Your appointment is 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**.

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

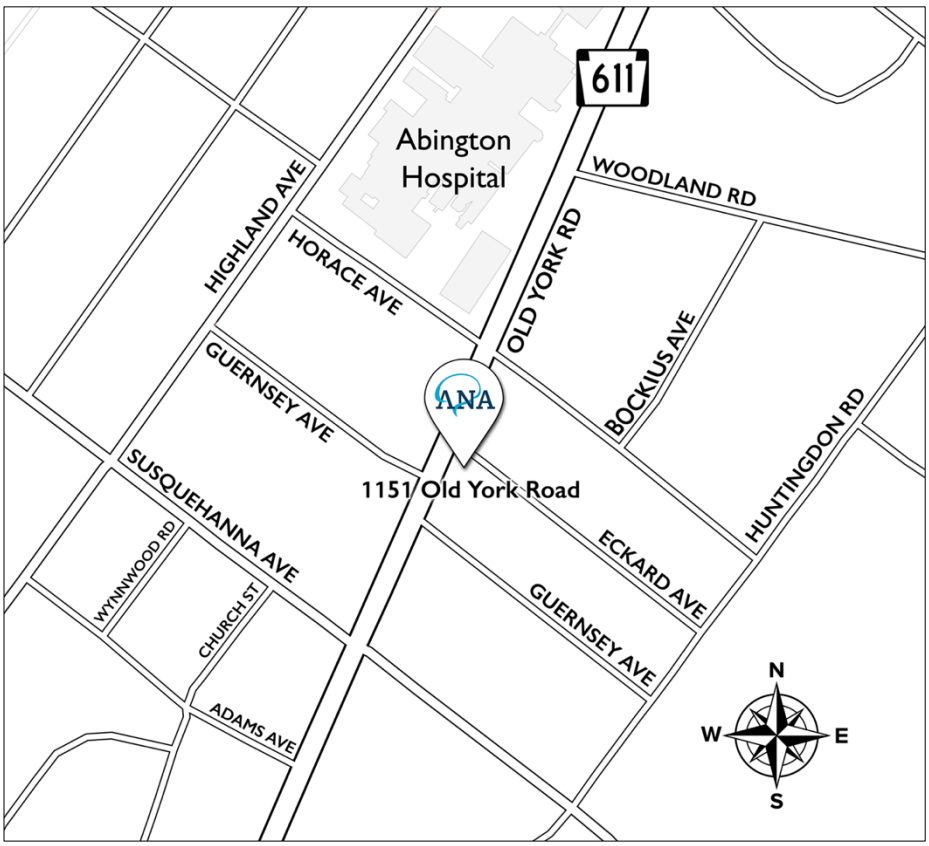
LEE J. HARRIS, MD | JAMES H. COOK, MD | DAVID C. WEISMAN, MD | BRAD C. KLEIN, MD | DAN J. GZESH, MD | JOHN S. KHOURY, MD | KANDAN KULANDAIVEL, MD
KARTIK SIVARAAMAN, MD | STEVEN D. FACTOR, MD | LISA M. LESCHEK-GELMAN, MD | DIANA Z. LI, MD | SARAH SMITH, CRNP | KAREN CHEN, PA-C

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.**

Rev. 2023

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 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.

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.

_____

_____

_____

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.

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

☐ Drugs/meds ☐ X-ray dye ☐ Other _____

Please fill out both sides of this form. *Rev. 2020*

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:**
☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures
☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis
☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease
☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease
☐ Brain tumor	☐ Brain tumor	☐ Brain tumor	☐ Brain tumor	☐ Brain tumor	☐ Brain tumor
☐ Other neurological	☐ Other neurological	☐ Other neurological	☐ Other neurological	☐ Other neurological	☐ Other neurological
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease
☐ Thyroid	☐ Thyroid	☐ Thyroid	☐ Thyroid	☐ Thyroid	☐ Thyroid
☐ Lung disease	☐ Lung disease	☐ Lung disease	☐ Lung disease	☐ Lung disease	☐ Lung disease
☐ Kidney disease	☐ Kidney disease	☐ Kidney disease	☐ Kidney disease	☐ Kidney disease	☐ Kidney disease
☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems

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

_____

_____

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:

☐ James H. Cook, MD	☐ John S. Khoury, MD	☐ Diana Z. Li, MD
☐ Steven D. Factor, MD	☐ Brad C. Klein, MD	☐ Kartik Sivaraaman, MD
☐ Dan J. Gzesh, MD	☐ Kandan Kulandaivel, MD	☐ David C. Weisman, MD
☐ Lee J. Harris, MD	☐ Lisa Leschek-Gelman, MD	☐ 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:

☐ Release ☐ Withhold	Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
☐ Release ☐ Withhold	Drug abuse, alcoholism, or other substance abuse
☐ Release ☐ Withhold	Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases

Patient signature: _____ **Today's date:** _____

Please fill out both sides of this form.

Rev. 7/2022

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.)

Please fill out both sides of this form. *Rev. 1/2021*

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: _____

Please fill out both sides of this form. *Rev. 6/2023*