



(Formerly known as:
NEUROLOGY CONSULTANTS AND SLEEP
DISORDERS CENTER)

A.J. Barot, M.D.
N.A. Barot, M.D.

www.vasleepneurology.com

Virginia Neurology & Sleep Centers New Patient Paperwork

We would like to welcome you as a new patient. Please take the time to complete this form as accurately as possible so that we may most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal regulations concerning the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). There are a total of 15 pages.

Date: _____

Name: _____ DOB: _____ AGE: _____
Last First M.I.

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced

Address: _____

City/State: _____ Zip Code: _____

Gender: _____ M _____ F

Home Phone: _____ Work Phone: _____

Email Address: _____

SSN: _____

Employer: _____ Address: _____

Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

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Virginia Neurology & Sleep Centers
Sleep well. Live well.

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Do you have children: Y N

Emergency Contact: _____ Phone: _____

Insurance: _____ Phone: _____ Subscriber: _____

Contract #: _____ HMO Referral? Y N

Responsible Party: _____ Address: _____

SSN: _____ Relationship to Patient: _____

Employer: _____

Worker's Comp. Carrier (if present): _____ Claim #: _____

Contact Name: _____ Phone: _____

Your family physician: _____

Phone: _____

If you were referred by someone, whom may we thank for sending you to our
practice? _____

Your chief complaint:

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Name: _____ DOB: _____

Hand preference: Right-handed Left-handed Both

**IF YOU ARE HERE FOR A SLEEP EVALUATION, PLEASE COMPLETE THE FOLLOWING FORM.
(IF YOU ARE HERE FOR A NEUROLOGY EVALUATION, PLEASE SKIP TO PAGE 6).**

Reason for referral/chief concern:

How long has this condition been present?

Please describe your bedroom sleep environment (e.g.: quiet, dark, etc.):

Please describe your bedtime routine (e.g.: watch TV, read, etc.):

Do you take any medication to help you fall asleep: Y N
If so, what is the medication name, dose, and frequency? _____

SLEEP TIMING AND DURATION:

	Bedtime (when lights are out)	Amount of time it takes to fall asleep	Wake time	Comments
Weekday				
Weekend				
Vacation				

Do you experience sensations of restlessness/uneasiness in your legs in the evenings? Y N

If "yes": Does the uneasy sensation get worse when your legs are at rest? Y N

If "yes": Do your legs feel better/relieved when you stretch or move them around? Y N

If "yes": Are these uneasy feelings worse in the evening/night than any other time of the day? Y N

How often do you get these restless/uneasy/uncomfortable sensations in your legs?

- Every night
- Two or more nights a week
- Once a week or less (infrequent)

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- Do you often have a difficult time falling asleep at the beginning of the night? Y N
- Do you often have difficulties with “shutting your mind off” while in bed? Y N
- After falling asleep, do you often have problems staying asleep? Y N
- If yes to any of the above 3 questions: Y N
- Do you often lie in bed frustrated because you cannot fall asleep? Y N
- Do you often worry about functioning the next day when you cannot sleep? Y N
- Do you spend time during the day thinking, planning or worrying about sleep? Y N
- Does stress often keep you up at night? Y N

SLEEP PERIOD: Do you have any of the following while sleeping:

	YES	NO	ANY PRIOR HISTORY?	COMMENTS
Dreams				
Nightmares				
Sleepwalking				
Screaming or crying without subsequent recollection				
Bedwetting				
Frequent movements				
Awakenings				If yes, about how often?
Snoring				If yes, constant or intermittent?
Choking, gasping, snorting, stop breathing (please circle those that apply)				If yes, do you know this because others tell you so or because you are aware of it yourself?
Waking to urinate				If so, about how often?
Reflux (heartburn)				
Bruxism (grinding your teeth)				
Frequent sweating				
Coughing				

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Do you have a: Pacemaker? ICD/Defibrillator? Latex allergy? Metal implant?

Past surgeries (Please list): _____

Previous hospitalizations: _____

Please list all the medications you are currently taking (including non-prescription medicines, vitamins, supplements and birth control pills). You may attach a list if you have one.			
Medication name	Dose/How often?	Years taken	Reason for taking

ALLERGIES: List any medication allergies you have: _____

FAMILY HISTORY:

Father: alive deceased age _____ Spouse: alive? _____

Mother: alive deceased age _____ Children: how many? _____

Brothers: how many alive _____ how many deceased _____

Sisters: how many alive _____ how many deceased _____

Circle those illnesses that run in your family:

- | | | |
|-------------------|---------------------|------------------------|
| Brain aneurysm | High blood pressure | Restless legs syndrome |
| Stroke | Heart disease | Sleep apnea |
| Diabetes | Neuropathy | Other: _____ |
| Dementia | Tremors | _____ |
| Headache/migraine | Parkinson's disease | _____ |

Do you have a family history of sleep disorders? If so, please list: _____

SOCIAL HISTORY:

- 1 Do you smoke? Y N If yes, how much? _____
- 2 Do you drink alcohol? Y N If yes, how much? _____
- 3 Do you drink caffeine? Y N If yes, how much? _____
- 4 Are you married? Y N
- 5 Do you have children? Y N If yes, how many? _____
- 6 Are you employed? Y N What do you do? _____

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Previous testing:

Have you had a recent MRI? _____ Where/When? _____
 Have you had a recent CT scan? _____ Where/When? _____
 Have you had a recent EEG (of the brain) ? _____ Where/When? _____
 EMG/Nerve Conduction Study? _____ Where/When? _____
 Sleep study? _____ Where/When? _____

List other relevant recent tests here: _____

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE:

Constitutional	Lack of appetite, feeling ill, fatigue, significant weight change
Eyes	Double vision, glasses, blindness, sensitivity to light, blurred vision, drooping of one or both eyelids
Ear/Nose/Throat	Pain, discharge, hearing changes, dizziness, ringing in ears
Cardiovascular	Chest pain, irregular heart beat or palpitations, fainting spells (syncope), ankle swelling (edema), dizziness with standing, cold hands and/or feet
Respiratory	Shortness of breath, wheezing, cough
Gastrointestinal	Heartburn or reflux, constipation, problems swallowing, difficulty controlling bowel movements
Genitourinary	Urinary urgency, incontinence (loss of bladder control), waking up to urinate at night, decreased sexual interest, problems with erection (for men)
Skin	Rash or color change, itching
Neurological	Difficulty with memory, speech difficulties, tremors, tingling or numbness, head injuries, seizures, loss of consciousness, headaches. <u>Sleep symptoms:</u> restless legs at night, snoring, daytime sleepiness, insomnia
Musculoskeletal	Joint pain, muscle pain, injuries
Endocrine	Goiter, obesity, excessive thirst, excessive urination
Psychiatry	Mood changes, behavior changes, hallucinations, panic attacks, drug abuse
Hematology	Bruising, bleeding, lymph node changes, anemia
Immune/Allergies	Sinus allergy symptoms, frequent infections/illnesses

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Epworth Sleepiness Scale

NAME: _____ DATE: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling simply tired? This refers to your usual way of life in recent times. Although you may not have done some of these things recently, try to calculate how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

- 0=would never doze
- 1=slight chance of dozing
- 2=moderate chance of dozing
- 3=high chance of dozing

SITUATION	CIRCLE CHANCE OF DOZING (0-3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place, e.g., theater or meeting	0	1	2	3
As a passenger in a car for an hour, without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

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Written Acknowledgement Form Notice of Privacy Practices and Patient Portal Access

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

PATIENT PORTAL: All patients are encouraged to sign up for our Patient Portal in order to communicate with the medical practice (e.g. clinical concerns, request medication refills) and to access personal medical records. **NOTE:** Any questions about the content of medical records (testing results, etc.) are typically not addressed through the Patient Portal and should be discussed with your provider during your office appointment.

I, _____ (please print patient name) have been provided a copy of

the Medical Practices Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

I also understand that I can sign up for the Patient Portal at anytime, and that it is recommended to use the Patient Portal to communicate with the practice.

Patient signature

Date

Authorized patient representative

Relationship to patient

Date

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Disclosures to Family Members and Friends

Patient Name: _____

Patient DOB: _____ Patient SSN: _____

I hereby agree that disclosures may be made to family and friends listed below as “Included,” related to my health or as needed for payment of health care services. I also understand that in cases where this form is not accessible or in cases of emergency, the physicians and staff will use their best judgment in complying with my wishes on this matter.

(Circle one)	<u>Relationship</u>	<u>Name</u>
Include – Exclude	Spouse	_____
Include – Exclude	Parent(s)	_____
Include – Exclude	Sibling(s)	_____
Include – Exclude	_____	_____
Include – Exclude	_____	_____
Include – Exclude	_____	_____

Patient/Guardian Signature: _____ Date: _____

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Medication Refill Policy

Refills of non-narcotic pain medication and any other medication prescribed by our physicians will be provided during regular business hours; all refill requests require a 48-hour notice.

Medication refills will be given only to those individuals who are actively being treated by our office. You must have been seen within the last 6 to 12 months; otherwise a follow-up visit is required prior to any refills.

Alteration of a prescription or use of a medication against medical advice will not be tolerated. Patients should not expect to be provided any future medications. Your care may be terminated and you may risk prosecution as directed by state and federal laws.

By signing below, you acknowledge that you have read, understand and agree to abide by the above stated MEDICATION REFILL POLICY.

Patient signature

Date

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Consent for Treatment/Financial Agreement

I have given permission to **Virginia Neurology & Sleep Centers**, and their staff to perform the following procedures/therapy deemed medically necessary: health history, physical exam, diagnostic procedures, radiology studies, urine drug screens, and treatment for my injury/illness. I understand that the information regarding the results of physical exam, diagnostic procedures and/or nature of my illness may be released to the insurance carrier providing coverage to me. I understand that it is ultimately my responsibility to be aware of the benefits available under my insurance plan, and understand that if I have special requests regarding facilities to be utilized for diagnostics tests/treatment, I should communicate those at the time of my visit(s).

I consent to have my medical information transferred to any physician and/or health care institution that I am referred to by **Virginia Neurology & Sleep Centers**. I consent to authorize **Virginia Neurology & Sleep Centers** to request any medical records from other health care providers.

Your signature below forms a binding agreement between Virginia Neurology & Sleep Centers (the provider of medical services) and the Patient, who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All copays and deductibles for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform Virginia Neurology & Sleep Centers of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When Virginia Neurology & Sleep Centers receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

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No Show Policy

In the event the patient or responsible party does not call 24 hours in advance to cancel or reschedule an appointment, a service fee of \$50.00 will be charged, an invoice will be mailed to patient or responsible party and payment will be due within thirty days.

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient’s Responsible Party will be responsible for the original check amount in addition to a \$35.00 Service Charge. Once notice is received of the returned check, Virginia Neurology & Sleep Centers will send out a letter to notify Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance – in addition to the \$35.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient’s Responsible Party, understands that Virginia Neurology & Sleep Centers has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient’s Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee of 50% will be added to the outstanding balance.

By signing below, you agree to accept medical treatment from our staff and full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)

Patient Signature Date

Responsible Party Name (Please Print)

Responsible Party Signature Date

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