NASHVILLE NEUROSCIENCE GROUP | AdvancedHEALTH

www.NashvilleNeuroscience.com
eMail: nng.advancedhealth@NashvilleNeuroscience.com
2004 Hayes Street, Suite 650 | Nashville, TN 37203
P (615) 284-4680 **F** (615) 284-4681

NEW PATIENT INFORMATION PACKET

- ☐ Directions to the Office
- ☐ Physician / Facility Release
- ☐ Headache Assessment
- ☐ Patient Financial Policy
- ☐ General Consent for Treatment
- ☐ Patient Rights
- ☐ Patient Information Form
- ☐ Medical History
- ☐ PHQ-2 and PHQ-9 Screening
- ☐ Release of Medical Information
- ☐ Notice of Privacy Practices Acknowledgement
- ☐ Request for Medical Records

Completion of the New Patient Information Packet includes extensive patient medical history information which are very important in order to provide the most comprehensive and beneficial medical evaluation with the Nashville Neuroscience Group. These forms may be accessed on our website and may be completed on the website or downloaded for completion at your convenience. It is **EXTREMELY IMPORTANT** that these are completed and brought with you on the day of your appointment. If it is not convenient for you to access these from our website, we would be happy to provide you with a copy by e-mail or by regular mail at your request.

Please also bring your insurance cards, both primary and secondary if applicable. Your insurance company requires us to collect all Co-pays at check in.

If your insurance requires a referral from your primary care physician please make sure that this has been accomplished and that we have it by the time of your scheduled visit. We will be unable to complete your visit if the referral has not been secured.

It is very important that you give 24 hours notice if you are unable to keep your scheduled appointment with the Nashville Neuroscience Group. Cancellations that are not made 24 hours in advance will result in a missed appointment charge to you of $150, which will need to be paid before you can reschedule.

New patients who do not show for their appointments or who cancel on the same day of the appointment will not be rescheduled unless there are significant extenuating circumstances. **A non-refundable deposit may also be required to reschedule the appointment. This deposit may be applied to future appointments.**

If you have had brain or any other CT or MRI imaging within the past 2 years, please bring a copy of the report as well as any other records you may have.

Our providers want to ensure that all patients receive ample time to discuss their medical concerns and further treatment options. We ask that you allow 2-4 hours in our office for your first appointment, which may include video viewing, history taking, physical examination and possible research study participation.

PLEASE DO NOT wear cologne, scented lotions or perfumes to the office as these may cause migraine for our other patients.

Our front office staff would be happy to assist you with any questions you may have prior to your appointment. We can be reached at (615) 284-4680 or email us at nng.advancedhealth@nashvilleneuroscience.com

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DIRECTIONS TO THE OFFICE

From the North:
Take I- 65 South to I-40 West (Memphis)
Exit 84-A (Huntsville - Knoxville)
Exit onto Charlotte/Church Street
Turn RIGHT on Charlotte Avenue and continue to 19th Ave.
Turn LEFT on 19th Ave. and continue to Hayes Street.
Turn RIGHT at the stop sign on Hayes Street, drive two blocks then turn RIGHT into parking garage

From the South:
I-65 North to I-40 West
Exit on to Church St.
Turn LEFT on Church Street and continue on to 19th Ave., North
Turn LEFT on 19th Ave., North and continue to Hayes Street.
Turn RIGHT on Hayes Street, drive two blocks and then turn RIGHT into the parking garage.

From the East:
Take I-40 West into Nashville and exit onto Church Street
Turn LEFT on Church Street and continue to 19th Ave., North
Turn LEFT on 19th Ave., North and continue to Hayes Street
Turn RIGHT on Hayes Street, drive two blocks and then the RIGHT into the parking garage.

From the West:
Take I-40 East into Nashville and exit onto Charlotte/Church Street
Turn RIGHT on Charlotte Avenue and continue on to 19th Ave., North
Turn LEFT on 19th Ave., North and to continue to Hayes Street
Turn RIGHT on Hayes Street, drive two blocks and then turn RIGHT into the parking garage

From the Southeast:
Take I-24 East to I-40 West
Exit onto Church St.
Turn LEFT on Church Street and continue on to 19th Ave., North
Turn LEFT on 19th Ave. and continue to Hayes Street
Turn RIGHT on Hayes Street drive two blocks and then RIGHT into the parking garage

Valet Park or park inside the garage, then walk to or take the elevators to the garage 1st floor entrance. Enter building and take elevators in front to the 6th floor. Our office is located to the right off of the elevators in Suite 650.

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PATIENT INFORMATION FORM

Full Legal Name _____ Name Normally Used (Nickname) _____

Street address (not P.O. Box) _____ City _____ State _____ Zip Code _____

Mailing address (if different from above) _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

SSN _____ - _____ - _____ eMail _____ Date of Birth _____ / _____ / _____

Age _____ Sex _____ Race _____ Marital Status _____ Employer's Name _____

SPOUSE'S INFORMATION

Name _____ Date of Birth _____ / _____ / _____

Address (if different from above) _____ Occupation _____

Employer's Name _____ Employer's Address _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

INSURANCE INFORMATION

Responsible Party Name _____ Phone No ( ) _____

Responsible Party Address _____

Primary Insurance _____ Contract Holder's Name _____

SSN _____ - _____ - _____ Date of Birth _____ / _____ / _____ Relationship _____

Co-Pay $ _____ Contract No. _____ Group No. _____ Effective Date _____

Secondary Insurance _____ Contract Holder's Name _____

SSN _____ - _____ - _____ Date of Birth _____ / _____ / _____ Relationship _____

Co-Pay $ _____ Contract No. _____ Group No. _____ Effective Date _____

EMERGENCY CONTACT

Contact Name _____ Phone No ( ) _____

Primary Care Physician _____ Phone No ( ) _____

Referring Physician _____ Phone No ( ) _____

Pharmacy Name _____ Phone No ( ) _____

I hereby authorize Nashville Neuroscience Group, as a holder of medical information; to release to the referring physician, family physician or any medical or medically related facility, information regarding my diagnosis and treatment. I authorize Nashville Neuroscience Group to release to my insurance carrier or its intermediates, information needed for this or any future related claim(s). I further request payments be made to Nashville Neuroscience Group. I authorize application of credits generated from over payment to other open balances on my account.

Signature of Responsible Party _____ **Date** _____

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PHYSICIAN / FACILITY RELEASE FORM

Other physicians involved in my care include (for example, specialists in Obstetrics/Gynecology, Urology, Ophthalmology, Neurosurgery, Cardiology or others):

Doctor's Name:	Specialty:	Phone Number:	Fax Number:
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____

I hereby authorize Nashville Neuroscience Group, as a holder of medical information; to release to the referring physician, family physician or any medical or medically related facility, information regarding my diagnosis and treatment. I authorize Nashville Neuroscience Group to release to my insurance carrier or its intermediates, information needed for this or any future related claim(s). I further request payments be made to Nashville Neuroscience Group. I authorize application of credits generated from over payment to other open balances on my account.

I understand that I am financially responsible to Nashville Neuroscience Group for all services regardless of any portion page by my insurance carrier. I understand that 24 hour notification is required for cancellation of any return appointment or a fee of $50 will be charged to me. **I also understand that 24 hour notification is required for cancellation of my first "new patient" appointment or a fee of $150 will be charged to me. A non-refundable deposit may also be required to reschedule appointment. This deposit may be applied to future appointments.** I understand and agree to pay either fee should I fail to provide a minimum of 24 hours notice of cancellation before an appointment.

The Nashville Neuroscience Group reserves the right to refer unpaid past-due balances to third parties for collection. In the event that any past-due balance is placed with a third party, I agree to pay any costs of such collection including agency fees, legal/attorney fees, and court costs.

Because this is an outpatient neurology practice with limited staffing, we do not provide after hours or weekend care, including urgent/emergency care or inpatient hospital care. If you have a medical emergency after office hours or on the weekend, please go immediately to your local emergency room or call your primary care physician.

_____ _____

Signature of Patient Date

We invite you to discuss frankly with us any questions regarding our services or fees. The best medical service is based on friendly, mutual understanding between doctor and patient.

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Name _____ **DOB** _____

MEDICAL HISTORY

1. **Chief concern:** Briefly state the reason for your referral; we will gather more detailed information later.

_____

2. **Current Medications** (Please include all over-the-counter medications, oral contraceptives, estrogen replacement, nasal sprays and eye drops.)

Medication	Tablet Strength	How taken:

3. **Past Medical History**
Have you ever had any difficulty with these conditions (Check all that apply, and briefly explain: year diagnosed, treating MD, etc.):

- ☐ Thyroid disease: _____
- ☐ Diabetes: _____
- ☐ Heart Disease_____
- ☐ High cholesterol: _____
- ☐ Heart attack: _____
- ☐ High blood pressure: _____
- ☐ Headaches: _____
- ☐ Kidney disease: _____
- ☐ Kidney stones: _____
- ☐ Ulcers/GI disease: _____
- ☐ Lung disease: _____
- ☐ Rheumatologic disorder:_____
- ☐ Fibromyalgia: _____

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☐ Rheumatoid arthritis: _____

☐ Lupus: _____

☐ Psychiatric illness: _____

☐ Previous psychiatric hospitalization? _____

☐ Depression: _____

☐ Anxiety: _____

☐ Head injury: _____

☐ Seizure (If yes, list type of seizures, and date of last seizure): _____

☐ Meningitis:_____

☐ Encephalitis:_____

☐ Stroke:_____

4. **Allergies** **Reactions**

Medication: _____ _____

_____ _____

Foods: _____ _____

_____ _____

Substances: _____ _____

_____ _____

5. **Past Surgical History:**

Please list all surgeries including the year performed, and the surgeon if possible.

_____

_____

_____

_____

_____

_____

6. **Hospitalizations:**

Yes ☐ No ☐

Year _____ Hospital _____ Reason _____

Year _____ Hospital _____ Reason _____

Year _____ Hospital _____ Reason _____

Year _____ Hospital _____ Reason _____

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Name _____ **DOB** _____

7. Family History

How many siblings do you have? _____ Brothers _____ Sisters

Has anyone in your family had: If so, whom?

- ☐ Thyroid disease: _____
- ☐ Diabetes: _____
- ☐ Heart Disease_____
- ☐ Heart attack: _____
- ☐ Stroke: _____
- ☐ High blood pressure: _____
- ☐ Headaches: _____
- ☐ Cancer: _____
- ☐ Renal disease: _____
- ☐ Liver disease: _____
- ☐ Seizers: _____
- ☐ Psychiatric illness: _____

Mother's age: _____ Father's age: _____

If deceased, cause of death? Mother: _____ Father: _____

8. Social history:

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children (ages): _____

Occupation: _____ Spouse's occupation: _____

Hobbies: _____

Regular exercise: Type: _____ How often: _____

Do you use tobacco? ☐ Yes ☐ No How much per day? _____ For how many years? _____

Do you drink alcohol? (Type and frequency) _____

Illicit substance use: _____

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Name _____ **DOB** _____

9. Health Maintenance:

Last Pap Smear: _____ Results _____

Last Mammogram: _____ Results _____

Last Colonoscopy: _____ Results _____

Last Bone Densitometry: _____ Results _____

Covid 19 Vaccine: Yes ☐ No ☐ Date _____

Sexually active? Yes ☐ No ☐

Last Menstrual period? Date: _____ Are menses ☐ regular or ☐ irregular?

Birth control method: **(check all that apply)**

☐ Not sexually active

☐ Oral contraceptive – Name and Dosage: _____

☐ IUD (Intrauterine device)

☐ Implant – Name _____ Date of last implant _____

☐ Injection – Name _____ Date of last injection _____

☐ Condom

☐ Vasectomy Year _____

☐ Hysterectomy Year _____

☐ Menopause Year _____

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HEADACHE ASSESSMENT

This portion is for those patients who have concerns regarding headache.

1. Headache history:
   How many types of headache do you have? _____
   Please give a **brief** description of each type of headache: _____
   _____
   _____

2. Location:
   Headache starts: ☐ Left side ☐ Right side ☐ Either side ☐ All over ☐ Face/jaw ☐ Neck
   ☐ Other: _____

   Headache: ☐ Usually stays in one place ☐ Sometimes moves around
   ☐ Often moves around ☐ Other: _____

3. Description of pain: My headache pain is:

   ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Boring
   ☐ Pounding ☐ Pulsating ☐ Crushing ☐ Stabbing ☐ Squeezing
   ☐ Tight pressure or band-like (non-pulsating) ☐ Sharp ☐ Piercing
   ☐ Jabs or jolts (brief, repeated, continuous)

4. Severity: My headache pain is: (If there is more than one type of headache, check all that apply)

   ☐ Mild to moderate ☐ Severe ☐ Very severe ☐ Unbearable

   Headache prevents normal activities such as working? ☐ Yes ☐ No
   If yes: ☐ Rarely ☐ Occasionally ☐ Often ☐ Unable to work at all

5. Frequency:
   Headaches occur _____ times per ☐ Day ☐ Week ☐ Month ☐ Year
   Are they increasing in frequency or severity? ☐ Yes ☐ No
   How many headache free days do you have per week? _____ Per month? _____

6. Duration:
   My headache begins: ☐ In the morning ☐ In the afternoon ☐ At night ☐ Different times of the day
   and seem to last: ☐ Up to 4 hours ☐ Up to 8 hours ☐ Over 8 hours ☐ More than 24 hours ☐ Several days

7. At what age did your headaches begin? _____

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8. Prodrome: Premonition of headache that usually occurs within 24 hours before headache onset

☐ Food cravings ☐ Yawning ☐ Euphoria ☐ Mood swings ☐ Irritability ☐ Depression
☐ Fatigue ☐ Burst of energy

9. Aura: Do you experience any of these warnings before the headache begins? ☐ No ☐ Yes

☐ Flashing lights ☐ Dizziness ☐ Tingling or numbness in leg or arm ☐ Double vision
☐ Nausea/vomiting ☐ Ringing in the ears ☐ Blind spots ☐ Zigzag lines
☐ Decreased level of consciousness ☐ Weakness of a limb ☐ Decreased hearing
☐ Visual halos around objects ☐ Speech disturbance ☐ Incoordination

10. Symptoms that may accompany headache (check all that apply):

☐ Nausea/vomiting ☐ Swollen eyelid ☐ Light sensitivity ☐ Droopy eyelid
☐ Visual disturbance ☐ Sound sensitivity ☐ Nasal congestion ☐ Insomnia
☐ Constriction of pupil ☐ Change in hearing ☐ Facial swelling ☐ Dizziness
☐ Skin changes on face ☐ Neck pain/stiffness ☐ Eye redness ☐ Early morning awakening
☐ Numbness ☐ Other:_____

Hormonal (For women only):

11. Are your headaches made worse by: (Please check all that apply)

☐ Menstrual cycle ☐ Pregnancy ☐ Premenstrual period ☐ Ovulation
☐ Birth control pills ☐ Menopause ☐ Hormone replacement therapy

Age at first menstrual cycle _____ Headaches started then? ☐ Yes ☐ No

Age at first oral contraceptives _____ Headaches ☐ worse ☐ better ☐ unchanged

Age at first hormone replacement therapy _____ Headaches ☐ worse ☐ better ☐ unchanged

Hysterectomy? ☐ No ☐ Yes If yes, with ovaries removed? ☐ Yes ☐ No

Age or Year _____ Headaches ☐ worse ☐ better ☐ unchanged

12. Is your overall condition:

☐ Staying the same ☐ Worsening ☐ Improving ☐ Affecting daily activities

13. Seasonality:

Headaches are most frequent in: ☐ Winter ☐ Spring ☐ Summer ☐ Autumn ☐ Non-seasonal

14. Things that alleviate your headaches:

☐ Cold ☐ Dark room ☐ Exercise ☐ External pressure ☐ Heat ☐ Ice
☐ Medication ☐ Rest ☐ Sleep ☐ Stress reduction ☐ Chiropractic ☐ Massage
☐ Biofeedback ☐ Acupuncture ☐ Other _____

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15. Aggravating Factors:

Headaches can be brought on by: (Please check all that apply)

☐ Fatigue ☐ Oversleeping ☐ Certain medications ☐ Coughing ☐ Exercise
☐ Lying down ☐ Under sleeping ☐ Exertion ☐ Loud noise ☐ Missing a meal
☐ Changes in weather ☐ Stress ☐ Bright light ☐ Relief from stress
☐ Hormonal changes ☐ Shaving/touching face ☐ Chewing or talking
☐ Odors (list): _____
☐ Foods (list): _____
☐ Alcohol (list): _____
☐ Other (list): _____

16. Caffeine use:

☐ Coffee _____ cups/day
☐ Tea _____ cups/day
☐ Soda _____ bottles/cans per day

Does caffeine seem to have any effect on your headache? ☐ Yes ☐ No ☐ Sometimes

17. How much water do you drink per day:

☐ None ☐ 1 bottle (16 oz) or less ☐ 1-2 bottles (16-32 oz) ☐ 3-4 bottles (48-64 oz)
☐ 4-5 bottles (64-80 oz) ☐ 5-6 bottles (80-96 oz) ☐ more than 6 bottles (over 96 oz)

18. How many meals do you eat per day: _____ breakfast/lunch/dinner

Protein with each meal? (dairy, egg, meat, nuts, vegetable protein such as soy) ☐ Yes ☐ No

19. How well do you sleep?

☐ I usually sleep well ☐ My sleep difficulty is most often with _____ initiating, or _____ maintaining sleep
☐ I sometimes have trouble sleeping ☐ I often have trouble sleeping ☐ I always have trouble sleeping

What time of day do you usually go to bed? _____
What time of day do you usually get up? _____
Do you nap during the day? ☐ Yes ☐ No Do you feel refreshed after sleeping overnight? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No Do you have restless leg movements? ☐ Yes ☐ No
Do you sometimes struggle to breathe at night? ☐ Yes ☐ No

20. Any previous head injuries – concussion, skull fracture, bleed? ☐ No ☐ Yes, describe _____

_____

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21. **ALL PATIENTS:** Review the list of medications below. Select any that you have tried in the past, **write down the dose if you can remember it, the side effects and whether or not it was effective.**

PREVENTIVE MEDICATIONS	Helpful?	Side Effects?	Dosage	ABORTIVE MEDICATONS	Helpful?	Side Effects?	Dosage
☐ Verapamil/Calan	☐ Yes ☐ No	☐ Yes ☐ No		☐ Cafergot	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Candesartan/Atacand	☐ Yes ☐ No	☐ Yes ☐ No		☐ Fiorinal/Butalbital+Aspirin	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Magnesium	☐ Yes ☐ No	☐ Yes ☐ No		☐ Midrin/Prodrin	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Riboflavin	☐ Yes ☐ No	☐ Yes ☐ No		☐ Anaprox(Naprosyn)	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Feverfew	☐ Yes ☐ No	☐ Yes ☐ No		☐ CBD Oil	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Prozac/Fluoxetine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Cambia/Diclofenac	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Paxil/Paroxetine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Zipsor/Diclofenac	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Zoloft/Sertraline	☐ Yes ☐ No	☐ Yes ☐ No		☐ Toradol/Ketoralac	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Celexa/Citalopram	☐ Yes ☐ No	☐ Yes ☐ No		☐ Steroids/Cortisone	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Lexapro/Escitalopram	☐ Yes ☐ No	☐ Yes ☐ No		☐ Stadol/Butorphanol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Effexor/Venlafaxine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Lortab/Norco/Hydrocodone	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Cymbalta/Duloxetine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Ultram/Tramadol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Elavil/Amitriptyline	☐ Yes ☐ No	☐ Yes ☐ No		☐ Percocet/Oxycodone	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Pamelor/Nortriptyline	☐ Yes ☐ No	☐ Yes ☐ No		☐ Mepergan/Demerol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Tegretol/Carbamazepine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Imitrex/Sumatriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Trileptal/Oxcarbazepine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Maxalt/Rizatriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Neurontin/Gabapentin	☐ Yes ☐ No	☐ Yes ☐ No		☐ Zomig/Zolmitriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Lyrica/Pregabalin	☐ Yes ☐ No	☐ Yes ☐ No		☐ Amerge/Naratriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Zonegran/Zonisamide	☐ Yes ☐ No	☐ Yes ☐ No		☐ Axert/Almotriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Inderal/Propranolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Frova/Frovatriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Toprol/Metoprolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Relpax/Eletriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Kerlone/Betaxolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Treximet/Sumatriptan+Naproxen	☐ Yes ☐ No	☐ Yes ☐ No	

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PREVENTIVE MEDICATIONS	Helpful?	Side Effects?	Dosage	ABORTIVE MEDICATONS	Helpful?	Side Effects?	Dosage
☐ Corgard/Nadolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ DHE - Ergotamine	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Tenormin/Atenolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Migranal/DHEA	☐ Yes ☐ No	☐ Yes ☐ No	
☐ BOTOX	☐ Yes ☐ No	☐ Yes ☐ No		☐ Fioricet/Butalbital+Tylenol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Wellbutrin/Buprpoprion	☐ Yes ☐ No	☐ Yes ☐ No		☐ Periactin/Cyproheptadine	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Depakote/Divalproex	☐ Yes ☐ No	☐ Yes ☐ No		☐ Ubrelvy	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Topamax/Topiramate	☐ Yes ☐ No	☐ Yes ☐ No		☐ Reyvow	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Keppra/Levitiracetam	☐ Yes ☐ No	☐ Yes ☐ No		☐ Nurtec	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Lamictal/Lamotrigine	☐ Yes ☐ No	☐ Yes ☐ No		**Additional information:**			
☐ Aimovig/Ajovy/Emgality/ Vyepti	☐ Yes ☐ No	☐ Yes ☐ No					
☐ Other Medications tried, not listed	☐ Yes ☐ No	☐ Yes ☐ No					

22. Previous Headache evaluation. What diagnostic tests for headache have you had in the past?

☐ CT scan ☐ MRI scan ☐ Sinus x-ray ☐ EKG ☐ Lumbar puncture

☐ Neuropsychiatric testing ☐ Other: _____

Where was testing done? _____

Previous headache treatment: (Include as much as you can recall, previous medical records or pharmacy printouts may be helpful. Use the next page also if several medications have been tried.) This information on medications tried will be very helpful.

Year Seen	Doctor's Name	Specialty / Treatment Provided	Results

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23. MIDAS Score _____

The Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your head-aches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS:

Please answer the following questions about **ALL of the headaches** you have had over the last 3 months. Write your answer in the box next to each question. **Write zero** if you did not have the activity in the last 3 months.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you **not do household work** (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work **reduced by half of more** because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months **did you miss** family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

24. Family history: What family members have headache?

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandparents

☐ Paternal Grandparents ☐ Children ☐ Others: _____

NASHVILLE NEUROSCIENCE GROUP | AdvancedHEALTH
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REVIEW OF SYMPTOMS (Mark any of the following complaints you currently have):

NEURO

☐ Dizziness

☐ Fainting / Blackouts

☐ Forgetfulness

☐ Headache

☐ Balance Trouble

☐ Pain
Where? _____
_____

☐ Weakness
Where? _____
_____

☐ Numbness
Where? _____
_____

HEME / SKIN

☐ Anemia

☐ Sores that won't heal

☐ Easy Bruising

ENDOCRINE

☐ Heat / Cold Tolerance

☐ Diabetes

☐ Thyroid Problems

☐ Abnormal Sweating

GASTROINTESTINAL

☐ Poor Appetite

☐ Bowel Changes

☐ Nausea

☐ Stomach Pain

☐ Vomiting

GENERAL

☐ Change In weight

☐ Snoring

☐ Fevers

☐ Restless Arms / Legs

☐ Fatigue

☐ Daytime Sleepiness

PSYCHIATRIC

☐ Psychiatric Care

☐ Suicide Attempt

☐ Chemical Dependency

☐ Depression

☐ Anxiety

CARDIOVASCULAR

☐ Pacemaker

☐ Chest Pain

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Varicose Veins

RESPIRATION

☐ Shortness of Breath

☐ Frequent Cough

☐ Asthma

☐ Emphysema / COPD

MALE / FEMALE

☐ Erectile Dysfunction

☐ Miscarriages

☐ Currently Pregnant?

EAR, NOSE, EYE, THROAT

☐ Blurred Vision

☐ Spot / Floaters

☐ Diff. Swallow

☐ Double Vision

☐ Strange Odor

☐ Taste Change

☐ Hearing Loss

☐ Loss of Speech

☐ Ringing Ears

☐ Sinus Problems

URINARY

☐ Lack of Bladder Control

☐ Painful Urination

☐ Kidney Stones

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PHQ-2 AND PHQ-9 DEPRESSON SCREENING

Name _____ Birthdate _____ / _____ / _____ Today's Date _____

Part of routine screening for your health includes reviewing mood and emotional concerns.
During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ☐ Yes ☐ No

Little interest or pleasure in doing things? ☐ Yes ☐ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, How often have you been bothered by the following problems?	**(0) Not At All**	**(1) Several Days**	**(2) More than Half the Days**	**(3) Nearly Every Day**
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

For Office Use Only: Total Score

Patient Financial Policy

This is an agreement between Nashville Neuroscience Group / AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Nashville Neuroscience Group and AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

We accept the following: Cash Credit Card *(Visa, MasterCard, Discover, American Express)*

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature:_____Date_____/_____/_____

Additional financial explanations are continued on the back side of this page

NASHVILLE NEUROSCIENCE GROUP | AdvancedHEALTH

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on_____/_____/_____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed:_____Date:_____/_____/_____

Attorney Name:_____Phone: _____

BILLING INFORMATION

STATEMENTS:
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize Nashville Neuroscience Group and AdvancedHEALTH To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE_____DATE_____

PARENT SIGNATURE_____DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

Nashville Neuroscience Group and / or AdvancedHEALTH may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE_____DATE _____

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE_____DATE _____

We charge a $20 flat rate for 1-5 pages plus .50 per additional page and postage.

I understand that Nashville Neuroscience Group and AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.

NASHVILLE NEUROSCIENCE GROUP AdvancedHEALTH

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who hasbeen exposed._____**(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient:_____Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative orOther: _____

Relationship:_____Telephone: _____

Address: _____

Signature of the above:_____Date:_____Time: _____

Signature of Witness:_____Date: _____

NASHVILLE NEUROSCIENCE GROUP | AdvancedHEALTH

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:_____Initials:_____

Reason: _____

_____

NASHVILLE NEUROSCIENCE GROUP AdvancedHEALTH

Patients' Rights

The patient's rights include:

- The right to receive a copy of the Notice of Privacy Practices
- The right to request confidential communications
- The right to request a restriction on the use and disclosure of PHI
- The right to know that the covered entity is not required to agree with the requested restriction unless the request is for a restriction of information to the health plan for a service or item which the patient pays for out of pocket, with no health plan involvement
- The right to inspect and copy the PHI
- The right to request amendments and corrections to the PHI
- The right to request an accounting of PHI disclosure

These are included in the Notice of Privacy Practices. Most require the patient to express their requests in writing. Forms for those requests are in this section of the manual. Providers have the authority to deny certain requests based on professional judgment.

Confidential Communications
Patients may request that the covered entity communicate with them through a method different than normally used, or to an alternate address or phone number, or through electronic means. However, the covered entity may require the patient to provide an effective means of contact, such as an address, phone number, or e-mail address, and may require the patient to explain how any additional costs to the practice will be paid. If the patient is unable to provide this information, the practice may deny the request.

If the patient prefers or requests electronic communications, he or she should be reminded that the PHI may not be secure. They should use the Electronic Communication Form to acknowledge the risk involved in this communication format.

Restrictions
Patients may request restrictions on how their PHI may be used. However, covered entities are not required to agree to the requested restriction. Patients may not request restrictions for uses required by law or for workers' compensation purposes. If the provider, using professional judgment, determines that agreeing to the restriction would not be in the best interest of the patient, the request may be denied.

Covered entities are required to grant a request for a restriction disclosure to the patient's health plan for a service or item for which the individual pays for totally out of pocket. This request must be made in writing. Another individual, such as a friend or family member, may pay for the service or item, but the patient cannot have another plan contribute toward the payment.

Inspect and Copy
Patients have the right to access, inspect, or copy routine PHI. However, they do not have the right to access, inspect, or copy psychotherapy notes or records restricted by another law, such as CLIA. The right to access PHI is suspended during participation in clinical trials. The patient usually agrees to this prior to the participation, and access is restored at the end of the trial.

Access may be denied to personal representatives if the provider, using professional judgment, has reason to believe that the access would not be in the patient's best interest, especially if the provider suspects that the patient may be subject to domestic violence, abuse, or neglect, or if the access may in any way endanger the patient or another individual. Access will also be denied to individuals other than the patient if the patient has requested a restriction and that request has been granted. In the case of inmates, access may be denied if it may endanger anyone there or if it might compromise the work of the facility.

A request for access must be acted upon within 30 days. If the records are not easily accessible (stored off-site, for example), the practice may have 30 more days to allow the access.

If the request is denied, this must be documented and communicated to the patient. The patient may appeal. This information must be added to the patient's medical record.

We are required to provide the information in electronic format if available. The format (examples: e-mail, disk, flash drive) must be acceptable to the requesting individual. We cannot use media provided by the patient due to security risks, and cannot require the patient to purchase media from us.

We will charge the patient the allowable rate for providing copies in any format.

Amendment
Patients may request an amendment to their medical record. The provider must review this request to determine whether the amendment is appropriate. The request may be denied -

- If the provider determines that the records are complete and accurate, the request may be denied
- If the correction does not apply to information in the designated record set
- If the information was not created by that covered entity (unless the provider who created the record is no longer available to make the correction)
- If it is part of a designated record set that is not available for access

The covered entity must act upon this request within sixty days. If it is unable to meet that response to the patient requesting the amendment, a copy of that response becomes part of the designated record set.

If the covered entity agrees to the amendment, the amendment must be made part of the designated record set and must be provided to any other agency or individual who was provided with the original information.

If the provider denies the amendment, the covered entity must communicate this information to the patient. The patient may submit a letter of disagreement and may request that the letter become part of the designated record set.

Accounting of Disclosures
Patients have the right to request an accounting of disclosures – incidents involving the use of their protected health information. At this time, the changes proposed in 2011 (and in the HITECH rule) were not incorporated. However, we are following those at this time, as they are the most current guidelines available.

For paper charts, this excludes disclosures for the purposes of treatment, payment, and health operations. The request may go back as far as six (6) years from the date of the request. The report must include -

- The date of the disclosure
- The name and address (if available) to whom the information was disclosed
- A description of the PHI disclosed
- The purpose of the disclosure

The report must be provided to the requesting individual within sixty days of the request. A one-time extension is allowed if the situation prevents a timelier reporting, but the practice must explain in writing the reason for the delay.

If the accounting includes multiple disclosures to the same entity or individual, a summary log may be used. If the disclosure is for research involving more than fifty individuals, the accounting must include the research protocol or activity, a description and criteria of the activities or protocols, a description of the PHI disclosed and the date of the disclosure, the name and address of the sponsor and the researcher, and a statement that the information could not be used for any additional purpose.

For electronic health records, the accounting includes disclosures for the purposes of treatment, payment, and health operations. This request may go back only three (3) years from the date of the request. For practices using electronic health records prior to January 1, 2009, the compliance date is January 1, 2014. For those acquiring electronic health records after January 1, 2009, but before January 1, 2011, the compliance date is January 1, 2011. For practices that implement electronic health records after January 1, 2011, compliance is required upon installation. However, the Secretary of HHS may delay these compliance dates.

At the time this document was developed, the Secretary of HHS had not yet published the required information to be included in the accounting.

The following disclosures are exempted from all accounting reports.

- Incident to a permitted or required disclosure
- Pursuant to a signed authorization
- To people involved in the patient's care
- For purposes of national security or intelligence
- To correctional institutes or law enforcement agencies
- Limited data sets
- Prior to the covered entity's compliance date
- With a written statement from an agency requesting information for health oversight or law enforcement that states that including the disclosure would impede their activities

Request for Medical Records

Records Released From:

Facility / Physician's Name: _____

Facility Phone Number: _____ Facility Fax No: _____

Patient Information:

Patient Name:_____DOB:_____SS#: XXX-XX _____

Address:_____

City, State, Zip Code:_____Phone:_____

Release Records To: ☐ *Same As Above*

Name:_____

Address:_____

City, State, Zip Code: _____

Phone:_____Fax:_____

Information Requested & Purpose of Disclosure:

Specific Categories

- ☐ All Records
- ☐ Office / Clinic Notes
- ☐ Imaging Reports
- ☐ Other _____

Or Dates from_____to _____

Fee Schedule

Please Note: Typically records sent from physician to physician, are sent free of charge.

Fee Schedule		Delivery Method	
Pages 1-5	$20.00	Fax ☐	Free
Pages 6+	$0.50 / page	Pick-up ☐	
Fees reflect TN statute 63-2-102, revised 06-2010			

Purpose of Disclosure

☐ Transfer of Care ☐ Personal Use ☐ Litigation/Legal ☐ Disability ☐ Insurance

Patient Signature

I hereby authorize Nashville Neuroscience Group and its affiliates to release or disclose to the above-named person(s) or organization all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection, unless otherwise noted. This authorization is valid for twelve (12) months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to cancellation notification. I understand that the information used or disclosed may be subject to re-disclosure by the recipient of this request and will no longer be protected by federal regulations.

Patient Signature:_____**Date:**_____

Signature of Legal Guardian:_____**Date:**_____

Witness Signature:_____**Date:** _____

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