ARIZONA NEUROLOGY CARE

P: (480) 939-3037
F: (480) 939-3173

NEW PATIENT PACKET

Section 1 - Patient Information

Patient Name: _____ DOB: _____

Biological Sex: ☐ M ☐ F ☐ Intersex Gender Identity: ☐ M ☐ F ☐ M-to-F ☐ F-to-M ☐ Non-binary

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Alternate Phone: _____

Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity: ☐ White ☐ Native American ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ Hispanic/Latino

Emergency Contact: _____ Phone: _____ Relationship: _____

Advanced Care Plan - Surrogate Decision Maker (Age 65 or Older)

Advanced Care Planning - Please check all that apply:

☐ DNR – Do Not Resuscitate ☐ Living Will ☐ No Advanced Directive ☐ Organ Donor

☐ Power of Attorney Name: _____ Phone: _____

☐ Surrogate Decision Maker Assigned Name: _____ Phone: _____

Section 2 - Contact Information

Cell Phone: _____ May We Leave a Detailed Message? ☐ Yes ☐ No

Alt Phone: _____ May We Leave a Detailed Message? ☐ Yes ☐ No

E-mail: _____ May We Leave a Detailed Message? ☐ Yes ☐ No

Arizona Neurology Care uses a secure HIPAA compliant email system to send confidential medical information. In addition, there is a secure internet e-mail portal; the web address is: https://mycw151.ecwcloud.com/portal21128/jsp/100mp/login_otp.jsp. The portal allows a secure two-way communication between clinical staff and patients. To access the portal, an e-mail address is required to sign up.

Section 3 - Acknowledgement and Agreement

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directed to Arizona Neurology Care. I understand that I am financially responsible for any balance. I also authorize Arizona Neurology Care or my insurance company to release any information required to process my claims. I further agree to electronic prescription inquiries with my pharmacy.

x _____ _____

Patient/Guardian Signature Date

Section 4 - Primary Care and Referring Provider Details

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do You Approve of Records being sent to Your Primary Care Physician? ☐ Yes ☐ No

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do You Approve of Records being sent to Your Referring Physician? ☐ Yes ☐ No

Section 5 - Health History

Main Reason for Your Visit Today:

Is this Visit Related to Worker's Compensation? ☐ Yes ☐ No Is this Visit Related to any Legal Action? ☐ Yes ☐ No

MEDICATIONS

Local Pharmacy: _____ **Phone:** _____

Address/Cross Streets: _____

List Your Prescribed and Over-the-Counter Medications Including Vitamins and Inhalers

Name:	Strength	Frequency Taken

Consent to Obtain External Prescription History

Please Initial: _____ I authorize Neurology Care and its affiliated providers to view my external prescription history.

(Section 5 - Health History Continued)

Allergies to Medications

Medication:	Reaction:

MEDICAL HISTORY

Handedness: ☐ Left-handed ☐ Right-handed

Have You Ever had any of these Medical Issues?

☐ Anxiety	☐ Depression	☐ HIV	☐ Osteoporosis
☐ Arrhythmia/Atrial Fibrillation	☐ Diabetes	☐ Kidney Disease	☐ Pregnancies
☐ Autoimmune Disease	☐ Headaches or Migraines	☐ Liver Disease	☐ Seizures/Epilepsy
☐ Blood Clots	☐ Heart Disease	☐ Loss of Consciousness	☐ Sleep Apnea
☐ Cancer	☐ High Blood Pressure	☐ Lung Problems	☐ Stroke
☐ Concussion	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Thyroid Disease

Have You Ever had any Other Medical Problems? ☐ Yes ☐ No If Yes Please Describe:

Family History

Please indicate whether any blood relatives have a history of the following conditions. Check all that apply.

☐ Brain Tumor	☐ Dementia or Alzheimer's	☐ Epilepsy or Seizures	☐ Migraine/Headaches
☐ Multiple Sclerosis	☐ Neuromuscular Disease	☐ Parkinson's Disease	☐ Stroke

☐ No Known Neurological Conditions in Family History

Fall History

If You are 65 Year of Age or Older, Please Specify Below the Frequency and Nature of Falls in the Past Year:

☐ **No falls in the past year** - You have not experienced any falls, with or without injury, in the last 12 months.

☐ **One fall without injury in the past year** - You experienced one fall that did not result in physical injury (no cuts, bruises, fractures, or other harm).

☐ **Two or more falls without injury in the past year** - You experienced two or more falls, none of which resulted in physical injury.

☐ **One fall with injury in the past year** - You experienced one fall that resulted in a physical injury, such as a sprain, fracture, laceration, or concussion.

☐ **Two or more falls with injury in the past year** - You experienced two or more falls, each resulting in a physical injury.

(Section 5 - Health History Continued)

SURGICAL HISTORY / HOSPITALIZATIONS (within the last 10 years)

Year:	Reason:	Hospital

Section 6 - Social History

1. Do You Drink Alcohol? ☐ Yes ☐ No

   If Yes, what kind? _____ Number of Drinks per Week: _____

2. Do You use or have You Ever Used Nicotine Products? ☐ Yes ☐ No Number of Years: _____ Year Quit: _____

   If Yes, which types? ☐ Cigarettes - Number per Day: _____ or Pks/Day: _____ ☐ Chew/Dip - Times a Day: _____

   ☐ Cigars - How Often? _____ ☐ Vaping - How Often? _____

Section 7 - Depression Screening

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐

(Healthcare professional: For interpretation of TOTAL please refer to accompanying scoring card) **TOTAL:** 0

10. If you checked any problems, 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

Section 8 - Review of Systems (select any symptoms you've had in the last month)

1. General/Constitutional

☐ Weight +/- _____ lbs. ☐ Change in Appetite ☐ Fatigue ☐ Fever/Chills ☐ Night Sweats

2. Opthalmologic

☐ Vision Loss ☐ Blurry Vision ☐ Double Vision ☐ Eye Pain ☐ Eyelids Drooping

3. HEENT

☐ Pain/Difficult Swallowing ☐ Pain/Difficulty Chewing ☐ Loss of Smell ☐ Hearing Loss ☐ Ringing in Ears

☐ Snoring ☐ Dry Mouth ☐ Jaw Pain

4. Cardiovascular

☐ Chest Tightness ☐ Palpitations/Irregular Heartbeat ☐ Leg Swelling

5. Musculoskeletal

☐ Back Pain ☐ Neck Pain ☐ Joint Pain ☐ Muscle Pain ☐ Weakness ☐ Spasticity

6. Neurologic

☐ Dizziness ☐ Balance Difficulty ☐ Change in Handwriting ☐ Change in Voice ☐ Difficulty Speaking

☐ Difficulty with Coordination ☐ Falls ☐ Headache ☐ Language Difficulty ☐ Loss of Consciousness

☐ Memory Loss ☐ Numbness/Tingling ☐ Seizures ☐ Speech Changes ☐ Tremor ☐ Walking Difficulty

7. Psychiatric

☐ Abnormally Elevated Mood ☐ Anxiety ☐ Depressed Mood ☐ Difficulty Concentrating ☐ Difficulty Sleeping

☐ Hallucinations ☐ Irritability ☐ Mood Swings

☐ None of the Above

Section 9 - Office and Financial Policies

Welcome to **Arizona Neurology Care**! It is our pleasure to provide you with excellent health care. We consider your care a TEAM process and your active participation is vital to your positive health outcome.

GENERAL INFORMATION

DEMOGRAPHICS/INSURANCE/PAYMENTS - Please alert us if your address, phone number(s) or insurance plan changes.

APPOINTMENTS - Plan to arrive 15 minutes prior to your appointment. Arrival 15 minutes or more after your appointment time is subject to no show fees and rescheduling.

LABS RESULTS - Lab results take 7-10 business days to process. We do NOT call you with lab results that can wait until your next appointment to discuss with the clinician.

REFERRALS - If you are referred to another specialist it will take up to 7-10 business days to get the referral processed. Once it is sent, you will be contacted by the accepting practice. We cannot control how long it takes them to reach you but if you have not heard from them after 2 weeks you should contact them directly.

GENERAL INFORMATION *(continued)*

MEDICATIONS - Please keep track of your medication supply! Contact your pharmacy when you are down to your last week of medications and request a refill. The pharmacy will contact us if they need to.
Additionally, many prescriptions and all controlled medications require an appointment with your provider to be refilled so scheduling and keeping routine visits is the best way to ensure you do not run out of medications and potentially endanger your health.

MESSAGES – Non-urgent messages left for the doctor and/or medical assistant after 3:00pm and over the weekend may not be returned until the next business day.

MEDICAL RECORDS - We are happy to provide you copies of your medical records once we have a HIPAA compliant signed release. There is an administrative fee of $35.00. That fee is waived if your records are sent to another provider directly or if you bring in a flash drive personally.

BILLING - Billing questions or concerns can be addressed by our billing company, Assurance RCM. You may reach them buy calling our office and choosing OPTION 4.

FINANCIAL POLICIES

INSURANCE - We will file Insurance charges as a courtesy. We are not responsible for how your insurance plan pays or assigns charges to you. Insurance plans change routinely. It is your responsibility to notify us if your plan changes. It is also your responsibility to verify that we are contracted with your new plan. Failure to do so could lead to non-payment by your insurance resulting in you being responsible for all charges.

LATE CANCEL/NO SHOW FEES - Because we are a specialist practice and work on cancellation lists daily to best accommodate all patients in serious need of our time, we consider it a simple courtesy to us and others for you to cancel any appointment you cannot attend 24 or more hours in advance of your scheduled appointment.

If you fail to contact the office 24 or more hours prior to your scheduled appointment to cancel or reschedule, and you miss your appointment, you are responsible for the following charges:

Please Initial: _____ $200.00 for a routine office visit Please Initial: _____ $500 for testing appointments

DISABILITY/FMLA AND WORK STATUS FORMS

Short-Term disability/FMLA and work status related forms will **ONLY** be completed during an in-person office visit with a clinician. We do not accept nor get involved in long-term disability cases, worker's compensation, or MVA/auto claims/liens.

I, _____, have read and understand ALL the above general and financial policies.

X _____ _____

Patient/Guardian Signature Date

Section 10 Code of Conduct for Patients and Visitors

To provide a safe and healthy environment for staff, visitors, patients, and their families, **Arizona Neurology Care** expects visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

- Please be considerate of other patients and do not use your cell phone for phone calls while in the waiting room.
- When interacting with any of our staff, please put your personal cell devices away and turn the ringer off before storing them away.
- Adults are expected to supervise their children while in the waiting room.
- Before leaving, please dispose of your personal trash in the wastebasket.

Our practice follows a zero-tolerance policy against aggressive behavior of any kind towards any person(s) and the following behaviors are prohibited and may result in dismissal from the practice.

- Physically assaulting or threatening to inflict bodily harm towards any person(s).
- Possessing firearms or any weapon, regardless of permit status, unless you are a uniformed police officer.
- Making verbal threats to harm another individual or to damage personal or business property.
- Rude behaviors through written, or electronic communication, including but not limited to profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
  *This includes multiple calls to the office regarding the same concern
- Making racial or cultural slurs or derogatory remarks
- Exhibiting inappropriate physical contact with, or sexual harassment of any kind towards any person(s).

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility.

	X	
Printed Name	Patient/Guardian Signature	Date

Section 11 - HIPAA - Notice to Patient

We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this to acknowledge receipt of the notice. You may refuse to sign this acknowledgment, if you wish.

I hereby acknowledge that I have been presented with a copy of **Arizona Neurology Care's** Notice of Privacy Practices. I authorize **Arizona Neurology Care** and/or its employees to relay any and all communications regarding my lab results, medical testing, referral information, billing/account information, **and any other pertinent health information in the following matter and to the following people:**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

	X	
Printed Name	Patient/Guardian Signature	Date