Consultants in Neurology, P.A.
Rowe Neurology Institute
8550 Marshall Dr, Suite 100
Lenexa, KS 66214
913.894.1500 or 800.753.6992
Fax: 913.894.1502
www.neurokc.com

THIS PAGE IS FOR YOUR INFORMATION – PLEASE KEEP FOR REFERENCE

Welcome to the **Rowe Neurology Institute!** We are glad you've chosen to receive your neurologic care here. There are several things you should know about a neuroscience institute, and how this is different from a regular doctor's office:

While our neurologists all see general neurology patients, each has areas of subspecialty, and typically has trained beyond what is standard for general neurologists. Your initial neurologist may want the input of a subspecialist within the Institute. Our areas of special expertise include:

Multiple Sclerosis	Memory Disorders
Headache	Neuropsychology
Sleep Disorder	

We have diagnostic facilities. This includes MRI scanning, EEG and EMG testing, Sleep disorder testing, and many other things not usually done through a regular neurology office.

We conduct research. We have an active research staff. Some patients may be asked if they are interested in participating in selected clinical research projects.

POLICIES:

NO TEST RESULTS ARE GIVEN OVER THE TELEPHONE. A visit with a provider is the best and only way to discuss results and their importance.

MEDICATIONS REFILLS ARE HANDLED DURING OFFICE VISITS. *Discuss prescriptions with your doctor at every visit, and keep track of the number of refills available at your pharmacy.* On the rare occasion when a refill is needed without an office visit, your pharmacy must fax the request. The number is 913-894-1502. It usually takes several days to process requests for medication refills, and they are only handled during regular business hours. **No refills are handled after hours or by the on-call physician.**

Your office visit is your time to speak with your provider. He or she will not be speaking with you by phone or email.

If you leave a message for a nurse, they will make every attempt to return calls within 48 hours. Please do not leave duplicate messages.

If you think you are having a medical emergency, do not call our office. Call 911 or go to the emergency room.

Patient Insurance Coverage Responsibility Disclaimer and Authorization

I understand that is my responsibility to know if CONSULTANTS IN NEUROLOGY, P.A. is an authorized provider according to my insurance contract. If for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I also understand that CONSULTANTS IN NEUROLOGY, P.A. is required by law and contract to collect from me, ON THE DATE OF SERVICE, any present co-payment amount required by my insurance contract.

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialist's appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization from my provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I understand and agree that if my Employer, Workman's Compensation Carrier, or my Insurance Plan does not pay in full that I will be responsible for payment for all charges. I also agree that in the event of collection, I agree to pay all outstanding charges, costs of collection including reasonable attorney's fees. I authorize my insurance company to pay all benefits directly to CONSULTANTS IN NEUROLOGY, P.A. and thereby agree to the release of relevant medical information to insurance carriers. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand and agree to the financial policy as stated above.

Authorization for Medical Treatment and Access to Prescription History

While I am here I permit the employees, the doctor, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that this care may include diagnostic testing, examinations, medical and or/surgical treatment and no guarantees have been made to me about the outcome of this care. I also grant permission to access my prescription history across providers. This prescription History enables the doctor to make a more informed clinical decision.

Acknowledgement of Notice of Privacy Practices/Consent to Treat/Lab Result Notification/Photograph Consent

I acknowledge that I have read the Notice of Privacy Practices. I understand that CONSULTANTS IN NEUROLOGY, P.A. may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request. I give CONSULTANTS IN NEUROLOGY, P.A. permission to leave a message on my answering machine or with the following family members regarding reports, or blood work if I am not home when they call. I give CONSULTANTS IN NEUROLOGY, P.A. permission to take my picture for identification purposes. I consent to general treatment, medical procedures, and medications prescribed by CONSULTANTS IN NEUROLOGY, P.A. I understand the physician's and staff of CONSULTANTS IN NEUROLOGY, P.A. will not discuss my health information with my family or friends unless I expressly authorize them to do so.

X _____HIPAA Copy given to patient X_____ Patient declined copy (please initial)

Approved family members to leave my health care messages with: _____

CONSULTANTS IN NEUROLOGY, P.A. will call my home pertaining to appointment reminders, clinical and or business related issues. Please check the following:

_____ DO NOT CALL ME_____ Call me and leave a message on my machine if there is "NO" answer

Cancellation of Appointment Policies

I understand that it is my responsibility to cancel at least 24 hours in advance (AT LEAST ONE BUSINESS DAY — MONDAY THRU FRIDAY ONLY) for all my appointments with CONSULTANTS IN NEUROLOGY, P.A. and that if I do not, there will be a fee of:

$250.00 for MRI, MRA, Sleep Study, CPAP Study or MSLT.
$50.00 for Physical Therapy or an Office Visit

I have read, understand and agree to all the policies as stated above.

Signature of Patient or Guarantor: X _____ Date:_____

Medicare Patients

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Consultants in Neurology, P.A. for any services furnished by Consultants in Neurology, P.A. I authorize any medical information about me to be released to the Health Care Financing Administration and it's agents as needed to determine these benefits or the benefits payable for related services

Signature of Patient or Guarantor: X _____ Date: _____

Date: _____

ROWE NEUROLOGY INSTITUTE **CONSULTANTS IN NEUROLOGY, P.A.**

******PLEASE PRINT LEGIBLY IN BLACK INK*****PLEASE PRINT LEGIBLY IN BLACK INK*******

PATIENT INFORMATION	**Spouse (or Parent if Patient is minor)**
Last Name First MI	Last Name First MI
Date of Birth Age Male Female Female	Date of Birth
SSN M S D W DP Married	SSN
Address	Address
City State Zip	City State Zip
Home Phone Cell Phone	Home Phone Cell Phone
Employer Work Phone	Employer Work Phone
Email Address	

EMERGENCY NOTIFICATION (Other than Spouse)

Name _____ **Relationship** _____ **Phone** _____

Is this a Workman's Compensation case ☐ Yes ☐ No
Is this an automobile injury case ☐ Yes ☐ No
Is this related to a specific injury ☐ Yes ☐ No If yes, please explain: _____

OTHER PHYSICIANS

Family Physician _____

Phone _____

Referring Physician _____

Phone _____

MEDICAL INSURANCE INFORMATION **PLEASE PRESENT INSURANCE CARD(S) AT THE RECEPTION DESK**

Primary Insurance Company:

Insurance Company _____

Insurance Phone _____

Subscribers Name _____

SSN/IDN _____

Date of Birth _____

Employer _____

Group # _____

Secondary Insurance Company

Insurance Company _____

Insurance Phone _____

Subscribers Name _____

SSN/IDN _____

Date of Birth _____

Employer _____

Group # _____

Date:_____

ROWE NEUROLOGY INSTITUTE **CONSULTANTS IN NEUROLOGY, P.A.**

******PLEASE PRINT LEGIBLY IN BLACK INK*****PLEASE PRINT LEGIBLY IN BLACK INK*******

Name _____ Age: ___Date of Birth_____ Sex: □ M □ F

What problem are you here to see the Doctor about: _____
_____
_____

Have you ever had any SURGERIES	
Type	**Date**

MEDICINES YOU ARE NOW TAKING (Include "over the counter" medicines, vitamins and supplements)		
Name	How much / How often	For what problem

PHARMACY INFORMATION		
Name	Location	Telephone Number

ALLERGIES TO MEDICINE ☐ None Known	
Name	Type of Reaction

Date:_____

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MEDICAL PROBLEMS (Diagnosed with disorder) Checkmark all that you have had.

YES	NO		YES	NO	
□	□	Seizures / Epilepsy	□	□	Hepatitis □ **B** or □ **C**
□	□	Stroke	□	□	HIV / AIDS
□	□	TIA	□	□	Lyme Disease
□	□	Multiple Sclerosis	□	□	Aneurysm
□	□	Headaches – Type_____	□	□	Bleeding disorder
□	□	Alzheimer's / Dementia	□	□	Blood clot / Blood vessel disease
□	□	Knocked out/head injury	□	□	Colon/Intestinal Disorder
□	□	Parkinson's Disease	□	□	Acid Reflux / Heartburn
□	□	Sleep Disorder – Type: Check Below	□	□	Ulcers
		□ **Sleep Apnea** □**Insomnia**	□	□	Thyroid disease
		□ other: _____	□	□	Bladder Problem – Type _____
□	□	Neck Problems	□	□	Kidney Problem – Type _____
□	□	Low back problems	□	□	Liver Disease
□	□	Cancer - Type_____	□	□	Lupus
□	□	Non-cancerous tumor	□	□	Low Testosterone
□	□	Diabetes	□	□	Total number of Pregnancies _____
□	□	High Blood Pressure	□	□	Number of Miscarriages _____
□	□	High Cholesterol	□	□	Sexual Dysfunction
□	□	Heart Problem – Type _____	□	□	Sexually Transmitted Disease
□	□	Depression / Anxiety			Type: _____ ☐ Treated ☐Untreated
□	□	ADD or ADHD	□	□	Anemia
□	□	PTSD	□	□	Iron deficiency
□	□	Other Psychiatric Disorder	□	□	B-12 deficiency
		Type: _____	□	□	Vitamin D deficiency
□	□	Passing Out	□	□	Environmental Allergies / Hayfever
□	□	Arthritis	□	□	Frequent infections
□	□	Osteoporosis or Osteopenia	□	□	Eye Glasses or Contact Lens (circle one)
□	□	Lung or Breathing Problem	□	□	Fibromyalgia
		Type _____	□	□	Hard of Hearing
□	□	Tuberculosis (TB)	□	□	Use of Hearing Aid
□	□	Chicken Pox	□	□	Dentures
□	□	Shingles			

Are there any other medical conditions we need to know about?

Social History

Occupation _____ Level of Education: _____

Marital Status: □ S □ M □ D □ W □ Other: _____ # of Children: _____

Ethnicity/Race: _____

Handedness: □ Right □ Left □ Ambidextrous □ Mixed

Date:_____

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PERSONAL HABITS (Checkmark all that apply)

□ **Yes** □ **No** Have you ever been a smoker? □ Current use □ Past Use
□ Cigarettes □ Cigars □ Pipe Packs/day _____ How many years?_____

□ **Yes** □ **No** Have you ever chewed tobacco How many years? _____

□ **Yes** □ **No** Do you usually drink **caffeinated** coffee, tea, energy drinks and/or soda**?**
(Checkmark use per day) □ OCCASIONAL (1-2) □ MODERATE (4-5) □ HEAVY (6-over)

□ **Yes** □ **No** Do you regularly drink **alcohol**? How many years? _____
(Checkmark use per week) □ OCCASIONAL (1-2) □ MODERATE (4-5) □ HEAVY (6-over)

□ **Yes** □ **No** Do you or have you used recreational/street **drugs**? What and how long? _____

□ **Yes** □ **No** Have you had extensive foreign **travel**? _____

□ **Yes** □ **No** Have you had exposure to **toxins**? _____

What are your hobbies? _____

FAMILY HISTORY	**(Checkmark as appropriate) (other than yourself)**	**Comments**
Stroke	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
TIA	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Brain Aneurysm	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Cancer	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Heart Attack	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Heart Disease	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Multiple Sclerosis	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Seizures	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Parkinson's Disease	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Tremor	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Migraines	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Headaches	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
High Blood Pressure	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Diabetes	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Polycystic Kidney Disease	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Lung Disease	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Depression	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Anxiety	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Alcohol or Drug Abuse	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Mental Illness	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Sleep Problems	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Senility or Dementia	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Other:	□ Father □ Mother □ Brother □ Sister □ Son □ Daughter	
Father: □ Alive □ Deceased If deceased, age _____ and cause of death _____		
Mother: □ Alive □ Deceased If deceased, age _____ and cause of death _____		

Date: _____

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Please check any and all appropriate boxes as they pertain to your CURRENT medical condition.

SLEEP
- ☐ Problems going to sleep
- ☐ Problems staying asleep
- ☐ Loud snoring
- ☐ Excessive daytime sleepiness
- ☐ Falling asleep when you shouldn't
- ☐ Legs moving restlessly

NEUROLOGIC
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Facial weakness
- ☐ Poor concentration
- ☐ Memory problems
- ☐ Difficulty walking
- ☐ Numbness
- ☐ Headaches
- ☐ Passing out
- ☐ Slurred speech
- ☐ Difficulty swallowing
- ☐ Lost ability to speak properly
- ☐ Lost ability to read properly
- ☐ Lost ability to write properly
- ☐ Unexplained spells
- ☐ Dizziness
- ☐ Tremors/shaking, etc.

EYES
- ☐ Blurred vision
- ☐ Color blindness
- ☐ Double vision
- ☐ Red eyes
- ☐ Inflammation
- ☐ Tearing
- ☐ Swollen eyelids
- ☐ Droopy eyelids
- ☐ Big pupils
- ☐ Small pupils
- ☐ Unequal pupils
- ☐ Worsened vision

EARS, NOSE, MOUTH, THROAT
- ☐ Deafness
- ☐ Ringing in ear
- ☐ Discharge from the ears
- ☐ Vertigo (dizziness)
- ☐ Ear pain
- ☐ Mouth pain
- ☐ Dental problems
- ☐ Congestion

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Swelling in Hands
- ☐ Swelling in Feet
- ☐ Stiffness
- ☐ Weakness of muscles
- ☐ Muscle shrinkage
- ☐ Arm Pain
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Thoracic pain (mid-back pain)

PSYCHIATRIC
- ☐ Irritability
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Bizarre behavior
- ☐ Need for psychiatric medications
- ☐ Drug addiction – including alcohol, past or present

ENDOCRINE
- ☐ Intolerance to heat or cold
- ☐ Excessive thirst
- ☐ Impotence
- ☐ Excessive facial hair
- ☐ Impossible to control blood pressure
- ☐ Thyroid problems

CONSTITUTIONAL SYMPTOMS
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight gain
- ☐ Fatigue

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Racing of the heart
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blue extremities
- ☐ Swollen extremities
- ☐ Cold extremities

RESPIRATORY
- ☐ Wheezing
- ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Night sweats
- ☐ Chest pain with breathing
- ☐ Shortness of Breath
- ☐ Blue extremities
- ☐ Need for oxygen

GASTROINTESTINAL
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Change in color of stool
- ☐ Hemorrhoids
- ☐ Blood in the stool
- ☐ Black tarry stools
- ☐ Incontinence of bowels
- ☐ Diarrhea
- ☐ Constipation

GENITOURINARY
- ☐ Urinary incontinence
- ☐ Blood in the urine
- ☐ Increased urinary frequency
- ☐ Up all night going to the bathroom
- ☐ Frequent urinary tract infections
- ☐ Going to the bathroom too often
- ☐ Change in color of urine

INTEGUMENTARY
- ☐ Change in skin color
- ☐ Stiffness
- ☐ Itching skin
- ☐ Dry skin
- ☐ Changes in hair
- ☐ Changes in nails
- ☐ Rash
- ☐ Sores
- ☐ Lumps

HEMATOPOIETIC/LYMPHATIC
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Swollen lymph nodes

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THE EPWORTH SLEEPINESS SCALE

Patient Name: _____ Date: _____

Please use the following scale, to decide the likeliness you would doze off or fall asleep in the following situations.

Even if you have NOT done some of these things RECENTLY, try to answer how they would have affected you.

Using the following scale, Please choose the most appropriate number for each situation:

0 = Would **NEVER** doze or fall asleep
1 = **Slight Chance** of dozing or falling asleep
2 = **Moderate Chance** of dozing or falling asleep
3 = **High Chance** of dozing or falling asleep

SITUATIONS:	**Chance of dozing**
Sitting and Reading	
Watching TV	
Sitting, inactive in a public place (Theatre, meeting, etc.)	
As a passenger in a car, for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch, without alcohol	
In a car while stopped, for a few minutes in traffic	
TOTAL :	

Add up the numbers you put in each box to get your total score. A total score of less than 10 suggest that you may not be suffering from excessive daytime sleepiness. A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

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Headache Patient Questionnaire

1. How often do you get headaches bad enough to interfere with your daily activities & how long do they last?

2. How often do you get milder headaches and how long do they last?

3. How old were you when you **first recall** having any kind of headache?

4. Has there been a **significant change** in your headaches recently? □ Yes □ No
   If Yes, please describe below.

5. How often do you **miss work or social activities** due to headaches?

6. How **often** do you take headache **relievers or pain pills**?

7. Are your headaches sometimes accompanied by (checkmark all that apply):
   - □ Nausea
   - □ Vomiting
   - □ Sensitivity to light
   - □ Sensitivity to sound
   - □ Sensitivity to odor

8. Are your headaches sometimes associated with (checkmark all that apply):
   - □ Seeing zig-zag lines
   - □ Having a blind spot
   - □ Losing vision to one side
   - □ Sensation of room spinning
   - □ Things look too big or too small
   - □ You pass out or come close to it
   - □ You go numb on one side
   - □ You get weak on one side

9. Is your headache pain sometimes (checkmark all that apply):
   - □ Made worse with movement/activity
   - □ One-sided
   - □ Pounding
   - □ Stabbing
   - □ Throbbing
   - □ Pressure

10. Do you have any of the following with your headaches? (checkmark all that apply):
    - □ Ringing ears
    - □ Neck pain
    - □ Tender scalp

11. Have you noticed any **mental status changes**? (checkmark all that apply):
    - □ Confusion
    - □ Disorientation
    - □ Sudden forgetfulness
    - □ Easily agitated

12. Have you had any **walking problems** or clumsiness?
    - □ Yes
    - □ No

13. Are your headaches **accompanied by**? (checkmark all that apply):
    - □ Nasal stuffiness
    - □ Redness of eye(s)
    - □ Drooping eyelid(s)
    - □ Easily agitated

14. Is your headache onset after **strenuous physical exercise or sex**?
    - □ Yes
    - □ No

15. Are your headaches **produced** (not just worsened) by **straining**, such as with a bowel movement?
    - □ Yes
    - □ No

16. Have your headaches had a recent **change in pattern**?
    - □ Yes
    - □ No

17. Have your headaches **worsened** over the past 4 weeks **despite medications** that previously worked?
    - □ Yes
    - □ No

18. Do your headaches occur with a **sudden onset**?
    - □ Yes
    - □ No

19. Do you have a history **of brain swelling** (Pseudotomor Ceribri or other)?
    - □ Yes
    - □ No

20. Do you have a history of **head trauma** within the past year?
    - □ Yes
    - □ No

21. Do your headaches **frequently awaken** you at night?
    - □ Yes
    - □ No

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The doctors at Rowe Neurology Institute know that mood and stress are linked to quality of life, and can be impacted by physical symptoms and quality of sleep. Answering the questions on the next two pages will provide us a more complete picture of you.

Together, these questionnaires should take less than five minutes to complete.

Remember, all the information you provide is kept completely confidential.

DASS 21

*Name:*_____ *Date:*_____

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week.* There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg. sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

SELF-REPORT SCALE

The following items describe feelings or experiences people have. Read each item carefully. Then circle the number of phrase that best describes you during the past week, including today. Checkmark only one number for each word. Try to answer every item.

	Not at All	A Little	Moderately	Quite a Bit	Extremely
1. Sad…….	□ 1	□ 2	□ 3	□ 4	□ 5
2. Joyful…….	□ 1	□ 2	□ 3	□ 4	□ 5
3. Unworthy……...	□ 1	□ 2	□ 3	□ 4	□ 5
4. Easily awakened……	□ 1	□ 2	□ 3	□ 4	□ 5
5. Inferior…….....	□ 1	□ 2	□ 3	□ 4	□ 5
6. Unable to pay attention…….	□ 1	□ 2	□ 3	□ 4	□ 5
7. Glum…….....	□ 1	□ 2	□ 3	□ 4	□ 5
8. Exhausted……...	□ 1	□ 2	□ 3	□ 4	□ 5
9. Woeful……...	□ 1	□ 2	□ 3	□ 4	□ 5
10. Blue……..	□ 1	□ 2	□ 3	□ 4	□ 5
11. Worthless…….	□ 1	□ 2	□ 3	□ 4	□ 5
12. Unhappy……...	□ 1	□ 2	□ 3	□ 4	□ 5
13. Punished……...	□ 1	□ 2	□ 3	□ 4	□ 5
14. Tired…….	□ 1	□ 2	□ 3	□ 4	□ 5
15. Sluggish……...	□ 1	□ 2	□ 3	□ 4	□ 5
16. Cheerless……..	□ 1	□ 2	□ 3	□ 4	□ 5
17. Energetic…….....	□ 1	□ 2	□ 3	□ 4	□ 5
18. A failure……...	□ 1	□ 2	□ 3	□ 4	□ 5
19. Low……..	□ 1	□ 2	□ 3	□ 4	□ 5
20. Loved……...	□ 1	□ 2	□ 3	□ 4	□ 5
21. Unable to concentrate…….	□ 1	□ 2	□ 3	□ 4	□ 5
22. Poor appetite……	□ 1	□ 2	□ 3	□ 4	□ 5
23. Despised……...	□ 1	□ 2	□ 3	□ 4	□ 5
24. Hated……	□ 1	□ 2	□ 3	□ 4	□ 5
25. Fitful sleep……...	□ 1	□ 2	□ 3	□ 4	□ 5
26. Criticized…….	□ 1	□ 2	□ 3	□ 4	□ 5
27. Fatigued……...	□ 1	□ 2	□ 3	□ 4	□ 5
28. Forgetful…….....	□ 1	□ 2	□ 3	□ 4	□ 5
29. Capable……	□ 1	□ 2	□ 3	□ 4	□ 5
30. Dreary…….....	□ 1	□ 2	□ 3	□ 4	□ 5
31. Trouble falling asleep…….	□ 1	□ 2	□ 3	□ 4	□ 5
32. Grim…….	□ 1	□ 2	□ 3	□ 4	□ 5
33. Rejected……...	□ 1	□ 2	□ 3	□ 4	□ 5
34. Despairing……	□ 1	□ 2	□ 3	□ 4	□ 5
35. Happy……...	□ 1	□ 2	□ 3	□ 4	□ 5
36. Weak……	□ 1	□ 2	□ 3	□ 4	□ 5
37. Gloomy……	□ 1	□ 2	□ 3	□ 4	□ 5
38. Forgotten…….....	□ 1	□ 2	□ 3	□ 4	□ 5
39. Active……...	□ 1	□ 2	□ 3	□ 4	□ 5
40. Sorrowful…….	□ 1	□ 2	□ 3	□ 4	□ 5
41. Somber…….	□ 1	□ 2	□ 3	□ 4	□ 5
42. Useless…….	□ 1	□ 2	□ 3	□ 4	□ 5
43. Miserable…….	□ 1	□ 2	□ 3	□ 4	□ 5
44. Alert…….	□ 1	□ 2	□ 3	□ 4	□ 5
45. Resented……...	□ 1	□ 2	□ 3	□ 4	□ 5
46. Uninterested in sex……..	□ 1	□ 2	□ 3	□ 4	□ 5
47. Unwanted…….	□ 1	□ 2	□ 3	□ 4	□ 5
48. Peaceful……...	□ 1	□ 2	□ 3	□ 4	□ 5
49. Restless……	□ 1	□ 2	□ 3	□ 4	□ 5
50. Deserted……...	□ 1	□ 2	□ 3	□ 4	□ 5

General Health Questions **Date_____**

Please checkmark your answer to the following questions related to your health quality *right now*.

1. **Do you have headache pain or discomfort that makes it hard to do paid work activities?** □ Yes □ No

If yes, checkmark the word below that describes how often headache pain affects your work:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

2. **Do you have headache pain or discomfort that makes it hard to do other daytime activities?** □ Yes □ No

If yes, checkmark the word below that describes how often headache pain affects daytime activities:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

3. **Do you have daytime sleepiness or fatigue that makes it hard to do paid work activities?** □ Yes □ No

If yes, checkmark the word below that describes how often sleep problems affect your work:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

4. **Do you have daytime sleepiness or fatigue that makes it hard to do other daytime activities?** □ Yes □ No

If yes, checkmark the word below that describes how often does sleepiness or fatigue affects your daytime activities:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

5. **Do you have daytime sleepiness or fatigue that makes it hard to go to social or family events?** □ Yes □ No

If yes, how many events have you missed in the last week? _____

If yes, checkmark the word below that describes how often sleepiness or fatigue affects going to social/family events:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

6. **Did you go to the emergency room (ER) or urgent care *in the last month*?** □Yes □No

If yes, how many total times did you go to the emergency room (ER) or urgent care? _____

If yes, what was the reason for the ER/urgent care visit(s)? _____

7. **Do you have pain/discomfort (not headache) that makes it hard to get in and out of bed?** □ Yes □ No

If yes, checkmark the word below that describes how often pain affects you getting in/out of bed:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

8. **Do you have pain/discomfort (not headache) that makes it hard to walk in a parking lot and/or in a store to buy household items?** □ Yes □ No

If yes, checkmark the word below that describes how often pain affects you in walking around a parking lot or store to buy household items:

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

9. **Do you have pain/discomfort (not headache) that makes it hard to do paid work activities?** □ Yes □ No

If yes, checkmark the world below that describes how often pain affects your paid work activities?

□ Rarely □ Sometimes □ Most of the Time □ All of the Time

Health Quality Scale

The below scale is meant to measure how you feel about your health quality ***today***.

Please place a line (|) on the scale where you believe your health quality is today, compared to your health in the past.

Overall health is much worse _____ Overall health is much better

ROWE NEUROLOGY INSTITUTE

MRI QUESTIONNAIRE

MRI #_____

PLEASE NOTE THERE IS A $250 CHARGE FOR MRI APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE. THIS POLICY IS STRICTLY ENFORCED.

NAME:_____ PHONE:_____

SEX:_____ HEIGHT:_____ WEIGHT:_____ AGE:_____ DOB:_____

PREVIOUS MRI/CT? OF BRAIN OR SPINE? YES or NO (CIRCLE ALL APPLICABLE)

SCAN TYPE _____ **WHEN** _____ **WHERE?**_____

RESULTS NORMAL OR ABNORMAL (CIRCLE ONE)

IF ABNORMAL, PROVIDE FILMS/REPORT TO MRI TECHNOLOGIST

YES	NO	EVER HAD **SURGERY** OF BRAIN / NECK / BACK / ARTERY. IF YES, TYPE & DATE:
YES	NO	ARE YOU PREGNANT / NURSING / IUD
YES	NO	DO YOU USE: WHEEL CHAIR, STRETCHER, WALKER, CANE, CRUTCHES
YES	NO	ADDITIONAL OXYGEN REQUIRED
YES	NO	CLAUSTROPHOBIC: MILD MODERATE SEVERE (SCRIPT GIVEN? Y N)
YES	NO	REMOVABLE DENTAL WORK / EYE OR EAR IMPLANTS
YES	NO	SHEET METAL WORK, WELDING OR GRINDING WORK (SCRIPT GIVEN Y N)
YES	NO	ANY METAL IN BODY (I.E. SHRAPNEL/GUNSHOT WOUND/IMPLANTS/FRAGMENTS/ DEVICES) EXPLAIN:
YES	NO	ANEURYSM CLIPS OR COILS / BLOOD VESSEL CLIPS / PACEMAKER WIRES/STENTS
YES	NO	CARDIAC PACEMAKER / DEFIBRILLATOR / HEART VALVE / NEUROSTIMULATOR
YES	NO	HAIR WEAVE
YES	NO	EPILEPTIC, PARKINSON'S DISEASE / SPASMS
YES	NO	INSULIN PUMP / SHUNTS / NITROGLYCERIN PATCH
YES	NO	DRUG ALLERGIES (LIST):
YES	NO	URINARY INCONTINENCE
YES	NO	ANY CONDITION PREVENTING YOU FROM LAYING STILL:
YES	NO	WILL YOU NEED ASSISTANCE CLIMBING ONTO EXAM TABLE...IF YES, HOW MANY PEOPLE WILL YOU NEED TO ASSIST YOU:
YES	NO	STAFF OPINION...WILL THIS PATIENT REQUIRE EXTRA TIME?

DESCRIBE YOUR SYMPTOMS:_____

_____

IF EXPERIENCING PAIN, WHERE & HOW LONG?_____

PATIENT SIGNATURE _____ DATE _____

REVIEWED IN CLINIC BY: _____

TECH Initials _____PATIENT SIGNATURE _____DATE _____

DO NOT WRITE BELOW THIS LINE -- FOR OFFICE PERSONNEL ONLY

Gadavist _____mL Dose: 0.1mL/kg
1mmol/mL

Injection site: _____

T1 delayed post injection: _____

SCREENED BY:_____ SCANNED BY:_____

Consultants in Neurology. P.A.
Rowe Neurology Institute
8550 Marshall Drive, Suite 100
Lenexa, KS 66214
913.894.1500 or 800.753.6992

Dear Patient:

RE: **Credit Policy**

We want to make you aware of our credit policy.

All co-pays must be paid at the time of your appointment. This is a requirement of your insurance company.

After your insurance has paid its portion, the balance is due when you receive your statement unless previous arrangements have been made and approved.

Options for large amounts:

1) For large deductibles and co-portions (insurance), a credit card will be held on file. Arrangements of 6 monthly payments must be made with our billing department prior to scheduling- via a credit card held on file. No charges against your credit card will commence until insurance pays or determines their portion. Please call our office upon receipt of your **first statement** to initiate the first payment either with credit card on file or other means of payment. For larger unmet deductibles, a pre-payment towards that deductible may be required to schedule your treatment.

2) Care Credit. You may apply for longer payment arrangements of
12 to 18 months of payments with no interest! Care Credit is a confidential credit card company (focused on healthcare) that you can apply for in the comfort of your home either by phone or directly online.

Please call our billing office at 913-894-1500 ext 4247 to make arrangements or to receive more information about Care Credit.

All arrangements need to be set up prior to testing or treatment. We will do whatever we can to assist you in payment for your services.

Cindy
Patient Accounts Manager
913-827-4247

Consultants in Neurology. P.A.
Rowe Neurology Institute
8550 Marshall Drive, Suite 100
Lenexa, KS 66214
913.894.1500 or 800.753.6992

Authorization to Charge Credit Card

Credit Card type

☐ Visa

☐ MasterCard

☐ Discover

☐ American Express

Name as it appears on the card: _____

Credit Card #: _____

Expiration date: _____

☐ I authorize Consultants In Neurology / Rowe Neurology Institute to use my credit card on file for monthly installments for up to six (6) months on the patient account balance listed herein, after insurance payments, which may include my deductible and co-pays. I understand that upon receipt of my **first statement** from Consultants in Neurology, I am to call the billing office to initiate these payments to avoid an auto charge and that failure to do so may result in the entire balance being charged to the card for which I have provided information.

Guarantor: _____ Date: _____
Signature

For Office Use Only

☐ Credit Card

☐ Debit Card

Patient Account: _____ Patient Name: _____

Verified by: _____ Date verified: _____