

NORAN NEUROLOGICAL CLINIC



Welcome to the Noran Neurological Clinic. In preparation for your first visit we are sending you some forms to review and complete prior to your appointment. The questions relate to your current medications and past medical history. We are also enclosing various authorizations as well as our privacy policy. Please bring the completed forms, as well as any records that might assist our physicians in your care; recent imaging (MRIs, CTs, or Xrays) can be particularly useful to have with you at your appointment.

We ask that you arrive at least 15 minutes before your appointment time to allow time to check in and review any additional forms that may be needed. Due to a new federal law designed to protect consumers from identity theft, we have to ask you to bring a government issued photo ID to your appointment. We're doing this to make sure no one else can use your insurance information to get medical treatment. We will also be collecting any copays that apply to that day's visit. We accept Visa, MasterCard, Discover, American Express, cash, or checks. If you need assistance with directions to our clinic, please call (612) 879-1600.

If you have questions prior to your visit, or find that you can't keep your appointment, please call (612) 879-1500. Please make any changes to appointment date and time with as much notice as possible, preferably more than 24 hours in advance of your appointment date.

We look forward to providing you with expert and friendly care.

Sincerely,
The Physicians and Staff of the Noran Clinic

P.S. Please ask about our new online patient portal "My Noran Clinic" at your appointment.

Name:
DOB:

NNC MD:
Age:

ACCT#
Gender:

What symptoms or neurologic condition are you being seen for today?

List:

Do you have any other new medical conditions? Yes No Pregnant? Yes No
List:

Have you ever been to the ER or hospitalized recently? Yes No Recent Surgery? Yes No
Details:

Have you had any recent changes in your job or family? Yes No
Details:

Are there any recent changes in your family's health? Yes No
Details:

Review of symptoms (mark below all that apply):

Head

- headache
- loss of vision
- spinning dizziness
- light headedness

Other Neurologic

- difficulty concentrating
- memory loss
- trouble walking
- falling
- arm weakness
- leg weakness
- numbness / tingling
- shaking / tremor

Musculoskeletal

- neck pain
- mid back pain
- low back pain
- shoulder pain
- knee pain
- other joint pain

Psychiatric

- depression
- anxiety

Cardiovascular

- palpitations
- swelling of feet

Respiratory

- shortness of breath
- heavy snoring

Gastrointestinal

- vomiting
- loss of bowel control

Genitourinary

- frequent urination
- loss of bladder control

Hematologic/Lymphatic

- bleeding tendency
- blood clots

Skin

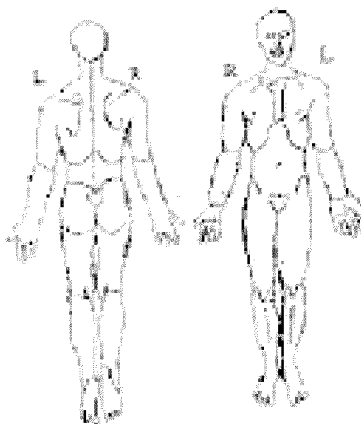
- rash
- hair loss

General

- weight loss
- weight gain
- difficulty with sleep

If you are having pain or numbness

Shade in areas of pain or numbness below:



Work:

Are you working now? yes no

Are hours restricted? yes no

Other restrictions? yes no

List:

If not working:

When did you last work? _____

When might you return to work? _____

Circle the number that relates to your overall level of pain:

(none) 1 2 3 4 5 6 7 8 9 10 (worst)

Signature: _____ Date: _____

Name:
DOB:

NNC MD:
Age:

ACCT#
Gender:

Past Medical History: mark below all that apply to you

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Systemic lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis | |

Past Surgeries: write below your past surgeries and approximate year none

Past Injuries: write below your injuries and approximate date none

Medications: list drugs and dosing (if known) below

Allergies: list drugs and reaction below

Social History:

- Education: How many years of school how you completed? _____ Are you in school now? yes no
- Work Status: work FT work PT unemployed laid off temp. disabled perm. disabled retired
- Occupation(s): _____ Handedness: right left
- Marital status: single partnered married separated divorced widowed
- Spouse / Partner: male female Number of children: _____
- Tobacco use: yes no Amount and frequency? _____ If quit, when? _____
- Alcohol use: yes no Amount and frequency? _____ If quit, when? _____
- Caffeine use: yes no Amount and frequency? _____ If quit, when? _____

Family History: mark below if a close relative (immediate family member) has had any of the following problems

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Attention deficit disorder | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Tics / Tourette's |
| <input type="checkbox"/> Birth defect | <input type="checkbox"/> Headaches / migraines | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Brain tumor | <input type="checkbox"/> Huntington's chorea | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Other neurologic |
| <input type="checkbox"/> Brain aneurysm | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Parkinson's disease | |

Mother: living deceased Father: living deceased

Signature: _____ **Date:** _____

NORAN NEUROLOGICAL CLINIC, P.A./MINNESOTA DIAGNOSTIC CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient Date of Birth: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of the Noran Neurological Clinic, P.A./Minnesota Diagnostic Center.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

CONTACT INFORMATION:

The contact information of the patient or personal representative who signed this form should be filled in below.

Address:

Telephone:
_____ (daytime)
_____ (evening)

The Patient or Personal Representative noted above was provided the Notice of Privacy Practices and this Acknowledgement Form and did not sign the Acknowledgement Form.

Reason for not signing:

Name Date

Position

NAME: _____ DOB: _____

GENERAL RELEASE OF INFORMATION:

I authorize Noran Neurological Clinic on behalf of myself and/or dependents to furnish medical records, including films and billing information to my insurance company, HMO or other third-party payer as may be necessary for the payment of a bill, determination of benefits or for utilization and quality review purposes.

I further authorize the release of this information to healthcare facilities that Noran Clinic may refer me to for continuing medical care, such as clinics, labs, therapy facilities, and other providers. I understand I am financially responsible for any balance not paid by my insurance and considered the responsibility of the patient. I hereby authorize payment of medical benefits to Noran Neurological Clinic for services provided to myself and/or dependents.

If not previously revoked, this authorization will terminate in one year.

Appointment Reminders and other health-related services:

We may use and disclose medical information to contact you in regard to an appointment, possible treatment options, or other benefits or services that may be of interest to you. We may call you and, if necessary, leave messages on your answering machine. We may send you a notice if you missed your scheduled appointment asking you to contact us to reschedule.

Insurance company: _____

Signature of patient or responsible party _____ Date: _____

If patient unable to sign...

Reason patient unable to sign: _____ *Relationship to patient* _____

MEDICARE LIFETIME CONSENT/AUTHORIZATION

I request payment of authorized Medicare benefits be made either to me or on my behalf to Noran Neurological Clinic for any services furnished to me by physician/clinic/ supervisor. I authorize any holder of hospital or medical information about me and/or any information needed to determine benefits payable for related services to be released to the Health Care Financing Administration and its agents. I permit a copy of this authorization to be used in place of the original.

MEDICARE ID#: _____

SIGNATURE: _____

NAME _____ DOB: _____

Insurance Coverage Information

Motor Vehicle Insurance Information

Minnesota is a no-fault state. All claims go through the patient's auto insurance regardless of fault.

Motor vehicle insurance carrier: _____

Date of injury: _____ Claim number: _____

Claims address: _____

Policy number: (only needed if claim number is not available): _____

Name and phone of the adjuster assigned: _____

Are you being treated for a motor vehicle related condition?.....Yes ___ No ___

If yes, has your case been settled?.....Yes ___ No ___

Is your case being denied?.....Yes ___ No ___

Do you have an attorney?.....Yes ___ No ___

Attorney's Name: _____ **Attorney's Phone Number:** _____

Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Worker Compensation Insurance Information

Name of Employer at time of injury: _____

Workers Comp insurance carrier: _____

Date of injury: _____ Nature of injury: _____

Claim number: _____

Claims address: _____

Name and phone of adjuster assigned to claim or contact at employer: _____

Are you being treated for a work related injury or condition?.....Yes ___ No ___

If yes, has your case been settled?.....Yes ___ No ___

Is your case being denied?.....Yes ___ No ___

Was a Motor Vehicle involved in the injury?.....Yes ___ No ___

Do you have an attorney?.....Yes ___ No ___

Attorney's Name: _____ **Attorney's Phone Number:** _____

Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Other Injury Information

Insurance carrier covering injury: _____

Date of injury: _____ Nature of injury: _____

Claim number: _____

Claims address: _____

Do you have an attorney?.....Yes ___ No ___

Attorney's name: _____ **Attorney's phone number:** _____

Check here if Noran Clinic should bill your Health Insurance should your insurance deny. List Health Insurance below.

Health Insurance

Primary Insurance information-

Name of insurance: _____ Insurance ph# _____ Effective date: _____

Policy number: _____ Group or account number: _____

Subscriber's name: _____ Subscribers date of birth: _____

Secondary Insurance information-

Name of insurance: _____ Insurance ph# _____ Effective date: _____

Policy number: _____ Group or account number: _____

Subscriber's name: _____ Subscribers date of birth: _____

Medication Education For Patients

The Noran Clinic strives to provide quality health care to our patients. We have outlined some general guidelines and helpful hints for you to refer to when you are on medication or refilling your prescription.

General Guidelines

Tell your physician about all medications you are taking, including non-prescription products such as dietary supplements, vitamins, herbal remedies, Tylenol, aspirin and other over the counter medications.

Tell your physician about any allergies you have or bad reactions you have had to medications in the past.

Do not stop medications without discussing it with your physician. Some medications require that you reduce the dose gradually as stopping abruptly may be harmful or cause other symptoms.

Take your medication exactly as your doctor prescribes. Take it only for the condition for which is prescribed.

Don't adjust your dose because of your size or how you feel. Consult your doctor before making any changes in how you take your medication.

Any medication can have any side effect. If you think you are experiencing an adverse or allergic reaction to the medication call your doctor immediately, or the Emergency Room if necessary.

Do not give your prescribed medication to family members or anyone else. Medication prescribed for you may not be appropriate for someone else and may be harmful.

Check the expiration date on medications you have at home. Read the labels on all prescription and over the counter medications, and discard anything that is past its expiration date. Throw out any old or damaged medication containers.

Keep all medication out of the reach of children!

Prescription Refills

The pharmacy and clinic work together, please call your pharmacy to request your refill (even if the bottle states no more refills).

Allow 24-48 hour notice for a refill request. Call during office hours 8am to 4:30pm, Monday through Friday.

The pharmacist may need the refill number from the label on the medication. Have your prescription bottle available when calling your pharmacy.

Refills will only be authorized during regular office hours. Our doctors cannot refill some medications when the clinic is closed. This is especially true with narcotics or controlled drugs.

There are certain medications that require written authorization and cannot be called to the pharmacy. For refills on these medications you must call our clinic during regular office hours. The written prescription can be mailed to you or picked up during clinic hours. Clinic hours are 8am to 5pm, Monday through Friday.