Name: _____ Date: _____

Welcome to South Puget Sound Neurology, the office of Patrick J. Hogan, III, DO, Leslie Noble, ARNP and Sharon K. Jung, ARNP.

Your reserved appointment time is _____ with Patrick Hogan, DO, Leslie Noble, ARNP or Sharon Jung, ARNP. This appointment will last approximately one hour.

The appointment reserves a time especially for you. Due to the demand for Neurological appointments, we ask that you notify our office at your earliest convenience if you will not be able to keep your appointment. **It is our office policy that if you fail to keep our first appointment without letting us know 24 hours in advance, you will be charged a $25.00 time loss fee.**

Please note that our office hours are Monday-Thursday 8am-4:30 pm. We are available from 8-12 on Fridays but with limited providers in office.

Enclosed you will find the forms that need to be completed PRIOR to your appointment. Please complete each form, in its entirety and mail back to our office, using the enclosed envelope as soon as possible. If you choose to not send forms by mail, please arrive to your appointment 30 minutes early. If we do not receive your paperwork (through either method) before your appointment start time, your appointment may be delayed or rescheduled.

Please bring your insurance card or cards and identification with you.

Our billing office will bill your insurance for your visit. However, if your insurance required that you have a referral from your primary physician for treatment, it is your responsibility to make sure and bring a copy of that referral with you. If we do not have a referral at the time of your visit, it will need to be rescheduled or paid as a non insurance visit. Our billing office accepts cash, personal checks, Visa, MasterCard, Discover and American Express as forms of payment. **Your co-payment is due at the time of treatment.**
We look forward to meeting you and assisting in your health care needs.

Sincerely,

Puget Sound Neurology

South Puget Sound Neurology
5006 Center Street Suite U
Tacoma WA 98409
Office: 253-284-4488 Fax: 253-272-4771

Patient Information

Name_____
Last middle first
Marital Status: Single___Married__Divorced___Separated_____ Date of Birth _____
Home Address _____
Street City State zip
Home phone(___)_____ Cell phone (___)_____ M_____ F____
Email address _____ SSN: _____
Employer _____ Occupation_____
Employer Address_____ work phone (___)_____
Spouse/Parent name _____ Date of Birth_____
Spouse/parent address _____
Street City State zip
Spouse Employer_____Address_____
Work phone(_____)_____

Completion of this information in its entirety is required at time of visit

Preferred Pharmacy: _____
Phone number: _____

How do you intend to pay? Cash___ Check_____ Credit Card_____ Insurance_____Other _____
Primary Insurance Co _____ phone (_____)_____
PPO_____ HMO _____
Subscriber _____ID#_____ Group# _____
Secondary Insurance Co _____ phone (_____)_____
PPO_____ HMO _____
Subscriber _____ID#_____ Group# _____

Reason for this visit: Illness_____ Injury_____ job related injury_____Auto____ Other _____
Date of injury or onset of problem_____ Claim # _____
Employer at time of injury _____
Attorney_____ phone_(___)_____ Claim open? Y N

In case of Emergency:
Relative to contact (other than spouse)_____phone _(_____)_____
Other person to contact (not a relative)_____phone (_____)_____

List other doctors providing care
Referred by _____ phone (_____)_____
Primary Care physician _____ phone (_____)_____
DO YOU WANT A COPY OF YOUR CONSULTATION TO GO TO YOUR DOCTOR? Y N
Have you had X-rays or Lab work in the last six months? Y N
If yes, where were they taken?_____

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim
Signature_____ Date_____

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FINANCIAL POLICY

1. You are responsible for payment of the services you receive in our office. Please understand that your medical insurance is a contract between you and your insurance company and you are ultimately responsible for any unpaid balance. Please note, it is YOUR responsibility to know what your policy covers and what id does not. Always carry your insurance card with you. You will need it for all office visits and may need it in case of emergency. Some insurance carriers require we verify your coverage for each office visit. Without this information, we may have to reschedule your appointment or you may have to pay at time of service.

2. We accept payment in case, check, Visa and Mastercard. **NSF checks will have a $40.00 NSF charge applied in addition to the amount of the check.** For your convenience, your bill can be paid on our website by visiting, www.psneurology.com/bill-pay

3. If you have insurance coverage, please give your identification cards and necessary forms to the receptionist. We would be glad to bill your insurance directly. **If you do not have insurance coverage or choose to bill your insurance company yourself, payment is due at the time of your appointment.**

4. **Co-payments are to be paid at the time of your appointment. There will be a $10.00 billing fee for co-payments not paid on date of service.**

5. Missed Appointments—There will be a $25.00 charge for missed appointments. We do require 24 hours notice if you cannot keep your appointment. Your insurance will not pay for missed appointments. This fee will be your responsibility and is required to be paid before your next appointment.

6. Disability/FMLA forms—There is a $25 charge for the completion of FMLA/Disability forms. Fee must be paid prior to physician completing your forms.

Our office sends out monthly statements. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance on your account. You are responsible for any balance due and coordination of payment with your insurance company. **There is a $10.00 re-billing fee for all unpaid balances over 30 days at each statement date.**

PATIENT SIGNATURE: _____ DATE_____

Office Policies

Welcome to our practice! Please review our office policies outlined below:

Insurance Information

Our providers are a provider for Medicare and most major insurance plans. We provide insurance billing. Anything not covered by insurance will be your responsibility.

We request payment at the time of your appointment for services that are not covered by insurance. Your insurance company may also require you to pay a co-payment (copay) at the time of your appointment. When necessary, our staff will work closely with patients who require a payment plan.

If you have any questions regarding which insurance plans we accept or any patient billing concerns, please call us at 253-284-4488. Questions regarding your coverage and benefits should be directed to your employer or insurance company.

Phone calls

Due to the high volume of phone calls, return calls from our providers cannot always be made on the same day. Please allow up to 2 business days to receive a return call for non-emergent issues.

If there is a question that can't be answered quickly, it is best to ask for a short appointment to discuss the problem.

For all medical emergencies, please call 911.

Medication Refills

If you need a prescription refill, it must be called into the pharmacy at least 2-3 business days prior to when you need to pick it up. Call the pharmacy directly to see if your prescription has been called in. Please do not call the office.

Legal and Insurance Forms

Our providers will make every effort to complete FMLA or other medical documentation forms. There will be a $25 up front fee for the completion of forms. In some cases, our providers may request an appointment for form completion.

Rescheduling and Cancellation of Appointments

Due to high demand for an appointment with our providers, we require that you give us 24-hour notice if you need to reschedule or cancel your appointment. If you miss an appointment without calling to cancel or without giving 24-hour notice, we will bill you a fee of $25 for the appointment time. Some situations will be excused.

Test Results

Test results, including lab work, MRI results, EEG results, and other testing will be discussed at your follow-up appointment unless our providers need for you to be aware of the results sooner.

Medical Records

We will be happy to forward a copy of your medical records to another physician. Please send a *signed medical release* request to the office.

Insurance Referrals

If you have an insurance that requires a referral, it is *your responsibility* to make sure you have a valid referral for your appointment with our providers. If our providers order tests that require referrals, the receptionist will call to initiate the referral process, but it is ultimately the responsibility of the patient to check that a referral has been authorized before any testing is done.

Fragrance-Free Policy

Due to the nature of our practice, we maintain a "fragrance-free" environment within our clinic. This is out of respect for smell-sensitive headache patients. Please refrain from wearing perfumes, strong smelling lotions and aftershaves while visiting our clinic.

Patient conduct

We make every effort to treat all patients with courteous respect and professionalism. We kindly ask that patients treat our staff with the same respect. Please remember that we are here to help you on behalf of the providers. Inappropriate behavior, including but not limited to inappropriate/lewd comments, yelling/ cursing at the staff will not be tolerated and will be grounds for dismissal from the practice.

Please sign below indicating that you have read and agree to all PSN office policies.

_____ _____

Signature Date

PUGET SOUND NEUROLOGY

INTEGRATIVE HEALTH CENTER

WWW.PSNEUROLOGY.COM

SUMMARY NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. You may obtain a copy by asking the front desk or Adrienne McNamara PhD who is the Privacy Officer for Puget Sound Neurology. She can be reached by phone at 253-284-4488. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our pledge to protect your privacy:

Puget Sound Neurology is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Puget Sound Neurology disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information; to request that we communicate with you in a certain way or at a certain location; and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run Puget Sound Neurology and assure that our Patients receive quality care;
- to provide basic contact information (no medical information is provided) to our development office for purposes of fundraising for Puget Sound Neurology; to support our standing as a federally qualified health center; and as required or permitted by law.

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WWW.PSNEUROLOGY.COM

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Effective May 7, 2020

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Puget Sound Neurology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We update this form annually; this form expires one year from signature date.

_____	_____	_____
Name of Patient (print)	Signature of Patient	Date
_____	_____	_____
Signature of Patient Representative (Required if Patient is a minor or an adult who is unable to sign this form)	Relationship to Patient	Date

I understand that my health care and the payment for my health care will not be affected if I do not sign this_____(initial)

COMMUNICATION PREFERENCES:

From time to time Puget Sound Neurology may wish to use or disclose your protected health information to individuals involved in your care for notification purposes after we have obtained your verbal or written permission.

How may we contact you? (please circle Yes or No)

Permission to call? Yes/No	Designated Number _____	Leave message? Yes/No
Permission to text? Yes/No	Preferred Cell Number_____	Receive mail? Yes/No

Puget Sound Neurology is authorized to: (Please check all that apply.)

- ☐ Notify or speak with my spouse or my family members, i.e., children, siblings, mother, father regarding treatment or proposed treatment. *Name and Relation:* _____
  *Family Member Phone Number:*_____
- ☐ Notify or speak to my caregiver regarding treatment or proposed treatment.
  Caregiver Name and Phone Number:_____
- ☐ Notify or speak to my friend regarding treatment or proposed treatment
  *Friend Name and Phone Number:*_____
- ☐ Notify my transportation service regarding my delivery or pick-up to or upon completion of my treatment
  Transport Service and Phone Number: _____
- ☐ Other *(please specify name, relation, and phone number):*
  _____

Patient Health History

Date:_____ Main symptom bringing you to our office_____

Name:_____ Age:_____

DOB:_____ Preferred language: English Spanish Other:_____

How did you hear about us? Dr. Referral: Which Doctor?_____ Internet search
Advertisement Word of mouth Other_____

Personal History - Please circle:

Gender: Female Male Handedness: Right / Left Race: Hispanic or Latino Not Hispanic or Latino

Ethnicity: White American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander Other: _____

Smoking status: Current, packs/day_____ Former, Quit date_____ Never

Present Weight_____ Weight 1 year ago_____ Weight 5 years ago_____ Height_____

Allergies to Medications:_____

Medications: (please include drug strength and frequency, please also list vitamins, herbal supplements)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Personal Medical History of past/present illnesses: List dates and specify please

Heart Disease/Murmur_____
High Cholesterol_____
High Blood Pressure_____
Diabetes_____
Anemia_____
Kidney Disease_____
Lung problems_____
Hearing Problems_____
Thyroid Disease_____

Eye disease_____
Arthritis_____
Liver disease_____
Epilepsy/Seizure_____
Migraines or Headaches_____
Tremors_____
Cancer, specify_____
Psychiatric illness_____
Autoimmune disorder_____

Asthma/Sinus problems____
Skin problems_____
Alcoholism_____
Meningitis/encephalitis_____
Head injury_____
Stroke _____
Memory problems_____
Other_____

Surgeries, Hospitalizations, Accidents, Injuries: (list most recent first)

Date Surgery/Hospitalization/Injury

_____
_____
_____
_____

Social History:

Do you drink: Coffee: ____ cups/day; Tea: ____ cups/day

Have you ever used or do you currently use:

Marijuana Other Drugs_____ Alcohol_____; amount/week_____

Education level: (Please circle) High School College, # Years ____ Post-Graduate, # Years ____

Occupation:_____ Are you Retired? ____ Are you on Disability?___

Marital Status: Married _____ Single_____ Divorced_____ Widowed_____

Do you exercise? _____ How regularly _____

Family History:

Relative	Age now or at death	Alive (A) or Deceased (D)	Health Conditions	If Deceased, cause of death
Father				
Mother				
Brother (s)				
Sister(s)				
Spouse				
Children				

Please fill in chart with your family history and specify if there is any family history of the following:

Please circle below and specify above if there is any family history of the following:

Migraines, Diabetes, Heart Disease, High Blood Pressure, Mental Illness, Epilepsy/Seizures, Multiple Sclerosis, Cancer, Tuberculosis, Stroke, Neurological Illness (specify), Kidney Disease, Autoimmune disorders (such as Lupus, Myasthenia Gravis, Rheumatoid Arthritis), Movement disorders (such as Parkinson's disease, Dystonia), Dementia (such as Alzheimer's)

Review of Systems: please CHECK any of the following symptoms or conditions which have ever been a problem: then CIRCLE those which are difficulties now:

GENERAL:	weight loss	weight gain	fatigue	difficulty sleeping
	stress	fevers	chills	night sweats
	difficulty swallowing	difficulty speaking		
Neurologic:	Headaches	Pain in neck area	weakness of arms or legs	seizures
	Loss of vision	back pain	Loss of muscle bulk	head trauma
	Blurred vision	joint pain	cramping of muscles	Memory loss
	Double vision	muscle pain	twitching of muscles	loss of hearing
	Dizziness	Numbness of arms or legs	loss of consciousness	tingling sensation
	Balance trouble	Difficulty with coordination	Difficulty walking	Facial Pain
	Poor concentration	Weakness of facial muscles	Loss of taste	Ringing in ears
	Difficulty swallowing	Difficulty finding right words	Loss of smell	Change in personality
	Difficulty controlling bladder	Difficulty controlling bowels	Problems pronouncing words	
CARDIOVASCULAR:	palpitations	chest pain		
RESPIRATORY:	shortness of breath	sleep apnea		
GASTROINTESTINAL:	reflux/indigestion	constipation	diarrhea	
URINARY:	increased frequency	hesitancy	urgency	incontinence
	urinary infections			
MUSCULOSKELETAL:	joint pain	bone pain	arthritis	back pain
	neck pain	muscle pain		
DERMATOLOGICAL:	rashes	oral ulcers	shingles	
HEMATOLOGICAL:	bruising	bleeding	blood clots	
PSYCHIATRIC:	depression	anxiety		

This page for Headache Patients ONLY

If you have headaches, please answer the following, otherwise skip this section:

History

When headaches started_____ Severity (scale of 1-10)_____ Location _____

Days per month with headache _____ Days per month headache free_____

Do you have symptoms before a headache starts? If so, please list symptoms_____

Associated symptoms:

nausea vomiting light sensitivity sound sensitivity spots before your eyes double vision

eye redness eyelid drooping nasal stuffiness dizziness loss of vision (both eyes/ one eye (right/left))

Triggers:

Sleep (too much/too little) stress depression/anxiety bending over sexual activity straining/coughing

Missed meal change in weather alcohol processed meats chocolate cheeses MSG citrus fruits

Menstrual periods Ovulation Other _____

Rescue medications tried: (please check box for those tried and indicated the year which the medicine was tried)

Over the counters:

Naproxen/Alleve _____ Ibuprofen/Advil _____Excedrin _____ Acetaminophen/Tylenol
Caffeine _____ Other _____

Triptans:

Axert_____ Imitrex _____ Amerge_____ Frova _____Relpax _____
Zomig _____ Maxalt _____ Other_____

Ergots:

Migranal _____ DHE _____ Other_____

Daily migraine medications:

Topamax _____ Nortriptyline _____ Amitriptyline_____ Verapamil _____
Propranolol _____ Depakote _____ Other_____

Muscle Relaxers: Tried/Failed or current

Soma/Carisanzporadol_____ Cyclobenzaprine/Flexeril_____ Methocarbamol/Robaxin_____

Tizanidine/Zanaflex_____ Baclofen/ Gablofen_____ Metaxalone/Skelaxin_____

Lorzone/ Chlorzoxazone_____ Norflex/ Orphenadrine Citrate ER_____