Welcome

Thank you for trusting Neurology and Sleep Sciences to care for your medical needs. Our promise to you includes quality medical care and reliable services. We’re glad to be part of your health care team. This sheet contains information about our services and practice guidelines.

Neurology

A neurologist specializes in care of the brain, spinal cord, peripheral nerves and muscular systems. Some examples of health issues we treat include seizure management, care of Alzheimer’s and Parkinson’s Disease patients, Multiple Sclerosis, carpal tunnel diagnosis, physical and stroke rehabilitation, sleep disorders, migraines, headaches, and many other related health issues.

What does a Neurological Exam consist of?

Like most medical exams, the neurological exam will start with the physician and / or his assistant asking you questions about any medications you are taking; whether or not you experience unusual symptoms with your hearing, vision, speech, sleep patterns or movement. The physician will need to know significant medical history for you and / or your family. Your sensory and motor reflexes will be tested and the physician will examine your head, neck and spine. Your initial examination will last for 15 minutes to about one hour, depending on your health problem. Return appointments generally take between 5 and 20 minutes.

Is There any Preparation for a Neurological Exam?

We ask that our patients bring a list of all medications that they are currently taking to each exam. You may also want to write out questions you have or specific information that you want to tell your doctor. Bring your medical history and visit our website for our forms.

Blood Levels

If you are on a medication that requires routine blood work, you should plan to have your blood drawn before your morning dose or right before your next dose of medication if taken later in the day. This will assure the most accurate assessment of your therapeutic level. For your convenience, our Columbus location is capable of drawing most blood work.

Important Points

◊ When contacting the office with questions or progress reports, patients will communicate with their physician’s medical assistant. You may use MyChart to contact your physician’s assistant. We have a team of medical assistants trained to deal with neurological questions. Your message will be forwarded to your physician for attention. In most cases, the physician will give instructions for medication changes or call and set up an appointment if necessary.

◊ You can request appointments via MyChart or call the office to schedule, cancel or reschedule appointments. We require 24-hour notice to cancel or reschedule appointments.

◊ Keep us up to date on changes; name, address, phone and insurance coverage.

◊ Please bring your photo id, insurance card(s) and a list of medications to every visit.

◊ Call your pharmacy 2-3 days before running out of medication. 

Continued on back . . .
Work Injuries

Having a work injury is always stressful. In order for us to help you and your employer, we ask that your referring physician give us your Workers Compensation information at the time the appointment is scheduled. This information must be provided prior to your visit in order for us to obtain authorization from the Workers Compensation carrier.

Payment for Services

Though we file insurance claims to assist you, Neurology and Sleep Sciences does expect payment at the time of service. Payments can be co-payments and deductibles set by your insurance company, or will mean payment in full if no insurance is available. For easy payment, we accept cash, check, MasterCard, Visa and Discover. If you have questions about how much your medical services will cost or to discuss financial assistance, please contact Patient Financial Services at (812) 375-3000.

Location

Main office: 1655 North Gladstone Avenue, Suite A; Columbus, IN 47201

M, T, Th and F: 8:00 am - 4:30 pm  Wednesday: 8:00 am - 3:30 pm

(812) 376-3100  (800) 319-2348  Fax: (812) 372-1431

Prescription Refills

Our Narcotic policy follows Indiana guidelines. All patients that receive a prescription for Narcotics must sign a Narcotic Agreement. If requesting a written prescription, please contact the office several working days in advance. When picking up a prescription from the office, a photo ID must be shown and the prescription signed for. If you are requesting non-narcotic refills, please contact your pharmacy. Note that it may take up to 48 hours to process your request. Refills are not called in after hours or on weekends and no prescriptions are sent out by mail.

Emergency Needs

Our office is closed on Saturday and Sunday. Should you have a medical emergency, please call your family physician or Columbus Regional Hospital at (812) 379-4441. Should you need neurological care, the physician on call from our practice will be called to assist in your treatment.

Release of Your Medical Information

Your family doctor and / or the doctor that referred you to see us will receive a written update of your progress after your visit. These are mailed directly to your doctor at no cost to you. In most instances, there is a charge for copying your records. We ask for 7-10 business days to complete forms and record requests. For information about copying cost, or to obtain an authorization form, call (812) 376-3100 or (800) 319-2348 or visit our website to download our forms.
Initial Visit Questionnaire

Today’s Date: __________________________

Referring Physician: __________________________

Patient Name: __________________________

DOB: __________________________

Age: __________________________ Sex: □ Male □ Female

Height: __________________________ Weight: __________________________

History of Present Illness

Reason to see the physician: __________________________

List all medications, dose and how often:

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Any problems with medications, including cost? □ Yes □ No

________________________________________

________________________________________

________________________________________

________________________________________

Other problems or concerns:

________________________________________

________________________________________

________________________________________

________________________________________

Continued on back . . .
Review of Symptoms
Check all that apply

General
☐ Pain
☐ Weight loss
☐ Weakness
☐ Fatigue
☐ Fever
☐ Chills
☐ Night sweats

Cardiovascular
☐ Chest pain
☐ Distress on exertion
☐ Breathe easily when upright only
☐ Sweat
☐ Faint
☐ Pacemaker
☐ Rheumatic fever
☐ Heart attack

Eyes
☐ Pain
☐ Discharge
☐ Redness
☐ Light sensitive
☐ Foreign body
☐ Swelling
☐ Itching
☐ Double vision

Gastrointestinal
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ G.E.R.D.
☐ Vomiting blood
☐ Bleeding
☐ Jaundice

ENMT
☐ Ear / nose / mouth / throat pain
☐ Recurrent URI
☐ Drainage
☐ Nasal obstruction
☐ Mouth breather
☐ Frequent sore throat

Genitourinary
☐ Difficulty / pain urinating
☐ Blood in urine
☐ Frequent urinating
☐ Side pain
☐ History of stones
☐ Pelvic Inflammatory Disease

Respiratory
☐ Rapid
☐ Wheeze
☐ Pleurisy
☐ Spitting up blood
☐ T.B.
☐ Disease
☐ Last chest x-ray

Musculoskeletal
☐ Joint swelling
☐ Joint redness
☐ Joint pain
☐ Gout
☐ Degenerative joint dis.
☐ Rheumatoid arthritis
☐ Infection in joints
☐ Back pain
☐ Neck pain

Integumentary
☐ Rashes
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>Neurological</strong></td>
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</table>
| ☐ ☐ Headache(s) | If yes, how many?_________________________________________
| ☐ ☐ Seizure(s) | If yes, how many?_________________________________________
| ☐ ☐ Episodes of passing out | If yes, how many?_________________________________________
| ☐ ☐ Loss of vision | If yes, □ Left eye □ Right eye □ Both
| ☐ ☐ Weakness of arm and / or leg | If yes, describe?_________________________________________
| ☐ ☐ Numbness of arm and / or leg | If yes, describe?_________________________________________
| ☐ ☐ Numbness of face | If yes, describe?_________________________________________
| ☐ ☐ New onset of pain | If yes, where?_________________________________________
| ☐ ☐ Change in speech |  
| ☐ ☐ Change in swallowing |  
| ☐ ☐ Double vision |  
| ☐ ☐ Vertigo / dizziness |  
| ☐ ☐ Change in memory or thinking |  
| ☐ ☐ Change in bowel / bladder function |  

| **Psychiatric** |  |
|☐ ☐ Do you feel depressed? |  |
|☐ ☐ Do you feel anxious? |  |
|☐ ☐ Weight loss or gain? |  |

| **Endocrine** |  |
|☐ ☐ Diabetes |  |
|☐ ☐ Thyroid disease |  |
|☐ ☐ Hypertension |  |
|☐ ☐ Enlarged nodes |  |

| **Hematologic / Lymphatic** |  |
|☐ ☐ Anemia |  |
|☐ ☐ Bleeding disorder |  |
|☐ ☐ Blood transfusion |  |

| **Allergic / Immunologic** |  |
|☐ ☐ Asthma |  |
|☐ ☐ Hay fever or allergic rhinitis |  |
|☐ ☐ Measles |  |
|☐ ☐ Mumps |  |
|☐ ☐ Chicken pox |  |

| **Sleep** |  |
|☐ ☐ Inability to sleep or stay asleep |  |
|☐ ☐ Currently taking sleeping pills | If yes, what kind?_________________________________________
|☐ ☐ Daytime tiredness | How often?_________________________________________
|☐ ☐ Inappropriate sleeping during day |  |
|☐ ☐ A.M. headaches |  |

Continued on back . . .
### Leg cramping / restless legs at night

### Snoring

### Apnea

### Are you using a CPAP?

#### If yes, is it working for you?

#### If no, why or why not?

### Any problems with equipment?

#### Past History

List all known allergies:

List all surgeries / outpatient procedures:

List all accidents, injuries or infections to head / brain:

List all recent blood work including where and when:

List all x-rays and scans including where and when:

#### Family History

List any illnesses that run in your family:

#### Social History

Marital Status:  □ Single  □ Married  □ Divorced  □ Widowed

Occupation: ___________________________________________  Highest level of education completed: ___________________________________________

How much caffeine do you drink per day? [soft drinks, coffee, tea]

#### Yes  No

- □ □ Do you smoke?  If yes, how much?
- □ □ Do you drink alcohol?  If yes, how much?
- □ □ Do you use drugs?  What drugs do you use?

Date reviewed with patient: ________________________________

Physician Signature ________________________________  Date: ________________________________
Notice of Privacy Practices for Protected Health Information Acknowledgment
and Patient Communication Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

Patient Name:___________________________________________________________________________________
Date of Birth:___________________________________ SSN:___________________________________________
E-mail Address:_________________________________________________________________________________

Please check to tell us how you wish to be contacted. Please note: first box is to let us know your preferred method of communication.

☐ Home:_________________________ ☐ OK to leave a detailed message ☐ Name / Number only
☐ Work:__________________________ ☐ OK to leave a detailed message ☐ Name / Number only
☐ Cell:___________________________ ☐ OK to leave a detailed message ☐ Name / Number only
☐ MyChart:________________________ ☐ OK to leave a detailed message ☐ Name / Number only

Written Communication
☐ Mail to my home  ☐ Mail to my office / work
Mailing address:______________________________________________________________________________

Please tell us with whom we are allowed to speak with regarding your health. We cannot speak to ANY family member without authorization except in emergency situations. This does NOT include the release of any documentation of visits or testing. An authorization is still needed to release records.

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<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
<th>What NSS can discuss</th>
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☐ If at any time I wish to change the information provided on this form, it is my responsibility to ask for a new form so my chart can be updated.

☐ My signature below indicates that I have been offered a written copy of the Practice’s Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

☐ My signature below indicates that I received a copy of Neurology and Sleep Sciences Welcome Letter regarding office policies.

Patient Signature / Legal Representative__________________________________ Date_____________________

Please note: We must have a copy of any Power of Attorney / Guardianship papers for your chart before your appointment or any communication is made by phone. Group homes, please provide a medical treatment release.