

# 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:

Blur 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

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
Easily 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/Nertigo	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

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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 \$226 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, a 35% 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

# Neurology at the Glen, S.C.

Zahra Sara Afshari MD

2640 Patriot Blvd, Suite 200, Glenview, IL 60026

## **Privacy Notice and Acknowledgement**

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

## **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 \$150.00 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. This is where your insurance either needs medical records or needs to speak to the doctor to answer questions on paper or on a phone call, in order to approve a Brand name medication or a procedure/imaging that is ordered.

## **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 \$50, 11-20 minutes \$75, and 21-30 minutes \$100. Most insurances do not pay for this and I am financially responsible for this. We encourage patients to schedule an appointment if they need a prolonged discussion with the doctor.

## **Medical Record Fees**

I understand that I am financially responsible for copies of my medical records. Neurology at the Glen follows State and Federal law Procedures (Public Act 92-228) for charges: Handling fee \$27.91, \$1.02 per page (page 1-25), \$0.70 per page (page 26-50), and \$0.35 per page (page 51 and on). Records can be picked up or faxed. If the office is to mail them, an additional \$9.45 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

# NEUROLOGY AT THE GLEN

Dr. Zahra Sara Afshari MD

2640 Patriot Blvd, Suite 200, Glenview, IL 60026

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## OFFICE DEPOSIT POLICY

Dear Perspective Neurology at the Glen Patient:

We are a small Neurology private practice office consisting of one physician. We spend a significant amount of time and effort with each patient, averaging 60-90 minutes face to face time. This allows us to fully understand the individual case. In order to be able to sustain this holistic care approach, our practice needs to assure financial reimbursement for all patients visits. For this reason, we implement a deposit policy towards medical services received. We will be expecting a deposit of \$300.00 per calendar year.

### **What does it cover?**

- Your Deductible (Of note, Medicare has a deductible of \$226 and 20% co-insurance)
- Your Co-Insurance
- Medical bills that your insurance does not pay for

### **What does it NOT cover?**

- Co-pays
- Vitamin Supplements & B12 shots
- EMG supplies
- Prior authorization fees
- Medical record fee

### **What if I have money left over at the end of the year?**

- The remainder can be applied as a credit towards the next year's deposit obligation

### **What if no further follow-up with Dr. Afshari is needed/desired?**

- Per your request, after confirmation that all your medical bills have been paid by you/your insurance, we can refund a credit card or send you a check for the remaining amount.

I have read the above deposit policy. By signing below, I am certifying that I fully agree with above.

\_\_\_\_\_ Patient or Guardian's Signature

\_\_\_\_\_ 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
	0	0	0	0

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Michael Greenek, and colleagues. Copyright © 2009 Pfizer Inc. All rights reserved.

## 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?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

**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