

Your appointment is on:

With:

At: **2325 Maryland Road, Suite 120, Willow Grove, PA 19090**



**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](http://abingtonneurology.com).

## Welcome to Abington Neurological Associates.

Dear

Thank you for choosing us for your care. You are scheduled for an appointment in **Suite 120 at our Willow Grove 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](http://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 Willow Grove

2325 Maryland Road, Suite 120  
Willow Grove, PA 19090

## Southbound on Route 611 (Easton Road):

- Turn right onto Blair Mill Road. (The new Wawa will be on your right.)
- Take Blair Mill Road to the second traffic light. Turn left onto Commerce Avenue.
- Turn right onto Maryland Road.
- We are the second driveway on the right. (There is a high tension tower by the driveway. Our blue building sits back a bit off the road.)

## Northbound on Route 611 (Easton Road):

- Pass the PA Turnpike and drive until you reach the intersection with Blair Mill Road. (The Speedway station will be on your left, and the new Wawa will be ahead of you on the far left).
- Turn left onto Blair Mill Road.
- Take Blair Mill Road to the second traffic light. Turn left onto Commerce Avenue.
- Turn right onto Maryland Road.
- We are the second driveway on the right. (There is a high tension tower by the driveway. Our blue building sits back a bit off the road.)

## Once you have found our driveway:

- Keep to the right when you first enter the parking lot. The section on the left is employee parking.
- Enter through the double doors.
- Suite 100 is the first door on your left.

## Note:

We are **NOT** in the offices at 2400 Maryland!

We are **NOT** in the Executive Mews!

We are **NOT** in the Abington Schilling Campus!

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: \_\_\_\_\_

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.

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

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

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

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"/> Stroke					
<input type="checkbox"/> Epilepsy/seizures					
<input type="checkbox"/> Multiple sclerosis					
<input type="checkbox"/> Parkinson's disease					
<input type="checkbox"/> Alzheimer's disease					
<input type="checkbox"/> Brain tumor					
<input type="checkbox"/> Other neurological					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Hypertension					
<input type="checkbox"/> Cancer					
<input type="checkbox"/> Heart disease					
<input type="checkbox"/> Thyroid					
<input type="checkbox"/> Lung disease					
<input type="checkbox"/> Kidney disease					
<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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# 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: \_\_\_\_\_

# 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:

- |                                               |                                                 |                                                    |
|-----------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> James M. Burke, MD   | <input type="checkbox"/> Lee J. Harris, MD      | <input type="checkbox"/> Kartik Sivaraaman, MD     |
| <input type="checkbox"/> James H. Cook, MD    | <input type="checkbox"/> John S. Khoury, 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"/> Christopher Hillery, PA-C |
| <input type="checkbox"/> Dan J. Gzesh, MD     | <input type="checkbox"/> Kandan Kulandaivel, MD |                                                    |

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