HISTORY

PATIENT NAME

REFERRING PHYSICIAN

DATE OF BIRTH

PRIMARY CARE PHYSICIAN

CHIEF COMPLAINT

PATIENT PHONE

PATIENT EMAIL

MEDICATIONS & DOSAGE
(Include over the counter)

ALLERGIES

PAST MEDICAL HISTORY

Anemia	Insomnia
Anxiety	Kidney disease
Asthma	Lung Disease
Cancer	Meningitis
Depression	Migraine
Diabetes	Seizure
Head Trauma	Stroke
Heart Disease	Thyroid Disease
High Cholesterol	Vascular Disease
Hypertension	Vitamin Deficiency

PAST SURGICAL HISTORY

SOCIAL HISTORY

Ethnicity:	Tobacco Use (Past & Present):
Race:	Alcohol Use (Past & Present):
Preferred Language:	Drug Use (Past & Present):
Marital Status:	
Number of Children:	
Occupation:	

FAMILY HISTORY

Cancer:

Dementia:

Heart Disease:

Parkinson's Disease:

Seizure:

Stroke:

REVIEW OF SYSTEMS

GENERAL		
Chills	Yes ☐	No ☐
Fatigue	Yes ☐	No ☐
Fever	Yes ☐	No ☐
Night Sweats	Yes ☐	No ☐
Poor Appetite	Yes ☐	No ☐
Sleep Problems	Yes ☐	No ☐
Weight Gain	Yes ☐	No ☐
Weight Loss	Yes ☐	No ☐
CARDIOVASCULAR:		
Chest pain	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Murmur	Yes ☐	No ☐
Palpitations	Yes ☐	No ☐
Poor Circulation	Yes ☐	No ☐
Swelling	Yes ☐	No ☐
EYES:		
Blurry vision	Yes ☐	No ☐
Eye Pain	Yes ☐	No ☐
Wears Glasses	Yes ☐	No ☐
EARS, NOSE & THROAT		
Ear Pain	Yes ☐	No ☐
Hearing Loss	Yes ☐	No ☐
Hoarseness	Yes ☐	No ☐
Ringing of Ears	Yes ☐	No ☐
Sinus Problems	Yes ☐	No ☐
ENDOCRINE:		
Cold Intolerance	Yes ☐	No ☐
Heat Intolerance	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Increased Thirst	Yes ☐	No ☐
Thyroid Problem	Yes ☐	No ☐
Vitamin Deficiency	Yes ☐	No ☐
GASTROINTESTINAL	Yes ☐	No ☐
Constipation	Yes ☐	No ☐
Diarrhea	Yes ☐	No ☐
Reflux	Yes ☐	No ☐
Ulcer	Yes ☐	No ☐
GENITOURINARY SYSTEM:		
Blood in Urine	Yes ☐	No ☐
Nighttime Urination	Yes ☐	No ☐
Painful Urination	Yes ☐	No ☐
Unable to Hold Urine	Yes ☐	No ☐
Urinary Accidents	Yes ☐	No ☐
HEMATOLOGICAL		
Blood clots	Yes ☐	No ☐
Easy bruising	Yes ☐	No ☐
Low blood counts	Yes ☐	No ☐
Transfusions	Yes ☐	No ☐

MUSCULOSKELETAL:		
Back Pain	Yes ☐	No ☐
Joint Pain/Swelling	Yes ☐	No ☐
Muscle Weakness	Yes ☐	No ☐
Neck Pain	Yes ☐	No ☐
NEUROLOGICAL:		
Clumsiness	Yes ☐	No ☐
Dementia	Yes ☐	No ☐
Dizziness/Vertigo	Yes ☐	No ☐
Fainting	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Loss of balance / Falls	Yes ☐	No ☐
Memory Problem	Yes ☐	No ☐
Migraine	Yes ☐	No ☐
Muscle Weakness	Yes ☐	No ☐
Numbness/Tingling	Yes ☐	No ☐
Parkinson's Disease	Yes ☐	No ☐
Radiating Pain	Yes ☐	No ☐
Seizure	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Tremor	Yes ☐	No ☐
ONCOLOGY		
Cancer	Yes ☐	No ☐
Immune Suppressed	Yes ☐	No ☐
Leukemia/Lymphoma	Yes ☐	No ☐
PSYCHIATRIC:		
Anxiety	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Drug Use	Yes ☐	No ☐
Excessive Alcohol Use	Yes ☐	No ☐
Mood Fluctuations	Yes ☐	No ☐
Panic Attacks	Yes ☐	No ☐
Suicidal Thoughts	Yes ☐	No ☐
RESPIRATORY:		
Cough	Yes ☐	No ☐
Coughing Blood	Yes ☐	No ☐
Shortness of Breath	Yes ☐	No ☐
Wheezing	Yes ☐	No ☐
SKIN:		
Hair Loss	Yes ☐	No ☐
Hives	Yes ☐	No ☐
Itching	Yes ☐	No ☐
Skin changes	Yes ☐	No ☐

NEUROLOGY AT THE GLEN

Zahra Sara Afshari MD

OFFICE FINANCIAL POLICY

There are numerous insurance networks in the Chicagoland market. Our physician is not a part of all of these networks and, therefore, she has not agreed to accept a reduced fee from all insurance companies. Many insurance companies pay a different percentage of charges based on whether or not the physician is a part of the network. **It is the responsibility of the patient** to know and understand the benefits of his/her particular insurance plan.

Insurance coverage is a contract between the patient and the insurance carrier; however, the office will assist in every way in order to maximize your insurance benefits. The patient will be responsible for any deductible, co-insurance, co-pay and non-covered benefits according to the insurance plan. By law, the insurance carrier must remit payment or deny the insurance claim within 30 days of initial notice of a claim. If an insurance problem occurs, the patient may be asked to assist the office in contacting the carrier and/or in filing a complaint with the State Insurance Commissioner.

The following information is our office policy concerning payment for professional services:

1. **If our physician is not contracted with your insurance plan network, the patient will be required to remit full payment at the time of the office visit.**

2. All patients will be required to establish financial arrangements for payment of their account.

3. According to each contract that we have with an insurance company, we are required to collect the co-payment at the time of service, as well as payment of deductible and co-insurance upon receipt of Explanation of Benefits.

4. Fees for procedures are not included with office visit and may be applied to your deductible or co-insurance.

5. Each month patients will receive a statement for services which is due and payable by the payment due date on the statement. If payment is late, or if the patient has not previously made financial arrangements, a second invoice will be mailed.

6. Any questions concerning the office financial policy or a patient's need for assistance should be immediately directed to the billing manager whose phone number is on your bill.

7. We accept Medicare. (The difference between the Medicare approved amount and the amount we billed Medicare is adjusted off of your account.) However, **there is a $166 calendar year deductible and a 20% co-insurance for all Medicare patients.** This balance may be paid by a secondary insurance, if not, the balance is the patient's responsibility.

8. If an insurance company has not settled a claim within 60 days, the patient will be notified and responsibility for the balance will transfer to the patient.

9. Accounts that have an outstanding balance for over 90 days may be sent to an outside collection agency. **If an account is sent to the collection agency, an 30% service fee will be added to the account balance.**

I have read this policy and hereby authorize my insurance benefits to be paid directly to this physician office, realizing that I am responsible to pay non-covered services. I further authorize the release of pertinent medical information to my insurance carriers.

_____ **Patient's or Guardian's signature**

_____ **Date**

A photocopy of this assignment shall be considered as effective and valid as the original

Neurology at the Glen, S.C.

Zahra Sara Afshari MD

2634 Patriot Blvd, Suite C, Glenview, IL 60026

Privacy Notice and Acknowledgement

I acknowledge that I have received Neurology at the Glen, SC Notice of Privacy Practices.

Assignment of Insurance Benefits

I hereby authorize payment to be made to Neurology at the Glen, SC for insurance benefits payable to me.

Financial Policy

I understand that I am financially responsible to Neurology at the Glen, SC for all services rendered to me whether covered or non-covered, as defined by my insurance company, which are not paid by any of my insurance carriers.

No Show Policy

I understand that if I fail to cancel an appointment with at least 24 advance notice I will be charged a cancellation fee. The fee is $100.00 and shall be paid prior to my next appointment. Two no-show/cancellation appointment may lead to termination of the physician-patient relationship.

Prior Authorization Policy

I understand that I will be charged a prior authorization fee in the amount of $25.00 for a request taking less than 20 minutes, and $50.00 for a request taking longer than 20 minutes.

Telephone Fees

I understand that there is a charge associated with telephone calls to the doctor longer than 5 minutes as follows: 5-10 minutes $29, 11-20 minutes $58, and 21-30 minutes $87.00. Most insurances do not pay for this and I am financially responsible for this.

Medical Record Fees

I understand that I am financially responsible for copies of my medical records. Neurology at the Glen follows State and Federeal law Procedures (Public Act 92-228) for charges: Handling fee $26.58, $1 per page (page 1-25), $0.66 per page (page 26-50), and $0.33 per page (page 51 and on). Records can be picked up or faxed. If the office is to mail them, an additional $5.75 will be charged. We are not able to send records electronically or burn them on a CD.

EMG Supplies

Most insurances do not pay for EMG supplies. The cost of the nerve conduction kit at $5 a piece and EMG needle at $20 a piece is patient responsibility on the day of study

Authorization for Disclosure of Medical Information

This authorization provides that my physician/provider of service may release clinical information related to my diagnosis and treatment, which may be requested by my insurance company or a designated agent. This information also includes all records requested by any insurance company for the purpose of enabling that insurance company to evaluate my claims or its liability under such policies or contracts or coordinating benefits pursuant to such policy or contract provisions.

_____ _____

Name of Patient Date of Birth

_____ _____

Signature of Patient/Representative Date

(PHQ-9) HEALTH QUESTIONNAIRE

INSTRUCTIONS:

1) Print out this health questionnaire **2)** Fill out the first page of the questionnaire **3)** Take both pages to your medical doctor for assessment

Name _____ **Date** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐
	Add Columns		+	+
	TOTAL			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.

Neurology at the Glen, S.C.
Zahra Sara Afshari MD
2634 Patriot Blvd, Suite C
Glenview, IL 60026
Phone 847-904-2298
Fax: 847-904-2168

Consent to use or Disclose Medical Information

I authorize Neurology at the Glen, SC to use and disclose the health and medical information of patient

_____ date of birth _____for the

purpose of continuation of medical care.

Please list physicians, family, friends, and anyone who could have access to your protected health information:

_____

_____

_____

_____

You have the right to revoke this CONSENT provided that you do so in writing, except to the extent that we have already used or disclosed the information in reliance with this CONSENT.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Date