Welcome to Piercey Neurology!

Attached you will find our new patient packet. Please complete these forms in their entirety. We welcome these forms back prior to your appointment, so that we may ensure all of your information is entered into your chart before you are seen. Please, complete these forms in blue or black ink.

Feel free to send them back via mail, email or fax. However, if your appointment is in the next week, please do not send via mail.

Please note, when sending by mail, it is always advisable to make a second copy to carry in with you in the event the mailed copy does not arrive.

You will notice that some of the forms require a signature or initials. You may sign the forms prior to returning them to us. You may also send these forms back to us unsigned, we will then obtain your signature in the office, on the day of your visit.

Thank you, we look forward to seeing you!

Piercey Team

APPOINTMENT: _____ at: _____ am / pm

WITH:
- ☐ Sydney Piercey, MD
- ☐ Allen Brooks, MD
- ☐ Jaime Conway, PA-C
- ☐ John Taylor, PA-C

LOCATION:

☐ Piercey Neurology Corvallis
650 SW 3rd St.
Corvallis, OR 97333
Phone: 541-207-3900

☐ Piercey Neurology Albany
631 SW Elm St. # 200
Albany, OR 97321
Phone: 541-928-2965

DIRECTIONS TO PIERCEY NEUROLOGY

CORVALLIS
650 SW 3rd St. Corvallis, OR 97333

Highway 34
Come across the bridge towards downtown Corvallis.

Turn left on 4th St., follow 4th St. to the south end of down town. Just before going under the overpass to the coast, take a left onto B St.

We are on the left hand corner of 3rd and B St.

Highway 20 (from Albany)
Follow Highway 20 all the way down to the south end of downtown, it will make some turns, but follow the signs.

Turn left on 4th St. to the end of downtown. Just before the overpass, turn left onto B St.

We are on the left hand corner of 3rd and B St.

The Coast/Philomath
Just after you come under the overpass into downtown Corvallis, you'll see us on the left corner. We are on the corner of 3rd St. and B St.

We are a tan building, with a brown wooden Piercey Neurology sign on the front of the building.

ALBANY
631 SW Elm St., # 200 Albany, OR 97321

Northbound I-5 (Lebanon/Eugene)
From I-5 Northbound, take Exit 233/US-20 towards Albany

Turn right onto US-20W and continue onto Pacific Blvd. SE, turn right onto SW 11th Ave. Then right onto SW Elm St.

We are on the right hand corner of Elm and 7th St.

Southbound I-5 (from Salem)
From I-5 Southbound, take Exit 234B
Merge onto OR-99E S/Pacific Blvd SE toward Albany.

Turn right onto SW 11th Ave. Then turn right onto SW Elm St.

We are on the right hand corner of Elm and 7th St.

99 E North (from Tangent, Pacific Blvd.)
From OR-99E, turn left onto 24th Ave. SW

Take the first right onto SW. Elm St.

We are on the right hand corner of Elm and 7th St.

HEALTH QUESTIONNAIRE

Due to the high volume of patients and as a courtesy to those patients on our waiting-list, please take note of our no show/cancellation policy. We require 24 hours' notice for all cancellations and rescheduling of appointments. For your convenience, you may call or leave a message to inform us of the cancellation. Cancelled or rescheduled appointments without a 24-hour notice are subject to a $50.00 rescheduling fee. Thank you! We look forward to seeing you!

Please complete all forms in blue or black ink.

Patient Name: _____

Age: _____ Date of birth: _____ SSN#: _____

Mailing Address: _____

City: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Today's date: _____ Do you need a translator? ☐ Yes (What language? _____) ☐ No

Who is filling out this Health Questionnaire? ☐ Patient ☐ Other: _____

Primary Care Provider: _____

Referring Provider (if different from above): _____

Other physicians you would like to receive a copy of your PIERCEY NEUROLOGY Clinic consultation:

_____

_____

I consent to the release of my medical information from PIERCEY NEUROLOGY LLC to the above listed health care providers:

Patient Signature: _____ **Date:** _____

Are your symptoms related to an MVA (Motor Vehicle Accident) ☐ Yes ☐ No
If yes, is your MVA claim closed? ☐ Yes ☐ No

Current neurological symptoms/concerns (if more space is needed, please attach sheet):

_____

_____

_____

_____

MEDICAL HISTORY:

CONDITION/ DIAGNOSIS:	Is this an active problem?	When did this become symptomatic?	When was this diagnosed?

SURGICAL HISTORY:

SURGERY:	Date of surgery?	What hospital/facility?	Comment:

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS?

TEST:	Where?	Date?	Comment:
Nerve or Muscle biopsy			
EMG/Nerve conduction study			
CAT Scan or MRI			

LIST ANY MEDICATION ALLERGY:

MEDICATION:	What type of reaction?	When did this happen?

CURRENT MEDICATION: Please include directions and amount (mg,) when noting medications.
Please list all medication you take, including over the counter medication.

Medication	Dosage:	How do you take this medication?	Start date?	Indication?

If you need more room, please attach a separate sheet. Thank you

FAMILY HISTORY:

If family history is not available please indicate here: ☐ Unknown

Has any family member been diagnosed with dementia? ☐ Yes (please describe below) ☐ No

Does any family member have migraine headaches? ☐ Yes (please describe below) ☐ No

Does any family member have a tremor? ☐ Yes (please describe below) ☐ No

Family member:	Medical diagnosis:	Comment:
Mother:		
Father:		
Siblings:		
Children:		

SOCIAL HISTORY:

(Social history questions are **OPTIONAL**; only answer questions you are comfortable answering.)

Occupation: _____ Highest level of education: _____

Hobbies: _____ Hours of day watching television: _____

Who besides you, lives in your home? _____

Do you have an Advanced Directive (Living Will) or POLST (Physician Orders for Life Sustaining Treatment) in place? ☐ Yes ☐ No ☐ Not Applicable

Do you have a Financial Power of Attorney? ☐ Yes ☐ No

Are you: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Optional: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Do you have children? ☐ Yes ☐ No If so, what are their ages: _____

Smoking: ☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?_____packs/day)

Would you like information on resources to help quit smoking? ☐ Yes ☐ No

Marijuana: ☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?_____)

Cocaine, amphetamines, IV drug use, or other recreational drug use:

☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?_____)

Alcohol: on an average day, how many alcohol containing drinks do you have? (

Alcohol: in an average week, how many alcohol containing drinks do you have? (

Are you under more than normal stress? ☐ Yes ☐ No If yes, please explain _____

_____

Do you use any of the following mobility devices?

Cane- (What % of time? _____) Walker- (What % of time? ____) Wheelchair- (What % of time? ____)

REVIEW OF SYSTEMS:
If you feel concerned with categories below; check "Abnormal", if not, please check, "Normal".

CATEGORY:		
GENERAL (Weight change, fever, etc.)	☐ Normal	☐ Abnormal
EYES/VISION	☐ Normal	☐ Abnormal
EARS/HEARING	☐ Normal	☐ Abnormal
NOSE/SINUS	☐ Normal	☐ Abnormal
NECK/SPINE	☐ Normal	☐ Abnormal
BREAST	☐ Normal	☐ Abnormal
RESPIRATORY	☐ Normal	☐ Abnormal
CARDIOVASCULAR (Heart, chest pain, etc.)	☐ Normal	☐ Abnormal
GI (abdomen/stomach)	☐ Normal	☐ Abnormal
GU (bladder/kidney)	☐ Normal	☐ Abnormal
Gynecological (pregnancies, menses changes, pelvic pain)	☐ Normal	☐ Abnormal
MUSCULOSKELETAL (joint pain, muscle weakness, injury, etc.)	☐ Normal	☐ Abnormal
SKIN	☐ Normal	☐ Abnormal
PSYCHIATRIC/MOOD	☐ Normal	☐ Abnormal
SLEEP	☐ Normal	☐ Abnormal

_____

_____

_____

_____

_____

_____

Together We Can Unleash the Cure!

Name:_____ **Date:**_____

Activities of Daily Living: Mark if you have difficulties in the following areas.

	Normal	Mild Infrequent	Moderate Occasional May need help	Severe Frequent Requires help	Unable to do
Tremor					
Pain					
Swallowing					
Feeding					
Dressing					
Handling medications					
Bathing, hygiene, toileting					
Shopping					
Cooking, cleaning					
Handling finances					
Handwriting					
Walking					
Turning in bed					

Name:_____ **Date:**_____

Speech	**Cognition**	**Gait and Balance**	**Swallow**
—Slurred —Soft —Difficult to hear —Hoarse	—Dementia —Word finding difficulty —Impaired memory —Confusion —Slow processing	—Slow gait —Impaired balance —Falls —Freezing —Cane —Walker _Wheelchair	—Excessive saliva —Dry mouth —Drooling —Choking
Gastrointestinal	**Sensory**	**Sleep**	**Genitourinary**
—Constipation —Reflux/GERD —Diarrhea —Abdominal pain	—Numbness —Tingling —Burning sensation —Headache —Dizziness	—Insomnia —Sleep apnea —Talking or yelling in sleep —Snoring —Acting out dreams —Excessive daytime sleepiness —Restless leg syndrome	—Urinary frequency —Urinary urgency —Incontinence —Recent UTI —Sexual dysfunction —Erectile dysfunction
Psychiatric	—Depression —Anxiety _Panic attacks —Vivid dreams _Nightmares —Hallucinations —Illusions —Compulsive behavior —Mood swings —Irritability —Loss of interest —Loss of motivation		
Family History	—Tremor —Parkinson's Disease —Dementia —Mental Illness —Other movement disorder	— Alzheimer's disease — Depression — Other neurological disorders — Other genetic disorder — Stroke	

HANDWRITING EVALUATION

Name:_____ **Date:**_____

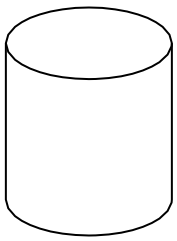
Are you: _____ Right Handed _____ Left Handed

Write any complete sentence of your choosing.

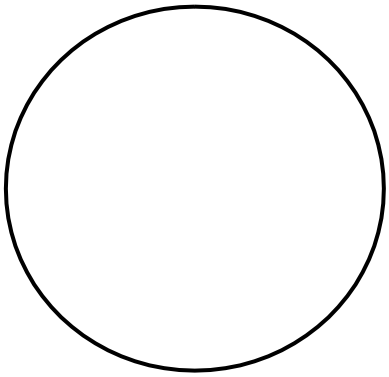
Sign your name.

Copy the following: "I love eating fruit."

Copy the following shape:



Draw hands on the clock to 9:30



CONSENT OF TREATMENT

Print Patient's Name:_____ Date of Birth:_____

Medical Consent: I wish to receive examination and treatment for my medical condition or injury. I understand that my practitioner will inform me of recommendations related to my treatment and that, unless I object, this consent includes any routine tests or examinations. If a special procedure or surgery is needed, I understand that my practitioner will discuss them with me and an additional consent may be required. I reserve the right to refuse any particular medical treatment or health care procedure that is proposed by my health care practitioner.

Release of Information: I authorize Piercey Neurology to release information from my medical records to any insurance carrier or government agency for the purpose of processing my claims for medical benefits. I understand that if any insurance company or government agency is paying for my claims for medical benefits they may have access to sensitive information about my diagnosis and treatment. Additionally, there may be quality improvement employees, utilization review employees, or my physician who may look at my medical record. **If I choose not to release my medical record information, I understand and agree that I will pay for all charges in the event that payment is denied.**

Authorization of protected information: A separate authorization will be required for release of the following information: HIV positive diagnosis, drug/alcohol addiction program records, psychotherapy notes and/or mental health program records.

Financial Agreement: I understand that I am responsible for determining my personal insurance requirements including eligibility, referrals and authorization. I am financially responsible for charges not covered by insurance. I also understand that I am responsible for paying deductibles, co-insurances, and co-pays. I agree to make payment according to the Piercey Neurology credit policy. In order to avoid a finance charge, all charges accrued must be paid in full within 90 days of the first statement's closing date. I understand that a service charge of $25 will be assessed for all checks returned for non-sufficient funds or written on a closed account.

Insurance Assignment: I certify that the information I have supplied is true and accurate to the best of my ability. I assign to Piercey Neurology any insurance benefits payable to me for services rendered. I direct all insurance companies, health care service plans, and other third party payers to make payment directly to Piercey Neurology.

Medicare Certification and Payment Request: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act or Medicaid is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize them to submit a claim to Medicare for payment to me.

Prescription Refills: Everything Important Takes Time. Please understand medication refills may take up to 48 hours to process after the request is made. You are part of our team. Please request medication refills at least two days before you may run out. Thank you, the PN team. Together we can unleash the cure!

Patient/Patient Representative Signature:_____

Relationship to Patient:_____Date:_____

I acknowledge that the Notice of Privacy Practices has been made available to me: (Initials) _____

VOLUNTARY INFORMATION DISLOSURE

Piercey Neurology strives to provide the highest quality of medical services for all of our patients. As our patient, we need your help.

As part of health care reform, medical providers using Electronic Health Records are being asked to collect information about their patients related to ethnicity and race. The information is used to benchmark trends in public health data. Your answers to the following questions are voluntary and confidential as protected by HIPAA laws. To learn more from Population Reference Bureau, see www.prb.org/Articles/2009/questionnaire.aspx.

Please take a few minutes to answer the following questions:

Print Patient's Name:_____ Date of Birth:_____

Race:

- ☐ Native American or Native Alaskan
- ☐ Asian or Asian American
- ☐ African or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____
- ☐ Patient refused
- ☐ Caucasian / White

Language:

- ☐ English
- ☐ Arabic
- ☐ Hindi
- ☐ Chinese
- ☐ Korean
- ☐ Spanish
- ☐ Russian
- ☐ Other _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient Refused

Status:

- ☐ Smoker
- ☐ Non-Smoker

At this time, our Clinic is requesting email addresses from our patients for future communications related to our Electronic Health Records. Your email will only be used for the purposes of patient communications and will not be shared with any third party. If you are willing to provide your email address, please write it below.

You will be given the opportunity to receive a real-time connection to your health information online, with access to your diagnosis history, medication details, immunizations and appointments.

Email Address: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I,_____authorize my medical records be disclosed,

FROM: _____

_____

_____

CONSISTING OF: ☐ Last Two Years ☐ Entire Record ☐ Specific: _____

_____

TO: _____

_____

_____

FOR THE PURPOSE OF: ☐ Self Use ☐ Legal ☐ Changing Doctors ☐ Moving/Relocating
☐ Referral/Consultation ☐ Continuity of Care/Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

☐ HIV/AIDS information
☐ Genetic testing information
☐ Alcohol/chemical dependency diagnosis, treatment or referral information
☐ Mental-health information
☐ Sexually transmitted disease information

PATIENT INFORMATION I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services ore reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization will also not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in a health plan. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Piercey Neurology or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

Unless revoked, this authorization expires one year from the date signed below. I understand that I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with my permission cannot be undone.

SIGNATURE: By signing below, you agree that you have read this authorization and understand it.

By:_____ **Today's Date:** _____ **DOB:**_____
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority: _____

AUTHORIZATION TO VERBALLY RELEASE PROTECTED HEALTH INFORMATION

I,_____ hereby authorize PIERCEY NEUROLOGY LLC to verbally share confidential information to the following individuals:

Name:_____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Concerning: (Check Only One)

☐ Appointment Dates / Times Only

☐ All matters relating to my health care including mental health, alcohol, drug treatment, and communicable diseases.

OR

☐ Only specific health care problems and treatment relating to: _____

_____

(Describe the conditions for which information may be released)

This authorization may be revoked at any time by notifying PIERCEY NEUROLOGY LLC in writing, but the revocation will not affect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire upon my written request for change or revocation, directed to PIERCEY NEUROLOGY LLC.

I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations.

_____	_____	_____
Patient's Signature	Date of Birth	Today's Date