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	Sleep Disorder
Headache	Neuropsychology

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. 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. We do encourage communication through the patient portal.

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, MSLT, Ambulatory EEG or Neuropsychological Testing.
$50.00 for 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	Date of Birth
SSN M S D W DP	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:_____

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

MEDICAL PROBLEMS Have you EVER had: Checkmark all that you have had.

YES

- ☐ Seizures / Epilepsy
- ☐ Stroke
- ☐ TIA
- ☐ Multiple Sclerosis
- ☐ Headaches – Type_____
- ☐ Alzheimer's / Dementia
- ☐ Knocked out/head injury
- ☐ Parkinson's Disease
- ☐ Sleep Disorder – Type: Check Below
  - ☐ **Sleep Apnea** ☐**Insomnia**
  - ☐ other: _____
- ☐ Neck Problems
- ☐ Low back problems
- ☐ Cancer - Type_____
- ☐ Non-cancerous tumor – Type _____
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Problem – Type _____
- ☐ Depression / Anxiety
- ☐ ADD or ADHD
- ☐ PTSD
- ☐ Other Psychiatric Disorder
  - Type: _____
- ☐ Passing Out
- ☐ Arthritis
- ☐ Osteoporosis or Osteopenia
- ☐ Lung or Breathing Problem
  - ☐ **Asthma**
  - ☐ Other _____
- ☐ Tuberculosis (TB)
- ☐ Chicken Pox
- ☐ Shingles
- ☐ Hepatitis ☐ **B** or ☐ **C**
- ☐ HIV / AIDS
- ☐ Lyme Disease
- ☐ Aneurysm
- ☐ Bleeding disorder
- ☐ Blood clot / Blood vessel disease
- ☐ Colon/Intestinal Disorder
- ☐ Acid Reflux / Heartburn
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Bladder Problem – Type _____
- ☐ Kidney Problem – Type _____
- ☐ Liver Disease
- ☐ Lupus
- ☐ Low Testosterone
- ☐ Total number of Pregnancies _____
- ☐ Number of Miscarriages _____
- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Disease
  - Type: _____ ☐ Treated ☐Untreated
- ☐ Anemia
- ☐ Iron deficiency
- ☐ B-12 deficiency
- ☐ Vitamin D deficiency
- ☐ Environmental Allergies / Hayfever
- ☐ Frequent infections
- ☐ Eye Glasses or Contact Lens (circle one)
- ☐ Fibromyalgia
- ☐ Hard of Hearing
- ☐ Use of Hearing Aid
- ☐ Dentures
- ☐ Alcoholism
- ☐ Drug Abuse

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:_____

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

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**? _____

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	

Are there any other medical conditions that run in your family?_____
_____

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 that you've had in the last 3 months.

SLEEP
- ☐ Problems going to sleep
- ☐ Problems staying asleep
- ☐ Snoring
- ☐ Excessive daytime sleepiness
- ☐ Falling asleep when you shouldn't
- ☐ Legs moving restlessly
- ☐ Sleep walking / talking
- ☐ Night Sweats

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

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
- ☐ 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
- ☐ Bizarre behavior

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

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
- ☐ Chest pain with breathing
- ☐ Shortness of Breath

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
- ☐ Easy bleeding
- ☐ Swollen lymph nodes

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

_____

Date: _____

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THE EPWORTH SLEEPINESS SCALE

Patient Name: _____

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.

Date: _____

Stop Bang Questionnaire

Name: _____ Age: _____ BMI: _____

Height: _____ Wt: _____ Neck Circumference: _____in

Shirt Collar Size: ☐ Small ☐ Medium ☐ Large ☐ X-Large

Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)
☐ YES ☐ NO

Tired: Do you often feel tired, fatigued or sleepy during the day?
☐ YES ☐ NO

Observed: Has anyone observed that you stop breathing during your sleep?
☐ YES ☐ NO

Blood **P**ressure: Do you have or are you being treated for high blood pressure?
☐ YES ☐ NO

BMI more than 35kg/m2? (If you're not sure ask the nurse)
☐ YES ☐ NO

Age over 50 years?
☐ YES ☐ NO

Neck circumference greater than 40 cm (15.75 in)?
☐ YES ☐ NO

Gender, male?
☐ YES ☐ NO

International Restless Leg Syndrome (IRLS) Symptoms Questionnaire

1. **Do you have the desire to move your legs, often because of discomfort or restlessness?**

   (The need to move is often accompanied by uncomfortable sensations. Some words used to describe these sensations include: creeping, itching, pulling, creepy-crawly, tugging or gnawing.)

   ☐ YES ☐ NO ☐ Not Applicable

2. **Does this desire occur or become worse when you are at rest, in other words, when you are sitting or lying down?**

   (The longer you are resting, the greater the chance the symptoms will occur and the more severe they are likely to be.)

   ☐ YES ☐ NO ☐ Not Applicable

3. **Do you note any relief of symptoms completely or partly during activity?**

   (The relief can be complete or only partial but generally starts very soon after starting an activity. Relief persists as long as the motor activity continues.)

   ☐ YES ☐ NO ☐ Not Applicable

4. **Do these symptoms occur or worsen only in the evening or at night?**

   (Activities that bother you at night do not bother you during the day)

   ☐ YES ☐ NO ☐ Not Applicable

Date: _____

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Headache Patient Questionnaire

1. How many days a month do you have any kind of a headache?

2. How many days a month do you have a severe headache or migraine?

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

4. When you have a migraine / headache, how many hours do they last on average?

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

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

7. Which medications have you **tried**: (circle all that apply) Advil, Aleve, Ibuprofen, Tylenol, etc.

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

9. Do these things ever happen when you have a headche (checkmark all that apply):
   - ☐ Seeing zig-zag lines
   - ☐ Having a blind spot
   - ☐ Things look too big or too small
   - ☐ You go numb on one side
   - ☐ Tearing of one eye
   - ☐ Running or stuffiness one nostril
   - ☐ Losing vision to one side
   - ☐ Sensation of room spinning
   - ☐ You pass out or come close to it
   - ☐ You get weak on one side
   - ☐ One drooping eyelid
   - ☐ Redness / Swelling one eye

10. Is your headache pain sometimes (checkmark all that apply):

☐ Made worse with movement/activity ☐ One-sided
☐ Pounding ☐ Stabbing
☐ Throbbing ☐ Pressure

11. Do you have any of the following with your headaches? (checkmark all that apply):

☐ Ringing ears ☐ Tender scalp
☐ Neck pain

12. Is your headache onset after **strenuous physical exercise or sex**?

☐ Yes
☐ No

13. Are your headaches **produced** (not just worsened) by **straining**, such as with a bowel movement?

☐ Yes
☐ No

14. Have your headaches had a recent **change in pattern**?

☐ Yes
☐ No

15. Have your headaches **worsened** over the past 4 weeks **despite medications** that previously worked?

☐ Yes
☐ No

16. Do your headaches occur with a **sudden onset**?

☐ Yes
☐ No

17. Do you have a history of **head trauma** within the past year?

☐ Yes
☐ No

18. Do your headaches **frequently awaken** you at night?

☐ Yes
☐ No

19. Do you **wake up** with a headache?

☐ Yes
☐ No

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 (ORDER 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:_____

_____

PATIENT SIGNATURE _____ DATE _____

REVIEWED IN CLINIC BY:_____

DID THE TECHNOLOGIST IDENTFTY THE PATIENT BY PHOTO ID AND BY STATING THEIR FULL NAME AND DOB: YES NO

TECH Initials ____ PATIENT SIGNATURE _____ DATE _____

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

Gadavist ____mL Dose: 0.1 mL/kg Lot# _____
1 mmol/mL

Injection site _____ Exp:_____

T1 delayed post injection _____

SCREENED BY:_____ SCANNED BY:_____

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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.

- **Many insurance plans now have large deductibles.**
- **If your initial visit is subject to your deductible, versus having a copay we will require a partial payment for that visit of $150.**
- **We do require a portion of your deductible to be paid at the time testing is scheduled. We will give you an estimate of your portion, however, keep in mind actual amounts are determined by your insurance company.**
- **We also require you to leave a Credit Card on file that will be held for the unpaid portion of your bill after insurance processes your claim. You will have the ability to call and set up a payment plan, before any auto debiting of your account would occur. If you do not pay your bill in full, you must set up a payment plan within two billing cycles. Failure to set up a payment plan for the balance after your insurance processes your claims will result in this card being charged.**
- **For most of these balances after insurance pays, we will allow 6 months of payments here at our office, with a minimum payment of $50 per month for small balances under $300.**
- **For larger amounts, if you cannot pay us in 6 monthly payments, we offer Care Credit (on balances over $800) at no interest for 6 or 12 months if you qualify with Care Credit. It is an outside company that you would apply to from your home computer or by phone. Contact our billing office if you need the information on how to apply and we can email that to you.**

Please call our billing office at 913-827-4247 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 S
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: _____