

Your appointment is with: Dr. Brad C. Klein, MD



At: **1151 Old York Road, Suite 200, Abington, PA 19001**



**Prior to arriving for your appointment, please fill out these forms completely.**

All forms in this packet must be filled out **completely** and returned to us by mail, by fax, or in person. If you arrive for your appointment without completed forms, your visit may be delayed or rescheduled. These forms are mailed out to all new patients and are also available at [www.abingtonneurology.com](http://www.abingtonneurology.com).

**Welcome to Abington Neurological Associates.**

Thank you for choosing us for your care. To ensure your appointment goes smoothly, follow these instructions:

**Arrive half an hour early.**

We ask that you **arrive 30 minutes prior** to your scheduled appointment, as this allows time to update your records and prepare you for your visit. Please note that if you arrive after this time, your appointment will likely be rescheduled.

**Call us at least one day in advance if you can't make it.**

Should you need to cancel or reschedule your appointment, we ask that you contact us at least 24 hours in advance at 215-957-9250. Failure to do so will result in a \$100 no-show fee. This policy is in place to ensure that we can offer open appointments to patients on our waiting list.

**Gather any relevant medical records.**

Please bring all pertinent medical records to your visit. Include the following:

- Written reports, films, and CDs from past testing, including bloodwork, MRI's, and CT scans.
- Recent hospital records, such as discharge summaries and emergency room reports.
- An up-to-date list of all medications and supplements that you take.

**Come prepared.**

Bring the following items to your appointment:

- Photo ID (mandatory)
- Insurance card(s) and prescription card (if you have one)
- Payment method
  - We accept cash, check, Visa, Mastercard, Discover, and American Express.
  - Copayments/coinsurance/deductible amounts are contractually required and must be paid at the time of the visit.
- Relevant medical records
- Referral (if applicable)
  - If your insurance requires an electronic referral, you must obtain it from your primary care physician prior to your appointment. Your physician may ask for our group NPI number, which is 1154432227.

We look forward to meeting you soon.

Sincerely,  
Abington Neurological Associates

**Address:** 1151 Old York Road, Suite 200, Abington, PA 19001 | **Phone:** (215) 957-9250 | **Fax:** (215) 957-9254 | **Web:** [www.abingtonneurology.com](http://www.abingtonneurology.com)

LEE J. HARRIS, MD | JAMES H. COOK, MD | DAVID C. WEISMAN, MD | BRAD C. KLEIN, MD | DAN J. GZESH, MD | JOHN S. KHOURY, MD | KANDAN KULANDAIVEL, MD  
KARTIK SIVARAAMAN, MD | STEVEN D. FACTOR, MD | LISA M. LESCHEK-GELMAN, MD | DIANA Z. LI, MD | SARAH SMITH, CRNP | KAREN CHEN, PA-C

## Directions to our office:

1151 Old York Road, Suite 200, Abington, PA 19001

### Southbound on Route 611

**(Old York Road):** After you pass Abington Hospital on your right, look for our office one block further south. Our office will be on your **left**.

*Note: There is a left turn lane at Eckard Avenue that your GPS might not know about.*

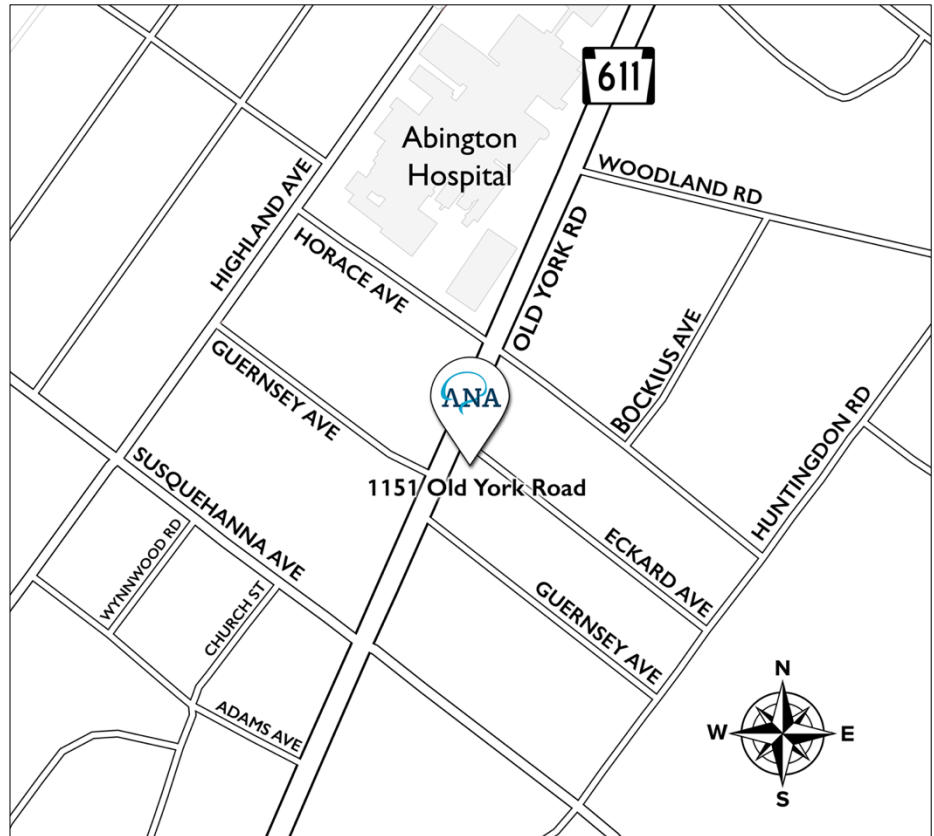
### Northbound on Route 611

**(Old York Road):** After you pass Wells Fargo on your right, look for our office two blocks further north. Our office will be on your **right**.

Our office is on Old York Road across from the magistrate's court and police station. The parking lot is accessible from the two side streets, Eckard Avenue and Guernsey Avenue.

When you enter the building, go to the second floor.

Please allow extra time for travel. **We ask that you arrive at our office 30 minutes before your scheduled appointment time.**



# Patient Information Sheet



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital status:  Married  Single  Widowed  Divorced Spouse's name: \_\_\_\_\_

Social security\*: \_\_\_\_\_ Email: \_\_\_\_\_

\*Last 4 digits required for us to access your electronic medical records

Home address: \_\_\_\_\_

## List your phone numbers and check the number where we can leave voice messages.

Home: \_\_\_\_\_  Work: \_\_\_\_\_  Cell: \_\_\_\_\_

## Tell us about your job. If you are retired and you get your insurance through your former employer, provide their information below.

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

## Who should we contact in case of an emergency?

Emergency contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone: \_\_\_\_\_ Are we allowed to release health information to this person?  Yes  No

## The responsible party is responsible for any unpaid balances:

Responsible party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

## Tell us about your primary health insurance. Call us if any of this information changes.

Primary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

## Tell us about your secondary health insurance. Call us if any of this information changes.

Secondary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

## Do you have a separate prescription card?

Prescription plan: \_\_\_\_\_ ID: \_\_\_\_\_

## Do you have a Power of Attorney? Yes No

If you do, please bring a copy with you to your first appointment or fax it to us at 215-957-9254.

Patient name: \_\_\_\_\_

**Which doctor referred you to us? (Leave blank if not applicable)**

Referring physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Who is your primary care physician?**

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Write down any other physicians you see on a regular basis. We will send copies of our office notes to them and to your primary care physician unless we are instructed not to. If it's a long list, you can bring it on a separate piece of paper.**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**What local pharmacy do you use?**

Local pharmacy: \_\_\_\_\_

Local pharmacy address: \_\_\_\_\_

**Do you use a mail order pharmacy?**

Mail order pharmacy: \_\_\_\_\_

Mail order pharmacy address: \_\_\_\_\_

**Answer these questions if you are a Medicare patient.**

Is Medicare your primary insurance?  Yes  No

Do you or your spouse work for a company that provides you with health insurance?  Yes  No

Are you entitled to Medicare because of disability or end-stage renal disease?  Yes  No

Are you entitled to any benefits under the Federal Black Lung Program?  Yes  No

Has the Department of Veterans Affairs authorized treatment for this illness?  Yes  No

# New Patient Headache History



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Today's date: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Handedness:  Left  Right  Ambidextrous

Occupation: \_\_\_\_\_ Marital status:  Married  Divorced  Widowed  Single

## What types of testing/treatment have you tried? Write the names of the care providers (if known).

- |   |   |
|---|---|
| <input type="checkbox"/> Primary care provider: _____     | <input type="checkbox"/> Massage: _____                 |
| <input type="checkbox"/> Neurologist: _____               | <input type="checkbox"/> Acupuncture/acupressure: _____ |
| <input type="checkbox"/> ENT/otolaryngologist: _____      | <input type="checkbox"/> Herbal/homeopathic: _____      |
| <input type="checkbox"/> Dentist/dental: _____            | <input type="checkbox"/> MRI scans: _____               |
| <input type="checkbox"/> Chiropractor: _____              | <input type="checkbox"/> CT scans: _____                |
| <input type="checkbox"/> Ophthalmologist: _____           | <input type="checkbox"/> Vascular studies: _____        |
| <input type="checkbox"/> Psychiatrist/psychologist: _____ | <input type="checkbox"/> Blood tests: _____             |
| <input type="checkbox"/> Biofeedback/relaxation: _____    | <input type="checkbox"/> Specialty: _____               |
| <input type="checkbox"/> Physical therapy: _____          | <input type="checkbox"/> Other: _____                   |

## General medical history

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### Describe when and how long you have experienced any of the following conditions:

- |   |   |
|---|---|
| <input type="checkbox"/> High blood pressure: _____ | <input type="checkbox"/> Anemia: _____    |
| <input type="checkbox"/> Diabetes: _____            | <input type="checkbox"/> Bleeding: _____  |
| <input type="checkbox"/> Thyroid disease: _____     | <input type="checkbox"/> Ulcers: _____    |
| <input type="checkbox"/> Heart failure/CHF: _____   | <input type="checkbox"/> Arthritis: _____ |
| <input type="checkbox"/> Heart attack/MI: _____     | <input type="checkbox"/> HIV/AIDS: _____  |
| <input type="checkbox"/> Emphysema/COPD: _____      | <input type="checkbox"/> Lupus: _____     |
| <input type="checkbox"/> Pneumonia/TB: _____        |   |

### List any other major illnesses. Include the year of onset.

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### List any important previous injuries. Include the date of the incident.

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### List any important hospital visits or surgeries. Include the date, hospital, and reason for admission.

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### If you have any allergies, check the appropriate box and write your allergy/allergies in the space below.

- Drugs/meds  X-ray dye  Other \_\_\_\_\_

Patient name: \_\_\_\_\_

List your medications, including supplements, drops, sprays, birth control, over-the-counter meds, pain pills, etc. If you can't fit them all in the space below, write the list on a separate sheet of paper.

| Name of medication | Dosage | # per day | Year started | Year stopped |
|--------------------|--------|-----------|--------------|--------------|
| _____              | _____  | _____     | _____        | _____        |
| _____              | _____  | _____     | _____        | _____        |
| _____              | _____  | _____     | _____        | _____        |
| _____              | _____  | _____     | _____        | _____        |
| _____              | _____  | _____     | _____        | _____        |

**Tell us about any tobacco use.**

- Current smoker: How many cigarettes or packs do you smoke per day? \_\_\_\_\_
- Former smoker: For how many years? \_\_\_\_\_ Why did you quit? \_\_\_\_\_
- Never a smoker     Light smoker     Other tobacco products: \_\_\_\_\_

**How many alcoholic drinks do you have during an average day?**

**Weekdays:** Bottles/cans of beer: \_\_\_\_\_ Glasses of wine: \_\_\_\_\_ Shots of liquor: \_\_\_\_\_

**Weekends:** Bottles/cans of beer: \_\_\_\_\_ Glasses of wine: \_\_\_\_\_ Shots of liquor: \_\_\_\_\_

Do you consume significantly less alcohol now than you did in the past?  Yes  No

**How many caffeinated drinks do you have during an average day?**

Cups of coffee: \_\_\_\_\_ Cups of tea: \_\_\_\_\_ Bottles/cans of soda: \_\_\_\_\_

**Write the age of each of your relatives. If they are deceased, write the letter D next to their age at death.**

Mother: \_\_\_\_\_ Sisters: \_\_\_\_\_ Daughters: \_\_\_\_\_

Father: \_\_\_\_\_ Brothers: \_\_\_\_\_ Sons: \_\_\_\_\_

**Check any conditions that your blood relatives have had.**

| Mother:                                       | Father:                                       | Sisters:                                      | Brothers:                                     | Daughters:                                    | Sons:   |
|---|---|---|---|---|---|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    |
| <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   |
| <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  |
| <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  |
| <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          |
| <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        |
| <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              |
| <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         |
| <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems |

**Tell us anything else we should know about your family history. Are other diseases common in your family?**

\_\_\_\_\_

\_\_\_\_\_

Patient name: \_\_\_\_\_

## Quality of life review

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### Sleep

Hours of sleep per night: \_\_\_\_\_

Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> I have no trouble falling and staying asleep | <input type="checkbox"/> I am excessively sleepy during the day  |
| <input type="checkbox"/> I have trouble falling asleep                | <input type="checkbox"/> My legs jerk while sleeping             |
| <input type="checkbox"/> I have trouble staying asleep                | <input type="checkbox"/> I have restless legs                    |
| <input type="checkbox"/> I wake up for no apparent reason             | <input type="checkbox"/> My headache awakens me                  |
| <input type="checkbox"/> I snore                                      | <input type="checkbox"/> I wake up with headaches in the morning |
| <input type="checkbox"/> I stop breathing in my sleep                 | <input type="checkbox"/> I sleep too much                        |
| <input type="checkbox"/> I have sleep apnea                           |  |

### Sexual function

Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Normal           | <input type="checkbox"/> No orgasms              |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Problems with erections |
| <input type="checkbox"/> Increased libido | <input type="checkbox"/> Other: _____            |

### Headache's effect on your ability to function in everyday life

Enter the **number of days missed per month** of work, school, and/or social and family activities.

- Work productivity: \_\_\_\_\_ days per month missed
- School productivity: \_\_\_\_\_ days per month missed
- Social/family activities: \_\_\_\_\_ days per month missed

## Types of headache

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The following pages contain detailed questions about your headache history and symptoms.

If you have **one** type of headache, fill in Headache Type 1 and skip Headache Type 2.

If you have **two** types of headache, fill in information for Headache Type 1 and Headache Type 2.

If you have **three or more** types of headache, photocopy or print out copies of the next three pages. You can get an electronic copy of this packet at [abingtonneurology.com/download-forms](http://abingtonneurology.com/download-forms).

# Headache Type 1

Are you ever headache free? If so, when?

- Never    Pregnancy    Vacations    Weekends    Random times    Other: \_\_\_\_\_

## Onset of first headache

How old were you when your headaches started? \_\_\_\_\_

What provoked your first headache?

- Unknown    Menarche    Pregnancy    Injury: \_\_\_\_\_    Other: \_\_\_\_\_

## Premonitory symptoms

Do you experience any of these symptoms **before** the headache?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heightened feeling of wellness | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Increased appetite  |
| <input type="checkbox"/> Hyperactive                    | <input type="checkbox"/> Sensitive to light     | <input type="checkbox"/> Decreased appetite  |
| <input type="checkbox"/> Extremely talkative            | <input type="checkbox"/> Sensitive to sounds    | <input type="checkbox"/> Feeling cold        |
| <input type="checkbox"/> Depressed feeling              | <input type="checkbox"/> Sensitive to odors     | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Irritable                      | <input type="checkbox"/> Difficulty with speech | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Feeling sluggish               | <input type="checkbox"/> Excessive yawning      | <input type="checkbox"/> Extreme thirst      |
| <input type="checkbox"/> Drowsy                         | <input type="checkbox"/> Neck stiffness         | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Restless                       | <input type="checkbox"/> Food cravings          | <input type="checkbox"/> Fluid retention     |
| <input type="checkbox"/> Difficulty concentrating       | <input type="checkbox"/> Weakness               | <input type="checkbox"/> Other: _____        |

## Aura (visual)

Do you experience any of these symptoms **before** the headache?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blurry vision   | <input type="checkbox"/> Loss of vision in one eye  | <input type="checkbox"/> Tunnel vision |
| <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Loss of vision on one side | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Zig zag lines   | <input type="checkbox"/> Total blindness            | <input type="checkbox"/> Other: _____  |

Do the symptoms spread?  Yes, the symptoms spread slowly    No, the symptoms begin all at once

When do visual symptoms start?  Before the pain    During the pain    Both before and during pain

How long do the visual symptoms last? \_\_\_\_\_

How much time elapses between the visual symptoms and the headache? \_\_\_\_\_

Do you have visual auras without headache pain?  Yes    No

## Aura (sensory)

Do you experience any of these symptoms **before** the headache?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Numbness/tingling — Right | <input type="checkbox"/> Room spinning    | <input type="checkbox"/> Weakness — General |
| <input type="checkbox"/> Numbness/tingling — Left  | <input type="checkbox"/> Lightheaded      | <input type="checkbox"/> Speech difficulty  |
| <input type="checkbox"/> Numbness/tingling — Both  | <input type="checkbox"/> Weakness — Right | <input type="checkbox"/> Unable to speak    |
| <input type="checkbox"/> Unsteadiness              | <input type="checkbox"/> Weakness — Left  | <input type="checkbox"/> Other: _____       |

When do sensory symptoms start?  Before the pain    During the pain    Both before and during pain

How long do the sensory symptoms last? \_\_\_\_\_

How much time elapses between the sensory symptoms and the headache? \_\_\_\_\_

Do you have sensory auras without headache pain?  Yes    No



# Headache Type 1

## Escalation time

On average, how quickly do your headaches escalate to their most severe intensity?

- Within seconds     Within 5 minutes     Within hours     Within days

## Headache character

Check all that apply:

- |  |                                   |                                       |
|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Throbbing/pulsating | <input type="checkbox"/> Shooting | <input type="checkbox"/> Dull         |
| <input type="checkbox"/> Stabbing            | <input type="checkbox"/> Achy     | <input type="checkbox"/> Tight        |
| <input type="checkbox"/> Pressure            | <input type="checkbox"/> Burning  | <input type="checkbox"/> Other: _____ |

## Location

- Sidedness:     Right-sided     Left-sided     Both sides     Varies
- Does it change sides?     No     Between attacks     During attacks     Both between and during

Check all that apply:

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Front of head | <input type="checkbox"/> Eye          | <input type="checkbox"/> Back of head |
| <input type="checkbox"/> Ear           | <input type="checkbox"/> Side of head | <input type="checkbox"/> Jaw          |
| <input type="checkbox"/> Temples       | <input type="checkbox"/> Neck         | <input type="checkbox"/> Around head  |
| <input type="checkbox"/> Other: _____  |                                       |                                       |

## Associated symptoms during headache

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Confusion                                  | <input type="checkbox"/> Increased urination  |
| <input type="checkbox"/> Sensitive to sound | <input type="checkbox"/> Memory issues                              | <input type="checkbox"/> Eye tearing:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both     |
| <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Insomnia                                   | <input type="checkbox"/> Nose congestion:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Blurred vision                             | <input type="checkbox"/> Eye redness:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both     |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Ringing in the ears                        | <input type="checkbox"/> Drooping eyelid:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Hearing pulsations in the ears             | <input type="checkbox"/> Change in pupil:<br><input type="checkbox"/> Larger <input type="checkbox"/> Smaller                           |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Room spinning                              | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Feeling as if you are swaying<br>on a boat |   |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Numbness<br><i>Where?</i> _____            |   |
| <input type="checkbox"/> Sore/stiff neck    | <input type="checkbox"/> Weakness<br><i>Where?</i> _____            |   |
| <input type="checkbox"/> Lightheaded        |   |   |
| <input type="checkbox"/> Anxiety            |   |   |
| <input type="checkbox"/> Irritability       |   |   |

## Activities that worsen headache

- |                                   |  |                                       |
|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None     | <input type="checkbox"/> Movement in general | <input type="checkbox"/> Walking      |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Exercise            | <input type="checkbox"/> Other: _____ |

## Sleep

- Do the headaches awaken you from sleep?     Yes     No
- Do you awaken with the headache in the morning?     Yes     No
- Do you awaken with headache after naps?     Yes     No     Not applicable

# Headache Type 1

## Provoking factors

What brings on a headache? Check all that apply.

- Food/beverage:**  Fasting  Chocolate  Caffeine  Nitrates  MSG  
 Alcoholic beverages  Red wine  White wine  Other: \_\_\_\_\_
- Physical exertion:**  Coughing  Talking  Chewing  Exercise  Sexual intercourse
- Hormonal:**  Before menses  During menses  After menses  
 Pregnancy  Menopause
- Stress:**  Work  Home  Family  Spouse  Other: \_\_\_\_\_
- Environmental:**  Temperature changes  Barometric pressure changes  
 Allergies  Altitude  Sunlight  Other: \_\_\_\_\_
- Sleep:**  Lack of sleep  Too much sleep  Change in wake/sleep

**Other triggers:** \_\_\_\_\_

## Relieving factors

- Lying down  Hot compress  Massage  
 Dark quiet room  Cold compress  Pregnancy  
 Keeping active/pacing  Standing  Other: \_\_\_\_\_

## Headache frequency

Enter the number of attacks:

\_\_\_\_\_ per day \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year  Continuous

**If you have continuous headache**, how often do your headaches become more severe and/or debilitating?

\_\_\_\_\_ per day \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year  Continuous  N/A

When are your headaches more frequent?

Spring  Summer  Fall  Winter  Weekends  Weekdays  Vacation  N/A

## Headache severity

Rate the pain on a scale from 0 to 10, where 0 is no pain and 10 is the worst.

**Range** of severity of pain for this headache type: Lowest: \_\_\_\_\_ Highest: \_\_\_\_\_

**Average** severity of pain for this headache type: \_\_\_\_\_

Is it worse with menses?  Yes  No

## Headache disability (decrease in function) during or after an attack

- Normal activity  Moderate decrease in function  Confined to bed  
 Slight decrease in function  Severe decrease in function

## Headache duration

How long do they last? Estimate the amount of time in minutes/hours/days.

**With medication:** \_\_\_\_\_ % of time they recur within 24 hrs: \_\_\_\_\_

**Without medication:** \_\_\_\_\_ % of time they recur within 24 hrs: \_\_\_\_\_

***If you only have one headache type, skip the next 3 pages.***

## Headache Type 2

Are you ever headache free? If so, when?

- Never    Pregnancy    Vacations    Weekends    Random times    Other: \_\_\_\_\_

### Onset of first headache

How old were you when your headaches started? \_\_\_\_\_

What provoked your first headache?

- Unknown    Menarche    Pregnancy    Injury: \_\_\_\_\_    Other: \_\_\_\_\_

### Premonitory symptoms

Do you experience any of these symptoms **before** the headache?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heightened feeling of wellness | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Increased appetite  |
| <input type="checkbox"/> Hyperactive                    | <input type="checkbox"/> Sensitive to light     | <input type="checkbox"/> Decreased appetite  |
| <input type="checkbox"/> Extremely talkative            | <input type="checkbox"/> Sensitive to sounds    | <input type="checkbox"/> Feeling cold        |
| <input type="checkbox"/> Depressed feeling              | <input type="checkbox"/> Sensitive to odors     | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Irritable                      | <input type="checkbox"/> Difficulty with speech | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Feeling sluggish               | <input type="checkbox"/> Excessive yawning      | <input type="checkbox"/> Extreme thirst      |
| <input type="checkbox"/> Drowsy                         | <input type="checkbox"/> Neck stiffness         | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Restless                       | <input type="checkbox"/> Food cravings          | <input type="checkbox"/> Fluid retention     |
| <input type="checkbox"/> Difficulty concentrating       | <input type="checkbox"/> Weakness               | <input type="checkbox"/> Other: _____        |

### Aura (visual)

Do you experience any of these symptoms **before** the headache?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blurry vision   | <input type="checkbox"/> Loss of vision in one eye  | <input type="checkbox"/> Tunnel vision |
| <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Loss of vision on one side | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Zig zag lines   | <input type="checkbox"/> Total blindness            | <input type="checkbox"/> Other: _____  |

Do the symptoms spread?  Yes, the symptoms spread slowly    No, the symptoms begin all at once

When do visual symptoms start?  Before the pain    During the pain    Both before and during pain

How long do the visual symptoms last? \_\_\_\_\_

How much time elapses between the visual symptoms and the headache? \_\_\_\_\_

Do you have visual auras without headache pain?  Yes    No

### Aura (sensory)

Do you experience any of these symptoms **before** the headache?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Numbness/tingling — Right | <input type="checkbox"/> Room spinning    | <input type="checkbox"/> Weakness — General |
| <input type="checkbox"/> Numbness/tingling — Left  | <input type="checkbox"/> Lightheaded      | <input type="checkbox"/> Speech difficulty  |
| <input type="checkbox"/> Numbness/tingling — Both  | <input type="checkbox"/> Weakness — Right | <input type="checkbox"/> Unable to speak    |
| <input type="checkbox"/> Unsteadiness              | <input type="checkbox"/> Weakness — Left  | <input type="checkbox"/> Other: _____       |

When do sensory symptoms start?  Before the pain    During the pain    Both before and during pain

How long do the sensory symptoms last? \_\_\_\_\_

How much time elapses between the sensory symptoms and the headache? \_\_\_\_\_

Do you have sensory auras without headache pain?  Yes    No

## Headache Type 2

### Escalation time

On average, how quickly do your headaches escalate to their most severe intensity?

- Within seconds    Within 5 minutes    Within hours    Within days

### Headache character

Check all that apply:

- |  |                                   |                                       |
|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Throbbing/pulsating | <input type="checkbox"/> Shooting | <input type="checkbox"/> Dull         |
| <input type="checkbox"/> Stabbing            | <input type="checkbox"/> Achy     | <input type="checkbox"/> Tight        |
| <input type="checkbox"/> Pressure            | <input type="checkbox"/> Burning  | <input type="checkbox"/> Other: _____ |

### Location

Sidedness:    Right-sided    Left-sided    Both sides    Varies

Does it change sides?    No    Between attacks    During attacks    Both between and during

Check all that apply:

- |  |                                       |                                       |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Front of head | <input type="checkbox"/> Eye          | <input type="checkbox"/> Back of head |
| <input type="checkbox"/> Ear           | <input type="checkbox"/> Side of head | <input type="checkbox"/> Jaw          |
| <input type="checkbox"/> Temples       | <input type="checkbox"/> Neck         | <input type="checkbox"/> Around head  |
| <input type="checkbox"/> Other: _____  |                                       |                                       |

### Associated symptoms during headache

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Confusion                                  | <input type="checkbox"/> Increased urination  |
| <input type="checkbox"/> Sensitive to sound | <input type="checkbox"/> Memory issues                              | <input type="checkbox"/> Eye tearing:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both     |
| <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Insomnia                                   | <input type="checkbox"/> Nose congestion:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Blurred vision                             | <input type="checkbox"/> Eye redness:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both     |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Ringing in the ears                        | <input type="checkbox"/> Drooping eyelid:<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Hearing pulsations in the ears             | <input type="checkbox"/> Change in pupil:<br><input type="checkbox"/> Larger <input type="checkbox"/> Smaller                           |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Room spinning                              | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Feeling as if you are swaying<br>on a boat |   |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Numbness<br><i>Where?</i> _____            |   |
| <input type="checkbox"/> Sore/stiff neck    | <input type="checkbox"/> Weakness<br><i>Where?</i> _____            |   |
| <input type="checkbox"/> Lightheaded        |   |   |
| <input type="checkbox"/> Anxiety            |   |   |
| <input type="checkbox"/> Irritability       |   |   |

### Activities that worsen headache

- |                                   |  |                                       |
|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None     | <input type="checkbox"/> Movement in general | <input type="checkbox"/> Walking      |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Exercise            | <input type="checkbox"/> Other: _____ |

### Sleep

Do the headaches awaken you from sleep?    Yes    No

Do you awaken with the headache in the morning?    Yes    No

Do you awaken with headache after naps?    Yes    No    Not applicable

## Headache Type 2

### Provoking factors

What brings on a headache? Check all that apply.

- Food/beverage:**  Fasting  Chocolate  Caffeine  Nitrates  MSG  
 Alcoholic beverages  Red wine  White wine  Other: \_\_\_\_\_
- Physical exertion:**  Coughing  Talking  Chewing  Exercise  Sexual intercourse
- Hormonal:**  Before menses  During menses  After menses  
 Pregnancy  Menopause
- Stress:**  Work  Home  Family  Spouse  Other: \_\_\_\_\_
- Environmental:**  Temperature changes  Barometric pressure changes  
 Allergies  Altitude  Sunlight  Other: \_\_\_\_\_
- Sleep:**  Lack of sleep  Too much sleep  Change in wake/sleep
- Other triggers:** \_\_\_\_\_

### Relieving factors

- Lying down  Hot compress  Massage  
 Dark quiet room  Cold compress  Pregnancy  
 Keeping active/pacing  Standing  Other: \_\_\_\_\_

### Headache frequency

Enter the number of attacks:

\_\_\_\_\_ per day \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year  Continuous

**If you have continuous headache**, how often do your headaches become more severe and/or debilitating?

\_\_\_\_\_ per day \_\_\_\_\_ per week \_\_\_\_\_ per month \_\_\_\_\_ per year  Continuous  N/A

When are your headaches more frequent?

Spring  Summer  Fall  Winter  Weekends  Weekdays  Vacation  N/A

### Headache severity

Rate the pain on a scale from 0 to 10, where 0 is no pain and 10 is the worst.

Range of severity of pain for this headache type: Lowest: \_\_\_\_\_ Highest: \_\_\_\_\_

**Average** severity of pain for this headache type: \_\_\_\_\_

Is it worse with menses?  Yes  No

### Headache disability (decrease in function) during or after an attack

- Normal activity  Moderate decrease in function  Confined to bed  
 Slight decrease in function  Severe decrease in function

### Headache duration

How long do they last? Estimate the amount of time in minutes/hours/days.

**With medication:** \_\_\_\_\_ % of time they recur within 24 hrs: \_\_\_\_\_

**Without medication:** \_\_\_\_\_ % of time they recur within 24 hrs: \_\_\_\_\_

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Patient name: \_\_\_\_\_

## Failed Headache Medications – Preventive

Indicate any drugs used daily for headache **prevention**. Where possible, provide the following information:

- **Dose:** Highest dose used (note whether it was divided throughout the day)
- **Time:** Length of time the medication was used, measured in weeks or months
- **NE:** Indicate if the medication was **not effective** (“NE”)
- **Side effects:** List any problems you had with the medication

| Medication                      | Dose | Time | NE? | Side effects? | Medication                              | Dose | Time | NE? | Side effects? |
|---------------------------------|------|------|-----|---------------|---|------|------|-----|---------------|
| <b>ACE inhibitor</b>            |      |      |     |               | <b>Monoclonal antibodies</b>            |      |      |     |               |
| lisinopril                      |      |      |     |               | Aimovig (erenumab)                      |      |      |     |               |
| <b>AED</b>                      |      |      |     |               | Ajoovy (fremanezumab)                   |      |      |     |               |
| Banzel (rufinamide)             |      |      |     |               | Emgality (galcanezumab)                 |      |      |     |               |
| Depakote (valproic Acid)        |      |      |     |               | Ubrovelvy (ubrogepant)                  |      |      |     |               |
| Dilantin (phenytoin)            |      |      |     |               | Vyepti (eptinezumab)                    |      |      |     |               |
| Gabitril (tiagabine)            |      |      |     |               | <b>Muscle relaxants</b>                 |      |      |     |               |
| Keppra (levetiracetam)          |      |      |     |               | Baclofen                                |      |      |     |               |
| Lamictal (lamotrigine)          |      |      |     |               | Flexeril (cyclobenzaprine)              |      |      |     |               |
| Lyrica (pregabalin)             |      |      |     |               | Lorzone (chlorzoxazone)                 |      |      |     |               |
| Neurontin (gabapentin)          |      |      |     |               | Parafon Forte<br>(chlorzoxazone)        |      |      |     |               |
| Tegretol (carbamazepine)        |      |      |     |               | Skelaxin (metaxalone)                   |      |      |     |               |
| Topamax (topiramate)            |      |      |     |               | Soma (carisoprodol)                     |      |      |     |               |
| Trileptal<br>(oxcarbamazepine)  |      |      |     |               | Zanaflex (tizanadine)                   |      |      |     |               |
| Vimpat (lacosamide)             |      |      |     |               | <b>NDRI</b>                             |      |      |     |               |
| <b>ARB</b>                      |      |      |     |               | Wellbutrin (bupropion)                  |      |      |     |               |
| Candesartan                     |      |      |     |               | Zyban (bupropion)                       |      |      |     |               |
| <b>Benzodiazepines</b>          |      |      |     |               | <b>Neuroleptics</b>                     |      |      |     |               |
| Ativan (lorazepam)              |      |      |     |               | Abilify (aripiprazole)                  |      |      |     |               |
| Klonopin (clonazepam)           |      |      |     |               | Haldol (haloperidol)                    |      |      |     |               |
| Librium<br>(chlordiazepoxide)   |      |      |     |               | Navane (thiothixene)                    |      |      |     |               |
| Limbitrol<br>(chlordiazepoxide) |      |      |     |               | Risperdal (risperdone)                  |      |      |     |               |
| Valium (diazepam)               |      |      |     |               | Seroquel (quetiapine)                   |      |      |     |               |
| Xanax (alprazolam)              |      |      |     |               | Triavil (phenothiazine)                 |      |      |     |               |
| <b>Beta blockers</b>            |      |      |     |               | Thorazine<br>(chlorpromazine)           |      |      |     |               |
| Corgard (nadolol)               |      |      |     |               | Zyprexa (olanzapine)                    |      |      |     |               |
| Inderal (propranolol)           |      |      |     |               | <b>NSAID</b>                            |      |      |     |               |
| Tenormin (atenolol)             |      |      |     |               | Arthrotec (diclofenac &<br>misoprostol) |      |      |     |               |
| Timolol                         |      |      |     |               | Cataflam (diclofenac)                   |      |      |     |               |
| Toprol (metoprolol)             |      |      |     |               | Clinoril (sulindac)                     |      |      |     |               |
| <b>Calcium channel blocker</b>  |      |      |     |               | Feldene (piroxicam)                     |      |      |     |               |
| Calan (verapamil)               |      |      |     |               | Indocin (indomethacin)                  |      |      |     |               |
| Cardizem (diltiazem)            |      |      |     |               | Mobic (meloxicam)                       |      |      |     |               |
| Norvasc (amlodipine)            |      |      |     |               | Relafen (nabumetone)                    |      |      |     |               |
| Plendil (felodipine)            |      |      |     |               | Voltaren (diclofenac)                   |      |      |     |               |
| Procardia (nifedipine)          |      |      |     |               | <b>SNRI</b>                             |      |      |     |               |
| <b>MAOI</b>                     |      |      |     |               | Cymbalta (duloxetine)                   |      |      |     |               |
| Nardil (phenelzine)             |      |      |     |               | Effexor XR (venlafaxine)                |      |      |     |               |
| Parnate (tranylcypromine)       |      |      |     |               | Savella (milnacipran)                   |      |      |     |               |

continued on next page...

Patient name: \_\_\_\_\_

## Failed Headache Medications – Preventive (continued)

| Medication                     | Dose | Time | NE? | Side effects? | Medication               | Dose | Time | NE? | Side effects? |
|--------------------------------|------|------|-----|---------------|--------------------------|------|------|-----|---------------|
| <b>Miscellaneous</b>           |      |      |     |               | <b>SSRI</b>              |      |      |     |               |
| Catapres (clonidine)           |      |      |     |               | Buspar (buspirone)       |      |      |     |               |
| Coenzyme Q10                   |      |      |     |               | Celexa (citalopram)      |      |      |     |               |
| Desyrel (Trazodone)            |      |      |     |               | Lexapro (escitalopram)   |      |      |     |               |
| Diamox (acetazolamide)         |      |      |     |               | Luvox (fluvoxamine)      |      |      |     |               |
| Feverfew                       |      |      |     |               | Paxil (paroxetine)       |      |      |     |               |
| Lithium                        |      |      |     |               | Prozac (fluoxetine)      |      |      |     |               |
| Magnesium                      |      |      |     |               | Zoloft (sertraline)      |      |      |     |               |
| Melatonin                      |      |      |     |               | <b>TCA</b>               |      |      |     |               |
| Methergine (methylergometrine) |      |      |     |               | Elavil (amitriptyline)   |      |      |     |               |
| Migrelief (Mg, B12, feverfew)  |      |      |     |               | Norpramin (desipramine)  |      |      |     |               |
| Periactin (cyproheptadine)     |      |      |     |               | Pamelor (nortriptyline)  |      |      |     |               |
| Petadolex                      |      |      |     |               | Sinequan (doxepin)       |      |      |     |               |
| Remeron (mirtazapine)          |      |      |     |               | Tofranil (imipramine)    |      |      |     |               |
| Sansert (methysergide)         |      |      |     |               | Vivactil (protryptaline) |      |      |     |               |
| Serzone (nefazodone)           |      |      |     |               | <b>Procedures</b>        |      |      |     |               |
| Vitamin B2 (riboflavin)        |      |      |     |               | Botox (botulinum toxin)  |      |      |     |               |

## Failed Headache Medications – Rescue/Abortive

Indicate any medicines that you have taken as a headache **rescue/abortive**. Where possible, provide:

- **Dose:** Highest dose used (note whether it was divided throughout the day)
- **NE:** Indicate if the medication was **not effective** (“NE”)
- **Side effects:** List any problems you had with the medication

| Medication                          | Dose | Time | NE? | Side effects? | Medication  | Dose | Time | NE? | Side effects? |
|-------------------------------------|------|------|-----|---------------|---|------|------|-----|---------------|
| <b>Anti-inflammatory</b>            |      |      |     |               | <b>Barbiturates</b>                                 |      |      |     |               |
| Advil, Motrin (ibuprofen)           |      |      |     |               | Fioricet (butalbital, acetaminophen, caffeine)      |      |      |     |               |
| Aleve, Anaprox, Naprelan (naprosyn) |      |      |     |               | Fioricet with codeine                               |      |      |     |               |
| Arthrotec (diclofenac, misoprostol) |      |      |     |               | Fiorinal (butalbital, aspirin, caffeine)            |      |      |     |               |
| Aspirin                             |      |      |     |               | Fiorinal with codeine                               |      |      |     |               |
| Cambia (diclofenac)                 |      |      |     |               | Phrenilin (butalbital & acetaminophen)              |      |      |     |               |
| Celebrex (celecoxib)                |      |      |     |               | Nembutal (pentobarbital)                            |      |      |     |               |
| Clinoril (sulindac)                 |      |      |     |               | <b>Benzodiazepines</b>                              |      |      |     |               |
| Daypro (oxaprozin)                  |      |      |     |               | Klonopin (clonazepam)                               |      |      |     |               |
| Excedrin                            |      |      |     |               | Valium (diazepam)                                   |      |      |     |               |
| Feldene (piroxicam)                 |      |      |     |               | Xanax (alprazolam)                                  |      |      |     |               |
| Indocin (indomethacin)              |      |      |     |               | <b>Combinations</b>                                 |      |      |     |               |
| Orudis, Oruvail (ketoprofen)        |      |      |     |               | Bellergal (belladonna, ergotamine, & phenobarbital) |      |      |     |               |
| Relafen (nabumetone)                |      |      |     |               | Cafergot (ergotamine & caffeine)                    |      |      |     |               |
| Toradol (ketorolac)                 |      |      |     |               |   |      |      |     |               |
| Vioxx                               |      |      |     |               |   |      |      |     |               |
| Voltaren (diclofenac)               |      |      |     |               |   |      |      |     |               |

continued on next page...







# HIPAA Policy



## Compliance with the Health Insurance Portability and Accountability Act

With my consent, Abington Neurological Associates, Ltd. may use and disclose health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

With my consent, Abington Neurological Associates, Ltd. may call my home or other designated locations as specified on the Patient Information Sheet in carrying out TPO, such as appointment reminders, insurance items, and any information pertaining to my clinical care.

With my consent, Abington Neurological Associates, Ltd. may mail to my home any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked personal and confidential.

This consent authorizes Abington Neurological Associates, Ltd. to use and disclose PHI about myself for treatment, payment, to healthcare operators.

Please refer to Abington Neurological Associates, Ltd. Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures.

Abington Neurological Associates, Ltd. reserves the right to revise its Notice of Privacy Practices at any time. It may be obtained by written authorization submitted to 1151 Old York Road, Suite 200, Abington, PA 19001.

***This notice is effective as of \_\_\_\_\_ and will expire seven years after this date. By signing below, I acknowledge that I have received a copy of this notice and that I authorize the person(s) listed below to be able to obtain my PHI.***

### Person(s) authorized to receive medical information on my behalf:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Patient name and signature:

Patient name: \_\_\_\_\_ Signature: \_\_\_\_\_

Personal representative: \_\_\_\_\_ Signature: \_\_\_\_\_

# Medical Records Release Request



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Patient instructions:** To obtain medical records from another facility, we may need to send a signed authorization granting them permission to release records to us. Please provide your signature below. You can also specifically permit or forbid the release of information regarding mental health, substance abuse, and HIV/AIDS.

At the request of the patient named above, please release the following medical information necessary for neurological treatment to **Abington Neurological Associates, Ltd:**

- Office visit notes
- Hospital visit records
- Diagnostic tests (e.g., radiology, sonography, electrodiagnosis)
- Laboratory reports (e.g., blood tests, biopsy, cytology)
- Other:

Please fax the above information to **215-957-9254** or mail to **1151 Old York Road, Suite 200, Abington, PA 19001**. If you have any questions, please call Abington Neurological Associates, Ltd. at **215-957-9250**.

**Requesting provider:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> James H. Cook, MD    | <input type="checkbox"/> John S. Khoury, MD      | <input type="checkbox"/> Diana Z. Li, MD       |
| <input type="checkbox"/> Steven D. Factor, MD | <input type="checkbox"/> Brad C. Klein, MD       | <input type="checkbox"/> Kartik Sivaraaman, MD |
| <input type="checkbox"/> Dan J. Gzesh, MD     | <input type="checkbox"/> Kandan Kulandaivel, MD  | <input type="checkbox"/> David C. Weisman, MD  |
| <input type="checkbox"/> Lee J. Harris, MD    | <input type="checkbox"/> Lisa Leschek-Gelman, MD | <input type="checkbox"/> Sarah Smith, CRNP     |

### Patient Consent

**I authorize release of records pertinent to my neurological care at Abington Neurological Associates.**

This includes specific permission to release the following sensitive information:

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychological, psychiatric, or other mental impairments<br>(excludes "psychotherapy notes" as defined in 45 CFR 164.501)                             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug abuse, alcoholism, or other substance abuse   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases |

**Patient signature:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

# Consent for General Care and Treatment



As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure(s) to be used so that you may make the decision whether 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).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. By providing your email address you authorize us to send you medical information, medical events, or information on services you may be eligible for. You may opt out at any time. We do not sell or share email addresses with any third party.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or physician assistant, or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended; I will be asked to read and sign additional consent forms prior to the tests(s) or procedure(s).

***I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.***

**Patient name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
*(Patient or authorized representative)*

**Today's date:** \_\_\_\_\_

**Authorized representative information, if applicable:**

**Name:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_  
*(Spouse, caregiver, etc.)*

# Financial Disclosure



We, the staff of Abington Neurological Associates, Ltd. thank you for choosing us as your healthcare provider. We believe that it is important for our patients to understand their financial responsibility. Please read the following information and sign below acknowledging your understanding. Thank you.

We accept cash, check, Visa, MasterCard, Discover, and American Express. Our office collects all expected patient responsibility amounts prior to service. A \$35.00 service fee will be charged for all returned checks.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will gladly submit the claim to your insurance carrier on your behalf, for insurances that we are in network. Please note that any copays, deductibles or non-covered services are your responsibility; and will be collected on the day of your appointment. If a referral is required, and is not obtained prior to your appointment, we reserve the right to reschedule your appointment, or bill you for services rendered. If you choose to be seen at our practice, outside of your insurance network/coverage, you will be solely responsible for all fees. In addition, if you require testing or medication, that requires preauthorization; our office will not be able to obtain this for you, due to our non-participation with your plan.

Any non-covered services such as injections of any kind, including Botox, Occipital, Nerve Blocks of any type, or infusions will be the responsibility of the patient. All balances for these services are due immediately.

**Starting 6/1/2023, Physician, PA and NP phone calls for medical advice that last over 5 minutes that are not within 7 days of a visit and do not result in an emergency appointment or ER visit, are considered billable encounters under the CPT codes G2012. The Medicare payment for this code is \$15.42. Your insurance provider may vary from these rates. Please check with your insurance company what your out of pocket expenses may be for these new services.**

**Forms:** Effective October 1, 2019, physicians may fill out appropriate forms (i.e. disability, FMLA, life insurance, etc.) for a \$20 service fee for the first page plus \$5 per additional page. Forms are to be given to the receptionist at the front desk when you check in. Do not give forms to the provider during the appointment. All forms must go through the Medical Records Department first - **no exceptions**. If you mail or fax a form to us, we cannot fill it out if it has been more than 30 days since your last appointment. Exceptions are made on a case-by-case basis. Please allow **at least 5-10 business days** for us to complete the forms.

**Missed Appointments: We require notice of cancellation 24 hours in advance.** This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance or are late for your appointment, a no-show fee will apply. **This fee is \$100.00 for new patients and \$75.00 for follow-ups. Repeated missed appointments without notification, or frequent cancellations, may result in being discharged from the practice so that we can provide care to other patients.**

We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account. Payment contracts are not available on elective services such as injections or infusions. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification.

***I have read and understand the above financial policy.***

**Patient name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_  
*Patient or authorized representative*

**Witness:** \_\_\_\_\_