M.A. Khan, M.D.
Rochester Neurological [illegible]nter 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[illegible]ck & Back Pain, Day Time Sleepiness Epilepsy, [illegible] 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 voice mail/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? (Husband/wife/daughter/son)______________________________

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

____

Signature   Date

PATIENT NAME: ______________________________ **Birthdate:** ______________

PAST MEDICAL HISTORY:

Hypertension_____ Diabetes _____ Stroke/TIA ____ Heart Problems ____ Thyroid_____ Cancer_____
Sleep Apnea_____ Psychiatric_____ Peptic Ulcer _____ High Cholesterol _____ Seizures______
Asthma _____ Anemic____ Hepatitis_____ HIV_____

Other health problems, please list:

____

PLEASE CHECK IF YOU HAVE ANY OF THESE:

NEUROLOGICAL:

Headaches_____
Arm/leg weakness____
Loss of Consciousness____
Numbness/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/Vomitting____
Joint Pain_____

Fatigue ____
Weight Loss/Gain_____
Diarrea_____
Urinary Changes_____

Sleeplessness____
Muscle Aches____
Loss of Appetite___

FAMILY HISTORY : ____

____

____

SOCIAL HISTORY:

Smoke: N / Y If yes, how much? __________ and for how long? __________

Alcohol N / y If yes, how much? __________ and how often? __________

Occupation ____

Marital Status: M/W/D/S

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

____

____

____

____

____

Signature: ______________________________ Date: ________________

ROCHESTER NEUROLOGICAL CENTER P.C.

Patient____
(Last Name) (First Name) (Initial)

Drug allergies: ____

Your main symptoms: ____

____

____

____

When did you first have these symptoms? ____

____

How frequently do you experience the symptoms?

____

____

How severe are your symptoms? ____

____

____

What makes the symptoms better/worse?

____

____

Please list any neuro diagnostic work done prior to this visit.

____

____

Any other details Dr. Khan should know about? ____

____

____

Your preferred pharmacy and phone number (with specific crossroads) :

____

OFFICE USE ONLY

BP:__________/__________ Height:______________ Weight:______________ Med List: Y/N RX Policy: Y/N

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: ____________________ Marital Status: M/W/D/S

Patient's SS#____________________

Occupation:____________________ If retired, past employment:____________________

Home Phone #:____________________ Cell/Work Phone #:____________________

Spouse or Responsible Party:____________________ Birthdate:______________

Primary Care Doctor and Phone:________________________________

Referred by: ________________________________ Did you find us online? Y/N

Emergency Contact and phone:________________________________

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 it's 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.

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Patient Signature Date