Your appointment is on:

With:

At: **Price Medical Building, 1245 Highland Avenue, Suite 301, Abington, PA 19001**

Please fill out these forms and return them to us within 5 days of receiving them.
All forms in this packet must be filled out and returned to us by mail, by fax, or in person. If these forms are not sent back to us within 5 days of the date of receipt, your appointment may be delayed or rescheduled. These forms are mailed out to all new patients, and are also available at abingtonneurology.com.

Welcome to Abington Neurological Associates.

Dear

Thank you for choosing us for your care. You are scheduled for an appointment in **Suite 301 at our Abington Hospital location** (see directions on the back of this sheet for details). To ensure that your appointment goes smoothly, please 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

Abington Office: Price Medical Building, 1245 Highland Avenue, Suite 301, Abington, PA 19001 | **Willow Grove Office:** 2325 Maryland Road, Suites 100 & 120, Willow Grove, PA 19001
Phone: (215) 957-9250 | **Fax:** (215) 957-9254 | **Web**: www.abingtonneurology.com

LEE J. HARRIS, MD | JAMES M. BURKE, 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 | CHRISTOPHER HILLERY, PA-C

Directions to our office in Abington Hospital

Price Medical Building, 1245 Highland Avenue, Suite 301, Abington, PA 19001

Southbound on Route 611 (York Road):

Turn right on Rockwell Road. (There will be a Lukoil gas station on your right.) Immediately bear left onto Highland Avenue.

Northbound on Route 611 (York Road):

Turn left onto Horace Avenue, then turn right onto Highland Avenue.

Parking notice:

The Woodland Garage located next to the Price Medical Building off of Highland Avenue will be closed for demolition. A new garage will be built in its place and is expected to be completed by Spring 2021. Throughout the construction period, our patients will have to utilize one of the other three self-parking garages or use valet parking. Alternative parking garages are:

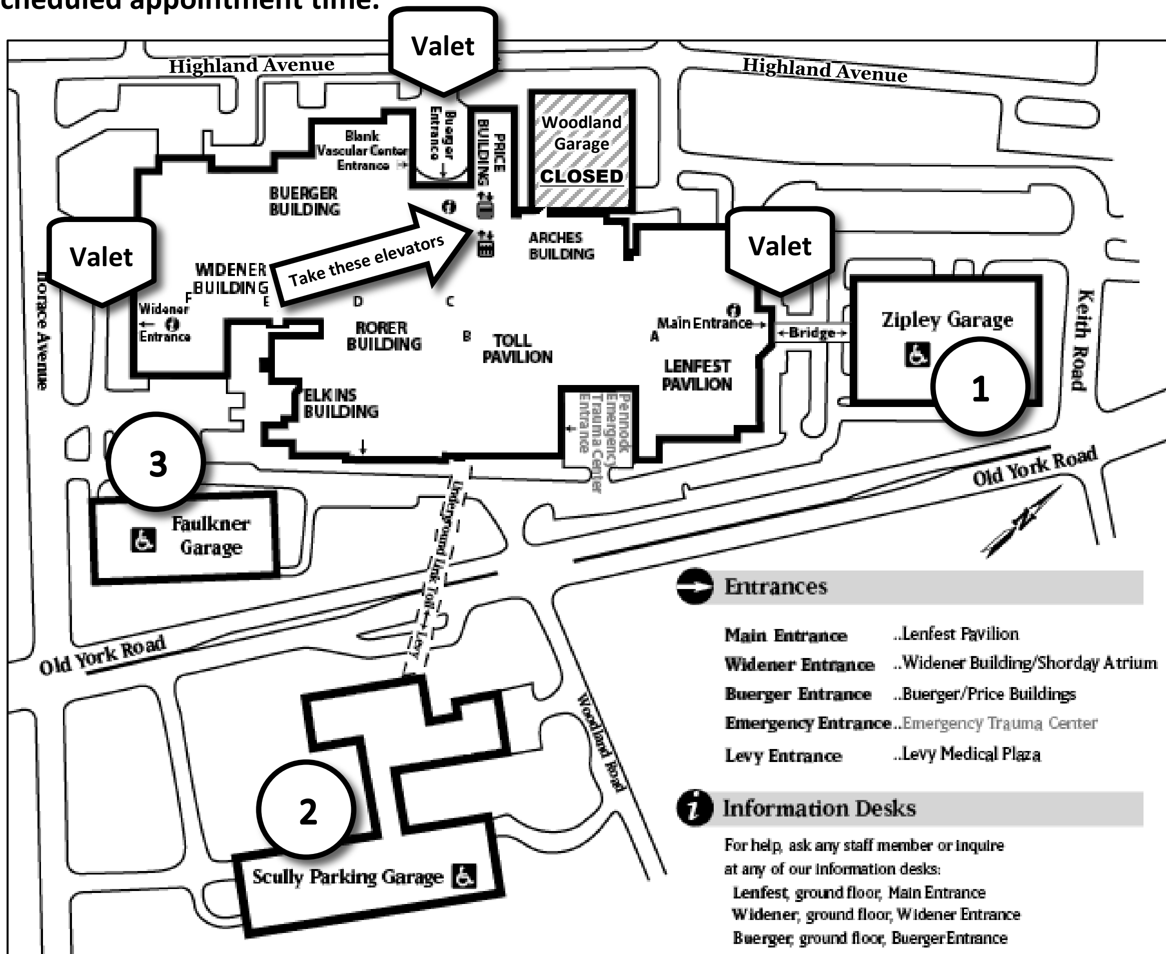
1. Zipley Garage (entrance off of Keith Road)
2. Scully Parking Garage (entrances off of Horace Avenue or Woodland Road)
3. Faulkner Garage (entrance off of Horace Avenue).

Patients who park in one of these garages for their appointment will receive a validated parking pass from our front desk staff for the inconvenience.

Once you are in the hospital:

Go to the **Price Medical Building**. Use the elevators to reach the third floor. **Suite 301** is the first door on the right.

Please allow extra time for travel and parking. **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: ____

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

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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: ________________

☐ CT scans: ________________

☐ Vascular studies: ________________

☐ Blood tests: ________________

☐ Specialty: ________________

☐ Other: ________________

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

☐ High blood pressure: ________________

☐ Diabetes: ________________

☐ Thyroid disease: ________________

☐ Heart failure/CHF: ________________

☐ Heart attack/MI: ________________

☐ Emphysema/COPD: ________________

☐ Pneumonia/TB: ________________

☐ Anemia: ________________

☐ Bleeding: ________________

☐ Ulcers: ________________

☐ Arthritis: ________________

☐ HIV/AIDS: ________________

☐ Lupus: ________________

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 ______________________

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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 2325 Maryland Rd, Suite 120, Willow Grove, PA 19090.

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: ________________

Name and signature:

Patient name: ______________________________ Signature: ____________________

Personal representative: ______________________________ Signature: ____________________

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Medical Records Release Request

Name: ____ **DOB:** ___________________

At the request of the above patient, 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)

Please fax the above information to **215-957-9254** or mail to **2325 Maryland Road, Suite 120, Willow Grove, PA 19001.** If you have any questions, please call Abington Neurological Associates, Ltd. at **215-957-9250.**

Requesting provider:

- ☐ James M. Burke, MD
- ☐ James H. Cook, MD
- ☐ Steven D. Factor, MD
- ☐ Dan J. Gzesh, MD
- ☐ Lee J. Harris, MD
- ☐ John S. Khoury, MD
- ☐ Brad C. Klein, MD
- ☐ Kandan Kulandaivel, MD
- ☐ Kartik Sivaraaman, MD
- ☐ David C. Weisman, MD
- ☐ Christopher Hillery, PA-C

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:

☐ Yes ☐ No Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" as defined in 45 CFR 164.501)

☐ Yes ☐ No Drug abuse, alcoholism, or other substance abuse

☐ Yes ☐ No Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases

Patient signature: ___________________________________ **Today's date:** ______________

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