Thank you for choosing to continue your care at Neurology Specialists, PC! Enclosed is a packet of information that is needed for your upcoming appointment. We will need you to return this information prior to your appointment. Please send back to our office via one of the following methods: mail to our Bloomington office at 813 West Second Street Bloomington, Indiana 47403, fax to (812) 330-0404, or email to ashley@neurologyspecialists.net or neurology@neurologyspeciailists.net.

You will need to complete this information packet *48 hours prior* your appointment on:

_____ at _____
Jamie C. Bales, MD Brian H. Moore, MD

OFFICE LOCATIONS:

( ) Bloomington office is located at: 813 W. 2nd Street, Bloomington, IN. 47403.

( ) IU Health Bedford office is located at: 2900 W. 16th Street, Bedford, IN. 47421.

( ) St. Vincent Dunn office is located at: 2520 Q Street, Bedford, IN. 47421

Please note: If this information is not returned at least 48 hours prior to your appointment, your appointment will have to be rescheduled.

Thanks,
Neurology Specialists, PC
813 W 2nd Street
Bloomington, Indiana 47403
Telephone: (812) 330-0303
Facsimile: (812) 330-0404

Directions to the Bloomington office:

We are located at 813 West Second Street in Bloomington, IN.

If you live in or are familiar with the Bloomington area, we are located on 2nd street in between the Eye Center of Southern Indiana and Bloomington Hospital. We are on the south side of the street, which is the same side of the street that the hospital and Eye Center are located. Our office is NOT visible from the road, so please look for a blue sign with the name Neurology Specialists. Pull into the drive and go to the furthest building in the back.

If you are coming from the north (ex. Indianapolis, Martinsville), take State Road 37 South. Once in the Bloomington area, get off of the highway at the 2nd Street exit. At the end of the ramp there will be a stop light. Turn left on to 2nd street. You will go through 5 stoplights. Our office is after the fifth stoplight. You will see a church and a shop named Beautiful Creations. We are just after these two buildings on the south side of the street. Our office is NOT visible from the road, so please look for a blue sign with the name Neurology Specialists. Pull into the drive and go to the furthest building in the back. If you have passed Bloomington Hospital, you have gone too far.

If you are coming from the south (ex. Bedford, Mitchell), take State Road 37 North. Once in the Bloomington area, get off of the highway at the 2nd Street exit. At the end of the ramp there will be a stop light. Turn left onto 2nd street. You will go through 5 stoplights. Our office is after the fifth stoplight. You will see a church and a shop named Beautiful Creations. We are just after these two buildings on the south side of the street. Our office is NOT visible from the road, so please look for a blue sign with the name Neurology Specialists. Pull into the drive and go to the furthest building in the back. If you have gone past Bloomington Hospital you have gone too far.

If you are coming from the east via State Road 46 (ex. Columbus, Nashville); State Road 46 becomes 3rd Street once you come into Bloomington. Follow 3rd Street past the Indiana University campus and through downtown Bloomington. You will reach College Avenue. At the 3rd Street/College Avenue stoplight, turn left. At the first light on College Avenue, turn right on to 2nd street. You will pass the Bloomington Hospital. We are one block west of Bloomington Hospital on the same side of the street.

Directions to the IU Health Bedford Office

Located at 2900 West 16th Street, Bedford, Indiana 47421

Our office is on the second floor, in the North suite.

If you are coming from the North (ex. Indianapolis, Martinsville): take State Road 37 South. Once in Bedford, turn left onto West 16th Street. Destination will be on the right.

If you are coming from the South (ex. Mitchell, Orleans): take State Road 37 North. Take the IN-37 N Ramp to US 50. Turn right onto West 16th Street. Destination will be on the right.

If you are coming from the East (ex. Seymour, Brownstown): take US-50 West/Indiana's Historic Pathways. Once in the Brownstown area, turn right onto US-50 West/Commerce Street/Indiana's Historic Pathways/North Spur and continue on until you are in Bedford. Once in Bedford, turn left onto 15th Street, and then left onto M Street. From M Street, take the first right onto 16th Street and the destination will be on the right.

****

Directions to the St. Vincent Dunn Office

Located at 2520 Q Street, Bedford, Indiana 47421

If you are coming from the North (ex. Indianapolis, Martinsville): take State Road 37 South. Once in Bedford, turn left onto 16th Street and travel to the Hardees, and then turn right onto Washington Street. From Washington Street, you will turn left onton 25th street, then right onto Q street. Our office will be on the left, located back side of building, suite B.

If you are coming from the South (ex. Mitchell, Orleans): take IN-37 N/State Road 37 North. Continue onto Indiana's Historic Pathways – North Spur. Once in Bedford, turn right onto 16th Street and travel to the Hardees, and then turn right onto Washington Street. From Washington Street, you will turn left onton 25th street, then right onto Q street. Our office will be on the left, located back side of the building, suite B.

If you are coming from the East (ex. Seymour, Brownstown): take US-50 West/Indiana's Historic Pathways. Once in the Brownstown area, turn right onto US-50 West/Indiana's Historic Pathways/North Spur and continue on until you are in Bedford. Once in Bedford, follow US-50 and then left onto M Street. Continue onto Indiana's Historic Pathways – North Spur/Mitchell Road. Turn right onto 23rd Street. Then turn left onto Q street. Destination will be on the left, located back side of the building, suite B.

REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Mr. / Mrs.	Miss / Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
Yes	No					M	F

Street address:	Social Security #:	Home phone #:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Referred to clinic by:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Please indicate *primary* insurance

Subscriber's name:	Subscriber's SSN:	Birth date:	Group no.:	Policy no.:	Co-payment:
					$

Patient's relationship to subscriber:	Self	Spouse	Child	Other	

Name of *secondary* insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	Self	Spouse	Child	Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home #: ( )	Work/Cell #: ( )

Neurology Specialists

Patient Health History

NAME: _____DOB:_____

(Please print clearly)

Primary Care Physician:_____

Chief Complaint: What is the reason for your visit today? (Please describe problem in detail including history of present illness):

_____

_____

Past Medical History: Please check all that apply to you:

- ❑ Arthritis
- ❑ Cancer: Type_____
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Heart problems
- ❑ Parkinson's disease
- ❑ Heart surgery
- ❑ High blood pressure❑ High Cholesterol
- ❑ Kidney Failure
- ❑ Pregnancy history # ____

Miscarriages # ____

- ❑ Confined to wheelchair
- ❑ Use of cane
- ❑ Use of walker
- ❑ Psychiatric disease
- ❑ Stroke/TIA
- ❑ Thyroid
- ❑ Tuberculosis/positive skin test
- ❑ Migraines
- ❑ Neuropathy
- ❑ Other, please list _____

Previous Surgeries: Please list past surgeries with approximate date

Social History:

Do you drink alcohol?	❑Yes ❑No
If yes are you interested in quitting?	☐ Yes ☐ No
Do you consume caffeine?	❑Yes ❑No
Do you use recreational drugs?	❑Yes ❑No
If yes are you interested in counseling?	☐ Yes ☐ No
Do you use tobacco or smoke?	☐Yes ❑No
If yes are you interested in quitting?	☐ Yes ☐ No
If no, are you a former smoker?	☐ Yes ☐ No

Family History: Do you know of any blood relative who have or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑Alzheimer's disease
- ❑ Brain Tumor
- ❑ Cancer, Type: _____
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Headaches/Migraines
- ❑ Heart Problems, Describe:
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disease, Type:
- ❑ Stroke
- ❑ Thyroid
- ❑ None

NAME: _____ **DOB:** _____

(*Please print clearly)*

Patient Health History

As you review the following list, please check any problems or conditions that you are experiencing or have experienced within the last **6 months.** If you do not have any of the problems listed in the section please check none.

General Health
- ❑ Good general health
- ❑ Anorexia
- ❑ Fatigue
- ❑ Feeling well
- ❑ Fever
- ❑ Night sweats
- ❑ Weight gain
- ❑ Weight loss
- ❑ Loss of appetite
- ❑ Shakiness

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Color changes
- ❑ Other: _____
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Painful chewing
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ Seasonal Allergies
- ❑ Nose Bleeds
- ❑ Voice Changes
- ❑ Drooling
- ❑ Other_____

Eyes
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Other: _____
- ❑ None

Respiratory
- ❑ Asthma
- ❑ Blood in cough
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Cardiovascular
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Edema
- ❑ Palpitations
- ❑ Fainting
- ❑ Other_____

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: vaginal discharge
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Male: testicle pain
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention
- ❑ Incontinence
- ❑ Other:

_____

Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other:

_____
- ❑ Incontinence of Stool
- ❑ Urgency with urination
- ❑ Urine retention
- ❑ Incontinence
- ❑ Other:

_____
- ❑ None

Muscles/Joints/Bones
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Black outs/loss of Consciousness
- ❑ Difficulty speaking
- ❑ Difficulty walking
- ❑ Facial drooping
- ❑ Headaches
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines
- ❑ Mini stroke
- ❑ Neuropathy
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Attention deficit
- ❑ Other: _____

Are you? ❑ right handed
- ❑ left handed
- ❑ Both

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Hallucinations
- ❑ Change in Personality
- ❑ Nervousness
- ❑ Other_____

Sleep
- ❑ Snoring
- ❑ Sleepwalking
- ❑ Nightmares
- ❑ Insomnia

Do you sleep well? ❑Yes ❑No
Do you feel rested when you wake? ❑Yes ❑No
Do you fall asleep during the day? ❑Yes ❑No

NAME: _____DOB:_____
(Please print clearly)

Allergies:

- ☐ Medication allergy — Type: _____
- ☐ Pollens — Type: _____
- ☐ Food — Type: _____
- ☐ Insect — Type: _____
- ❑ Latex
- ☐ Other — Others: _____

Medications: Please list all medications you are taking, including over-the-counter medicines such as aspirin, etc, along with the dose and frequency of medication.

Pharmacy Information:

What pharmacy do you use locally? _____
Mail Order Pharmacy? _____

Have you had any MRI or CT scans in the past 10 years? _____ Yes _____ No

If yes, please list date and location: _____

Have you had any EEG or EMG exams in the past 10 years? _____ Yes _____ No

If yes, please list date and location: _____

Have you seen a Neurologist in the past for your condition/diagnoses? _____Yes _____ No

If yes, please list the physician, location, and contact information:
_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the below listed physicians to release information to Neurology Specialists, P.C. This authorization will remain in force for one year (365 days) from the date signed unless revoked in writing.

Name, address, phone and fax number of individual or organization

Name, address, phone and fax number of individual or organization

Name, address, phone and fax number of individual or organization

Name, address, phone and fax number of individual or organization

Release of Information/Medical Record Diagnosis: I hereby authorize the physician(s), physician assistant and staff of Neurology Specialists, P.C. to release a complete report of services rendered including diagnosis, findings and details of treatment and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payer, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, or other intermediaries responsible for payment of my charges. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

Patient name (**please print**): _____ DOB: _____
Patient/Guardian Signature: _____ Date: _____

Neurology Specialists
813 West Second Street
Bloomington, IN 47403
Phone: (812) 330-0303
Fax: (812) 330-0404

Financial Policy and Authorization

1. **Authorization for Treatment:** I hereby authorize the physician assistant and staff of Neurology Specialists, P.C. to conduct such examinations, perform procedures as are medically required, and administer such treatment and medications as deemed necessary or advisable.

2. **Authorization for Assignment of Benefits**: In consideration of medical services provided I hereby assign and transfer to the physician(s) all of my rights, title and interest to medical reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered by my physician, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full within 90 days my account will be placed for collection unless a payment plan arrangement has been made and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

3. **Insurance filing**: I understand that as a courtesy, Neurology Specialists, P.C. will file for benefits with my insurance company/companies. I understand that fees may exceed charges allowed by my insurance carrier. I agree to be responsible to Neurology Specialists, P.C. for the full balance of the charges that are not paid by my private insurance carrier including any deductible, co-payments and co-insurance.

4. **Payments at the time of Visit**: Neurology Specialists, P.C. accepts cash, checks, Visa and MasterCard. I understand that nonsufficient fund check will have a $25 fee added to my account. I understand that my insurance policy is a contract between me and my insurance carrier. I am aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under my medical insurance plan. If my insurance carrier requires a co-payment, co-insurance or deductible the payment is due at the time of service. I will also be responsible for payment of any outstanding patient balances. If I do not have health insurance coverage, I will be responsible for payment in full for my visit and any services rendered. I understand that I will be asked to pay this prior to service.

5. **Pre-certification**: If my insurance requires a pre-certification, it is my responsibility to make sure it is obtained. I will be held financially responsible if the pre-certification is not obtained.

6. **Motor Vehicle Accident**: If you are being treated for a personal injury such as a motor vehicle accident, please note that Neurology Specialists, P.C. will NOT file benefits on your behalf to an automobile insurance carrier. We also DO NOT accept attorney liens. All payments for services rendered will be expected at the time of your visit.

7. **Failed Appointments**: In the event that I do not show for a scheduled appointment without calling 24 hours in advance to cancel, I understand that I will be charged a $50.00 fee that is non-refundable.
I hereby certify that I have read and fully understand this financial policy and authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained from any treatment.

8. **Disability/FMLA forms:** If your neurological condition requires time off from work, we will fill out the necessary forms and/or copy medical records (fees will apply) in a timely manner for you.

Patient name (**please print**): _____ DOB: _____
Patient/Guardian Signature: _____ Date: _____

Name:_____ DOB:_____

(Please print clearly)

NOTICE OF PRIVACY PRACTICES

I have received the HIPAA Notice of Privacy Practices as provided by Neurology Specialists, P.C. I understand I can request this document in entirety at any time. I understand this notice describes how my personal information is used and disclosed and how I can get access to my health information.

Patient Signature: _____ Date: _____

The people listed below have permission to receive medical information on my behalf. For example, the people listed could include family members, other physicians, insurance companies, worker comp. agencies, lawyers, etc. Please list and sign the bottom of this form. If you would not like to list anyone, simply sign at the bottom of this form.

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Signature: _____ Date: _____

How may we contact you?
Please **check (√)** the ways in which we can contact you. Also, in the space provided, list the numbers or email addresses in which we can contact you. May we leave a message? YES or NO (please circle)

____ Home Phone # _____

____ Work Phone # _____

____ Cell Phone # _____

____ Email address: _____