Your appointment is on:

With:

At: **2325 Maryland Road, Suite 100, 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.

Welcome to Abington Neurological Associates.

Dear

Thank you for choosing us for your care. You are scheduled for an appointment in **Suite 100 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

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 100
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.**

Rev. 2019

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.

Rev. 2019

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: _____

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: _____

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.

_____

_____

_____

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 _____

Rev. 2019

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: _____

Rev. 07/2019

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:** _____