M.A. Khan, M.D.
Rochester Neurological Center P.C.
Board Certified Neurologist
Board Certified Neurophysiologist
Board Certified Sleep Specialist
940 W. Avon Road, Suite 8, Rochester, MI 48307
Tel: 248-651-5600 Fax: 248-651-0300

Headache, Neck & Back Pain, Day Time Sleepiness, Epilepsy, Stroke, Sleep Apnea, Stroke, Head Injury, Narcolepsy, MS, Dizziness, Sleep Apnea, Restless Leg Syndrome, Parkinson's, Dementia, and other Sleep, Nerve, Muscle & Neurological Disorders

Dear New Patient,

Welcome to Rochester Neurological Center, P.C. Our staff is dedicated to providing you with the highest quality of care. Our office hours are Monday, Tuesday, and Thursday from 9am-5pm, and Wednesday and Friday from 9am-1pm. Please allow 24 hours for messages to be returned if you call after hours. If you need immediate assistance from Dr. Khan after hours, please call (248) 321-0628.

Our prescription policy will supply you with enough medication to last until your next follow up visit with us. If your insurance allows, we will also add an additional month in case you are unable to keep your scheduled appointment. A $10 fee may be applied if prescriptions are requested in between appointments.

All co-pays are expected at the time of service. We accept all major credit cards, checks and cash. We ask that a 24-hour notice be given if you are unable to keep your appointment, and a $35 fee may be applied otherwise. Records are provided to our patients for a fee of $35.00. Please inform us of any insurance changes to prevent the office visit being billed to you directly.

I _____, understand that as part of my health care, RNC originates and maintains paper and electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

You have the right to object to the use of my health information for directory purposes and to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or health care operations.

Rochester Neuro Center is not required to agree to the restrictions requested. You may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. By refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations. As part of this organization's treatment, payment, or health care operations, it may become necessary to disclose protected health information to another entity, via fax.

~ May we leave a message on your answering machine or with a family member? **Y / N**

~ Who may we give personal information to in regards to your healthcare, or about billing concerns?

Name:_____ **Relation:**_____

Thank you for choosing Rochester Neurological Center, P.C.

_____

Signature **Date**

ROCHESTER NEUROLOGICAL CENTER P.C.

NOTICE

Due to many changes in insurance policies, it is not always possible for us to know and interpret each and every policy therefore:

1. Please make sure you know your insurance policy coverage. It is your responsibility, as the patient, to contact your insurance and check if a procedure is covered under your individual policy.

2. If you have **Blue Care Network HMO** or **Humana HMO**, you will need a **Global Referral from your Primary Care Physician** before you are seen. If your Global Referral has **expired**, you are responsible for obtaining an up-to-date Global Referral from your Primary Care Physician prior to being seen in the office.

3. We do accept **HAP HMO/PPO** Plans that are in the **Crittenton** and **Beaumont Networks Only**. We do not take the Henry Ford, DMC, or Genesis networks. We do not take HAP Mid-West plans since they are a form of Medicaid.

At the time of your visit, please inform us of any changes that may have occurred in your policy. Have your Insurance card ready for us to review.

Failing to do so may result in you (the patient) being responsible for all costs incurred.

SIGNATURE:_____ DATE: _____

ROCHESTER NEUROLOGICAL CENTER P.C.
NEW PATIENT INFORMATION AND CONSENT

Patient:_____
(Last Name) (First Name) (Initial)

Responsible Party (If minor): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M / F Age: _____ Birthdate: _____/_____/_____ Patient's SS#: _____

Home Phone #:_____ Cell/Work Phone #: _____

Spouse or Responsible Party: _____ Birthdate: _____

Primary Care Doctor and Phone #: _____

Emergency Contact and Phone #:_____

How did you hear about our office?_____

If you were referred by a doctor, please name:_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to Dr. M.A. Khan all medical benefits, if any. Otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. M.A. Khan for any services furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charges determination of the Medicare carrier. I consent to Dr. M.A. Khan and his staff for providing chronic care management services as described.

_____

Patient Signature **Date**

ROCHESTER NEUROLOGICAL CENTER P.C.

Patient: _____
(Last Name) (First Name) (Initial)

WHAT IS THE REASON FOR YOUR VISIT:

Your main symptoms: _____

_____

_____

_____

When did you first notice these symptoms? _____

_____

How frequently do you experience the symptoms? _____

_____

How severe are your symptoms? _____

_____

What makes the symptoms better/worse? _____

_____

_____

ANY NEURO DIAGNOSTIC WORK DONE PRIOR TO THIS VISIT LIST HERE: _____

_____

_____

ANY OTHER DETAILS YOU WOULD LIKE DR. KHAN TO KNOW? _____

_____

_____

YOUR PREFERRED PHARMACY'S LOCATION & PHONE # (with specific crossroads): _____

_____

_____

*** OFFICE USE ONLY ***

WEIGHT: _____ **HEIGHT:** _____ **BP:** _____/_____ **Med List: Y / N** **RX Policy: Y / N**

PAST MEDICAL HISTORY: (Please check if ever previously diagnosed with any of the following.)

☐High Blood Pressure	☐Diabetes	☐Cancer	☐Sleep Apnea	☐ Anemic
☐Seizures	☐Stroke/TIA	☐High Cholesterol	☐Psychiatric	☐Hepatitis
☐Heart Problems	☐Thyroid	☐Peptic Ulcer	☐Asthma	☐HIV

Other health problems, please list: _____

_____

ARE YOU CURRENTLY EXPERIENCING: (Please check those you are *currently* experiencing.)

NEUROLOGICAL:

☐Headaches
☐Arm/leg weakness
☐Loss of Consciousness
☐Numbness and Tingling
☐Dizziness
☐Hearing Difficulty
☐Buzzing Ear
☐Gait Difficulty
☐Speech Difficulty
☐Blurry Vision

PSYCHIATRIC:

☐Anxiety
☐Memory Loss
☐Depression
☐Stress

GENERAL:

☐Chest Pain
☐Shortness of Breath
☐Nausea
☐Vomiting
☐Joint Pain
☐Weight Loss
☐Weight Gain
☐Diarrhea
☐Urinary Changes
☐Sleeplessness
☐Muscle Aches
☐Loss of Appetite

SOCIAL HISTORY:

Tobacco Use: Never / Former / Current

If current, how many packs per day? _____ and for how many years? _____

If former, how many packs per day?_____ and how many years quit? _____

Alcohol: Y / N If yes, how frequently? _____ and usually how many drinks? _____

Recreational Drug Use: Y / N If yes, please list drugs used and frequency of use: _____

_____

Marital Status: M / W / D / S **Occupation:** _____

If retired, past employment: _____

FAMILY HISTORY: _____

_____

Signature:_____ **Date:**_____

DRUG ALLERGIES: _____

_____

_____

MEDICATIONS LIST (or provide a list and we will make a copy): _____

_____

_____

_____

_____

_____

_____

_____

ANY TRIED AND FAILED MEDICATIONS? :

(Please list the name of the medication and the side effects you experienced)

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____

EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

Situation	Responses	Score
Sitting and Reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching Television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for an hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
TOTAL SCORE		