NEUROLOGY & SLEEP CLINIC OF SOUTHERN VA

RAFAEL V. HURTADO, MD
BOARD CERTIFIED IN NEUROLOGY & SLEEP MEDICINE
178 Executive Dr, Danville VA 24541
Phone: (434)792-3232 Fax: (434)792-3236

PATIENT INFORMATION (Please print and complete all information)

Last Name:_____ **Sex**: F ☐ M ☐ **Age:**_____ **Date of Birth:**_____

First Name:_____ **Middle Initial:**_____ **Home Phone:**_____

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **SSN:**_____

Person to contact if patient is a minor:_____ **Daytime Phone:**_____

Cell Phone:_____ **Email Address:** _____

Patient's Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Patient's Employer:_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Employment Status: Full Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐

Have you or any family members been seen here before? Yes ☐ No ☐ **If yes, who?**_____

INSURED (Name of the person the insurance is through, disregard if same as patient)

Relationship of Patient to Insured: Husband ☐ Wife ☐ Parent ☐ Child ☐ Adopted Child ☐ Other ☐

Last Name:_____ **Sex**: F ☐ M ☐ **Age:**_____ **Date of Birth:**_____

First Name:_____ **Middle Initial:**_____ **Home Phone:**_____

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____**SSN:**_____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Employer:_____

Employer's Address:_____

_____

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I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to referring and family physicians and to my insurance company, if applicable, and that a copy of this authorization can be used in place of the original. I allow fax transmittal of my medical records, if necessary. I authorize claims to be billed electronically. I understand and agree that I am responsible for any charges not paid by insurance after 90 days. I acknowledge full financial responsibility for services rendered by the Neurology & Sleep Clinic of Southern VA, including deductibles, co pays, non-covered services, coinsurance and items considered "not medically necessary", including appeals and rejections by my insurance company. I understand that payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. If my account is placed with a collection agency, I will be responsible for the balance of my account and an additional 30% of the balance will be added to cover collection fees. I understand that there is a $50.00 return check fee. I also understand that a 24 hour notice is required for cancellations. A $25.00 "no show" fee will be charged to all patients if a 24 hour notice is not given. I also authorize the Neurology & Sleep Clinic to leave messages for me at the phone numbers I have provided. I have read and fully understand the above terms for treatment, financial responsibility, release of medical information, permission to leave messages and insurance authorization.

Signature:_____ **Date:**_____

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PATIENT HISTORY

PATIENT NAME:_____ DATE:_____

How did you hear about us? Doctor ☐ Family ☐ Friend ☐ Yellow Pages ☐ Ad☐ Other ☐

Referring Doctor:_____ Telephone No.:_____

Family Doctor:_____ Telephone No.:_____

Reason for today's visit:_____

PERSONAL HISTORY

Do you currently have or have had in the past any of the following problems:

	Yes	No		Yes	No		Yes	No
Stroke			**Pneumonia**			**Swallowing Disorder**		
Seizures			**Asthma**			**Stomach Ulcers**		
Hearing Loss			**Tuberculosis**			**Hepatitis**		
Headaches			**Emphysema**			**Sleep Apnea**		
Sinusitis			**Angina (heart pain)**			**Kidney Disease**		
Nasal Polyps			**Tonsillitis**			**Lyme Disease**		
Hoarseness			**Thyroid Disease**			**Diabetes**		
Snoring			**Heart Attack**			**Cancer**		
Food Allergies			**High Blood Pressure**			**HIV/AIDS**		
Bronchitis			**Indigestion**			**Blood Transfusion**		

Other:_____

List any medications you are allergic to:_____

_____

List any medications you are currently taking:_____

_____

List any surgeries and/or hospitalizations:_____

_____

_____

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Do you drink alcohol? Yes ☐ No ☐ If yes, how much?_____

Do you smoke? Yes ☐ No ☐ If yes, what do you smoke and how much?_____

Are you pregnant? Yes ☐ No ☐

Do you ingest caffeine? Yes ☐ No ☐ If yes, how much?_____

Do any of your immediate family members suffer from:

	Yes	No		Yes	No
Diabetes			**Tuberculosis**		
Cancer			**Bleeding Disorders**		
High Blood Pressure			**Seizures**		
Heart Disease			**AIDS**		
Migraines			**Hearing Problems**		
Parkinson's Disease			**Alzheimer's**		
Multiple Sclerosis			**Narcolepsy**		

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YOUR VISIT MAY NOT BE RELATED TO A SLEEP CONDITION; HOWEVER, PLEASE FILL OUT THIS QUESTIONNAIRE AS PART OF YOUR HISTORY AND PHYSICAL EXAMINATION.

EPWORTH SLEEPINESS SCALE

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

SITUATION	CHANCE OF DOZING
SITTING AND READING	
WATCHING TV	
SITTING INACTIVE IN A PUBLIC PLACE (e.g. theater or a meeting)	
RIDING IN A CAR FOR AN HOUR WITHOUT STOPPING	
LYING DOWN TO REST IN THE AFTERNOON	
SITTING AND TALKING TO SOMEONE	
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	
SITTING IN YOUR CAR WHILE STOPPED IN TRAFFIC FOR A FEW MINUTES	

SCORING:

7 OR LESS= NORMAL AMOUNT OF SLEEPINESS

8-9= AVERAGE AMOUNT OF SLEEPINESS

10-15= EXCESSIVE SLEEPINESS DEPENDING ON THE SITUATION AND MEDICAL ATTENTION MAY BE SOUGHT

16 AND UP= EXCESSIVE SLEEPINESS THAT REQUIRES MEDICAL ATTENTION

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TO BE COMPLETED BY HEALTH CARE PROVIDER

ALL INFORMATION REQUIRED FOR NASAL CPAP REIMBURSEMENT

(Information must be included in a dictated note)

HISTORY

Circle all that apply:

Snoring Choking/Gasping during sleep Observed apneas Morning headaches Daytime Sleepiness History of stroke Mood disorder Hypertension Ischemic heart disease Heart failure Severe pulmonary disease Neuromuscular disease Impaired cognitive function

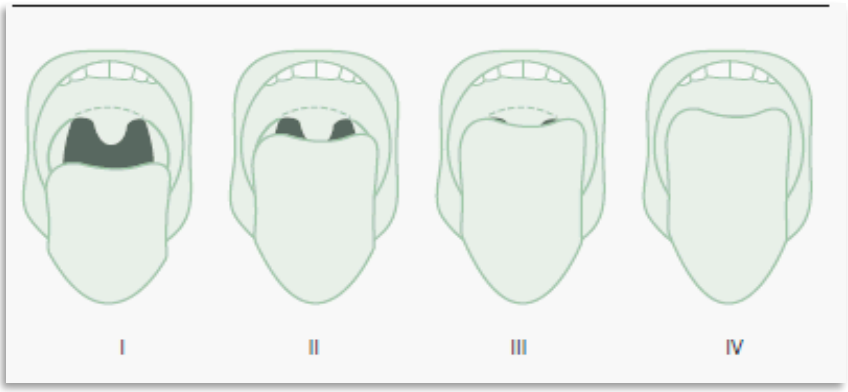
PHYSICAL EXAM

Body Mass Index:_____ Neck Circumference:_____ inches

Upper Airway:

Mallampati Class:_____

Other



Respiratory:

Cardiovascular:

Signature:_____ **Date:**_____

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize release of information as necessary to file claims with my insurance and assign benefits otherwise payable to me to the Neurology & Sleep Clinic of Southern VA, as indicated on the claim. I understand that I am financially responsible for any balance on my account to include collecting fees, attorney fees, and court costs due to delinquency. A copy of this signature is as valid as the original. I also authorize the Neurology & Sleep Clinic of Southern VA to obtain a copy of my insurance card.

_____ _____

Signature Date

Patient's Name:_____

Subscriber's Name:_____

I, the undersigned, request and authorize the payment of Medicare and/or other insurance, in whole or in part, for services rendered to me, or one of more of my dependent(s), by the Neurology & Sleep Clinic of Southern VA, notwithstanding Section 38.2-2201 (B) of the Code of Virginia 1950, as amended. If my treatment or the treatment of my dependent(s) relates to an injury for which I am entitled to recover for my personal injury from a third party, I hereby assign to the Neurology & Sleep Clinic of Southern VA, with respect to such injuries. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and/or other insurance companies, and its agents, any information needed to determine these benefits payable for related services.

_____ _____

Signature Date

I have read and understand the financial policy of the Neurology & Sleep Clinic of Southern VA. I understand that my insurance is an arrangement between my insurance company and myself. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at the Neurology & Sleep Clinic of Southern VA, fees will be due and payable immediately.

_____ _____

Signature Date

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Patient Name:_____ Date of Birth:_____

Due to the HIPAA Compliance Information you have read and signed, we are asking our patients for a list of people to whom we can disclose information.

If this information is not given to us, we will not be able to disclose any information, including appointments or patient billing, to anyone other than those specified. (Please refer back to your HIPAA Notice for ways that we may still disclose information).

If any changes occur, you are required to come to the office and make the appropriate changes in writing.

Family Members and Relationship

_____Medical Info._____Billing Info._____

In Person_____By Phone_____Both_____

_____Medical Info._____Billing Info._____

In Person_____By Phone_____Both_____

_____Medical Info._____Billing Info._____

In Person_____By Phone_____Both_____

Other and Relationship

_____Medical Info._____Billing Info._____

In Person_____By Phone_____Both_____

_____Medical Info._____Billing Info._____

In Person_____By Phone_____Both_____

_____Medical Info._____Billing Info._____

In Person_____By Phone_____Both_____

Signature:_____ Date:_____