HEADACHE CENTER at Piercey Neurology LLC

Welcome to the Headache Center at Piercey Neurology LLC

Attached you will find the paperwork which must be completed in entirety (in blue or black ink) in preparation for your consultation appointment. These forms are **REQUIRED BEFORE WE WILL SCHEDULE YOUR CONSULTATION APPOINTMENT** so that we may ensure all of your information is reviewed thoroughly, verified for accuracy, and entered into your chart before you are seen. After your information is reviewed, we will contact you via telephone to arrange an appointment. You may use the space at the bottom of the page to record this date and time.

It is important for your safety and best possible care, we must have a list of ALL medications you are taking (daily or as needed, even if sparingly, prescribed and over-the-counter, including vitamins/nutraceuticals, in all forms including oral, nasal, inhaled, injected, etc.) with medication dosage and instructions for use. You may attach an extra page, if necessary.

We prefer for you to return your paperwork via in-person delivery to our clinic, US mail, or fax. Please note, when sending by mail, it is always advisable to make a second copy as a back-up in the event the mailed copy does not arrive. Email correspondence is NOT HIPAA-compliant. Should you choose to send your medical information via email, your submittal acknowledges that you have been informed that you are using a non-HIPAA compliant means of communication and accept the risk. Note that any information received in our office via email is downloaded within 1 business day of receipt, stored appropriately, and then deleted from email. For future medical correspondence, please sign up for our Patient Portal (see the link at the top of our webpage) as this is a HIPAA-secure means of communication.

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

PLEASE NOTE THE FOLLOWING:

- Check in at least 15 minutes prior to your appointment time so we may verify all of your information has been entered correctly.
- If you arrive late, we will need to reschedule your appointment.
- If you fail to arrive for your appointment, we will not reschedule your appointment.
- Bring photo ID as well as all insurance cards with you to your appointment.
- Insurance copay is due at the time of your appointment.
- Do not wear cologne, perfume, or scented lotions to your appointment, and refrain from smoking prior to your appointment as these odors can trigger migraines in other patients, staff, and health care providers.

Thank you! We look forward to seeing you!

Headache Center at Piercey Neurology LLC
305 SW C Avenue
Corvallis, OR 97333
Phone: 541.207.3900
Fax: 541.207.3232
Email: team@pierceyneurology.com

Appointment information:

□ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

Date: _____ Time: _____ AM PM

Directions to:

305 SW C Avenue
Corvallis, OR 97333

Via Highway 34:

- Come across the bridge toward downtown Corvallis. This will take you on to NW Harrison Blvd.
- Turn left onto NW 4th St and travel 0.7 miles.
- Just before the overpass, turn left onto SW C Ave.
- Piercey Plaza is at the end of the street on the left.

Via Highway 99 from Salem:

- Traveling south on Hwy 99, enter downtown Corvallis. This will turn into NW 4th St.
- Just before the overpass, turn left onto SW C Ave.
- Piercey Plaza is at the end of the street on the left.

Via Highway 99 from Eugene:

- Traveling north on Hwy 99, enter downtown Corvallis. This will turn into SW 3rd St.
- Just after the overpass, turn left onto SW B Ave.
- Turn left on SW 4th St.
- Just before the overpass, turn left onto SW C Ave.
- Piercey Plaza is at the end of the street on the left.

Via Highway 20 from Albany:

- Follow Highway 20 toward downtown Corvallis. This will turn into NW 2nd St.
- Turn right on NW Harrison Blvd.
- Turn left onto NW 4th St and travel 0.7 miles.
- Just before the overpass, turn left onto SW C Ave.
- Piercey Plaza is at the end of the street on the left.

Via Highway 20 from Philomath:

- Follow Highway 20 toward Corvallis.
- Take the ramp on the right toward downtown Corvallis (follow signs for US-20 / OR-99W).
- Turn left onto SW B Ave.
- Turn left onto SW 4th St.
- Just before the overpass, turn left onto SW C Ave.
- Piercey Plaza is at the end of the street on the left.

HEADACHE HEALTH QUESTIONNAIRE

Please complete all forms in blue or black ink.

Patient Name:_____

Age: _____ Date of Birth: _____ Gender: _____

Email: _____ SSN#: _____

Mailing Address:_____

City: _____ Zip: _____

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

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

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

Pharmacy: _____

Pharmacy Location/Address: _____

Primary Care Provider:_____

Referring Provider (if different from above):_____

Other health care providers you would like to receive a copy of your consultation:

_____

_____

I consent to the release of my medical information from the HEADACHE CENTER at Piercey Neurology LLC to the above listed health care providers.

Patient Signature:_____ **Date:**_____

IF PATIENT IS A MINOR OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is a minor under the age of 15 OR is unable to sign because: _____

_____ _____ _____

Parent's/Guardian's Signature Date Time

_____

Relationship to Patient

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

_____

_____

HEADACHE CENTER at Piercey Neurology LLC

MEDICAL HISTORY:

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

Do you have, or have you had in the past, any of the following conditions (please circle):

Abuse _____
ADD/ADHD
Allergies (seasonal)
Anemia
Anxiety
Arnold Chiari Malformation
Asthma
Autoimmune Disease
Bipolar Disorder
Bleeding Disorder
Cancer_____
Car Sickness in Childhood
Cervical Dystonia/Spasmodic Torticollis
Depression
Diabetes
Fainting
Gastroparesis
Heart Attack
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
IBS – Constipation
IBS – Diarrhea
Infant Colic
Kidney Disease
Kidney Failure
Kidney Stones
Liver Disease
Low Blood Pressure
Multiple Sclerosis
Osteoporosis
Rheumatoid/Osteoarthritis
Scoliosis
Seizure Disorder
Sexually Transmitted Disease
Stroke or TIA (Transient Ischemic Attack)
Thyroid Disease
Tuberculosis
Ulcers

SURGICAL HISTORY: ☐ **None**

SURGERY	Date	Hospital/Facility	Comments

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS? ☐ **None**

TEST	Date	Hospital/Facility	Normal/Comments if Abnormal
EMG/Nerve conduction study			
CT brain			
CT neck			
MRI brain			
MRI neck			
MRA brain			
MRA neck			

MEDICATION ALLERGIES: ☐ **No Known Drug Allergies**

Medication	Reaction	When

FAMILY HISTORY:

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

Do any of your family members have migraine headaches? ☐ Yes (please describe below) ☐ No

Do any of your family members have brain cancer? ☐ Yes (please describe below) ☐ No

Do any of your family members have a brain aneurysm? ☐ Yes (please describe below) ☐ No

Family member:	Health condition(s):	Comment(s):
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		
Mother		
Father		
Sibling(s)		
Child(ren)		

SOCIAL HISTORY:

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

Occupation:_____ Highest level of education: _____

Hobbies: _____ Hours/day of screen time (TV, phone, computer):____

Who, besides you, lives in your home? _____

Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Are you: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partnership

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

Smoking: ☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?_____/day)
Would you like information on resources to help quit smoking? ☐ Yes ☐ No

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

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

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

Do you use any of the following mobility devices? ☐ Yes ☐ No If "Yes: "

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

When did your headaches begin? Specifically, was there a provoking event? e.g. puberty, pregnancy, head or neck injury, illness, stress, hormonal changes, etc.?):_____

_____

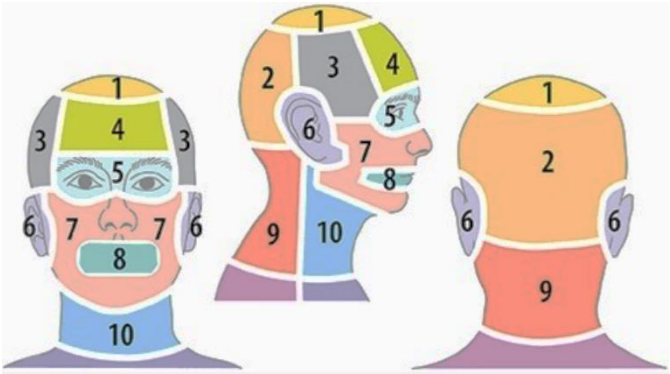
_____

_____

_____

Over time, your headaches have (check one): ☐ remained relatively stable.
☐ increased in frequency and duration over time.

Headache Characteristics:



Location (check all that apply):

☐ Right side only ☐ Right = Left
☐ Left side only ☐ Top
☐ Right > Left ☐ Front
☐ Left > Right ☐ Back

← Please identify your *primary pain generator* (the area where most of your pain comes from) on the image to the left. _____

Character (check all that apply): ☐ Dull ache ☐ Icepick/stabbing ☐ Electrical shock
☐ Throbbing/Pulsating ☐ Squeezing ☐ Pressure ☐ Exploding ☐ Imploding

Minimal intensity of your head pain (0 being no pain, 10 being the worst pain possible): _____
Maximal intensity of your head pain (0 being no pain, 10 being the worst pain possible): _____

Time until your head pain reaches maximal intensity: ☐ seconds ☐ minutes ☐ hours ☐ days

Average duration of exacerbations: ☐ seconds ☐ minutes ☐ 1-4 hours ☐ 4-12 hours
☐ 12-24 hours ☐ 1-2 days ☐ 2-7 days ☐ > 7 days

Do you experience a daily headache which is continual in nature? ☐ No ☐ Yes

On average, how many days per month do you experience the following headaches? (If your headaches vary dramatically, please provide a range in the number of days.)

Description	Days Per Month (should total 30)	Your Pain Level (1-10)
No pain or associated symptoms are present, able to function normally		0
Mild pain is present but does not need treatment		
Pain requires intervention but does not interfere with activities		
Pain is disruptive, not working at peak ability but functioning		
Unable to carry on daily activity due to pain and/or associated symptoms		
Unable to do anything but lie in bed		

HEADACHE CENTER at Piercey Neurology LLC

Do you have any of these prodromal symptoms that occur ***1-2 DAYS BEFORE*** your headache starts?

Appetite changes:	☐ Yes	☐ No	Mood changes:	☐ Yes	☐ No
Yawning:	☐ Yes	☐ No	Urination changes:	☐ Yes	☐ No
Fatigue:	☐ Yes	☐ No	Neck pain/stiffness:	☐ Yes	☐ No

Do you have any of these aura symptoms that occur ***IN THE HOUR BEFORE*** your headache starts?

Numbness or tingling:	☐ No	☐ Yes	_____
Changes in vision:	☐ No	☐ Yes	_____
Word finding difficulties:	☐ No	☐ Yes	_____

Do you have any of these symptoms ***AT THE TIME OF*** your headache?

Nausea:	☐ Yes	☐ No	Neck pain/stiffness:	☐ Yes	☐ No
Vomiting:	☐ Yes	☐ No	Jaw pain:	☐ Yes	☐ No
Light sensitivity:	☐ Yes	☐ No	Dizziness/lightheadedness:	☐ Yes	☐ No
Sound sensitivity:	☐ Yes	☐ No	Vertigo (room spinning):	☐ Yes	☐ No
Smell sensitivity:	☐ Yes	☐ No	Restlessness/agitation:	☐ Yes	☐ No

Eye watering:	☐ Yes	☐ No	If Yes:	☐ Left	☐ Right	☐ Both
Eye redness:	☐ Yes	☐ No	If Yes:	☐ Left	☐ Right	☐ Both
Eyelid droop:	☐ Yes	☐ No	If Yes:	☐ Left	☐ Right	☐ Both
Nose running:	☐ Yes	☐ No	If Yes:	☐ Left	☐ Right	☐ Both

Do you have any other neurological symptoms before or with your headache? ☐ Yes ☐ No

If "Yes," please explain: _____

Do you have any headache triggers? (Check all that apply):

☐ Menses	☐ Skipped meal	☐ Lack of sleep	☐ Oversleep	☐ Noise
☐ Bright lights	☐ Alcohol	☐ MSG	☐ Stress	☐ Anxiety
☐ Motion sickness	☐ Weather changes	☐ Tight hats	☐ Tight glasses	☐ Tight collar

☐ Foods: _____ ☐ Odors: _____

Other (please explain): _____

Is your headache triggered by coughing? ☐ Yes ☐ No

Is your headache triggered by using the bathroom? ☐ Yes ☐ No

Is your headache better or worse with lying down? ☐ Better ☐ Worse ☐ No change

Does your head pain awaken you from a sound sleep? ☐ Yes ☐ No

Do you have a history of head injury ***without*** loss of consciousness? ☐ Yes ☐ No

If "Yes," please explain: _____

Do you have a history of head injury ***with*** loss of consciousness? ☐ Yes ☐ No

If "Yes," please explain: _____

Do you have a history of neck or spine injury? ☐ Yes ☐ No

If "Yes," please explain: _____

Estimated date of most recent eye exam: _____ ☐ Normal ☐ Abnormal _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently trying to conceive? ☐ Yes ☐ No

HEADACHE CENTER at Piercey Neurology LLC

CURRENT MEDICATION(S):

Please list all medication you currently take, *including over-the-counter medications*. Attach a separate sheet, if necessary.

Medication	Dosage	Instructions	Start date	Reason for medication

How many days/month do you take quick acting pain relief medications (prescription or over-the-counter) for your headaches?

_____

_____

BEHAVIORAL OR ALTERNATIVE THERAPIES TRIED FOR HEADACHES:

Physical Therapy?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Massage Therapy?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Chiropractic Therapy?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Acupuncture?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Osteopathic Manipulative Therapy?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Biofeedback?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
TENS unit?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Cefaly® device?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Trigger point injections?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Nerve blocks?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Toxin (Botox) injections?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Dietary restrictions?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Application of ice?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain
Application of heat?	☐ Yes ☐ No	If "Yes," ☐ Helpful	☐ No help	☐ Uncertain

Other: _____

PREVIOUS CONSULTATIONS: Have you seen any of the following specialists for your headaches?

Neurologist: _____

Ear, Nose, and Throat Specialist: _____

Dentist: _____

Allergy Specialist: _____

Pain Management/Interventional Pain Specialist: _____

MEDICATIONS (PREVENTATIVE OR ABORTIVE) PREVIOUSLY TRIED (check all that apply):

For unlisted medications (including over-the-counter medications, herbal supplements), attach a separate sheet, if necessary.

Medication	Comments (helpful, no help, side effects)
☐ Topamax / Topiramate / Trokendi / Qudexy	
☐ Zonegran / Zonisamide	
☐ Depakote / Divalproex / Valproic acid / Valproate	
☐ Gabapentin / Neurontin	
☐ Lyrica / Pregabalin	
☐ Lamictal / Lamotrigine	
☐ Amitriptyline / Elavil	
☐ Nortriptyline / Pamelor	
☐ Protriptyline	
☐ Propranolol	
☐ Atenolol	
☐ Metoprolol	
☐ Nadolol	
☐ Timolol	
☐ Verapamil	
☐ Effexor / Venlafaxine	
☐ Zoloft / Sertraline	
☐ Prozac / Fluoxetine	
☐ Paxil / Paroxetine	
☐ Lexapro / Escitalopram	
☐ Flexeril / Cyclobenzaprine	
☐ Baclofen / Lioresal	
☐ Tizanidine / Zanaflex	
☐ Robaxin / Methocarbamol	
☐ Skelaxin / Metaxalone	
☐ Aimovig / Erenumab	
☐ Emgality / Galcanezumab	
☐ Ajovy / Fremanezumab	
☐ Vyepti / Eptinezumab	
☐ Ubrelvy / Ubrogepant	
☐ Nurtec ODT / Rimegepant	
☐ Reyvow / Lasmiditan	
☐ Imitrex / Treximet / Sumatriptan	
☐ Maxalt / Rizatriptan	
☐ Zomig / Zolmitriptan	
☐ Amerge / Naratriptan	
☐ Relpax / Eletriptan	
☐ Axert / Almotriptan	
☐ Frova / Frovatriptan	
☐ Dihydroergotamine (DHE) Injection	
☐ Migranal (DHE) Nasal Spray	
☐ Cafergot / Ergotamine	
☐ Midrin	
☐ Prodrin	
☐ Butalbital medications (Fioricet, Esgic, Fiorinal)	
☐ OTC NSAIDs (Ibuprofen, Advil, Naproxen, Aleve, etc.)	
☐ Toradol / Ketorolac - Injection or Oral	
☐ Cambia / Zipsor / Diclofenac	
☐ Indocin / Indomethacin	
☐ Mobic / Meloxicam	
☐ Celebrex / Celecoxib	

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☐ Phenergan / Promethazine	
☐ Compazine / Prochlorperazine	
☐ Chlorpromazine	
☐ Reglan / Metoclopramide	
☐ Zofran / Ondansetron	
☐ Tylenol / Acetaminophen	
☐ Excedrin	
☐ Prednisone	
☐ Dexamethasone	
☐ Magnesium	
☐ Riboflavin (Vitamin B2)	
☐ Butterbur (Petadolex)	
☐ Feverfew	
☐ Boswellia (Gliacin)	
☐ Melatonin	

LIFESTYLE:

How many hours do you sleep per night? _____ Typical hours: _____ to _____

Quality of Sleep: ☐ Good ☐ Poor If "Poor," check all that apply:

☐ Difficulty falling asleep ☐ Multiple awakenings throughout the night ☐ Early morning awakenings

☐ I have never been tested for sleep apnea.

☐ I have been tested for sleep apnea and this was negative – date of testing: _____

☐ I have been diagnosed with sleep apnea and use a CPAP – date of diagnosis: _____

☐ I have been diagnosed with sleep apnea and do not use a CPAP – date of diagnosis: _____

How many glasses of noncaffeinated fluids do you drink daily? ☐ 0-4 glasses ☐ 4 glasses ☐ 4+ glasses

How many cups of caffeine do you drink daily (including coffee, tea, iced tea, soda)? _____ cup(s)

How many days/week do you exercise? _____ What kind of exercise(s) do you do? _____

Overall Mood (1 being severely depressed and 10 being very happy): _____

REVIEW OF SYSTEMS:

If you feel concerned with categories below, check "Abnormal" and explain; if not, please check "Normal."

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)	☐ Normal ☐ Abnormal_____
GI (abdomen/stomach)	☐ Normal ☐ Abnormal_____
GU (bladder/kidney)	☐ Normal ☐ Abnormal_____
GYNECOLOGICAL (menses, pelvic pain)	☐ Normal ☐ Abnormal_____
MUSCULOSKELETAL (joints, muscles)	☐ Normal ☐ Abnormal_____
SKIN	☐ Normal ☐ Abnormal_____
PSYCHIATRIC/MOOD	☐ Normal ☐ Abnormal_____

PATIENT CODE OF CONDUCT

HEADACHE CENTER at Piercey Neurology has a zero-tolerance policy for inappropriate behavior to staff, providers, or other patients. The code of conduct also applies to chaperones and caregivers who may accompany the patient into the office for their appointments. If you, or anyone accompanying you, violate of any of the following policies, then you and your party will be asked to leave immediately.

1. Patient will treat all staff members and providers with respect with words (includes written, verbal, or electronic form of communication), body language, and gestures. Any degree of foul language is considered disrespectful.
2. Patient will refrain from any form of intimidation, harassment, or violence toward any person. This includes sexual, ethnic, or other types of harassment, whether verbal or physical in nature.
3. Patient will be honest and factual with all communication with staff members and providers.
4. Possession of illicit drugs or alcohol on the premises is not allowed.
5. Attending appointments "under the influence" may be grounds for restriction of privileges, rights, and services, or termination/discharge. Persons believed to be under the influence will be given the opportunity to call someone to pick them up or transportation will be arranged by our staff. If they leave the facility driving a vehicle, law enforcement will be notified.
6. Legal prescriptions and over-the-counter drugs may be brought on premises and used in their prescribed manner.
7. Prescribed medications must be used appropriately, as directed, including duration of refills. For example, if a prescription states MUST LAST 30 DAYS, it is your responsibility, as well as the pharmacy's, to assure that the medication is not filled earlier than every 30 days unless clearance has been provided by our clinic. Please note, noncompliance with a single medication may result in discontinuation of all oral medication prescriptions through our clinic.
8. Our clinic is a smoke-free environment as this is a prominent trigger of headaches in patients, staff, and providers.
9. Weapons (including but not limited to firearms) are not allowed within our building.

ACTION TO BE TAKEN IN THE EVENT OF A VIOLATION

1. Manager will review the information provided.
2. Manager will interview all staff involved, as well as the patient, chaperone, and caregiver.
3. If patient is determined to be in non-compliance with the patient code of conduct, he or she may be discharged or terminated from the practice.

SIGNATURE: By signing below, you agree that you have read this code of conduct, understand it, and agree to abide by it.

Signature:_____ **Today's Date:** _____ **DOB:** _____

(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority: _____

NO SHOW / CANCELLATION POLICY

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:

- Appointment cards are provided at the time of your previous appointment.
- Reminder Calls are made the day before your appointment unless you have an outstanding balance, in which case the reminder call is made the week before.
- We require 24 hours' notice for all cancellations and rescheduling of appointments. You may call to leave a message to inform us of the cancellation at any time of day or night.
- Please note that weekend days are not considered within the "24 hours." Monday appointments require cancellation on Friday or earlier.
- We understand that unforeseen circumstances/emergencies sometimes occur. In these instances, please notify our office AS SOON AS POSSIBLE to reschedule.
- Cancelled or rescheduled appointments without a 24-hour notice are subject to a $25.00 rescheduling fee.
- If you arrive 10 minutes past your scheduled appointment time, you will be considered a 'no-show'. Your appointment will be rescheduled, and the $25.00 rescheduling fee will apply.
- Should you accrue 3 "no show" appointments, you will no longer be considered a patient in our clinic. This means that all of your medication refills through our office will be cancelled. In this case, you must return to your Primary Care Physician to request a referral to another neurologist.
- No-showed initial consultation appointments will not be rescheduled unless they are missed due to an emergency.

Thank you for your consideration of our schedule and other patients!
We look forward to seeing you!

I, _____, acknowledge the above no show / cancellation
(Printed Name)
policy, and agree to comply with this policy.

Patient Signature:_____**Date:**_____

IF PATIENT IS A MINOR OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is a minor under the age of 15 OR is unable to sign because: _____

_____ _____ _____
Parent's/Guardian's Signature Date Time

_____
Relationship to Patient

HEALTH INSURANCE INFORMATION

Please complete this section even though we have a copy of your insurance card(s) on file. Thank you!

Patient: _____ Date of Birth: _____

Are any of your symptoms related to:

MVA (Motor Vehicle Accident) ☐ No ☐ Yes

OJI (On-the-Job Injury)? ☐ No ☐ Yes

If "Yes," is your MVA or WC (Workers' Compensation) claim closed? ☐ No ☐ Yes

Primary Insurance Company: _____

Subscriber ID#: _____

Group #: _____

Subscriber Name: _____

Relationship to Patient: _____

Date of Birth: _____

Secondary Insurance Company: _____

Subscriber ID#: _____

Group #: _____

Subscriber Name: _____

Relationship to Patient: _____

Date of Birth: _____

I, _____, certify that the above information is correct.
(print name)

Patient Signature:_____**Date:**_____

IF PATIENT IS A MINOR OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is a minor under the age of 15 OR is unable to sign because: _____

_____ _____ _____
Parent's/Guardian's Signature Date Time

_____
Relationship to Patient

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 for your understanding, from the Piercey Neurology team.

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, visit www.prb.org.

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 _____
- ☐ Patient refused

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/Disability ☐ 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 _____Mental-health information (including memory tests)

_____Genetic testing information _____Sexually transmitted disease information

_____ Alcohol/chemical dependency diagnosis, treatment or referral 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.

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

Description of personal representative's authority:_____

AUTHORIZATION TO VERBALLY RELEASE PROTECTED HEALTH INFORMATION (PHI)

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 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