Attention Patients:

We would like to inform you of our 2016 Practice Policies that are effective immediately.

Co-Payments are due and will be collected at time of service. For your convenience we accept cash, checks, and all major credit cards.

MEDICARE PATIENTS:

AS REQUIRED BY MEDICARE, PLEASE PROVIDE US WITH YOUR REFERRING PHYSICIAN. Without this, Medicare will not process and/or pay for this or any future dates of services.

Please note we do NOT participate with any Medicaid plans. If you have Medicaid as supplement insurance, you will be responsible for any deductible and/or 20% co-insurance.

WORKER’S COMPENSATION & HMO PATIENTS:

We will no longer be able to see patients without an active referral on file from your Claim’s Adjuster and/or PCP with insurance authorization. If you have any questions or concerns, please see Front Desk.

CANCELLATION AGREEMENT:

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

If an appointment is not cancelled at least 48 hours in advance, you (not your insurance company) will be charged a $25.00 cancellation fee. If you should fail to show up for an appointment or call, you will be charged a $50.00 no-show fee. A missed EMG/Nerve test and Infusion will result in a charge of $100.00. A missed Sleep Study will result in a $200.00 charge.

We appreciate your understanding and cooperation.

Integrated Neurology Services

PATIENT SIGNATURE:__________________________________________

DATE:___________________________________
NAME: (Last) ____________________________(First) __________________________(MI) ____________

Home Address: Street/PO Box: _____________________________________________________________

City: __________________________ State: __________________________ Zip Code: __________________________

Primary Phone Number: __________________________*This number WILL be called for Appointment Reminders.

E-mail: ________________________________________________________________

Date of Birth: ____________ Age: ________ Gender: ________ Social Security#: ____________

Marital Status: _____Single______ Married______ Divorced______ Widowed______ Other ________

Race: __American Indian or Alaskan__ Asian_____ Black______ Caucasian_____ Pacific Islander_____ Other ______

Ethnicity: ___Hispanic___ Non-Hispanic____ Decline Language/s: ________________________________

Employer: __________________________ Occupation: __________________________

Emergency Contact: __________________________ Relationship: __________________________ Phone #: __________________________

Referring Doctor: __________________________ Specialty: __________________________ Phone #: __________________________

Primary Doctor: __________________________ Phone #: __________________________

PRIMARY INSURANCE:

Insurance Address: ________________________________________________________________

Policy #: __________________________ Group #: __________________________

Policy Holder’s Name: (Last) __________________________(First) __________________________ (MI) ____________

DOB: ____________ Sex: _____ SS# ____________ Employer: __________________________

Relationship of Patient to Policy Holder: _____ Self____ Spouse_____ Child_____ Other ______

Do you have a Secondary Insurance? Yes No If Yes, Please provide the following info below.

SECONDARY INSURANCE:

Insurance Address: ________________________________________________________________

Policy #: __________________________ Group #: __________________________

Policy Holder’s Name: (Last) __________________________(First) __________________________ (MI) ____________

DOB: ____________ Sex: _____ SS# ____________ Employer: __________________________

Relationship of Patient to Policy Holder: _____ Self____ Spouse_____ Child_____ Other ______

PATIENT AUTHORIZATION: I hereby authorize Integrated Neurology Services to apply benefits on my behalf for services rendered and request the payments from my insurance company to be made directly to this office. I authorize the office for release of information related to services rendered to my insurance company to expedite the payment of my claim. I understand that this authorization may be revoked by me at anytime in writing ** Required by HIPPA

This is acknowledgment that I have read and understand the above:

Signature: __________________________ Date: __________________________
Integrated Neurology Services

Patient Name: [ ]
Date: [ ]

Reason(s) for neurological consultation:

Current Symptoms (Review of Systems):
- Fever
- Chills
- Weight Up/Down
- Visual Changes, Eye Pain
- Hearing Loss, Ringing in Ears, Ear pain
- Sinus Congestion, Runny Nose, Sneezing
- Chest Pain, Palpitations
- Shortness of Breath, Wheezing
- Diarrhea, Constipation, Vomiting
- Abdominal Pain
- Acid Reflux
- Leg Swelling
- Bruising, Bleeding
- Heat/Cold Intolerance
- Urinary Frequency/Urgency
- Rash

Past Medical History (check all that apply):
- Acid Reflux/GERD
- AIDS/HIV
- Alcoholism
- Alzheimer’s/Dementia
- Anemia
- Aneurysm
- Anxiety Disorder
- Arthritis
- Asthma
- Atrial Fibrillation
- Autoimmune Deficiency
- Back Problems/Pain
- Bleeding Disorder
- Blood Clot
- Blood Transfusion
- Cancer (Type? ____________)
- Carotid Artery Surgery
- Cataracts
- Chronic Fatigue
- Chronic Pain (Where? ____________)
- Concussion
- Congenital Heart Disease/Defects
- COPD
- Depression
- Diabetes
- Eating Disorder
- Epilepsy
- Erectile Dysfunction
- Fibromyalgia
- Glaucoma
- Gout
- Headache
- Dizziness
- Numbness/Tingling (Where? ____________)
- Pain (Where? ____________)
- Confusion/Memory Loss
- Tremors/Shaking (Where? ____________)
- Trouble Chewing/Swallowing
- Speech Changes
- Imbalance
- Weakness (Where? ____________)
- Bowel/Bladder Incontinence
- Joint Pain/Muscle Pain
- Sleeping Problems, Snoring
- Anxiety/Depression
- Other (please specify):

[ ] Head Injury
[ ] Heart Disease
[ ] Heart Valve Problem
[ ] Hepatitis B or C
[ ] Herpes
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Joint Disorder
[ ] Kidney Disorder
[ ] Liver Disorder
[ ] Lupus
[ ] Migraines
[ ] Mild Cognitive Impairment
[ ] Multiple Sclerosis
[ ] Muscle Disease
[ ] Neuropathy
[ ] Osteoporosis
[ ] Pacemaker
[ ] Parkinson’s Disease
[ ] Peripheral Vascular Disease
[ ] Pneumonia
[ ] Post Traumatic Stress Disorder
[ ] Shingles
[ ] Skin Disorder
[ ] Sleep Apnea
[ ] Stroke
[ ] Substance Abuse
[ ] Thyroid Disorder
[ ] Tuberculosis
[ ] Other

Patient Signature ____________________________________
Past Surgeries (include date/year):
1.
2.
3.
4.
5.

Family History: Has anyone in your family ever had any of the following conditions? Please specify family member.

- Alcoholism: ___________________
- Alzheimer’s/Dementia: __________________
- Aneurysm: ___________________
- Anxiety: ___________________
- Blood clots: ___________________
- Brain Tumor: ___________________
- Depression: ___________________
- Diabetes: ___________________
- Heart Attack: ___________________
- High Blood Pressure: ___________________
- High Cholesterol: ___________________
- Migraines: ___________________
- Multiple Sclerosis: ___________________
- Muscle Disease: ___________________
- Neuropathy: ___________________
- Parkinson’s Disease: ___________________
- Seizures: ___________________
- Stroke: ___________________
- Thyroid Disease: ___________________
- Other: ___________________

Medications

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<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Time</th>
<th># Of times taken per day</th>
<th>Prescribing Physician</th>
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</table>

Medication Allergies (include type of reaction):
1.
2.
3.
4.
5.

Social History:

Smoking:   none ever   previous smoker (when did you quit?)
   current smoker (amount?)
Alcohol:   none ever   previous drinker (when did you quit?)
   current use (# of drinks per week)

Patient Signature__________________________
HIPAA

Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information.

Circle all that apply:

- Myself Only
- Spouse
- Adult Children
- Parents
- Sibling(s)
- Personal Representative
- Employer

Print Name(s) of above:

__________________________________________________________________________

__________________________________________________________________________

My signature below authorizes the release of my personal medical information to any specialists I may be referred to and to process insurance claims/applications, prescriptions, and lab work.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payments from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry treatment, payments or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide such restrictions.

Patient/Responsible Party Name: __________________________ Date: __________________________

Patient/Responsible Party Signature: __________________________
WEBVIEW REGISTRATION

The HIPAA Privacy Rule grants individuals the right of access to inspect and obtain a copy of protected health information (PHI) about the individual. Meaningful Use regulation requirements include the obligation of eligible professionals and hospitals to provide patients the ability to view online, download, and transmit their health information, and of eligible professionals to use secure electronic messaging to communicate with patients on relevant health information. We thank you for your assistance on this matter.

To access your medical information online navigate to https://webview.mckesson.com/insweb/

Your email address: ________________________________

WEBVIEW SECURITY QUESTION & DISCLOSURE

Patient Name:_____________________________________________

Security Question: What is your favorite color?

Security Answer:___________________________________________
(ex: Green)

PATIENT E-MAIL COMMUNICATION DISCLOSURE CONSENT

Integrated Neurology Services will use all reasonable means to protect the security and confidentiality of e-mail information sent and received. However, Integrated Neurology Services, cannot guarantee the security and confidentiality of e-mail communication, and will not be held liable for improper disclosure of confidential information that is not caused by Integrated Neurology Services misconduct. Thus patient consent to the use of e-mail is required and includes agreement with the following conditions:

Integrated Neurology Services may use e-mail to communicate the following information:

1. Receive and respond to questions from patients, including non-urgent patient health issues and prescription refill requests.

2. Test and consultation results.

3. Other information including medical or drug alerts, patient education, new services or other patient information.

Integrated Neurology Services will not share patient e-mail addresses with any third parties.

APPROVED:

__________________________  _________________________
Signature by parent or guardian if patient under 18 yrs  Date
RELEASE OF MEDICAL RECORDS
Physician(s) or Facility with current records:

MD/Facility Name: ________________________________

Address: __________________________________________

Phone: _____________________ Fax:_____________________

Please release my records to the following physician(s) or facility:

Integrated Neurology Services
  Simon Fishman, MD
  Neal Maru, MD
  Natalia Kayloe, MD

6355 Walker Lane #313
Alexandria, VA 22310
P. 703-313-9111
F. 703-313-4945

Please send all information during all of my treatment with you or your facility. With my authorization I release you and/or your facility and the doctor(s) and/or facility receiving these records from legal responsibilities with regard to my records realizing that my records may contain sensitive information.

Patient Name: ________________________________

Date of birth :________________________

Signature:______________________________

Guardian (If patient is a minor): ________________________

Date: ____________________________________