ___ Yes ___ No Is this related to an auto accident? ___ Yes ___ No

PRIMARY INS: _____
ID #: _____
GROUP# _____
EFFECTIVE DATE: _____
ARE YOU THE POLICY HOLDER? ___ Yes ___ No
* IF NO, PLEASE PROVIDE THE POLICY HOLDER'S:
NAME: _____ DOB: _____
Employer: _____
RELATIONSHIP TO YOU: _____

SECONDARY INS: _____
ID #: _____
GROUP# _____
EFFECTIVE DATE: _____
ARE YOU THE POLICY HOLDER? ___ Yes ___ No
* IF NO, PLEASE PROVIDE THE POLICY HOLDER'S:
NAME: _____ DOB: _____
Employer: _____
RELATIONSHIP TO YOU: _____

WORK INJURY INFORMATION:

Date of injury: _____ Is this claim open & active? **Y N** Claim #: _____

Claims Manager: _____ Phone Number: _____

Employer at time of injury: _____ Insurance Company: ___ Washington State L&I
___ Broadspire ___ Sedgwick ___ Eberle Vivian ___ other: _____

PLEASE READ THE FOLLOWING STATEMENT BEFORE SIGNING:

I authorize treatment of the patient named above and agree to pay for all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I also authorize the healthcare provider or insurance company to release any information required to process the claim. In addition, I will not withhold or delay payment if my insurance company denies payment of any charges. I understand that there will be a \$25 fee (per RCW 62A.3-515&520) on returned (NSF) checks. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Past due balances will be charged 1% interest per month (per RCW 19.52) on the unpaid balance.

By my signature below, I acknowledge that the Notice of Privacy Practices has either been offered to me or received by me.

Signature: _____ Relationship: ___ self ___ spouse ___ legal guardian ___ other _____

Date: _____ Printed Name (if other than patient): _____

NEUROLOGY HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
 and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		M	F	DOB and Age:		
Marital status:	Single	Partnered	Married	Separated	Divorced	Widowed
Referring doctor:	Handedness:		Right	Left		

Who is your primary care doctor?

For what problem are you being seen today?

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed Circle if None

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Surgeries Circle if None

Year	Reason	Hospital

Other hospitalizations Circle if None

Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No
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Please go to next pages

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		Circle if None
Name the Drug	Strength	Frequency Taken
Allergies to medications		No known drug allergies (check here if none)
Name the Drug	Reaction You Had	
Pharmacy Name:	Location:	Phone Number:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Occupation <i>(if not presently working, please list most recent occupation)</i>	Are you working disabled retired?				
	What is your present occupation? (Briefly explain)				
	Grade level of education				
	Is this a work related injury ? No Yes <i>(please provide the following information below)</i>				
Date of Injury:		Claim Number:		Employer at time of injury?	
Claims Manager:		Claims Manager Phone Number:			
Exercise	Sedentary (No exercise)				
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min)				
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	None	Coffee	Tea	Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			Yes	No
	If yes, what kind?				
	How many drinks per week (circle one)? 1-2/week 3-4/week 5-6/week 7-8/week >10/week				
	Are you concerned about the amount you drink?			Yes	No

	Have you considered stopping?	Yes	No
	Have you ever experienced blackouts?	Yes	No
	Are you prone to "binge" drinking?	Yes	No
	Do you drive after drinking?	Yes	No
Tobacco	Do you use tobacco?	Yes	No
	Cigarettes – pks./day	Chew - #/day	Pipe - #/day
	# of years	Or year quit	
Drugs	Do you currently use recreational or street drugs?	Yes	No
	Have you ever given yourself street drugs with a needle?	Yes	No
	Have you ever used recreational or street drugs? If yes, which ones?	Yes	No
Personal Safety	Do you live alone? If not, with whom?	Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	M F	
Mother				M F	
Sibling	M F			M F	
	M F		M F		
	M F		Grandmother <i>Maternal</i>		
	M F		Grandfather <i>Maternal</i>		
	M F		Grandmother <i>Paternal</i>		
	M F		Grandfather <i>Paternal</i>		
	M F				

Is there a Family History of any of the following and if Yes, Who?

- Epilepsy or convulsions Yes No
- Migraine Yes No
- Neuropathy Yes No
- Multiple sclerosis Yes No
- Autoimmune illness: SLE, RF, other: Yes No

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	Yes	No
Do you take birth control pills or hormone replacement therapy?		

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain .		
Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	Other:

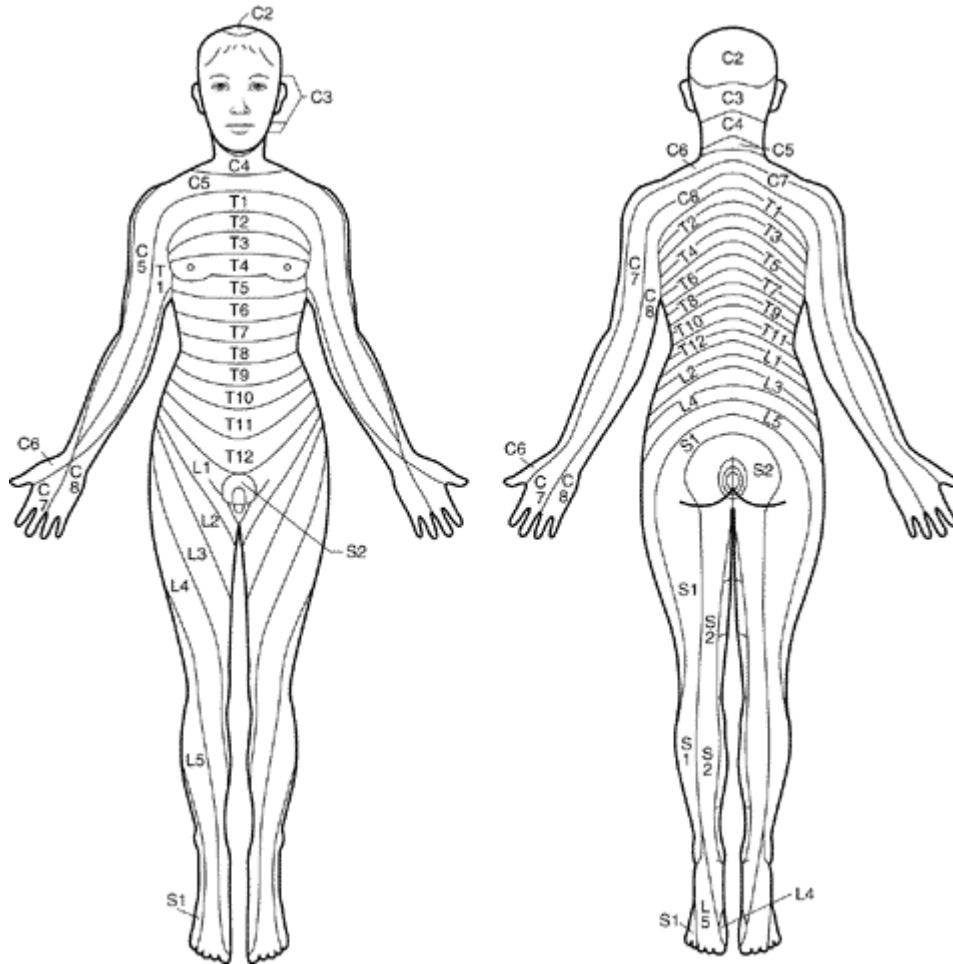
RECENT DIAGNOSTIC TESTING
What tests have you had since your illness and what are the results (if known?)
Laboratory tests:
Cat Scan:
MRI:
EEG:
EMG, Nerve conduction:
Other tests:

** If you are completing this form on-line, please stop here, print the form and complete the pain diagram by hand. Thank you

PAIN DIAGRAM

PLEASE FILL IN THE DIAGRAM BELOW IF YOUR **CHIEF SYMPTOMS** ARE PAIN RELATED

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL



Indicate areas of PAIN, TINGLING and/or NUMBNESS on the figures

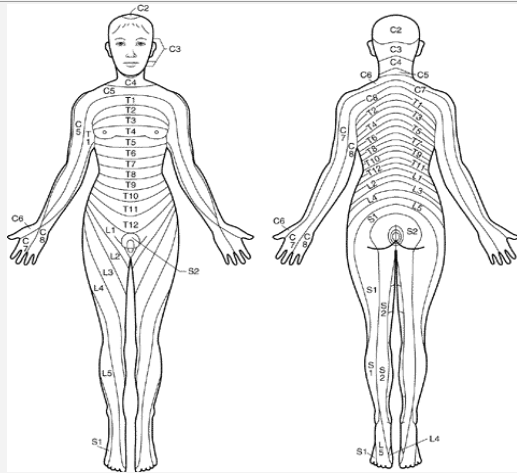
What was your pain level on *average* during the past week? (please circle the appropriate number)

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Pain as bad as it can be

PLEASE STOP HERE

The following will be filled out by the physician

PRESENT ILLNESS
Onset
Duration
Course



Pain (symptom):
 Location:
 Mode of Onset:
 Increasing Factors:
 Decreasing Factors:
 Quality:
 Duration:
 Severity: Average
 Trigger factors:

PERTINENT NEGATIVES NONE/DENIES

<input type="checkbox"/> Headaches	<input type="checkbox"/> Loss of consciousness/syncope	<input type="checkbox"/> Change Bowel/ Change in bladder
<input type="checkbox"/> Diplopia	<input type="checkbox"/> Focal weakness	<input type="checkbox"/> Muscle fatigue/Cramping/ Fasciculation
<input type="checkbox"/> Loss of Vision/Optic Neuritis	<input type="checkbox"/> Sensory loss	<input type="checkbox"/> Ataxia/dysmetria
<input type="checkbox"/> Dysarthria	<input type="checkbox"/> Radicular Pain	<input type="checkbox"/> Bradikinesia Postural instability/ Rigidity
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Paresthesias, dysesthesias	<input type="checkbox"/> Chorea Dystonia
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Gait difficulty Falls	<input type="checkbox"/> Tremor
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/>

OTHER NEUROLOGICAL PROBLEMS

<input type="checkbox"/> Stroke or TIA's	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Seizures/ Epilepsy
<input type="checkbox"/> Brain Tumors	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Dementia or Alzheimer's	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Shingles
<input type="checkbox"/> Encephalitis/Meningitis	<input type="checkbox"/> Myasthenia	<input type="checkbox"/> Migraines or Cluster Headaches
<input type="checkbox"/> Low back pain, neck pain, pinched nerve	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Head trauma/ concussion

NAME:

DOB:

Date:

PHYSICAL EXAMINATION

Constitutional BP pulse standing:

CV RR S1S2 Pulse regular/irreg

Neck Bruit R L

CNS
Glab/Snout/Palment/Grasp
 CN

Motor /5 R arm /5 L arm /5 R leg /5 L leg
Fascic

Tone R arm L arm R leg L leg

Contract
 Sensory: LT/ PP/ Vib/ Joint cortical:

DTR

Coordination Finger tap, FN HS RAM

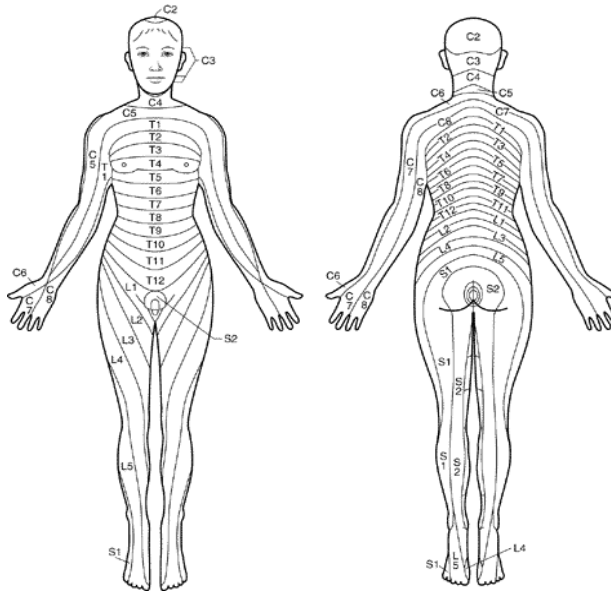
Gait Romberg Ataxia

Other: SLR Lhermitte's Tinnel's PAD

Other: Sensory level

Other: Parkinson

Other:



Normal neurological exam

Laboratory Imaging Studies

CT of reviewed:

MRI of Brain C/T/L Spine reviewed:

CLINICAL ASSESMENT

Diagnosis

- 1.
- 2.
- 3.

Plan: Assessment and Diagnostic Testing

Comments

Laboratory (see attached)

Imaging (see attached)

MRI CT CTA MRA (Brain Neck) with Contrast of BRAIN, C-SPINE, T-SPINE, LS-SPINE

EEG Awake Sleep

EMG NCS

Right / Left Upper Lower Extremity Eval for:

VEP/BAEP/TIBIAL /MEDIAN Evoked Potential

Right/ Left Upper Lower Extremity

LP (under fluoroscopy) see attached orders

Obtain Medical records from:

Referral/Consultation

Treatment Recommendations

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

Obtain Previous Medical Records:

Patient Handouts given:

Discussed side-effects of prescribed meds

FOLLOW UP _____ **WEEKS/MONTHS/YEAR/PRN**

FOLLOW UP WITH: REFERRING PHYSICIAN/ PCP/SPECIALIST



NEUROLOGICAL ASSOCIATES OF WASHINGTON, P.L.L.C.

BELLEVUE

1600 116th Ave NE, Suite 302
Bellevue, WA 98004
Phone: 425-455-5440
Fax: 425-455-1431

KIRKLAND

13107 121st Way NE, Suite A
Kirkland, WA 98034
Phone: 425-899-6200
Fax: 425-899-6220

Authorization of Verbal Disclosure and Protected Health Information

Due to the recent implementation of the new Federal guidelines known as HIPAA, we are required to have your signature to verbally discuss any protected health information with persons not directly involved in your health care. (i.e. family members, care givers) If you would like to designate a person (persons) to communicate with us regarding your healthcare, please list them below.

I hereby give my authorization for verbal disclosure of my protected health care information to be disclosed to:

1. Name of Person: _____

Relationship to you: _____ Phone#: _____

2. Name of Person: _____

Relationship to you: _____ Phone#: _____

3. Name of Person: _____

Relationship to you: _____ Phone#: _____

4. Name of Person: _____

Relationship to you: _____ Phone#: _____

Patient Name: (please print) _____

Signature: _____ **Date:** _____

***** NOTE: This authorization expires ONE YEAR from original date signed and must be updated on a yearly basis.**

**Neurological Associates of Washington
Cancellation and/or No-Show Policy**

Many doctors, especially Family Practice, stack patients (book them into overlapping time slots) to avoid having large holes in their schedules. We are very careful not to stack appointments and try to ensure that our patients get the very best care and our full attention. When our patients cancel with little or no notice or simply do not show up for their appointment, that time is wasted and there is no one to fill the hole. (If given proper notice, we are often able to fill it with someone from our lengthy cancellation list.)

Due to the increase of last-minute cancellations and no-shows in our appointment schedules, we have no choice but to implement the following:

Appointments that are cancelled without at least one business days notice will be billed directly to the patient as follows:

- New Patient = \$75.00
- Follow up or Revisit = \$50.00

Appointments where the patient does not show up or does not call to cancel until after the fact will be billed directly to the patient as follows:

- New Patient or 1hour Revisit = \$100.00
- Follow up or Revisit = \$75.00

I have read the above policy, understand and agree to pay the penalty assigned to me if I should no-show or cancel my appointment without the required notice.

(signature of patient)

_____ Patient Name

_____ Date

****Exceptions will be made for truly extenuating circumstances.**



Notice of Privacy Practices

~ In Accordance with Federal Regulations ~

Neurological Associates of Washington keeps necessary records of your medical condition and care. We would be happy to provide you with a copy of these records upon request and will not disclose these records to others unless you direct us to do so or unless the law authorizes or compels us to do so. Please feel free to submit to us any comments or corrections regarding these records.

Our **Notice of Privacy Practices** (please see next 2 pages) describes in more detail how your health information may be used and disclosed and how you can access this information.

By signing below, you will be acknowledging that you understand the Notice of Privacy Practices of Neurological Associates of Washington. This signed form will also be retained in your medical record and will remain effective until revoked by you in writing.

Additionally:

1. *May we leave messages regarding your appointment on your answering machine or voicemail at home?* No Yes

2. *May we discuss your medical care with anyone that answers the telephone at your home?* No Yes

3. *Are there any members of your family, household or those coming with you to this appointment with whom we should not discuss any of your health care issues?*
 No Yes _____

4. *Do you have any suggestions regarding how we may improve our Patient Privacy Program?*
 No Yes

Signature

Date / Time

Print Name

If not signed by Patient, Guardian Name

Relationship to Patient

If the patient is a minor or not legally competent, the parent or legal guardian should sign this document for the patient.

This following describes how your medical records may be used and how you can obtain access to this information.



Notice of Privacy Practices

~ In Accordance with Federal Regulations ~

Neurological Associates of Washington respects your privacy and understands that your personal health information is very sensitive. Accordingly, we will not disclose your information to others unless you ask us to do so, or unless the law authorizes or requires us to do so (see below).

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers and the billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing health care to you. This will help them remain informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
 - medical quality review by your health plan;
 - accounting, legal, risk management, and insurance services;
 - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;



Notice of Privacy Practices

~ In Accordance with Federal Regulations ~

- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights, please contact our Kirkland Office (tel.: 425-899-6200) during our usual business hours

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our Bellevue office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Kirkland Office (tel.: 425-899-6200).

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our Kirkland Office. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.



Notice of Privacy Practices

~ In Accordance with Federal Regulations ~

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
 - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
 - to public health or legal authorities
 - to protect public health and safety
 - to prevent or control disease, injury, or disability
 - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- For your benefit, this Notice is also listed on the Web site: **<http://neuroassociates.us>**

Thank you for your time and attention! We encourage you to contact us with any suggestions or comments. –

*The physicians and staff at Neurological Associates of
Washington.*