NEW PATIENT INFORMATION

MAIL OR FAX THE COMPLETED PACKET
BEFORE SCHEDULING AN APPOINTMENT

Neurology Solutions
MOVEMENT DISORDERS CENTER

Robert M. Izor, M.D.
12345 North Lamar Blvd., Suite 260 | Austin, TX 78753 | **P** 512 977-7000 | **F** 512 977-7001

NEW PATIENT VISITS

Welcome to Neurology Solutions Consultants, a Movement Disorders Center.

As a New Patient, you will be scheduled to see Dr. Izor as soon as your new patient packet is complete and your Medical Records have been received and reviewed by our office. At NSC we believe in a TEAM approach, so you will be scheduled for your initial assessment, and several follow up visits for testing, medication review, etc.

On your first visit, you will be scheduled with the doctor, you will be examined and will receive specific instructions, lab orders, medications, etc. This visit is approximately 1 – 2 hours depending on your disease state.

Your second visit will be with our Nurse Practitioner or Physician's Assistant. This is a time to review previous instructions, test results, medication options, and lab work.

Your third visit will be for baseline testing. This may entail neurocognitive assessment, Unified Parkinson's Disease Rating Scale, Tremor Assessment Testing, Spasticity Rating Scales, etc. This is to establish a baseline of symptoms. We will usually try to repeat this testing every 6 months in order to effectively manage your symptoms and disease state.

On your fourth visit, you will be scheduled for a baseline physical therapy evaluation. This evaluation is a thorough assessment of strength, flexibility, balance and functional mobility. The importance of the physical therapy evaluation is to assess your gait, balance, safety issues, etc., as well as to ensure that you have a home exercise program that is appropriate for you. During the evaluation, you will have an opportunity to discuss any pain complaints, postural concerns, etc. We will try to repeat these evaluations every 6 months to effectively manage your disease state and progression.

Your fifth visit will be to review all the testing results and follow up with you on your medications, any questions, etc.

Subsequent follow up visits will be determined by Dr. Izor at your fifth visit and will be with either Dr. Izor, our Nurse Practitioner, or our Physician's Assistant.

We are pleased to have you as a New Patient and we will try our best to manage your symptoms as effectively as possible. We believe that our TEAM approach is a great asset to managing your continued care.

Thank you for your cooperation.

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NEW PATIENT QUESTIONNAIRE

1. Do you reside in a nursing home? ☐ YES ☐ NO

2. If so, what is the name of your nursing home? _____

3. Nursing home phone number: _____

4. Do you receive hospice care? ☐ YES ☐ NO

5. Do you receive home health and if so, name of company? ☐ YES ☐ NO

_____

6. Are you in a skilled nursing facility, if so, what facility? ☐ YES ☐ NO

_____

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NEW PATIENT INFORMATION

Today's Date: _____ Would you like to register for our blog? ☐ YES ☐ NO

Name: _____

SSN: _____ Birthdate: _____ Gender: ☐M ☐F Marital Status: ☐M ☐S ☐W ☐D

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Would you like to register for our Patient Portal? ☐ YES ☐ NO Language: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Race: (Please Check) ☐ American Indian or Alaska Native ☐ African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic ☐ Other ☐ Prefer not to Disclose

Ethnicity: (Please Check One) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to Disclose

Name of Spouse: _____ Birthdate: _____

Occupation: _____ SSN: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Emergency Contact: _____ Relationship: _____

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

Pharmacy & Phone Number: _____

How did you hear about our practice? _____

Preferred method of contact: ☐ MOBILE ☐ HOME ☐ PORTAL

Who can we discuss your medical information with? Please provide name & relationship:

_____

Signature of Patient or Legal Guardian: _____ Date: _____

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NEW PATIENT INFORMATION – CONT.

Complete this page if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____ SSN: _____

Occupation: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

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INSURANCE INFORMATION

Today's Date: _____

Patient's Name: _____

(PRIMARY INSURANCE)

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: _____ Insured's Name: _____

Group Number: _____ Policy ID Number: _____

(SECONDARY INSURANCE)

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: _____ d's Name: _____

Group Number: _____ Policy ID Number: _____

Did you sustain an injury at work?
☐YES ☐NO

Are you covered under an employer or union policy?
☐YES ☐NO

Is your spouse or other family member employed?
☐YES ☐NO

Are you currently employed?
☐YES ☐NO

Do you have a secondary insurance policy?
☐YES ☐NO

Have you ever served in the military?
☐YES ☐NO

Are you covered under any other health care plan?
☐YES ☐NO

Are you enrolled in a Medicare Advantage Plan?
☐YES ☐NO

Have you made any changes to your choice of Medicare options in the last open enrollment period?
☐YES ☐NO

I am a new patient to this practice and am in a pre-existing provision with my insurance carrier.
☐YES ☐NO

Who is responsible for this bill?_____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature of Patient or Responsible Party: _____ Date: _____

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PATIENT HISTORY QUESTIONNAIRE (PHQ)

Today's Date: _____ Name: _____

Primary Care Physican: _____ Phone: _____

Referring Physican: _____ Phone: _____

Please list all of your current doctors, conditions treated, and their phone numbers:

1. Physican: _____ Phone: _____ Fax: _____

   Conditions Treated: _____

2. Physican: _____ Phone: _____ Fax: _____

   Conditions Treated: _____

3. Physican: _____ Phone: _____ Fax: _____

   Conditions Treated: _____

4. Physican: _____ Phone: _____ Fax _____

   Conditions Treated: _____

Past Medical History: Please check all that apply.

- ☐ aneurysm
- ☐ anxiety disorder
- ☐ arthritis
- ☐ asthma
- ☐ autoimmune disease
- ☐ back problems
- ☐ bleeding disorder
- ☐ brain tumors
- ☐ COPD
- ☐ cancer
- ☐ cerebral palsy
- ☐ congenital anomalies
- ☐ coronary artery disease
- ☐ dementia
- ☐ depression
- ☐ developmental problems
- ☐ diabetes
- ☐ encephalitis
- ☐ epilepsy/seizures
- ☐ fibromyalgia
- ☐ head trauma/injury
- ☐ headaches
- ☐ heart attack
- ☐ heart disease
- ☐ heart problems
- ☐ hepatitis
- ☐ hospitalizations
- ☐ hyperlipidemia
- ☐ hypertension
- ☐ hyper thyroidism
- ☐ hypothyroidism
- ☐ kidney disease
- ☐ liver disease
- ☐ lung disease
- ☐ lupus
- ☐ MRSA
- ☐ meniers
- ☐ meningitis
- ☐ mental problems
- ☐ migraines
- ☐ multiple sclerosis
- ☐ neck injury
- ☐ neurological problems
- ☐ obstructive sleep apnea
- ☐ othropaedic problems
- ☐ osteoporosis
- ☐ other sleep disorders
- ☐ PTSD
- ☐ Parkinsons disease
- ☐ pneumonia
- ☐ sleep disorders
- ☐ spine problems
- ☐ stroke
- ☐ thyroid problems
- ☐ tuberculosis
- ☐ ulcers
- ☐ vertigo
- ☐ vision or eye problems

Please explain: _____

_____

_____

_____

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MEDICATION CHART

Please list all of your current medications below:

NAME OF MEDICATION & DOSAGE (MG)	WHAT TIME(S) DO YOU TAKE IT?	REASON FOR TAKING	MEDICATION START DATE & SIDE EFFECTS IF ANY

List any over the counter medications, vitamins, herbal supplements, or alternative therapies and the date you started taking them:

_____

_____

_____

PATIENT SIGNATURE: _____

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FAMILY AND SOCIAL HISTORY

Do you have any significant drug and/or allergic reactions? Please list them:

_____

_____

Please list any major surgeries and/or other hospitalizations and the dates they occurred:

_____

_____

Family History/ Please circle or fill in the blank:

Father: ☐ALIVE ☐DECEASED Age: _____

List any medical problems: _____

Mother: ☐ALIVE ☐DECEASED Age: _____

List any medical problems: _____

List any significant medical problems with other blood related family members such as uncles/aunts/brothers/sisters:

_____

_____

Social History/ Please check a single answer for each category or fill in the blank:

Recent travel? ☐YES ☐NO Where: _____

Smoking status: ☐NEVER SMOKER ☐FORMER SMOKER ☐CURRENT EVERY DAY SMOKER
☐CURRENT SOME DAY SMOKER ☐UNKNOWN IF EVER SMOKED

Years of tobacco use: _____

Deaf or serious hearing difficulty: ☐YES ☐NO

Blind or serious difficulty seeing: ☐YES ☐NO

Difficulty concentrating, remembering or making decisions: ☐YES ☐NO

Difficulty walking or climbing stairs: ☐YES ☐NO

Difficulty dressing or bathing: ☐YES ☐NO

Difficulty doing errands alone: ☐YES ☐NO

Alcohol intake: ☐NONE ☐OCCASIONAL ☐MODERATE ☐HEAVY

Able to care for self: ☐YES ☐NO

Advance directive: ☐YES ☐NO

Alcohol years of use: _____

Animal exposure: ☐YES ☐NO

Are you currently employed: ☐YES ☐NO

Caffeine intake: ☐NONE ☐OCCASIONAL ☐MODERATE ☐HEAVY

Drugs abused: _____

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FAMILY AND SOCIAL HISTORY – CONT.

Education: ☐ LESS THAN 8TH GRADE ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12
☐ 2 YEAR COLLEGE ☐ 4 YEAR COLLEGE ☐ POST GRADUATE

Employer: _____

Exercise level: ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

Exposure to chemicals or toxins: ☐ YES ☐ NO

Exposure to heavy metals: ☐ YES ☐ NO

Family history of heart disease: ☐ YES ☐ NO

Hand dominance: ☐ LEFT ☐ RIGHT ☐ BILATERAL

Has smoked since age: _____

High blood pressure: ☐ YES ☐ NO

High Cholesterol: ☐ YES ☐ NO

HIV risk factors: ☐ YES ☐ NO

Illicit drugs: ☐ YES ☐ NO

If yes, please list the illicit drug used: _____

Marital status: ☐ UNKNOWN ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED
☐ WIDOWED ☐ DOMESTIC PARTNER

Medical power of attorney: ☐ YES ☐ NO

If yes, list your MPOA: _____

Accident related injury: ☐ YES ☐ NO

Chewing tobacco: ☐ YES ☐ NO

Currently pregnant: ☐ YES ☐ NO

Diet: ☐ REGULAR ☐ VEGETARIAN ☐ VEGAN ☐ GLUTEN FREE ☐ SPECIFIC
☐ CARBOHYDRATE ☐ CARDIAC ☐ DIABETIC

General stress level: ☐ LOW ☐ MEDIUM ☐ HIGH

Illicit drugs years of use: _____

Live alone or with others: ☐ ALONE ☐ WITH OTHERS

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REVIEW OF SYSTEMS

Please update on each visit.
Check all that apply.

Today's Date: _____ Name: _____

CONSTITUTIONAL
- ☐ fever
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss
- ☐ exercise intolerance
- ☐ sedation
- ☐ lethargy

EYES
- ☐ dry eyes
- ☐ irritation
- ☐ vision change

ENMT
Ears:
- ☐ difficulty hearing
- ☐ ear pain

Nose:
- ☐ frequent nosebleeds
- ☐ nose problems
- ☐ sinus problems
- ☐ decreased or absent sense of smell

Mouth/Throat:
- ☐ bleeding gums
- ☐ dry mouth
- ☐ snoring
- ☐ oral abnormalities
- ☐ vocal tremor
- ☐ hoarseness
- ☐ weak voice
- ☐ choking
- ☐ sore throat
- ☐ mouth ulcer
- ☐ teeth abnormalities
- ☐ mouth breathing

CARDIOVASCULAR
- ☐ chest pain on exertion
- ☐ arm pain on exertion
- ☐ shortness of breath when walking
- ☐ shortness of breath when lying down
- ☐ palpitations
- ☐ known heart murmur
- ☐ lightheadedness

RESPIRATORY
- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ coughing up blood
- ☐ sleep apnea

GASTROINTESTINAL
- ☐ abdominal pain
- ☐ nausea
- ☐ vomiting
- ☐ constipation
- ☐ change in appetite
- ☐ black or tarry stools
- ☐ frequent diarrhea
- ☐ vomiting blood
- ☐ indigestion
- ☐ GERD

GENITOURINARY
- ☐ urinary loss of control
- ☐ difficulty urinating
- ☐ increased urinary frequency
- ☐ blood in urine
- ☐ incomplete emptying
- ☐ vaginal dryness
- ☐ unexplained vaginal bleeding
- ☐ erectile dysfunction (ED)
- ☐ lack of morning erections

MUSCULOSKELETAL
- ☐ muscle aches
- ☐ muscle weakness
- ☐ joint pain
- ☐ back pain
- ☐ swelling in the extremities
- ☐ neck pain

INTEGUMENTARY
- ☐ abnormal mole
- ☐ growth or ulcer
- ☐ jaundice
- ☐ rash
- ☐ laceration

NEUROLOGIC
- ☐ weakness or paralysis
- ☐ numbness or tingling
- ☐ seizures
- ☐ dizziness or spinning sensation
- ☐ frequent or severe headaches
- ☐ restless legs
- ☐ tremor
- ☐ bladder symptoms
- ☐ bowel symptoms
- ☐ confusion
- ☐ memory loss
- ☐ speech disorder
- ☐ blackouts
- ☐ muscle twitching
- ☐ cramps
- ☐ headaches
- ☐ vertigo
- ☐ dizziness
- ☐ tinnitus
- ☐ blurred vision
- ☐ visual loss
- ☐ double vision
- ☐ difficulty with gait or walking

PSYCHIATRIC
- ☐ depression
- ☐ sleep disturbances
- ☐ alcohol abuse
- ☐ anxiety
- ☐ hallucinations
- ☐ suicidal thoughts
- ☐ restless sleep
- ☐ feeling unsafe in a relationship

ENDOCRINE
- ☐ fatigue
- ☐ hair loss
- ☐ increased hair growth
- ☐ cold intolerance
- ☐ increased thirst
- ☐ decreased sexual interest (libido)

HEMATOLOGIC/ LYMPHATIC
- ☐ swollen glands
- ☐ easy bruising
- ☐ excessive bleeding

ALLERGIC/ IMMUNOLOGIC
- ☐ runny nose
- ☐ itching
- ☐ frequent sneezing
- ☐ asthma

BP: _____ /_____
HR: _____
Weight: _____
Temp.: _____

If you have no symptoms to report for today's visit please initial and date below:

_____

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NSC APPOINTMENT GUIDELINE

1. Please arrive 10-15 minutes before your appointment time. Patients that are more than 15 minutes late may need to reschedule their appointment. **Accidentally missed appointments will result in a charge of $35 to your account if not excused by contacting the office at least 24 hours in advance.**

2. **Copays will be collected at the time of the appointment.**

3. Patient appointment time will be recorded when the provider enters the room.

4. A thorough neurological exam will be performed followed by a brief discussion.

5. Follow-ups may last from 25-40 minutes. Additional follow-ups will be offered until the diagnosis and management plan are fully understood.

6. Dictation and documentation may occur during the visit.

7. Patients may be video recorded to capture their neurological status as part of the visit. These recordings may be shown to other medical professionals for diagnostic or educational purposes.

8. In order to limit the risk of emergencies on the weekends, **please do not start any medication changes on Thursday, Friday, Saturday, or Sunday.**

I have read and agree to participate in the guidelines as described.

Patient Name (Print please): _____

Patient Signature: _____ Date: _____

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CONSENT TO TREAT

I (or my legal guardian/parent) authorize Robert Izor, M.D., to provide medical care reasonable by today's standards.

Patient Name (Print please): _____

Date of Birth: _____

Signature of Patient/ Legal Guardian: _____ Date: _____

NOTIFICATION FOR HOSPITAL EMERGENCIES

I understand that Dr. Robert Izor has medical privileges at the North Austin Medical Center located at Mopac and Parmer Lane. For Neurological emergencies, I understand that I will need to go to this hospital if I would like to be under the care of Dr. Robert Izor.

Signature of Patient/ Legal Guardian: _____ Date: _____

ASSIGNMENT OF BENEFITS

Neurology Solutions Movement Disorders Center
12345 N. Lamar Blvd, Suite 260
Austin, Texas 78753
512-977-7000

Date:
Patient:
DOB:

I, _____, understand that services rendered to me by Neurology Solutions Movement Disorders Center are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Neurology Solutions Movement Disorders Center and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by the insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Neurology Solutions Movement Disorders Center within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to Neurology Solutions Movement Disorders Center immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Neurology Solutions Movement Disorders Center to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated: _____

Witness: _____

Patient/ Legal Guardian: _____

Signature of Policyholder: _____

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Dear Patient:

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

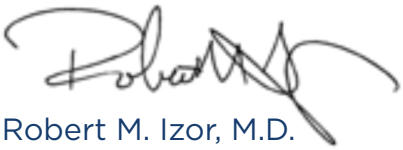
If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,



Robert M. Izor, M.D.
Medical Director

Neurology Solutions
MOVEMENT DISORDERS CENTER

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ADVANCE PRACTICE NURSE / PHYSICIANS ASSISTANT CONSENT FOR TREATMENT

This office has on staff an advance practice nurse & physician's assistant to assist in the delivery of medical care.

An advance practice nurse & physician's assistant is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. A physician's assistant is someone who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. Our Advance Practice Nurses have trained with Dr. Izor to help him treat our patients.

I have read the above, and hereby consent to the services of an advance practice nurse or physician's assistant for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse or physician's assistant and request to see a physician.

Patient Name (Print please):_____

Signature of Patient/ Legal Guardian: _____ Date: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Neurology Solutions Consultants upon request in person or by mail to the address specified at the time of the request.

Provider: (Name and Address)	Patient: SS# DOB:

RECORDS AUTHORIZED TO BE RELEASED (Please check records to be released.)

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Lab reports
- ☐ Radiological images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with responses or dispositions
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (These records should be redacted to protect information pertaining to other patients.)
- ☐ Other (specify):

Extent or nature of records to be released:

This information will be used for the purpose of:

- ☐ Providing advocacy service
- ☐ Verifying my eligibility for services
- ☐ Other activities at the request of the individual
- ☐ Continuing Care

I ALSO UNDERSTAND THAT:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Neurology Solutions Consultants, P.A. may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient or Representative Signature Date

Name of Representative

Relationship to Patient

This authorization will expire one year from the date of the signature above. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

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HIPAA POLICY

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Neurology Solutions Movement Disorders Center is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- Basis for planning care and treatment
- Source of information for applying a diagnosis and surgical information to a bill
- Means of communication among the many health professionals who contribute to care and treatment
- Means by which a third party payer can verify that services billed were actually provided.
- Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

We here at Neurology Solutions Movement Disorders Center are committed to obeying all federal, state and local laws and regulations regarding privacy practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

List of person(s) with whom NSC may share medical information:

_____

_____

_____

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer at 512-977-7000, x109.

I have read and understand the above Notice of Privacy Practices.

Signature of Patient/ Legal Guardian: _____ Date: _____

Neurology Solutions
MOVEMENT DISORDERS CENTER

Robert M. Izor, M.D.
12345 North Lamar Blvd., Suite 260 | Austin, TX 78753 | **P** 512 977-7000 | **F** 512 977-7001

E-PRESCRIBE CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. It has been determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Neurology Solutions Consultants can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/ Legal Guardian: _____ Date: _____

Relationship to Patient: _____

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PDQ-39

Patient Name: _____ Date: _____

Please complete the following & please check one for each question

Due to having Parkinson's disease, how often during the last month have you:

Never (N) Occasionally (Oc) Sometimes (S) Often (Of) Always (A)

1.	Had difficulty doing the leisure activities which you like to do?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
2.	Had difficulty looking after your home (DIY, housework, cooking)?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
3.	Had difficulty carrying shopping bags?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
4.	Had problems walking half a mile?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
5.	Had problems walking 100 yards?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
6.	Had problems getting around the house as easily as you would like?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
7.	Had difficulty getting around in public?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
8.	Needed someone else to accompany you when you went out?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
9.	Felt frightened or worried about falling over in public?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
10.	Been confined to the house more than you would like?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
11.	Had difficulty washing yourself?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
12.	Had difficulty dressing yourself?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
13.	Had problems doing up your shoe laces?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
14.	Had problems writing clearly?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
15.	Had difficulty cutting up your food?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
16.	Had difficulty holding a drink without spilling it?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
17.	Felt depressed?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
18.	Felt isolated and lonely?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
19.	Felt weepy or tearful?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
20.	Felt angry or bitter?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
21.	Felt anxious?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
22.	Felt worried about your future?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
23.	Felt you had to conceal your Parkinson's from people?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
24.	Avoided situations which involve eating or drinking in public?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
25.	Felt embarrassed in public due to having Parkinson's disease?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
26.	Felt worried by other people's reaction to you?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
27.	Had problems with your close personal relationships?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
28.	Lacked support in the ways you need from your spouse/ partner?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
29.	Lacked support in the ways you need from your family/ close friends?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
30.	Unexpectedly fallen asleep during the day?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
31.	Had problems with your concentration, e.g. when reading or watching TV?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
32.	Felt your memory was bad?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
33.	Had distressing dreams or hallucinations?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
34.	Had difficulty with your speech?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
35.	Felt unable to communicate with people properly?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
36.	Felt ignored by people?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
37.	Had painful muscle cramps or spasms?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
38.	Had aches and pains in your joints or body?	☐ N ☐ Oc ☐ S ☐ Of ☐ A
39.	Felt unpleasantly hot or cold?	☐ N ☐ Oc ☐ S ☐ Of ☐ A

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DIRECTIONS

SOUTH BOUND I-35
Exit PARMER LANE
Turn RIGHT onto PARMER
Get in immediate LEFT LANE, turn LEFT onto LAMAR BLVD.
Turn LEFT onto INDIAN MOUND
Turn RIGHT into PARK CENTRAL parking lot
Arrive at 12345 NORTH LAMAR BLVD., SUITE 260, AUSTIN, TX 78753

NORTH BOUND I-35
Exit YEAGER LANE
Turn LEFT onto YEAGER LANE
Turn RIGHT onto LAMAR
Turn RIGHT onto INDIAN MOUND
Turn RIGHT into PARK CENTRAL parking lot
Arrive at 12345 NORTH LAMAR BLVD., SUITE 260, AUSTIN, TX 78753

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