INSTITUTE OF **NEUROMUSCULAR MEDICINE**

Patient Provider Partnership for Specialist Care

At **Institute of Neuromuscular Medicine**, our goal is to provide you with the highest standard of specialty care that we have been entrusted with by your Primary Care Physician. Your care will be coordinated with your Primary Care Physician who acts as your Patient Centered Medical Home (PCMH). Below are some guidelines to make the best of this partnership:

This means that our practice will make every effort to:

- Schedule your appointment as soon as possible keeping in mind the goals and recommendations of your Primary Care Physician.
- Communicate regularly with your Primary Care Physician making sure that we receive and provide information to coordinate your care.
- Consider all your needs when we work with you to develop your treatment plans and health goals.
- Have open and honest discussions with you regarding your health and plans for managing your care.
- Provide you with information to help you learn how to self-manage your condition, and assist you with establishing goals for the chronic condition we are assisting you with.
- Work with you to create a plan for any other urgent health care need that may arise related to your chronic condition.
- Be available to you by phone and in the office to answer your questions and concerns as they arise.

This means you should make every effort to:

- Make and keep all appointments recommended by our office. If you must cancel an appointment, make every attempt to reschedule it as soon as possible.
- Follow through with recommended testing and contact the office if you cannot get these tests completed.
- Participate and commit to the treatment plan and health care goals developed by you and your physician or other health professional.
- Be sure you understand the treatment plan. If you do not understand, ask questions until you feel comfortable with the agreed upon treatment plan.
- Tell us immediately if you are not able to follow the treatment plan for any reason so we can assist you in adjusting the plan so you get the best results.
- Follow up with your Primary Care Physician for your overall healthcare needs.

As part of comprehensive quality care and to support population management healthcare information is shared among care partners as necessary.

BlueCross BlueShield Association

ST. JOHN MEDICAL GROUP
A PHYSICIAN ORGANIZATION

INSTITUTE OF **NEUROMUSCULAR MEDICINE**

Cancellation Policy

A specific time has been reserved especially for you. A broken appointment is a loss and inconvenience to everyone.

As a courtesy, we attempt to confirm appointments the day before. However, we do not assume responsibility for the appointment time.

If you need to change your appointment, we require at least a 24-hour notice. We reserve the right to charge for appointments broken or cancelled without 24-hour advanced notice. Our charges are as follows:

Physician Appointments:

$90.00 fee for a 30-minute appointment

Massage and Physical Therapy:

$50.00 fee for 30-minute appointment
$80.00 fee for 60-minute appointment

We appreciate your understanding and cooperation in this matter.

INSTITUTE OF **NEUROMUSCULAR MEDICINE**

Co-payment and Out of Pocket Costs

Out of pocket and co-payments are contractual obligations with your insurance company. You are required to pay these services at the time of each visit. Out of pocket costs may include, but are not limited to:

- Co pays on office visits
- Deductibles/coinsurance
- Non-covered services
- Forms that need to be completed by your physician

If you cannot make your required out of pocket costs or co-payments, we reserve the option to:

- Reschedule your appointment
- Charge a $5.00 administrative fee in addition to your co-pay for that date of service

For cash patients:

We understand that medical costs can be overwhelming. Here at Institute of Neuromuscular Medicine, we will do what we can to keep your medical costs down.

Unfortunately, we cannot have one set fee for your visit. The provider you see at the time of service determines this according to the level of service provided. We cannot quote you what your charges will be before you see the doctor.

Payment is expected in full at the time of service. If full payment is received at the time of the visit, your services will be discounted.

Patient Information

Patient Name:_____ Soc.Sec.No:_____

Address:_____
Street City State Zip Code

Phone: ( )_____ ( )_____ ( )_____
Home Business Cell

Date of Birth:_____ Email Address:_____

Employer:_____ Occupation:_____ ( )_____
Pharmacy: Name & Location or ph#

How did you hear about our office:_____

Insurance Card Holder Information:

Name of Policy Holder:_____ Relationship:_____ Date of Birth:_____

Address of policy holder:_____ Phone:_____

Emergency Contact Information:

Emergency Contact:_____ Relationship:_____

Emergency Contact Numbers: ( )_____ ( )_____
Home Cell

Please answer the following:

Can we leave Private Health Information (such as, but not limited to: normal test results, medication changes, etc) on your answering machine or by email? ☐ Yes ☐ No If no, please specify below:

☐ No one other than myself ☐ Spouse (Name)_____ ☐ Other (Name)_____

I authorize this office to call and confirm scheduled appointments one to two days in advance and to leave a message on home voicemail / recorder or with another family member: ☐ Yes ☐ No

Do you have an Advanced Directives and Power of Attorney for Health Care? _____ If not, would you like us to provide you with this information? Yes ☐ No ☐

Please sign:

_____ _____ _____
Patient or Guardian Signature Relationship Date

We will need copies of your insurance card and drivers license

INSTITUTE OF **NEUROMUSCULAR MEDICINE**

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Institute of Neuromuscular Medicine (INM) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by INMM describes such uses and disclosures more completely.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. INMM reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request INMM.

With this consent, Institute of Neuromuscular Medicine may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, INMM may mail to my home or other alternative location, any items that assist the practice of carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, INMM may email to my home or other alternative location, any items that assist the practice of carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request how that INMM restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow INMM to use and disclose PHI to carryout TPO. In the course of providing care, our providers will share patient information with other providers who are involved in the patients care as appropriate.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or revoke it later, INMM may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Name of Legal Guardian (if applicable)

INSTITUTE OF **NEUROMUSCULAR MEDICINE**

Verifications and Acknowledgments

Policies and Procedures:

I acknowledge that I have read and/or received a copy of the Institute of Neuromuscular Medicine, P.L.C. Patient Notice of Privacy Practices effective September 23, 2013:

Signature:_____ Date: _____ /_____ /_____

Out-of-Pocket and Co-Payment Policy:

I have been presented with a copy of the out of pocket and copayment policies and understand my responsibilities:

Signature:_____ Date: _____ /_____ /_____

Cancellation Policy:

I have been presented with a copy of the cancellation policy and understand my responsibilities:

Signature:_____ Date: _____ /_____ /_____

Privacy Policy:

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under Federal and State law, and outlining my rights regarding my health information:

Signature:_____ Date: _____ /_____ /_____

Authorization to Release Information and Assignment of Benefits:

I authorize the release of any medical information necessary to process my claim. I permit a copy of this authorization to be used in place of the original:

Signature:_____ Date: _____ /_____ /_____

I hereby authorize Institute of Neuromuscular Medicine to apply for benefits on my behalf for covered services rendered by Dr. Shah or his associates. I request that payment from my insurance company be made directly to Institute of Neuromuscular Medicine. I permit a copy of this authorization to be used in place of the original:

Signature:_____ Date: _____ /_____ /_____

Today's Date: _____

Patient Name: _____ DOB: _____

HISTORY OF CHIEF COMPLAINT

Why would you like to be seen? _____

_____

_____

Symptoms came on: ☐ Suddenly ☐ Gradually Describe: _____

_____

How long have you experienced these symptoms? _____

How did the episode of pain occur?

☐ Work-related injury ☐ Recreational accident
☐ Vehicle accident ☐ No known cause
☐ Other _____

If your pain is the result of an injury, please describe the incident in detail. **Date of accident/injury:** _____

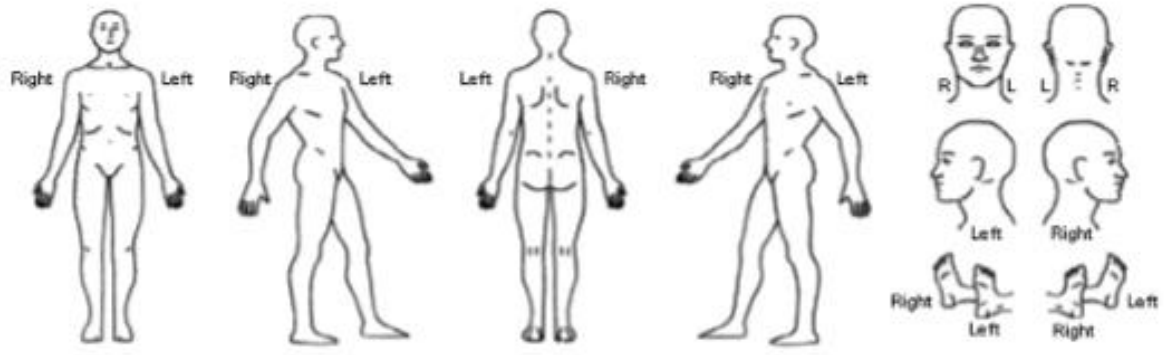
_____

_____

Mark the areas on this diagram where you currently experience pain using the codes indicated below. Include all affected areas. **Lightly** shade areas of pain. If pain is intense in a particular area, **darkly** shade those areas.

KEY

Use letters below to indicate type and location of discomfort			
A = Ache **N** = Numbness	**B** = Burning **P** = Pins & Needles	**S** = Sharp/Stabbing **T** = Tightness/Stiffness	**O** = Other



How would you describe your overall severity of pain?

☐ Mild nuisance ☐ Severe. It is ruining the quality of my life.
☐ Mild to moderate, but I can live with it ☐ None, I have no pain.
☐ Moderate. I am having difficulty dealing with it.

How frequently does your pain occur? ☐ Constantly Present ☐ Comes and goes

Does the pain vary in intensity? If so, what seems to make it better or worse?

	Heat	Ice	Rest	Certain position	Movement/stretching
Better	☐	☐	☐	☐	☐
Worse	☐	☐	☐	☐	☐

PRIOR TREATMENTS

Treatment	Result	Treatment	Result
☐ Spinal injections	_____	☐ Chiropractic	_____
☐ Trigger Point injections	_____	☐ Osteopathic	_____
☐ Steroid injections	_____	☐ Surgery	_____
☐ Prescriptions	_____	☐ Acupuncture	_____
☐ Bracing	_____	☐ TENS unit	_____
☐ Traction	_____	☐ Corrective Exercises	_____
☐ Massage	_____	(trainer or yoga instructor)	
Other: _____	_____	Other: _____	_____

TESTS DONE

✱✱✱✱✱ Please bring copy of any reports and discs/films to your first appointment ✱✱✱✱✱

Test	Date	Result
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST YOUR OTHER HEALTHCARE PROVIDERS

Provider	Specialty	Problem being treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALL PRIOR SURGERIES

Type of surgery	Body location	Month/Year	Surgeon/Facility
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CANCER HISTORY

Location: _____ When: _____

Treatment: _____ Status: _____

Additional Information: _____

_____

_____

SYSTEM REVIEW

Current and Past Medical History

☐ Chicken pox
☐ Hepatitis: Type _____
☐ Other_____
☐ HIV
☐ Herpes
☐ Other: _____

☐ Depression
☐ Panic Attacks
☐ Anxiety
☐ Bipolar Disorder
☐ ADD/ADHD
☐ Narcolepsy
☐ Sleep Apnea
☐ Insomnia
☐ Other: _____

☐ Alcoholism
☐ Drug Addiction/Abuse _____

☐ Hypertension
☐ Myocardial Infarction
☐ Blocked Artery
☐ Varicose Veins
☐ Rheumatic Fever
☐ Heart Murmur
☐ CHF
☐ Blood Clots
☐ Other: _____

☐ Migraines
☐ Other Headaches
☐ Seizure Disorder
☐ Parkinson's
☐ Concussion/Closed Head injury/ Traumatic Brain Injury
☐ Stroke
☐ Other: _____

☐ Stomach/Duodenal Ulcer
☐ Gallbladder Disease
☐ Other: _____
☐ Diverticulitis
☐ Liver Disease

☐ Asthma
☐ Chronic Bronchitis
☐ Other: _____
☐ COPD/Emphysema
☐ Tuberculosis

☐ Kidney Stones
☐ Gout
☐ Kidney Disease
☐ Prostate Problems
☐ Bladder Problems
☐ Other: _____

☐ Diabetes
☐ Blood Transfusion
☐ Anemia
☐ Bleeding Tendency
☐ Thyroid Disease
☐ Other: _____
☐ Rheumatoid Arthritis
☐ Lupus
☐ Sickle Cell Anemia
☐ Psoriasis
☐ Eczema

☐ Allergies (Seasonal)
☐ TMJ Problems
☐ Hearing Loss
☐ Other: _____

Medical Allergies: _____
_____
Reaction: _____
_____

Check the following symptoms that you are CURRENTLY experiencing

General/Constitutional

☐ Weakness ☐ Chills ☐ Change in weight/appetite
☐ Night sweats ☐ Fevers ☐ Change in sleeping habits
☐ Fatigue

Mood/Sleep

☐ Falling asleep
☐ Staying asleep
☐ Early awaking
☐ Not awaking rested
☐ Sleeping too much
☐ Witnessed apnea
☐ Poor memory
☐ Indecisiveness
☐ Low self-esteem
☐ Loss of interest
☐ Sad mood
☐ Poor concentration
☐ Anxiety
☐ Moodiness

Cardiovascular

☐ Chest pain
☐ Ankle swelling
☐ Easy fatigue
☐ Trouble breathing at night
☐ Trouble climbing stairs
☐ Blood clots/phlebitis
☐ Palpitations/heart pounding

Nervous System

☐ Headache
☐ Dizziness
☐ Double vision
☐ Muscle weakness
☐ Tremor/hand shaking
☐ Loss of Coordination
☐ Numbness/tingling

Gastrointestinal

☐ Stomach/abdominal pain
☐ Indigestion/heartburn
☐ Black, tarry stools
☐ Changes in bowel habits
☐ Loss of control of bowels
☐ Difficulty swallowing
☐ Vomiting/nausea
☐ Diarrhea/constipation
☐ Blood in stools

Respiratory

☐ Wheezing
☐ Frequent bronchitis
☐ Shortness of breath with minimal exertion
☐ Frequent or chronic cough

Genitourinary

☐ Pain w/ urination
☐ Urgency
☐ Leaking urine
☐ Frequent urination
☐ Difficulty starting stream
☐ Weak stream
☐ Frequent infections
☐ Blood in urine
☐ Loss of bladder control
☐ Excessive nighttime urination

Endocrine/Heme/Lymph/Immune

☐ Excessively hot
☐ Excessively cold
☐ Cold hands or feet
☐ Discoloration of hands or feet
☐ Always hungry
☐ Swollen glands
☐ Pain or tightness in legs w/ walking
☐ Easy bruising
☐ Swelling

Eyes, Ears, Nose, Throat

☐ Glasses/contacts
☐ Blurring or spots
☐ Eye pain
☐ Double vision
☐ Ringing in ears
☐ Loss of/decreased hearing
☐ Taste or smell changes
☐ Excessive snoring
☐ Frequent sore throats
☐ Double vision
☐ Hoarseness
☐ Neck swelling

SOCIAL AND PERSONAL HISTORY

Currently live: ☐ Alone ☐ With family ☐ With significant other ☐ With friends

Last grade/degree completed in school: _____

Occupation: _____

Are there any health risks associated with your job, home environment, or activities? ☐ Yes ☐ No

If yes, please explain: _____

_____

Diet and Nutrition

Do you exercise regularly? ☐Yes ☐No How often? _____ Type: _____

Approximate # of glasses of water consumed per day _____ _____

Do you mostly: ☐Cook at home ☐Eat out ☐Eat prepared or prepackaged foods

Do you eat a lot of: ☐Vegetables ☐Fruits ☐Sugar ☐Fats ☐Animal products

Coffee or tea? ☐Regular ☐Decaffeinated ☐None Number of cups/day: _____

Habits

Do you currently smoke? ☐Yes ☐No If yes, how much: _____ How many years: _____

Are you a former smoker? ☐Yes ☐No

Do you chew tobacco? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No Amount: _____ oz # _____ of drinks per week/month/year

Do you currently use drugs? ☐Yes ☐No Type: _____ Frequency: _____

Have you ever used drugs? ☐Yes ☐No Type: _____ Frequency: _____

Family Health History

Have any family relatives (mother, father, brother, sister, grandfather, grandmother, aunt, uncle, cousin, nephew, niece, son, daughter) suffered from any of the following? Please list the people relative to their relationship to you:

Condition	Relationship to you	Condition	Relationship to you
Cancer	_____	Nerve/muscle diseases	_____
Heart trouble	_____	Seizures (fits, epilepsy)	_____
Stroke	_____	Anemia (low blood)	_____
Asthma or hayfever	_____	Bleeding problems	_____
Diabetes (sugar)	_____	Rheumatic fever	_____
Gout	_____	Alcoholism	_____
Kidney disease	_____	Mental illness	_____
Arthritis	_____	Physical Deformity	_____
Other: _____	_____	Other: _____	_____

PATIENT NAME: ____________________ DOB: ____________________

ALLERGIES: List medical allergies and reactions

MEDICATION HISTORY LOG

List any medications and supplements you are currently taking

MEDICATION	DOSAGE	SIG	START	UPDATED		D/C	COMMENTS