



# Child/Adolescent Neurology Information Form

*The patient or his/her guardian is responsible for bringing his/her referral for each and every visit. Bring a copy of your HMO/PPO insurance card, TennCare/Medicaid card or Medicare card. For insurance purposes, we must have the patient's name as it appears on his or her birth certificate (no nicknames).*

**Patient:** \_\_\_\_\_ DOB \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

**Who can we contact in an emergency?** \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**Patient's father/legal guardian:** \_\_\_\_\_ How are they related to the patient? \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_ email: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Patient's mother/legal guardian:** \_\_\_\_\_ How are they related to the patient? \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_ email: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Primary care doctor** \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Primary doctor's address: \_\_\_\_\_

**Referring doctor** \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Referring doctor's address: \_\_\_\_\_

## Insurance Information

*We file many different insurance plans. It is the patient's responsibility to verify our participation in his/her plan. Tell us if your insurance requires specific facilities for lab work, EEG, CT, MRI, etc. We cannot be responsible if care/testing is done at a non-provider facility.*

Hospital you use for testing: \_\_\_\_\_ Lab for blood work: \_\_\_\_\_

**Primary insurance:** \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance's address: \_\_\_\_\_ Insurance's phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance/Medicaid number: \_\_\_\_\_ Group: \_\_\_\_\_ Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Under whose name is this insurance? \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Their address: \_\_\_\_\_

**Secondary insurance** \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance's address: \_\_\_\_\_ Insurance's phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance/Medicaid number: \_\_\_\_\_ Group: \_\_\_\_\_ Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Under whose name is this insurance? \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Their address: \_\_\_\_\_

**Who completed this form?** \_\_\_\_\_ **Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Is this office visit for an accident related episode or workman's compensation?** \_\_\_\_\_

# Patient Neurology Permission Form

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number \_\_\_\_\_ Chart#: \_\_\_\_\_

## Consent for Care

I hereby give my consent for treatment by Pediatric Neurology, P.A. or MidSouth Physicians Group

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_

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## Authorizes Benefits to Physician – Financial Responsibility

I hereby authorize Pediatric Neurology, P.A. / MidSouth Physicians Group to furnish information to insurance carriers concerning this treatment and I hereby irrevocably assign to the doctor all insurance benefits otherwise payable to me but not to exceed the charges shown. I understand that I am financially responsible for all charges not covered by this authorization. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for collection of this account.

**Patients are responsible for payment, co-payment and deductible at the time services are rendered.**

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_

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## Medicare - Medicaid Certification

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act are corrected. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carrier, any information needed for this or related Medical claim. I request that payment of authorized Medicare/Medicaid/TennCare benefits be made on my behalf to Pediatric Neurology, P.A. / MidSouth Physicians Group

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_

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## Permission to Release Information

Please list family members or other person, *if any*, whom we may discuss information about the patient's general medical condition, diagnosis, treatment and health care operation:

\_\_\_\_\_  
\_\_\_\_\_

Can confidential messages such as appointments, messages to call our office, lab results, or xray results be left on your answering machine, voice mail or at your office?  Yes  No

**If not**, how we can contact you, such (by mail or by a specific phone number): \_\_\_\_\_

I understand that I can revoke this authorization at any time by notifying Pediatric Neurology, P.A. / MidSouth Physicians Group in writing. The revocation will be effective from the date received and will not be retroactive

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_

**Pediatric/Adolescent Neurology Initial Questionnaire**

Phone (901) 405-0275

Fax: (901) 405-0287

Date: \_\_\_\_\_

1. **Patient's Name:** \_\_\_\_\_ **Sex** \_\_\_\_\_ **Age:** \_\_\_\_\_

Who filled out this form? \_\_\_\_\_ How are you related to the patient? \_\_\_\_\_

2. **Chief Complaint:** Please describe the patient's problems:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

How long has the patient had these problems? \_\_\_\_\_

Who has treated them for these problems? \_\_\_\_\_

What medicines or treatments have been tried? \_\_\_\_\_

3. **Family History:** Place a check mark by those family members who have the following problems:

	Father	Mother	Brothers	Sisters	Dad's Parents	Mom's Parents
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has anyone in the family had a similar problem like the patient's? \_\_\_\_\_

Mother's age: \_\_\_\_\_ Any health problems? \_\_\_\_\_

Father's age: \_\_\_\_\_ Any health problems? \_\_\_\_\_

How old are the patient's brothers and sisters? Do they have any medical or school problems? \_\_\_\_\_

4. **Pregnancy:** What hospital was the patient born at? \_\_\_\_\_

How long was the pregnancy? \_\_\_\_\_ How long was the labor? \_\_\_\_\_

Describe any problems that occurred during the pregnancy (medications, drugs, cigarettes or alcohol): \_\_\_\_\_

Was the patient born: Head first? \_\_\_\_\_ Feet first? \_\_\_\_\_ By C-section? \_\_\_\_\_ Emergency C-section? \_\_\_\_\_

What was their birth weight? \_\_\_\_\_ What were the Apgar scores? \_\_\_\_\_

In the Delivery Room was there breathing problems? \_\_\_\_\_ A slow heart rate? \_\_\_\_\_ Oxygen given? \_\_\_\_\_

5. **Nursery:** While in the nursery, did the patient have:

\_\_\_\_\_ Problems breathing                      \_\_\_\_\_ Seizures                      \_\_\_\_\_ Jaundice

\_\_\_\_\_ Meningitis                      \_\_\_\_\_ Feeding problems                      \_\_\_\_\_ Apnea

Describe any other problems the patient had in the nursery after they were born:

How many *days or weeks* did the patient stay in the hospital after they were born? \_\_\_\_\_

6. **Development:** How old was the patient in *months or years* when they first:

_____ Smiled	_____ Pulled to a stand	_____ Pedaled a tricycle
_____ Rolled Over	_____ Walked	_____ Bicycled-no training wheels
_____ Sat alone	_____ Said their first word	_____ Wrote their own name
_____ Crawled	_____ Put words together	_____ Read without help

7. **Past Medical History:** ✓ Check any of the following conditions that the **PATIENT** has a history of:

<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Tension Headaches	<input type="checkbox"/> Blood pressure	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Sinus infections	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Sinus Headaches	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Cancer
<input type="checkbox"/> Seizures	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> AIDS
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Intestinal diseases	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Soiling pants	<input type="checkbox"/> Depression
<input type="checkbox"/> Spinal cord injury	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Smoking
<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Drug use

Tell us about any surgeries, hospitalizations, injuries, allergies or infections the patient had and how old he was.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

8. **Review of Systems:** ✓ Check any of the following problems the **PATIENT** has:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Clumsiness or poor balance	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Facial numbness	<input type="checkbox"/> Choking
<input type="checkbox"/> Passing out	<input type="checkbox"/> Trouble walking	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Speech problems	<input type="checkbox"/> Drooling
<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Leg or arm weakness	<input type="checkbox"/> Poor vision	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Nausea
<input type="checkbox"/> Personality change	<input type="checkbox"/> Leg or arm numbness	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Trouble tasting	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Leg or arm stiffness	<input type="checkbox"/> Double vision	<input type="checkbox"/> Trouble chewing	<input type="checkbox"/> Weight loss

Describe any medical problems the patient has (including any medications they take):

\_\_\_\_\_

\_\_\_\_\_

9. **School:** What school does the patient go to? \_\_\_\_\_

What grade is he in? \_\_\_\_\_ What grades has he repeated? \_\_\_\_\_

What letter grades does he make? \_\_\_\_\_ Teacher's name? \_\_\_\_\_

What psychological tests have been done to rule out learning problems? \_\_\_\_\_

What special classes (like Special Ed, Resource, Chapter, Speech or Gifted Classes) does he take?

\_\_\_\_\_

10. **Questions:** What questions do you have about the patient's problem, medical tests, medicines or therapies?

Are you worried about the way your child is learning, behaving or developing?

\_\_\_\_\_

\_\_\_\_\_

# **Neurology Notice of Privacy Practices**

## **HIPAA (Health Insurance Portability and Accountability Act)**

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by law to protect the privacy of your information, provide this Notice about our information practices, and follow the information practices that are described in this Notice.

### **Your Health Information Rights**

Although your health record is the physical property of NEUROLOGY, the information belongs to you. You have the right to inspect your health record and obtain a copy of it. You also have the right to obtain an accounting of certain disclosures of your health information, request communications of your health information by alternative means or at alternative locations, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **Our Responsibilities**

NEUROLOGY is required to maintain the privacy of your health information, to provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this Notice, and notify you if we are unable to agree to a requested restriction. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this Notice.

### **Examples Of Disclosures For Treatment, Payment, And Health Operations**

NEUROLOGY will use your health information for treatment purposes. For example, information obtained by a nurse, physician, or other member of our healthcare team will be recorded in your record and used to determine a course of treatment. Members of our healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

NEUROLOGY will use your health information for payment purposes. For example, a bill may be sent to you or an insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

NEUROLOGY will use your health information for regular health operations. For example, members of the healthcare team may use the information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

### **Other Permitted Disclosures and Uses of Your Health Information**

Unless you notify us that you object, we may use or disclose health information **to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition**. Unless you notify us that you object, we may disclose your health information to **members of the clergy**. Health professionals may disclose to **a family member**, other relative, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

We may use or disclose your protected health information in an **emergency treatment situation**. In this event, you will be notified of our privacy practices as soon as reasonably practicable after treatment.

We may also contact you to provide **appointment reminders** or to provide you with **information about treatment alternatives**.

There are some services provided in our organization through contacts with **business associates**. An example would be certain laboratory tests provided by an outside lab (business associate). When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

We may disclose health information to **funeral directors** consistent with applicable law to carry out their duties.

We may contact you as part of a **research program** concerning your possible participation in a study. You may be given the opportunity to accept or decline participation in qualifying studies. However, your health information **shall not be sold** for any purpose.

We may disclose to the **Food and Drug Administration** (FDA) health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to **workers compensation** or other similar programs established by law.

As required by law, we may disclose your health information to **public health or legal authorities** charged with preventing or controlling disease, injury, or disability.

We may disclose health information **for law enforcement purposes** as required by law or **in response to a valid subpoena**. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

## Right to Obtain Notice

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this notice electronically. This Notice may be changed at any time.

## Requesting Copies of Your Health Record

You may request a copy of your health record. We will provide a copy within ten (10) working days after receiving your request. We use a copying service that will charge you per page depending upon the length of your record. They may require that these costs be paid prior to copying. If costs are paid in this way, you or your authorized representative have a right to receive the records without delay after receiving payment. As a courtesy, there are no charges for records being sent to physicians and schools.

## Requesting Restrictions on Use and Disclosure

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You may also request that your health information not be disclosed to family members or friends who may be involved in your care. You must state the specific restriction requested and to whom you want the restriction to apply. This office is not required by law to agree to a restriction that you may request.

## Requesting an Accounting

You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. It excludes disclosures we may have made to you, or to family members involved in your care. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

## Requesting Changes to Your Health Record

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

## For More Information Or To Report A Problem

If you have questions and would like additional information, contact Lisa James at 901-405-0275 EXT. 2029, 7645 Wolf River Circle, Germantown, TN 38138. If you believe your privacy rights have been violated, you can file a complaint with Loretta M. Brown, 7645 Wolf River Circle, Germantown, TN 3813 at 901-869-2914. Or, you may contact the Secretary of the Federal Health and Human Services Department. There will be no retaliation for filing a complaint.

## Neurology / Midsouth Physicians Group

This Notice of Privacy Practices (HIPAA -Health Insurance Portability and Accountability Act) describes how information about you may be used and disclosed and how you can get access to his information. Please review it carefully. We are required by law to protect the privacy of you information, provide this notice about our information practices and follow the information practices that are described in this notice.

I acknowledge that I have been provided with a copy of a Notice of Privacy Practices for Neurology/Midsouth Physicians Group. I also acknowledge that I have read and understand the notice and have been provided with an opportunity to ask questions.

Patient's Name \_\_\_\_\_

Relationship to the patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_