WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

New Patient Intake Paperwork

Last Name: _____ First Name: _____ MI: _____

Address: _____City: _____ State: _____ Zip:_____

Social Security #: _____ Date of Birth: _____ Sex: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Marital Status: _____ Language: _____ Race: _____ Ethnicity: _____

Email: _____Responsible Party: _____ Relationship: _____

Emergency Contact Name/Phone: _____

Primary Insurance: _____ State: _____ Subscriber #: _____

Relationship: _____ Insured Name: _____DOB: _____ Group #: _____

Secondary Insurance: _____ State: _____ Subscriber #: _____

Relationship: _____ Insured Name: _____DOB: _____ Group #: _____

PCP Name/Number: _____ Referred by: _____

Pharmacy: _____ Phone: _____ Address: _____

NOTE: If your insurance requires a referral, it is your responsibility, as the patient, to obtain this authorization and make sure it is available to our office the day of your appointment. Your insurance carrier may not cover expenses occurred without this authorization. If no valid referral is on file, your appointment will be rescheduled.

ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to West TN Neurology. I am financially responsible for non-covered services. I also authorize the physician to release any information required to process this claim. I understand that I am responsible for paying my bill in full after 90 days, if my insurance has failed to do so.

By signing this document, I authorize West TN Neurology Clinic to obtain any and all personal health information, including medical treatment and prescription history.

Signature: _____ Date: _____

(Patient or Legal Guardian, if minor)

***Continue to next page.**

WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

I hereby give my consent to West TN Neurology Clinic, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). West TN Neurology Clinic, PLLC notice of privacy practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. West TN Neurology Clinic, PLLC reserves the right to revise its notice of privacy practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to West TN Neurology Clinic, PLLC privacy officer at 6570 stage Road, Suite 202 Bartlett, TN 38134.

With this consent, West TN Neurology Clinic, PLLC may call my phone 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 results among others.

With this consent, West TN Neurology Clinic, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards in patient statements as long as they are marked personal or confidential.

With this concern, West TN Neurology Clinic, PLLC may email to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements. I have the right to request that West TN Neurology Clinic, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to West TN Neurology Clinic, PLLC use and disclosure of my PHI to carry out TPO.

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

Signature: _____ Date: _____

(Patient or Legal Guardian, if minor)

***Continue to next page.**

WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

Guarantor Financial Responsibility

At West TN Neurology Clinic, PLLC we strive to give you the best possible care. In order to serve this purpose, it is important you understand the process of reimbursement. Please read this financial responsibility form and sign at the bottom to acknowledge you understand your accountability.

Insurance Coverage, Network Provider

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations, as well as authorization requirements. This information can be obtained by contacting your insurance carrier. It is also your responsibility to know if our providers are in or out of network with your insurance carrier. If you do not have coverage within your network, you will be responsible for payment in full.

Copayments, Coinsurance & Deductibles

Copayments and coinsurances are your responsibility. Your insurance company expects us to collect from you at the time of service.

You are responsible for your deductible. Deductible is determined by your individual contract with your insurance carrier. We may not have full detailed information about your deductible amount or how much of that has been met. You are responsible for finding out all your deductible information prior to appointment at our office.

Referral, Non-covered Services & Medical Necessity

All patients are responsible for payment if their insurance denies payment for any services rendered because they were stated as “non-covered services” or deemed as “medically unnecessary “. To avoid this please check with your insurance carrier prior to receiving any treatment. Obtain required authorizations or referrals before your visit is scheduled.

Self-Pay

All cash patients and patients without valid insurance information are considered a self-pay patient. A self-pay patient is required to pay for the office visit and any testing on the day service is to be rendered to the front desk personnel. Should you have insurance, but are unable to provide information, at the time of your visit you are expected to pay at the time of service until your insurance information is on file.

Cancellation(s) and Missed Appointment(s)

Please note patients will be charged $50 for all tests or procedures, and $50 for any office visit not canceled ***24 hours prior to the scheduled time.***

Collection Agency

If your account is placed with a Collection Agency, a collection fee of up to 33.3% may be added to your account and shall become part of the Total Amount Due. You will be responsible for any and all reasonable collection fees including collection fees, reasonable attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Signature: _____ Date: _____

(Patient or Legal Guardian, if Minor)

***Continue to next page.**

WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

Medical History

Patient Name: _____ Date: _____

Describe your medical problem:_____

List and describe your past medical illness:_____

Have you had any of these? Please circle:

a. High Blood Pressure
b. Heart Disease
c. Cancer
d. Diabetes Mellitus (sugar diabetes)
e. Stroke
f. Epilepsy
g. Mental Illness
h. Other: _____

List any operations you've had: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List of medications you are taking: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all medication allergies: _____ _____

_____ _____ _____

Family History: Father Age: _____ Illness: _____ Cause of Death: _____

Mother Age: _____ Illness: _____ Cause of Death: _____

Brother(s): _____

Sister(s): _____

Has anyone in your immediate family ever had? Please circle.

a. High Blood Pressure
b. Heart Disease
c. Cancer
d. Diabetes Mellitus (sugar diabetes)
e. Stroke
f. Epilepsy
g. Mental Illness
h. Migraine

Weight History: Present Weight _____ Usual Weight _____

Any major changes in weight? _____ How much? _____ How many meals do you eat each day? ____

Habit History:

a. Smoking
   1. Cigarettes per day? _____ How long? _____ Date Started? _____
   2. Cigars per day?_____How long?_____Date Started?_____
   3. Pipes per day?_____How long?_____Date Started?_____
b. Alcohol: Never____Occasional_____Moderate____Heavy_____
c. Coffee: Cups per day? _____

***Continue to next page.**

WEST TN NEUROLOGY
P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM
6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

REVIEW OF SYSTEMS

NAME: _____ DOB: _____ DATE: _____

Please circle if you have <u>currently or recently</u> had any of the following.

ALLERGY/IMMUNE	CARDIOLOGY	CONSTITUTIONAL	CPAP ROS	DERMATOLOGY
Ear fullness Hives Itchy eyes Nasal/Seasonal allergies Runny nose Scratchy throat Sinus congestion Recurrent infections	Chest pain Irregular heartbeat Leg swelling Pain in leg while walking Palpitations Shortness of breath	Fatigue Fever Loss of appetite Night sweats Weakness Weight gain in past 12 months Weight loss in past 12 months	Dry mouth Mouth venting Nasal congestion Nasal dryness Snoring with CPAP in place	Rash Hives Lumps
ENDOCRINOLOGY	**ENT/RESPIRATORY**	**GASTROENTEROLOGY**	**MUSCULOSKELETAL**	**NEUROLOGY**
Cold intolerance Excessive sweating Excessive thirst Heat intolerance Hot flashes Urinating frequently	Change in voice Chronic cough Coughing up blood Difficulty swallowing Frequent nasal allergies Frequent nosebleed Hearing loss Ringing in ears Sinus problems Sore throat	Abdominal pain Blood in stool Constipation Diarrhea Difficulty swallowing Heartburn Nausea Vomiting ***Date of last colonoscopy***?	Back pain Joint pain Joint swelling Leg cramps Shooting arm pain Shooting leg pain Arthritis Bone or Joint Pain - Which ones?	Balance difficulty Dizziness Headache Loss of sensation in specific body area Loss of strength in specific body area Memory problems Numbness Seizure Tingling Tremors Trouble with coordination
OPHTHALMOLOGY	**PSYCHOLOGY**	**RLS/PLM ROS**	**UROLOGY**	
Blurring of vision Cataracts Diminished vision Double vision Loss of vision Pain	Anxiety Depression Hallucinations Suicidal thoughts	Restless leg symptom Restless sleep	Blood in urine Difficulty urinating Erectile or other sexual dysfunction Recurrent urinary tract infection	

***Continue to next page.**

WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

Patient Agreement for Prescription of Controlled Substances

The purpose of this patient agreement for the prescription of controlled substance ("agreement ") is to prevent any misunderstandings about medicines that you will be taking for pain management and ensure that you and your physician comply with all laws regarding the prescription and use of controlled pharmaceuticals.

I understand this agreement is essential to the trust and confidence necessary in a doctor-patient relationship, and that if I break this agreement, my doctor may stop prescribing controlled medicines for me and may terminate me from further treatment at West TN Neurology Clinic PLLC or by other physician employment.

I agree to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

Females only – I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my doctor if I believe I may be pregnant. I agree not to take any medication without a physician's approval if I become pregnant.

I will not use any illegal controlled substance (including marijuana, cocaine, and/or heroin), unless prescribed by my physician.

I will not share, sell, or trade my medication with anyone. I will bring all unused pain medication to every visit.

I will not attempt to obtain controlled medications, stimulants, or anti-anxiety medications from any other prescribers.

I will safeguard my medicine. I understand that no allowance will be made for lost or stolen medication.

I agree that refills of my prescriptions for pain medication should be obtained only during routine office visits. It is understood that emergency refill requests may only be obtained during regular office hours. No refills will be available after hours, on weekends, or holidays.

I agree to use ONLY the following pharmacy for filling prescriptions of all controlled substances:

_____

Pharmacy name: Address: Phone Number

I authorize the doctor and my pharmacy to cooperate with city, state, and federal law enforcement agencies, or the Board of Pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that if it is required to determine my compliance with the pain management program in this agreement, I will submit to random drug testing, at my expense.

I agree to only use my medication at the prescribed dosage and frequency/rate and understand that not following the order as prescribed may result in my injury, overdose, and/or death.

I attest that the above guidelines have been fully explained to me and that my questions and concerns regarding my treatment have been adequately answered. I have been given a copy of this agreement.

This agreement is entered into on (date): _____
Patient signature: _____
Physician signature: _____

***Continue to next page.**

WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

COVID-19 QUESTIONAIRE

Patient Name: _____Date of Birth: _____ Temperature:_____

Anyone in your household or you know has been diagnosed with COVID19? Yes ____ No ____

Do you have a cough now or in the last week: Yes___ No___

Do you have fever/chills now or in the last week: Yes___ No___

Do you have repeated shaking with chills now or in the last week: Yes___ No___

Do you have any other respiratory symptoms now or in the last week: Yes___ No___

Do you have muscle aches or pain now or in the last week: Yes___ No___

Do you have loss of taste or smell now or in the last week: Yes___ No___

Do you have a sore throat now or in the last week: Yes___ No___

Do you have diarrhea now or in the last week: Yes___ No___

Do you have shortness of breath or difficulty breathing now or in the last week: Yes___ No___

Have you been in close proximity to anyone who has been sick within the last week? Yes___ No___

Signature: _____ Date: _____
(Patient or Legal Guardian, if minor)

***Continue to next page.**

WEST TN NEUROLOGY

P: 901 - 213 – 4225
F: 901 - 213 – 4226
WEST TN NEUROLOGY.COM
SALMAN SAEED, MD, FAAPM

6570 STAGE ROAD, SUITE 202, BARTLETT, TN 38134
315 E TICKLE ST, SUITE A, DYERSBURG, TN 38024

Medical Records Authorization

PATIENT AUTHORIZSATION FOR USE/DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth:_____SSN:_____

I, the undersigned, authorize the disclosure of my protected health information, or the protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction as to the terms and conditions of such request. I understand that subsequent disclosures by person(s) or organization(s) authorized to receive such protected health information may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

I, the undersigned, authorize and request West TN Neurology to:

☐ Release information to ☐ Obtain information from

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

This release applies to:

☐ Complete Medical Records (including Labs, any test and radiology reports)
☐ Itemized Billing
☐ Test/Radiology Report(s)
☐ Other: _____

This authorization and request is valid without limitation until written notice of its revocation is received. This authorization is good for the individual/facility noted above. No information will be provided on any other individual/facility without receiving written approval.

You must check one answer for each statement.

☐ NO LIMITATIONS - Including HIV/Substance Abuse/Mental or Behavioral Health
☐ LIMITATIONS: Check all related information that you DON'T want released:
☐ HIV/AIDS

I hereby acknowledge that I have read and understand the information set forth and that any questions have been answered to my satisfaction.

I hereby state that I am the _____ Parent _____ Legal Guardian _____ Other: _____ of the patient and authorized to sign for the release of healthcare information on their behalf.

Signature: _____ Date: _____
(Patient or Legal Guardian, if minor)

I, the undersigned, authorize West TN Neurology to release all protected health information to the following individuals.

NAME	RELATIONSHIP

Signature: _____ Date: _____
(Patient or Legal Guardian, if minor)