

HARTFORD NEUROLOGY, LLC

Welcome to our office. Please take a few minutes to complete this New Patient Registration form to the best of your knowledge. Do not hesitate to ask for our assistance. Thank you.

PATIENT INFORMATION

Name _____ Home Telephone (____) _____

Date of Birth _____ Age _____ Social Security # _____ Cell #(____) _____

Address _____ City/State/Zip _____

Employer _____ Occupation _____

Address _____ Telephone _____

Spouse/Guardian/Other _____ Occupation _____

Employer _____ Telephone _____

Address _____

Work Related Injury? Yes _____ No _____ **Auto Accident Injury?** Yes _____ No _____

***If answered yes, is there an existing claim?** _____ Yes _____ No

INSURANCE/BILLING INFORMATION

Primary Insurance Company _____

Address _____

Name of Insured _____ D.O.B. _____ Insured SS# _____

Relationship to _____ ID# _____ Group# _____ Co pay _____

Secondary Insurance Company _____

Address _____

Name of Insured _____ D.O.B. _____ Insured SS# _____

Relationship to _____ ID# _____ Group # _____ Co pay _____

MEDICAL INFORMATION

Referring Physician _____ Referring Dr. Phone Number _____

Address _____

Primary Care Physician (PCP) _____ PCP Phone Number _____
(If different from above)

Address _____

Any known allergies? _____

Pharmacy _____

ADDRESS & TOWN

Have you ever seen a neurologist in the past? _____ If yes, who/where? _____

I hereby authorize the release of medical information and/or payment directly to Hartford Neurology, LLC.

Signature _____ Today's Date _____

HARTFORD NEUROLOGY, LLC
Patient Questionnaire form

Patient: _____ **Date:** _____

History:

Chief Complaint: _____

History of Present Illness:

*Location: _____ *Quality: _____

*Severity: _____ *Duration: _____

*Timing: _____ *Modifying factors: _____

*Associated symptoms: _____

MEDICAL HISTORY:

***Past medical history**

Diabetes:.....No Yes
Hypertension..... No Yes
Cancer..... No Yes
Stroke..... No Yes
Heart trouble.....No Yes
Arthritis/gout.....No Yes
Convulsions.....No Yes
Bleeding tendency.....No Yes
Acute infections.....No Yes
Venereal disease.....No Yes
Hereditary defects..... No Yes

Other illnesses and hospitalizations When? Why?

Current Medications-*include dosage & instructions*

Patient Social History:

Marital status: Single___ Married___ Separated___ Divorced___ Widowed___
Use of alcohol: Never:___ Rarely:___ Moderate:___ Daily:___
Use of tobacco: Never:___ Previously, but quit:___ Current packs/day:___
Use of drugs: Never:___ Type/frequency:_____
Excessive exposure at work from: Fumes:___ Dust:___ Solvents:___ Air-borne particles___

Patient Family History:

	<u>Age</u>	<u>Diseases</u>	<u>If deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Have you ever seen a neurologist before? If so, when and who? _____

Have you ever had a:

CAT or MRI scan No Yes: when and where? _____
EMG No Yes: when and where? _____
EEG No Yes: when and where? _____
Spinal tap No Yes: when and where? _____

HARTFORD NEUROLOGY, LLC
Patient Questionnaire Form

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ PCP: _____

Current Weight: _____ Height: _____

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS

Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes

EYES

Visual loss No Yes
 Glaucoma No Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss No Yes
 Ringing in the ears No Yes

CARDIOVASCULAR

Heart trouble No Yes
 Lightheaded or dizziness No Yes
 Chest pain or angina No Yes
 Palpitations No Yes
 Swelling in the feet or ankles No Yes

RESPIRATORY

Chronic or frequent cough No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Asthma or wheezing No Yes
 COPD No Yes
 Sleep Apnea No Yes

GASTROINTESTINAL

Rectal bleeding or blood in stool No Yes
 Abdominal pain or heartburn No Yes
 Peptic ulcer disease No Yes

GENITOURINARY

Painful urination No Yes
 Frequent urination No Yes
 Change in force of stream when urinating No Yes
 Incontinence or dribbling No Yes
 Nephrolithiasis (kidney stones) No Yes
 Hematuria (blood in urine) No Yes
 Recurrent Urinary Tract Infection No Yes

MUSCULOSKELETAL

Joint pain or swelling No Yes
 Muscle Weakness No Yes
 Muscle pain or cramps No Yes
 Low Back pain No Yes
 Neck Pain No Yes

INTEGUMENTARY/SKIN and BREAST

Rash or itching No Yes

NEUROLOGICAL

Frequent or recurring headaches No Yes
 Convulsions or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Stroke No Yes
 Head injury No Yes
 Difficulty walking No Yes
 Memory loss No Yes
 Daytime sleepiness No Yes

PSYCHIATRIC

Depression No Yes
 Anxiety No Yes

ENDOCRINE

Thyroid disease No Yes
 Diabetes No Yes

HEMATOLOGICAL/LYMPHATIC

Anemia No Yes
 Past blood transfusion No Yes

ALLERGIES:

Physician Note:

MEDICATION LIST: include dosage & instructions

**HARTFORD NEUROLOGY, LLC
PRIVACY NOTICE**

As a patient of Hartford Neurology, LLC, we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician(s) so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Hartford Neurology, LLC is providing you, the patient or the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

The policy of Hartford Neurology, LLC is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Hartford Neurology, LLC in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present or future information that Hartford Neurology, LLC receives from you as our patient.

We will use this information to provide caring and quality medical care to you. Examples of PHI include diagnosis, treatment, and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most efficient manner. For insurance carriers, your information will be used for claims submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. Hartford Neurology, LLC limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amount of information provided to that which is "minimally necessary" in order to carry out their work.

We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. Hartford Neurology, LLC will provide you with an Authorization Form that will need to be signed by you, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian, at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers' Compensation purposes.

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any requests for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Hartford Neurology, LLC will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments or complaints regarding the management of your PHI, please contact Linda Manion, Hartford Neurology, LLC, Complaint Department at (860) 522-4429, x 12.

I acknowledge that I have received the above Hartford Neurology, LLC Privacy Notice.

✓ **Patient Name**

✓ **Date**

Hartford Neurology, LLC

CONSENT FOR TREATMENT AND RELEASE INFORMATION

I AUTHORIZE to **HARTFORD NEUROLOGY, LLC'S** use & disclosure of all individual identifiable personal, health, financial, & demographic information (known as Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment & reimbursement
- Obtaining authorizations from my insurance for test (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical care
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purpose & all other uses are known collectively as Treatment, Payment, & Other healthcare options or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to **HARTFORD NEUROLOGY, LLC**, when needed for the purpose of TPO.

I CONSENT to HARTFORD NEUROLOGY, LLC discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

- 1. _____ **Relationship:** _____
- 2. _____ **Relationship:** _____
- 3. _____ **Relationship:** _____
- 4. _____ **Relationship:** _____

I CONSENT to HARTFORD NEUROLOGY, LLC leaving messages on my answering machine.

I have been given the opportunity to review HARTFORD NEUROLOGY, LLC's, Privacy Notice.

I understand my rights to restrict the use & discloser of PHI & to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms & conditions of HARTFORD NEUROLOGY, LLC's Privacy Notice, the practice has the right to & will withhold treatment except where required by law.

PATIENT NAME: _____

PATIENT'S SIGNATURE _____ **DATE:** _____

INSURED OR GUARDIAN'S SIGNATURE _____ **DATE:** _____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and discloser of protective health information for treatments, payments, & other healthcare operations without a signed consent & prohibits the use and discloser of protective health information for non healthcare related activities without specific & explicit authorization.