Midwest
Neurology Associates
Samer Kassar M.D.

NEW PATIENT INFORMATION

Patient Name _____
Last **First** **MI**

Address _____
Street **City** **State** **Zip**

Home Phone _____ **Cell Phone** _____

Email _____ **Marital Status** _____

SSN _____ **Date of Birth** _____ **Age** _____

Emergency Contact Name _____ **Relation** _____

Emergency Contact Phone Number _____

Employer _____ **Phone number** _____

Spouse Name _____ **Spouse Date of Birth** _____

Responsible Party (other than patient):

Name _____ **Phone Number** _____

Relationship to Patient _____ **Date of Birth** _____

Insurance Policy Holder (other than patient):

Name _____ **Relation** _____ **SSN** _____

Address _____ **Phone Number** _____
Street **City** **State** **Zip**

Pharmacy Name _____ **Zip Code** _____ **Phone Number** _____

Primary Physician _____ **Phone Number** _____

Referring Physician _____ **How did you hear about us?** _____

Authorization to Pay Benefits to Provider

I request that Payment of authorized Medicare benefits and all Non-Medicare benefits be made either to me or on my behalf for any services furnished me by Midwest Neurology Associates, P.C., including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, it's agents, and all other respective agent's information needed to determine these benefits for related services. I understand that I am financially responsible to Midwest Neurology Associates, P.C., for services not covered by my policies. In the event that my account is turned to collections, I agree to pay all collection costs and attorney's fees. According to the HIPAA guidelines, I acknowledge that I have had available and/or received the Notice of Privacy Practices from Midwest Neurology Associates, P.C.

Signature _____ Date _____

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Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Midwest Neurology Associates for the purposes of treatment, payment, and health care operations.

For treatment: this includes verbal and written information that we obtain about you and use to treat you. It may include, but is not limited to, communication with other professionals about past or future care, consultation about your case, and/or referral to another provider.

For payment: this includes any activities we must undertake in order to get reimbursed for the services we provide to you. It may include, but is not limited to, submitting bills to insurance companies or collection agencies, and authorizations for services.

For health care operations: this means any activities that are needed to run the business of Midwest Neurology Associates. These activities may include, but are not limited to, quality assurance activities, outcomes evaluation, business planning and development, processing grievances and complaints, and certain activities that may include fund raising and research.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Midwest Neurology Associates' Notice of Privacy Practices prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur during my treatment, for payment of my bills, or in the performance of health care operations of the practice as well as my rights and the practice's duties regarding my protected health information. The Midwest Neurology Associates' Notice has been provided to me. The Notice is also provided in the front office and on the practice's web site. The terms of the Notice may change. I may obtain a revised notice of privacy practices by accessing the Midwest Neurology Associates' website, by calling the office and requesting a revised copy be sent in the mail, or by asking for one at the time of my next appointment.

I understand that diagnosis or treatment of me by Midwest Neurology Associates may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction on how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Midwest Neurology Associates is not required to agree to the restrictions that I request, but if the practice agrees, the restriction is binding on the practice.

I understand that I have the right to revoke this consent, in writing, at any time. I understand that this revocation does not apply to information already used or disclosed on the basis of my prior written consent.

Your signature below is only acknowledgement that you received this Notice of Privacy Practices.

_____

Print Name

_____ _____

Signature Date

Midwest
Neurology Associates
Samer Kassar M.D.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact the Compliance Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment, Payment, Healthcare Operations: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose your protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information. See Consent for Purpose of Treatment, Payment and Healthcare Operations form.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Compliance Officer to request that these materials not be sent to you.

In compliance with federal and state laws, we may make your protected health information available electronically through an electronic health information exchange to other health care providers and health plans that request your information for purposes of Treatment, Payment, and Health Care Operations; and to public health entities as permitted by law. Participation in an electronic health information exchange also lets us see other providers' and health plans' information about you for purposes of Treatment, Payment, and Health Care Operations.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to sub-communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law**
- **Public Health**
- **Communicable Diseases**
- **Health Oversight**
- **Abuse or Neglect**
- **Food and Drug Administration**
- **Legal Proceedings**
- **Law Enforcement**
- **Coroners, Funeral Directors, and Organ Donation**
- **Research**
- **Criminal Activity**
- **Military Activity and National Security**
- **Workers' Compensation**
- **Inmates**
- **Required Uses and Disclosures**

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is

subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the Compliance Officer if you have questions about access to your medical records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting the Compliance Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for your information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Compliance Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated records set for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Compliance Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon requests, even if you have agreed to accept this notice electronically.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer, Privacy Officer or Vice President of Human Resources of your complaint. You also have the right to file a complaint with The Joint Commission. To do so, call (800)994-6610 between 8:30 a.m. to 5:00 p.m. Monday through Friday. We will not retaliate against you for filing a complaint.

Your signature below is only acknowledgement that you received this Notice of Privacy Practices.

_____

Print Name

_____ _____

Signature Date

Midwest
Neurology Associates
Samer Kassar M.D.

Cancellation/No Show Policy For Appointments and Procedures

Cancellation/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee. This fee will NOT be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen. However, we must try to keep the other patients and doctors on time.

If a patient is fifteen (15) minutes past their scheduled time we will have to reschedule the appointment.

Cancellation/No Show Policy for Procedures

Due to the large block of time needed for procedures, including EMG/EEG/Botox/Pain Injections, last minute cancellation can cause problems and added expenses for the office.

If a procedure is not cancelled at least 2 days in advance you will be charged a fifty dollar ($50) fee. This fee will NOT be covered by your insurance company.

Account Balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over one hundred dollars ($100) must make payment arrangements prior to future appointments being made.

_____

Print Patient Name

_____ _____

Patient or Guardian Signature Date

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NEW PATIENT HISTORY FORM

Name: _____

Reason for Visit: _____

Please list any current medications you are taking or attach a written list:

_____ mg _____ times a day
_____ mg _____ times a day
_____ mg _____ times a day
_____ mg _____ times a day

_____ mg _____ times a day
_____ mg _____ times a day
_____ mg _____ times a day
_____ mg _____ times a day

All known allergies: _____

_____

Smoking habits (circle one): Daily Sometimes Former Never

Family History

Please check all that apply, if applicable please list how that family member is related to you. (mother, father, etc.)

_____ Migraines _____ Relation
_____ Epilepsy _____ Relation
_____ Dementia/Alzheimer's _____ Relation
_____ Multiple Sclerosis _____ Relation
_____ Aneurysm _____ Relation
_____ Stroke _____ Relation
_____ High Blood Pressure _____ Relation
_____ Heart Disease _____ Relation
_____ Cancer _____ Relation
_____ Parkinson's _____ Relation

Medical History

Please check all that apply to you.

_____ Stroke or TIA
_____ High Blood Pressure
_____ Seizures
_____ Diabetes

_____ Cancer
_____ Rheumatic Fever
_____ Arthritis
_____ Thyroid Disease

_____ Multiple Sclerosis
_____ Heart Disease
_____ Migraine Headaches

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NEW PATIENT HISTORY FORM

Neurological Symptoms

Please check all that apply to you and list the date symptoms began.

Symptom	Date of Onset	Symptom	Date of Onset
___ Migraines	_____	___ Fatigue	_____
___ Headaches	_____	___ Insomnia	_____
___ Head Trauma	_____	___ Anxiety	_____
___ Difficulty Walking *(Off Balance)*	_____	___ Depression	_____
___ Neck Pain/Injury	_____	___ Suicidal Thoughts	_____
___ Back Pain/Injury	_____	___ Liver Problems	_____
___ Loss of Consciousness *(Fainting)*	_____	___ Kidney Problems	_____
___ Dizziness/Vertigo	_____	___ Slurred Speech	_____
___ Light Headedness	_____	___ Memory Loss	_____
___ Decreased Hearing	_____	___ Seizures	_____
___ Ringing in Ears	_____	___ Muscle Spasms	_____
___ Trouble Swallowing	_____	___ Tremors	_____
___ Nausea/Vomiting	_____	___ Numbness/Tingling	_____
___ Vision Changes	_____	___ Feeling Weak	_____
___ Problems Concentrating	_____	___ Weight Gain	_____ lbs in the last year
___ Attention Problems	_____	___ Weight Loss	_____ lbs in the last year
___ Comprehension Difficulties	_____	___ Pregnant	_____ Due Date

Previous Hospitalization and/or Surgeries

_____

_____

_____

_____

219-836-2096 | 1100 Joliet St, Suite 201, Dyer, IN 46311

PATIENT INFORMATION AUTHORIZATION

PATIENT NAME (PLEASE PRINT) _____D.O.B _____

It is the policy of **MIDWEST NEUROLOGY ASSOCIATES, P.C.** that all personnel much preserve the integrity and the confidentiality of medical and financial information pertaining to our patients. The purpose of this policy is to ensure that **MIDWEST NEUROLOGY ASSOCIATES, P.C.** and its officers, employees and agents have the necessary medical and financial information to provide the highest quality of service while protecting the confidentiality of that information to the highest degree possible. To the end we ask that the patient complete the following information.

Information regarding the status of my medical condition may be given to:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Signature of Patient: _____**Date:**_____

(I was offered a copy of the Notice of Privacy Practices)

Midwest Neurology Associates
1100 Joliet St, #201
Dyer, IN 46311
(219) 836 - 2096

GAD-7

Patient Name _____ DOB: _____

Over the last **2 weeks** how often have you been bothered by any of the following problems?
0 = Not at all
1 = Several days
2 = More than half of the days
3 = Everyday

1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to control or stop worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

TOTAL SCORE: _____ **DATE:** _____

Midwest Neurology Associates
1100 Joliet St. #201
Dyer, IN 46311
(219) 836-2096

PHQ-9

Patient Name_____ DOB: _____

Over the **last 2 weeks** how often have you been bothered by any of the following problems?

0 = Not at all
1= Some Days
2 = More than half of the days
3 = Nearly everyday

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 hurting yourself in some way	0	1	2	3

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 At All Somewhat Difficult Very Difficult Extremely Difficult

TOTAL SCORE: _____ **DATE:** _____