DCND
Dayton Center for
Neurological Disorders

# Patient Information

Please review and update the information below

**CURRENT PATIENT INFORMATION- PLEASE PRINT**

Last Name: _____

First Name: _____

Middle: _____

Date of Birth: ____/_____/_____

Patient email: _____

Address: _____City & State: _____ Zip code: _____

Cell #: _____ Home /Work# _____

Gender: _____

Social Security #: _____

Patient preferred language: _____

Race: _____ Patient Ethnicity: _____

Are you living in an assisted/nursing facility?

◯ Yes ◯ No If yes, which facility? _____

**Emergency Contact Information**:

Name: _____

Relationship: _____ Cell phone #: _____

Email: _____

Power of Attorney: _____ POA #: _____

DNR: ☐ Yes ☐ No Living Will: ☐ Yes ☐ No

*If you answered yes to these questions, our office will need a copy of the document for your medical record.

**Guarantor Information (where statements should be sent)**

Last Name: _____

First Name: _____

Date of Birth: _____/_____/_____ Phone: _____

Email: _____

Address: _____

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# Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____

Patient Name Date

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my health information.

I understand that Dayton Center for Neurological Disorders (DCND) may use or disclose my protected health information for treatment, payment or health care operations-- which means for providing health care to me, the patient; handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Dayton Center for Neurological Disorders has a detailed document called, *"Notice of Privacy Practices"* which contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the document before signing this agreement. If I ask, DCND will provide me with the more current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review the copy of the *Notice of Privacy Practices*. My signature means I agree to allow DCND to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dayton Center for Neurological Disorders has taken action relying on this consent.

_____

Patient signature Date

_____

Relationship to patient Date

**INDIVIDUALS WE CAN SHARE YOUR MEDICAL INFORMATION WITH:**

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

## POLICIES, RELEASES AND FINANCIAL RESPONSIBILITY

Payment is due at the time of service unless we are contracted with your insurance company, or you make other arrangements for payment prior to your visit.

1. All patients must complete the patient registration and health history questionnaire prior to being seen by the our providers.
2. All patients are required to provide a current copy of their insurance card and driver's license at each visit. Patients are also required to notify DCND of any changes to their insurance, demographics and whom we can share information with. DCND will not be responsible for any denials for inaccurate insurance information given or omitted by the patient.
3. I authorize the release of medical record information to the referring physician, other documented physicians, my insurance carrier(s) and the above named in accordance with HIPAA.
4. I consent to treatment necessary for the care of the above named.
5. Co-payments/unpaid balances are to be paid at the time of service, unless DCND is contracted with your insurance company. If you are not able to pay your balance in full, you must contact the DCND billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency.
6. Your insurance policy is a contract between you, your insurance carrier and your employer. It is the patient's responsibility to know and understand your insurance policy.
7. I authorize my insurance carrier(s) to make payments directly to DCND, if appropriate.
8. If DCND is not contracted with your insurance company and/or in network, it is your responsibility to make payment in full at the time of service. DCND will help you file your claim, but your insurance company will reimburse you directly. If you have a secondary or tertiary policy, you will need to forward a copy of your Explanation of Benefits (E.0.8.) for further billing. Patients are responsible for payment of annual deductibles and co-insurance. DCND is unable to process any third party claims (i.e.: personal injury).
9. If you do not have medical insurance, payment for any DCND service is required at the time of appointment unless prior arrangements have been made with the DCND billing office.
10. If a check is returned unpaid from the bank, a charge of $50.00 will be applied to your account.
11. If your insurance requires that you have a referral from your primary care physician, it is your responsibility to ensure that our office receives the referral prior to your appointment date. If we do not receive that referral, you will be responsible for payment of services provided or your appointment may be rescheduled.
12. Our DCND staff will try their best to pre-certify any testing that your physician might order. However, it is ultimately the patient's responsibility to check with their insurance company to see if the test needs pre-certification prior to the test being done.
13. If you are unable to make your scheduled appointment, and we are not notified at least 24 hours in advance, you may be charged a $50 cancellation fee. (Please refer to our Appointment policy for further explanation, by visiting www.dcndinc.com.) **_____Initial**
14. I understand I have certain patient rights regarding my protected health information and I authorize DCND to disclose that information to carry out treatment, payment, and health care operations. Please refer to our Notice of Privacy Practices for more information. It can be found at www.dcndinc.com. **_____Initial**

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization. I have read the above information regarding my address, insurance and personal representative and certify that it is correct and accurate. I agree to the terms outlined in this policy and understand my obligations regarding any charges incurred.

**PATIENT SIGNATURE _____Date _____**

**REPRESENTATIVE SIGNATURE _____ Date _____**

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# APPOINTMENT POLICY

In an effort to provide clear understanding of DCND's scheduling practices, the following policy has been put into place to better inform our patients.

Patients are reminded of their appointment with our office by a phone call two days prior to their appointment. You can also sign up for email and SMS reminders through our patient portal.

**If you need to cancel or reschedule your appointment, please contact our office a minimum of 24 hours prior to your scheduled appointment time. Call 937-439-6186.**

**Arriving Late:** If you are more than 10 minutes late for your scheduled appointment time, we will attempt to accommodate your needs. However, this is not a guarantee that the physician or PA can see you. You may have to be rescheduled.

**First Missed Appointment:** This is defined as a failure to notify us by phone call or secure message through the patient portal within the 24-hour cancellation/reschedule window. Missing your first appointment will result in being placed on the end of DCND's "cancellation list." Please note that this may result in a 3-month wait for an appointment slot. **You may be charged $50 as reimbursement to the practice for time and resources lost.**

**Second Missed Appointment:** Failure to notify our office (as defined above) for the second time may result in the cancellation of all future appointments and being terminated from the practice. Please keep in mind that the 2 missed appointments do not have to be consecutive. **You may be charged $50 as reimbursement to the practice for time and resources lost.**

**Interpreter:** DCND will provide an interpreter for patients who require this service. However, if you cancel or reschedule your appointment without providing adequate notification (as defined above), the patient/guarantor will be responsible for any cancellation fees billed by DCND and the interpreter service. **Appointments will not be scheduled without acknowledgment of the appointment policy. If you miss an appointment and are billed the cancellation fee, future appointments will not be scheduled prior to receipt of payment.**

**Chaperone:** The patient has the right to a chaperone during sensitive physical exams. This chaperone is an authorized member of the DCND health care team.

**Abusive Patients or Family Members:** Patients or family members that are deemed as having an abusive behavior towards our physicians, residents, physician assistants, or staff will result in immediate termination from our practice.

**By signing below, you are stating that you understand our appointment policy, and you agree to abide by the statements listed above.**

**INTERPRETER REQUIRED** (SELECT ONE) ____NO ____ YES LANGUAGE _____

**PATIENT NAME** (printed)_____ Date of Birth_____

**PATIENT NAME** (signed)_____ Date _____

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# HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provide better understand your medical concerns and conditions.
If you cannot remember specific details, please approximate. Add any notes you think are important.
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

**CURRENT MEDICATIONS** - PLEASE LIST THE MEDICATION YOU CURRENTLY TAKE. IF NONE. PLEASE CIRCLE "NONE" NONE

| Name of Medication | Dosage | Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

**MEDICATION/ALLERGY SENSITIVITY** - PLEASE LIST ALL MEDICATION ALLERGIES. IF NONE, PLEASE CIRCLE "NONE". NONE NONE

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |

**YOUR PROVIDERS** - PLEASE LIST ALL OF DOCTORS YOU CURRENTLY SEE

| |
|---|
| 1. |
| 2. |

**PHARMACIES** - LIST NAME, ADDRESS AND PHONE NUMBERS, BOTH LOCAL AND MAIL AWAY.

| |
|---|
| 1. |
| 2. |

**PAST MFDICAL HISTORY** – CHECK ALL BOXES THAT APPLY TO YOU. IF NONE. PLEASE CIRCLE "NONE. NONE

| | | |
|---|---|---|
| ☐ Brain Tumor | ☐ Polio | ☐ Allergies/Hay Fever |
| ☐ Dementia | ☐ Peripheral Neuropathy | ☐ Anemia |
| ☐ Headaches – Migraine | ☐ Muscle Disease | ☐ Bleeding Disorder |
| ☐ Headaches – Tension | ☐ Other Neuromuscular Disease | ☐ Cancer |
| ☐ Headache - Cluster | ☐ Arthritis | ☐ Diabetes |
| ☐ Head Trauma/Injury | ☐ Obstructive Sleep Apnea | ☐ Exposure to Toxins |
| ☐ Intracranial Bleed | ☐ Poor Sleep Quality | ☐ Genito-Urinary Disease |
| ☐ Stroke | ☐ Daytime Sleepiness | ☐ HIV |
| ☐ TIA | ☐ Sleep Disturbance | ☐ Hyperthyroidism |
| ☐ Carotid Artery Disease | ☐ Narcolepsy | ☐ Hypothyroidism |
| ☐ Syncope/ Passing Out | ☐ Coronary Artery Disease | ☐ Kidney Disease |
| ☐ Seizures/Epilepsy | ☐ Heart Attack (MI) | ☐ Liver Disease |
| ☐ Parkinson's Disease | ☐ Atrial Fibrillation | ☐ Measles |
| ☐ Multiple Sclerosis | ☐ Other Arrhythmias | ☐ Menstrual/ Sexual Dysfunction |
| ☐ Anxiety/Panic Attacks | ☐ Cardiac Valve Disease | ☐ Mumps |
| ☐ Depression | ☐ Heart Murmur | ☐ Peptic Ulcer Diseases |
| ☐ Cervical Spine Diseases | ☐ Congestive Heart Failure | ☐ Peripheral Vascular Disease |
| ☐ Neck Injury | ☐ Hypertension | ☐ Reflux |
| ☐ Lumbar Spine Disease | ☐ COPD | ☐ Tuberculosis |
| ☐ Back Injury | ☐ Asthma | ☐ Venereal Disease |
| ☐ Spinal Cord Injury/Disease | ☐ Pneumonia | ☐ Other: |

**REVIEW OF SYSTEMS** - PLEASE CHECK ALL THAT APPLY TO YOU. IF NONE, PLEASE CIRCLE "NONE" NONE

| | | | | |
|---|---|---|---|---|
| ☐ Headache | ☐ Stiffness | ☐ Tinnitus | ☐ Personality Changes | ☐ Weight Loss |
| ☐ Speech Difficulty | ☐ Poor Balance | ☐ Syncope | ☐ Lethargy | ☐ Fever |
| ☐ Double Vision | ☐ Trouble Walking | ☐ Seizures | ☐ Fatigue | ☐ Cardiac |
| ☐ Other Visual Changes | ☐ Clumsiness | ☐ Other spells | ☐ Pain | ☐ Respiratory |
| ☐ Trouble Swallowing/Dysphagia | ☐ Drooling | ☐ Memory Loss | ☐ Ear Nose Throat | ☐ Peripheral Vascular |
| ☐ Loss of Taste/Smell | ☐ Bladder Problems | ☐ Confusion | ☐ Difficulty Chewing | ☐ Arthritis |
| ☐ Weakness: Arms/ Legs | ☐ Bowel Problems | ☐ Poor Concentration | ☐ Hoarseness | ☐ Dermatologic |
| ☐ Numbness: Arms/ Legs | ☐ Dizziness | ☐ Depression | ☐ Nausea | ☐ Hematologic |
| ☐ Facial Numbness | ☐ Vertigo | ☐ Hallucinations | ☐ Vomiting | |

**FAMILY HISTORY** - PLEASE CHECK ALL THAT APPLY. IF UNKNOWN, PLEASE CIRCLE "UNKNOWN" UNKNOWN

| PROBLEM | IMMEDIATE RELATION | PROBLEM | IMMEDIATE RELATION |
|---|---|---|---|
| ☐ Aneurysm | | ☐ Kidney Disease | |
| ☐ Arthritis | | ☐ Migraines | |
| ☐ Bleeding or Clotting Disorders | | ☐ Multiple Sclerosis | |
| ☐ Brain Tumor | | ☐ Muscle Disease | |
| ☐ Cancer (Malignant Neoplastic Disease) | | ☐ Neuropathy | |
| ☐ Connective Tissue Disorder | | ☐ Parkinson's Disease | |
| ☐ Dementia/Alzheimer's | | ☐ Psychiatric Disorders | |
| ☐ Diabetes | | ☐ Restless Leg | |
| ☐ Epilepsy/Seizures | | ☐ Snore | |
| ☐ Headaches | | ☐ Sleep Apnea | |
| ☐ Heart Disease | | ☐ Spine Disease | |
| ☐ Hypertension | | ☐ Stroke (Cerebrovascular Accident) | |
| ☐ Insomnia | | ☐ Thyroid Disorder | |

**SOCIAL HISTORY/LIFESTYLE** - PLEASE CIRCLE OR DESCRIBE IN THE ROWS BELOW

| | |
|---|---|
| Smoking Status: Current / Former/ Never | Exercise Level None / Occasional / Moderate / Heavy |
| Tobacco- years of use: | Aspartame (diet drinks): Yes / No |
| Occupation: | Are you currently employed? Yes / No |
| Smoking (how much per day/week?): | Do you currently use a gait aid or other assisted device? Yes / No |
| Chewing Tobacco: Current / Former / Never | Single or Multi-level home? Single / Multi level |
| Alcohol Intake: None / Occasional / Moderate / Heavy | Any PT/OT in the last 12 months? Yes / No |
| Caffeine Intake: None / Occasional / Moderate / Heavy | How many steps in the home? |
| Illicit Drugs: | Sleep aids?: Yes / No |
| Marital Status: Single / Married / Divorced / Widow | Sleep aids-what type?: |
| Number of Children: | Sleep aids- how long?: |
| Education Level: | General Stress Level: High / Medium / Low |

**SURGICAL PROCEDURE**

| Month/Year | Illness/Operation | Complications (Y/N) |
|---|---|---|
| | | |
| | | |
| | | |

***To my understanding, this represents an accurate portrayal of my health history. I will inform DCND as changes or updates occur.***

Patient Signature Date

Patient Representative Signature Relationship Date