NEW PATIENT PACKET

Neurology Solutions
MOVEMENT DISORDERS CENTER

ROBERT M. IZOR, M.D.

9011 MOUNTAIN RIDGE DRIVE, SUITE 100 - AUSTIN, TX 78759 - P 512-977-7000 - F 512-977-7001

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 address and 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: _____

Name (Last, First MI): _____ SSN: _____

Birthdate: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D

First Name Used: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Work Phone: _____

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? _____

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

Language: _____

Preferred method of contact: ☐ MOBILE ☐ HOME ☐ PORTAL

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: _____

Policy ID Number: _____ Group Number: _____

(SECONDARY INSURANCE)

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone: _____ Insured's Name: _____

Policy ID Number: _____ Group 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 in a pre-existing provision with my insurance carrier.
☐ YES ☐ NO

Accident related injury:
☐ 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
- ☐ orthopedic 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? If so, please list them:

_____

_____

Please list any major surgeries and/or other hospitalizations with 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. Include if uncles/aunts/brothers/sisters/etc.

_____

_____

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

Do you have any pets? ☐ YES ☐ NO

Have you been exposed to chemicals or toxins? ☐ YES ☐ NO Details:_____

Have you been exposed to heavy metals? ☐ YES ☐ NO Details:_____

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

Exercise level: ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

How many days of moderate to strenuous exericse, like a brisk walk, did you do in teh last 7 days? _____

Able to care for self: ☐ YES ☐ NO

Blind or serious difficulty seeing: ☐ YES ☐ NO

Deaf or serious hearing difficulty: ☐ 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

Hand dominance: ☐ LEFT ☐ RIGHT ☐ BILATERAL

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

Are you currently employed: _____

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FAMILY AND SOCIAL HISTORY – CONT.

Smoking status: ☐ NEVER SMOKER ☐ FORMER SMOKER ☐ CURRENT EVERY DAY SMOKER
☐ CURRENT SOME DAY SMOKER ☐ UNKNOWN IF EVER SMOKED
☐ SMOKER - CURRENT STATUS UNKNOWN ☐ UNKNOWN IF EVER SMOKED
☐ NOT TOLERATED ☐ PATIENT REFUSED ☐ NOT INDICATED

How many years have you smoked tobacco? : _____

Do you or have you ever used any other forms of tobacco or nicotine? ☐ YES ☐ NO

Do you or have you ever used e-cigarettes or vape? ☐ NEVER USED ELECTRONIC CIGARETTES
☐ FORMER USER OF ELECTRONIC CIGARETTES ☐ CURRENT USER OF ELECTRONIC CIGARETTES

What was the date of your most recent tobacco screening?_____

What is your level of alcohol consumption? ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

Do you use an Illicit or recreational drugs? ☐ YES ☐ NO If yes, please list the illicit drug used: _____

What is your level of caffine intake? ☐ NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY

Have you been to an area known to be high risk for COVID-19? ☐ YES ☐ NO

In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that person was ill? ☐ YES ☐ NO NOTES:_____

In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill? ☐ YES ☐ NO NOTES:_____

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night?)
☐ NOT AT ALL ☐ ONLY A LITTLE ☐ TO SOME EXTENT ☐ RATHER MUCH ☐ VERY MUCH

Genger Identity: ☐ IDENTIFIES AS MALE ☐ IDENTIFIES AS FEMALE ☐ TRANSGENDER MALE/FEMALE-TO-MALE (FTM) ☐ TRANSGENDER FEMALE/MALE-TO-FEMALE (MTF) ☐ GENDER NON-CONFORMING (NEITHER EXCLUSIVELY MALE OR FEMALE) ☐ ADDITIONAL GENDER CATEGORY/OTHER PLEASE SPECIFY_____
☐ REFUSES TO DISCLOSE

Assigned Sex at Birth: ☐ MALE ☐ FEMALE ☐ CHOOSE NOT TO DISCLOSE ☐ UNKNOWN

Pronouns: ☐ HE/HIM ☐ SHE/HER ☐ THEY/THEM

Sexual Orientation: ☐ LESBIAN, GAY OR HOMOSEXUAL ☐ STRAIGHT OR HETEROSEXUAL ☐ BISEXUAL
☐ SOMETHING ELSE/PLEASE DESCRIBE_____ ☐ DON'D KNOW
☐ CHOOSE NOT TO DISCLOSE

Medical power of attorney: ☐ YES ☐ NO If yes, list your MPOA. Please provide a copy of your MPOA with this packet : _____

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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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NEW PATIENT VISITS

Welcome to Neurology Solutions Consultants, a Movement Disorders Center.

As a New Patient, you will be scheduled as soon as we receive your completed new patient packet. At NSC we believe in a TEAM approach, so you may be seen by the doctor, advanced practice provider (APP), doctor of physical therapy (DPT) or medical 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.

NSC APPOINTMENT GUIDELINE

1. Please arrive 10-15 minutes before your appointment time. **Patients that arrive past their appointment time will need to reschedule their appointment.** Accidentally missed appointments will result in a charge of $75 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. Subsequent follow-ups, cognitive, motor and physical therapy appointments may last 45-60 minutes. Additional follow-ups will be offered until the diagnosis and management plan are fully understood.

4. Chart review, dictation and/or documentation may occur during the visit.

5. 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 diagnositc or educational purposes.

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

ADVANCED PRACTICE PROVIDER

This office has on staff an advance practice provider (APP) to assist in the delivery of medical care. An APP is not a doctor. An APP is a registered nurse who has received advanced education and training in the provision of health care. An APP can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. Our APP has trained with Dr. Izor to help him treat our patients.
I have read the above, and hereby consent to the services of an APP for my health care needs.
I understand that at any time I can refuse to see the APP and request to see a physician.

CONSENT TO TREAT

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

OFFICE PAYMENT POLICY

Effective September 1, 2007, our office policy regarding outstanding account balances is as follows: Before being seen in the office again, you must pay 25% of your outstanding balance and set up a reasonable payment plan for the remaining balance. We will schedule a monthly payment of the same amount that will be due by the same date each month, until paid in full.

If you have Medicare with no secondary insurance, you will be responsible at the time of service to pay the 20% co-insurance.

All patients including pump patients must keep up the scheduled monthly payments or we will not be able to see you in the office. We will have no choice but to refer you to the hospital emergency room.

ASSIGNMENT OF BENEFITS

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.

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.

Thank you for your cooperation.

E-Prescribing

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.

PHONE CONTACT CONSENT AND AUTHORIZATION

I, _____, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize [ProviderProfileFullName] ("Healthcare Provider") or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

Signature of Patient or Legal Representative Witness:_____

Printed Patient Name: _____

Date Signed:_____

HIPAA

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement:

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon

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.

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

_____

_____

_____

Signature of Patient or Legal Representative Witness:_____

Printed Patient Name: _____

Date Signed:_____

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.

Physician or Facility releasing records (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 (choose one option below):

- ☐ Providing advocacy service
- ☐ coordination of care
- ☐ 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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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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