WINCHESTER NEUROLOGICAL CONSULTANTS, INC.
Pediatric Registration Form

Name:			**SSN:**
Last First Middle Initial			
Address:			
Street/PO Box	*City*	*State/Zip Code*	
Phone: ( )	**( )**	**( )**	
Cell	*Home*	*Other*	
DOB: / /	**Age:**	**Sex:** M F	**Marital Status:** S M D W
Language: English Spanish Other	**Ethnicity:** Hispanic or Non-Hispanic	**Race:**	
Mother's Name:	**DOB: / /**	**SSN:**	
Phone: ( )	**( )**	**( )**	
Home	***Cell***	***Other***	
Father's Name:	**DOB: / /**	**SSN:**	
Phone: ( )	**( )**	**( )**	
Home	***Cell***	***Other***	
E-Mail Address:	**Referring Physician:**		
Primary Care Physician:			
Reason for Visit Due to Accident? Yes No			

Insurance Information	
Primary Insurance	**Secondary Insurance:**
Insured's Name:	**Insured's Name:**
Insured's DOB	**Insured's DOB:**
Insured's SSN:	**Insured's SSN:**
Relationship to Insured:	**Relationship to Insured:**
Insurance Company:	**Insurance Company:**
Address:	**Address:**
Phone:	**Phone:**
Policy # Group #	**Policy # Group #**

I, the undersigned, authorize payment of medical benefits to Winchester Neurological Consultants, Inc. for any services furnished to me by the physician. I authorize release of any medical or other information necessary to process insurance claims/related treatment to the health care financing administration and its agents. I am responsible for payment of serviced rendered.

Signature:_____Date:_____

Winchester Neurological Consultants, Inc.
PRACTICE FINANCIAL POLICY STATEMENT

Thank you for choosing our physicians for your Neurological health care needs. We are committed to providing the very best medical care and treatment. The following is a statement of our Financial Policy, which you must read, agree to and sign, prior to treatment.

Practice Payment Policy Guidelines:

- **Patients/ (guardians) are financially responsible for all charges, regardless of third-party involvement.**
- **Full payment is due at time of services, unless prior insurance billing arrangements have been made.**
- **Patients with insurance will be required to pay all "out-of-pocket" financial obligations at time of service.**
- **We accept: Cash, Check, and debit/credit cards: Visa/ Master Card.**

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you **must** inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements pre-authorizations or pre-certifications from their primary care physicians. Patients are responsible for securing the necessary written referrals, received the necessary pre-authorizations or pre-certifications from your primary care physician or health plan prior-to service rendered. If you have not received the necessary authorizations prior to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for **each office visit.**

Self-Pay Patients: Patients without insurance coverage are expected to pay for service received in full at time of service.

Patient with Private Insurance / Medicare / Medicaid Coverage: Our physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the "assignment of benefits" below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we don't participate in (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement:

I understand that I am financially responsible for all charges, regardless of third-party involvement. I agree to pay any deductible coinsurance, co-payment, or serviced deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding serviced will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount due will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and will be subject to the possible dismissal of the patient from our care. If my account is forced to collection I agree to pay all collection costs, including, but not limited to, court costs, attorney's fees equal to 33.33% of the amount owed, and accrued interest charges to date. I agree to pay a $25.00 returned check fee. Copies of my medical records can be obtained with advance notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a minimum charge of $25.00 for each form.

Authorization & Assignment of Insurance Benefits:

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical service rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the above policy.

_____ _____

Patient / Responsible Party / Guardian Signature Date

Winchester Neurological Consultants, Inc
125 Medical Circle
Winchester, VA 22601

Consent for Release and Use of Confidential Information
And
Acknowledgement of Notice of Privacy Practices

I, _____hereby
(Name of Patient or Authorized Agent)

give my consent to Winchester Neurological Consultants, Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

I acknowledge the review and /or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed: _____ Date: _____

If not the patient, please specify your relationship to the patient_____.

Office Use Only

- The patient would not sign this form as requested on __/___/___ by Staff:_____

WINCHESTER
NEUROLOGICAL
CONSULTANTS

Due to the HIPAA Privacy Act, we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware that these persons designated by you will have full access to your Private Health Information (PHI).

NAME:	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____
_____	_____

YOUR NAME: _____

YOUR SIGNATURE: _____

DATE: _____

WINCHESTER
NEUROLOGICAL
CONSULTANTS

PATIENT INFORMATION SHEET

Patient Name:_____ **Date:**_____

Date of Birth: _____ **Age:** _____ **Gender:** **Female** **Male**

Referring Doctor: _____

Referring Doctor's Address: _____

Referring Doctor's Phone #: _____

Primary Care Physician/Family Physician: _____

Primary Care Physician's Address: _____

Primary Care Physician's Phone #:_____

Preferred Pharmacy:_____ **Pharmacy Phone #:**_____

Pharmacy City:_____**Pharmacy State/Zip:**_____

To the Patient or Caregiver:
This information will be placed in the medical record. It is important to complete each section to the best of your ability and knowledge. If you are uncertain of dates, give approximate dates.

Patient Name: _____

Chief Complaint: Please check all of those that apply to today's visit. Feel free to write in more if you need:

- □ Memory Impairment
- □ Headache
- □ Double Vision
- □ Vertigo
- □ Dizziness
- □ Syncope/Passed out
- □ Seizure/Epilepsy
- □ Muscle Weakness
- □ Weakness
- □ Muscle Pain
- □ Numbness
- □ Low back pain
- □ Neck pain
- □ Confusion
- □ Long-Term Memory Loss
- □ Short-Term Memory Loss
- □ Visual Loss
- □ Visual Disturbance
- □ Blurred Vision
- □ Tinnitus
- □ Noises in Ears
- □ Fainting
- □ Difficulty Speaking
- □ Difficulty Swallowing
- □ Leg Pain - □ right □ left
- □ Leg Numbness - □ right □ left
- □ Leg Weakness - □ right □ left
- □ Autism
- □ Developmental Delay
- □ Childhood Behavioral Disturbances
- □ Sleeping Difficulty
- □ Night Cramps
- □ Insomnia
- □ Jerking of Extremities

Details: _____

_____

_____

_____

Past Medical History: Please check all that apply to your medical history.

- □ Heart Disease
- □ Lung Disease
- □ Diabetes
- □ Blood Pressure
- □ Cancer
- □ Stroke
- □ Ulcers
- □ Hyperlipidemia (high cholesterol)
- □ Neck Pain
- □ Back Pain
- □ Encephalitis
- □ Meningitis
- □ Seizures
- □ Paralysis
- □ Memory Loss/Alzheimer's
- □ Major Trauma
- □ Anxiety
- □ Depression
- □ Bleeding Disorder
- □ Urinary/Bladder
- □ Thyroid
- □ Eye problems

Details: _____

Patient Name: _____

Family History: Please list any significant medical or neurological conditions in your family, including those who are deceased (please give approximate age at time of death and cause of death).

Mother _____

Father _____

Brothers _____

Sisters _____

Children _____

Social history:

Occupation: _____

Still in School? □ Yes

Retired? □ Yes

Marital Status: □ Married □ Widowed □ Divorced □ Separated □ Single □ Live-In

Do You Smoke? □ Yes □ No □ Former If yes, how much? _____

Do you drink alcohol? □ Yes □ No If yes, how much? _____

Do you use street drugs? □ Yes □ No If yes, what and how often? _____

How many children do you have? Male: _____ Female: _____

Patient Name: _____

Current Medications: (Please include over-the-counter, non-prescription, and complementary medical treatments)

Name	Strength	Schedule
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6)_____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____

Allergies To Medications and Other Substances:

□ No Known Drug Allergies
□ Allergy History Unknown

□ Acetaminophen
□ Adhesive Tap
□ Allergy History/Unknown
□ Aminoglycosides
□ Barbiturates
□ Benzodiazepines
□ Betadine
□ Cephalosporins
□ Codeine/Codeine Derivatives
□ Epinephrine
□ Erythromycin's
□ Iodinated Contrast
□ Latex
□ Local Anesthetics(Amide-Procaine)
□ Local Anesthetics(Ester – Lidocaine)
□ Morphine Derivatives
□ NSAIDS
□ Penicillins
□ Seafood
□ Shellfish
□ Sulfa Drugs
□ Tetracyclines
□ Vaccines - Albumin

□ Other _____

Patient Name: _____

Review of Systems:

To help us best evaluate you, please check any symptoms which you have recently experienced, and add note, if applicable.

General
- □ Appetite loss
- □ Chills
- □ Dietary changes
- □ Excessive crying
- □ Fatigue
- □ Fever
- □ Medication change
- □ Night sweats
- □ Obesity
- □ Tiredness
- □ Weight gain >10 lbs
- □ Weight loss >10 lbs
- □ Left-handed
- □ Right-handed

Skin
- □ Bruising
- □ Clamminess
- □ Excessive sweating
- □ Hair growth
- □ Hair loss
- □ Hives
- □ Itching
- □ Nail changes
- □ New lesions
- □ Rash
- □ Skin color changes

HEENT
- □ Headache
- □ Head injury
- □ Blurred vision
- □ Double vision
- □ Visual disturbances
- □ Visual loss
- □ Hearing loss/Deafness
- □ Ear pain
- □ Ringing in the ears
- □ Spinning sensation
- □ Vertigo
- □ Seasonal allergies
- □ Sleep apnea
- □ Snoring
- □ Facial numbness/tingling

Neck
- □ Neck mass
- □ Neck pain
- □ Neck stiffness
- □ Swollen glands

Respiratory
- □ Cough
- □ Decreased exercise tolerance
- □ Difficulty breathing
- □ Snoring
- □ Wheezing
- □ Fallen asleep driving vehicle
- □ Shortness of breath

Cardiovascular
- □ Abnormal blood pressure
- □ Chest pain
- □ Difficulty breathing lying down
- □ Difficulty breathing on exertion
- □ Edema
- □ Elevated blood pressure
- □ Fainting/Blacking out
- □ Irregular heart beat
- □ Leg pain and/or swelling
- □ Palpitations
- □ Rapid heart rate
- □ Shortness of breath

Musculoskeletal
- □ Back pain
- □ Calf pain
- □ Joint pain
- □ Joint redness
- □ Joint stiffness
- □ Joint swelling
- □ Muscle atrophy
- □ Muscle cramps
- □ Muscle pain
- □ Muscle weakness
- □ Neck pain
- □ Left leg pain
- □ Left arm pain
- □ Right leg pain
- □ Right arm pain
- □ Muscle spasms

Neurological
- □ Auras
- □ Decreased memory
- □ Difficulty speaking
- □ Dizziness
- □ Dysesthesia
- □ Fainting
- □ Focal neurological symptoms
- □ Headaches
- □ Hyperactivity
- □ Incontinence stool
- □ Incontinence urine
- □ Incoordination
- □ Loss of consciousness
- □ Numbness
- □ Seizures
- □ Syncope
- □ Spinning sensation
- □ Stroke
- □ Tremor
- □ Unsteadiness
- □ Visual changes
- □ Weakness
- □ Muscle twitching
- □ Tingling

Behavioral/Other
- □ Irritability
- □ Loss of energy
- □ Decreased libido
- □ Loss of interest
- □ Spontaneous crying
- □ Anxiety
- □ Change in sleep pattern
- □ Delusions
- □ Depression
- □ Early awakening
- □ Fearful
- □ Frequent crying
- □ Hallucinations
- □ Hypersomnolence
- □ Impaired cognitive function
- □ Inability to concentrate
- □ Insomnia/poor sleep
- □ Memory loss

Endocrine
- □ Appetite changes
- □ Cold intolerance
- □ Excessive thirst
- □ Excessive urination
- □ Hair changes
- □ Heat intolerance
- □ Hot flashes
- □ Sexual dysfunction
- □ Thyroid problems

Hematology
- □ Abnormal bleeding
- □ Anemia
- □ Blood clots
- □ Easy bruising
- □ Enlarged lymph nodes
- □ Nose bleed
- □ Pinpoint hemorrhages
- □ Prolonged bleeding

Behavioral/Other, *(Continued)*
- □ Mood changes
- □ Panic attacks
- □ Suicidal ideation
- □ Suicidal planning

Patient Name: _____

If you suffer from headaches, please answer the following:

1) On how many days in the last 3 months were your activities reduced by at least half because of
your headaches? _____ days

2) On a scale of 0-10, on average, how painful were these headaches?
_____
(0 = No pain at all, and 10 = pain as bad as it can be)

Diagnostic Studies: Please check all diagnostic studies you have had related to this visit.

Study performed	Date	Location where test was
□ MRI Brain	_____	_____
□ MRI Spine	_____	_____
□ CT Brain	_____	_____
□ EMG/Nerve Study	_____	_____
□ Myelogram	_____	_____
□ Arteriogram	_____	_____
□ EEG	_____	_____
□ Other	_____	_____

Winchester Sleep Center

At Winchester Neurological Consultants, Inc.

ACCREDITED MEMBER CENTER

Date: ____/____/____

Patient Name: _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described in the chart below, in contrast to feeling *just tired*? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the <u>most appropriate number</u> for each situation:

0 = I would never doze **2 = Moderate chance of dozing**

1 = Slight chance of dozing **3 = High chance of dozing**

Situation:	**Score:**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theatre or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car while stopped for a few minutes	_____
Total:	_____

Stop Bang (If not already provided by your office.)

HT _____ WT _____ BMI: _____ Neck Circumference: _____

Age (years) _____ Sex: (please circle) M or F

Do you have high blood pressure (even if controlled with medication?) Yes ____ No ____

Have you been told you stop breathing when you sleep? Yes ____ No ____

Do you snore? Yes ____ No ____

Are you excessively tired during the day? Yes ____ No ____