



Welcome to Abington Neurological Associates!

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

### **Confirm your appointment.**

To ensure timely access to care and better accommodate our patients, **all appointments must be confirmed at least 24 hours in advance**, or they will be **automatically cancelled** and offered to patients on our waitlist. You may confirm your appointment by responding to our reminder message or calling our office. This helps us provide the best possible care to every patient.

### **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.

### **Arrive half an hour early.**

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

### **Come prepared.**

*Required* for your first appointment:

- **Photo ID, insurance card(s), and prescription card (if applicable).**
- **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 (if applicable).** If you have imaging results on CD/DVD, drop the discs off at the x-ray file room in Abington Jefferson Hospital (Buerger Building, ground floor) prior to your visit.
- **Current list of medications and supplements.**
- **Referral (if applicable).** If your insurance requires an electronic referral, you must obtain it from your primary care physician **prior** to your appointment. Our group NPI number is 1154432227.

### **All enclosed forms must be fully completed prior to your appointment.**

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).

We look forward to meeting you soon.

Sincerely,  
Abington Neurological Associates

## Directions to our office:

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

### Southbound on Route 611

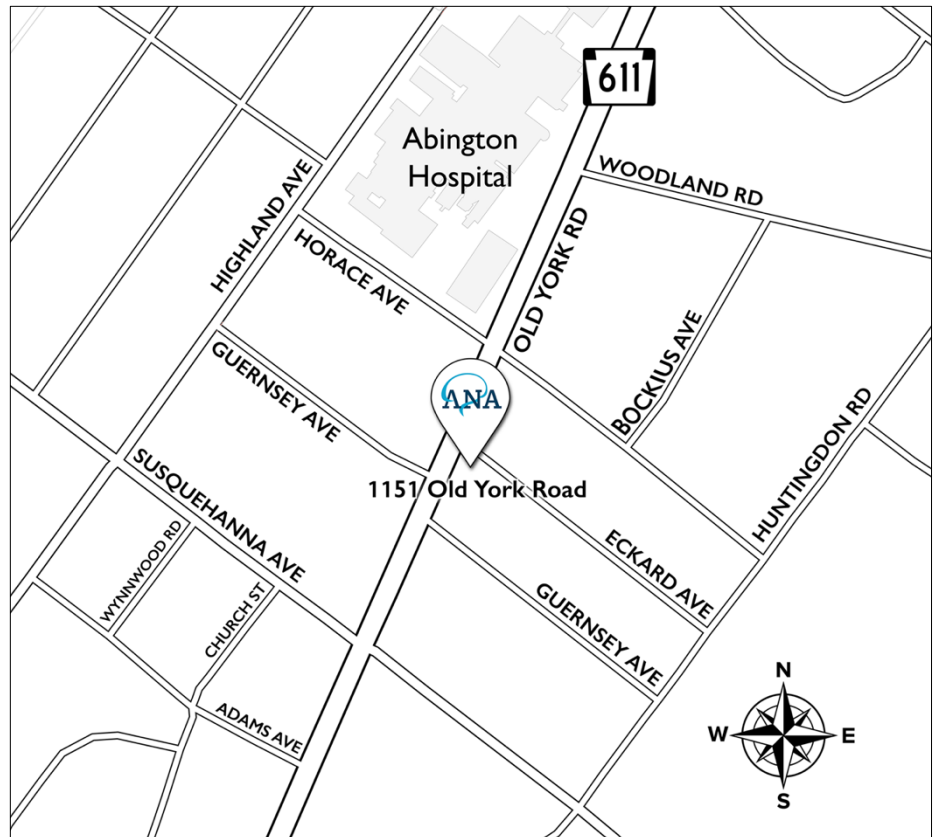
**(Old York Road):** After you pass Abington Hospital on your right, look for our office one block further south. Our office will be on your **left**.

*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 our building, go up 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: \_\_\_\_\_

*\*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 Medical Power of Attorney?**  Yes  No **Do you have a living will?**  Yes  No

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

**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 History



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

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

**What is the main reason for your visit? Describe your symptoms and how long you have experienced them.**

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**Have you had any tests or specialty evaluations for the problem? Include date, body part, and location.**

MRI scans: \_\_\_\_\_  Blood tests: \_\_\_\_\_

CT scans: \_\_\_\_\_  Specialty: \_\_\_\_\_

Vascular studies: \_\_\_\_\_  Other: \_\_\_\_\_

**Describe when and how long you have experienced any of the following conditions.**

High blood pressure: \_\_\_\_\_  Anemia: \_\_\_\_\_

Diabetes: \_\_\_\_\_  Bleeding: \_\_\_\_\_

Thyroid disease: \_\_\_\_\_  Ulcers: \_\_\_\_\_

Heart failure/CHF: \_\_\_\_\_  Arthritis: \_\_\_\_\_

Heart attack/MI: \_\_\_\_\_  HIV/AIDS: \_\_\_\_\_

Emphysema/COPD: \_\_\_\_\_  Lupus: \_\_\_\_\_

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 \_\_\_\_\_

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?**

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# 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:** \_\_\_\_\_

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

*Patient or authorized representative*

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

# Authorization for Release of Medical Records



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

**Patient instructions:** To obtain medical records from other healthcare providers, we might need your signed authorization for them to share records with us. Please sign below to grant permission.

We also need to know if you would allow us to disclose any health information related to mental health, substance abuse, and HIV/AIDS. Even if these do not apply to you right now, we need to know what to do if they become relevant in the future.

## Patient authorization

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

This includes specific instructions to release or withhold the following sensitive information:

- |                                  |                                   |  |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Release | <input type="checkbox"/> Withhold | Psychological, psychiatric, or other mental impairments<br>(excludes "psychotherapy notes" as defined in 45 CFR 164.501)                             |
| <input type="checkbox"/> Release | <input type="checkbox"/> Withhold | Drug abuse, alcoholism, or other substance abuse   |
| <input type="checkbox"/> Release | <input type="checkbox"/> Withhold | Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases |

Patient signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

## For office use only

### Requesting provider:

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

For the purposes of neurological treatment, please release the following information to Abington Neurological Associates. You may fax the records specified below to **215-957-9254** or mail them to **1151 Old York Road, Suite 200, Abington, PA 19001**. If you have any questions, call **215-957-9250**.

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