PIERCEY NEUROLOGY LLC
650 SW 3rd Street, Corvallis OR 97333-4437
Phone: 541-207-3900, Fax: 541-207-3232
http://www.pierceyneurology.com

Welcome to Piercey Neurology!

Attached you will find our new patient packet. Please complete these forms in their entirety. We welcome these forms back prior to your appointment, so that we may ensure all of your information is entered into your chart before you are seen. Feel free to send them back via mail, or fax. However, if your appointment is in the next week please do not send via mail.

Please note, when sending by mail, it is always advisable to make a second copy to carry in with you in the event the mailed copy does not arrive.

You will notice some of the forms require a signature or initials, you may send these forms back to us now and we will get your signature in the office, on the day of your visit.

Thank you and we look forward to seeing you!

Piercey Team

Directions to PIERCEY NEUROLOGY LLC, Corvallis

If you are coming from Highway 34

Come across the bridge into downtown Corvallis.

Turn Left on 4th St. Follow 4th St. all the way down to south end of down town.

Just before going under overpass to the coast, take a left on B St.

You'll see us on the left corner. We are on the corner of 3rd and B St.

Highway 20

Follow Highway 20 all the way down to south end of down town, it will make some turns, but follow the signs.

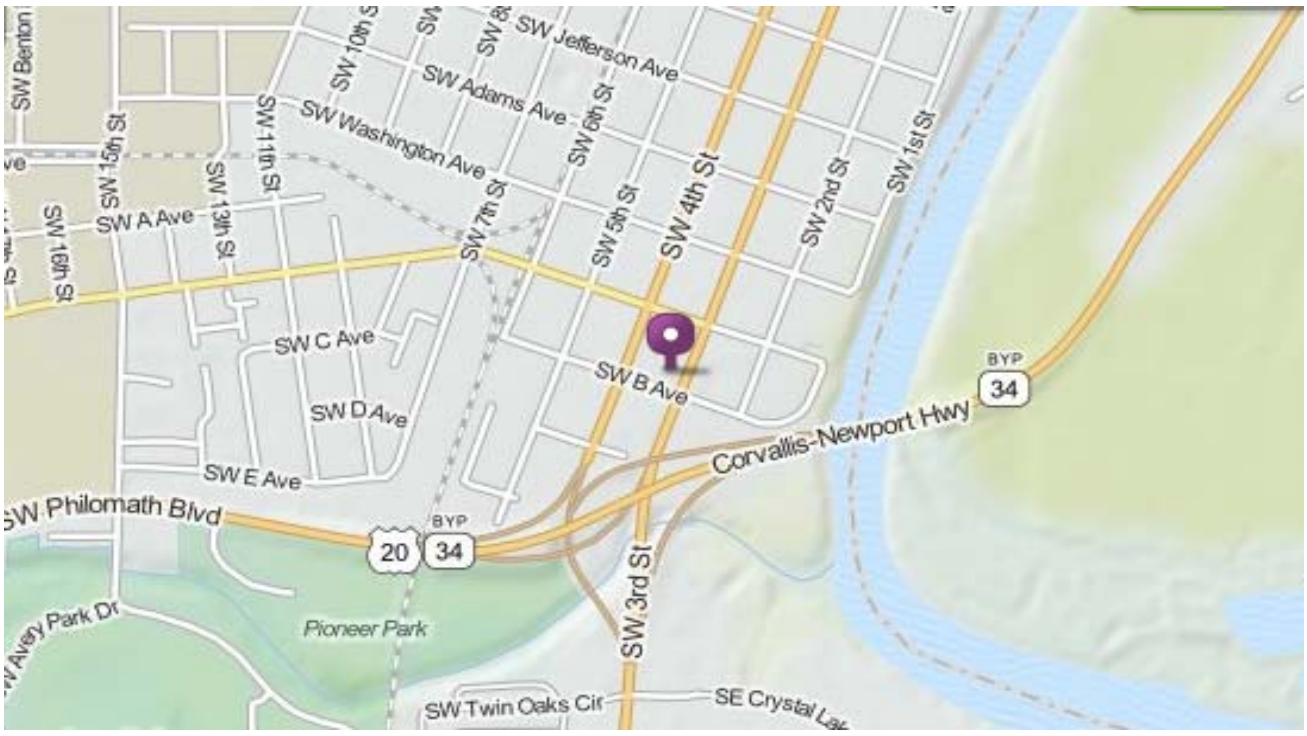
Just before going under overpass to coast, take a left on B St.

You'll see us on the left; we are on the corner of 3rd and B St.

If you are approaching from the Coast

Just after you come under the overpass into downtown Corvallis, you'll see us on the left corner. We are on the corner of 3rd St. at the cross of B St.

We are a tan building, with a brown wooden Piercey Neurology sign on the front of the building.



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Health Questionnaire

Due to the high volume of patients and as a courtesy to those patients on our waiting-list, please take note of our no show/cancellation policy. We require 24 hours' notice for all cancellations and rescheduling of appointments. For your convenience, you may call or leave a message to inform us of the cancellation. Cancelled or rescheduled appointments without a 24-hour notice are subject to a $50.00 rescheduling fee. Thank you! We look forward to seeing you!

Patient Name: _____

Age: _____ Date of birth: _____ SSN#: _____

Mailing Address: _____

City: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Today's date: _____ Do you need a translator? ☐ Yes (What language_____) ☐ No

Who is filling out this Health Questionnaire? ☐ Patient ☐ Other :_____

Primary Care Provider: _____

Referring Provider (if different from above): _____

Other physicians you would like to receive a copy of your PIERCEY NEUROLOGY Clinic consultation:

Provider: _____ Provider: _____
(Please provide contact information of health care providers listed above who do not practice in Oregon.)

I consent to the release of my medical information from PIERCEY NEUROLOGY LLC to the above listed health care providers:

Patient Signature: _____ **Date:** _____

Are your symptoms related to an MVA (Motor Vehicle Accident)? ☐ Yes ☐ No
If yes, is your MVA claim closed? ☐ Yes ☐ No

Current neurological symptoms/concerns (if more space is needed, please attach sheet):

_____

_____

_____

_____

_____

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MEDICAL HISTORY:

CONDITION/ DIAGNOSIS:	Is this an active problem?	When did this become symptomatic?	When was this diagnosed?

SURGICAL HISTORY:

SURGERY:	Date of surgery?	What hospital/facility?	Comment:

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS?

TEST:	Where?	Date?	Comment:
Nerve or Muscle biopsy			
EMG/Nerve conduction study			
CAT Scan or MRI			

LIST ANY MEDICATION ALLERGY:

MEDICATION:	What type of reaction?	When did this happen?

CURRENT MEDICATION:

Please list all medication you take, including over the counter medication.

Medication	Dosage:	How do you take this medication?	Start date?	Indication?

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FAMILY HISTORY:

If family history is not available please indicate here: ☐ Unknown
Has any family member been diagnosed with dementia? ☐ Yes (please describe below) ☐ No
Does any family member have migraine headaches? ☐ Yes (please describe below) ☐ No
Does any family member have a tremor? ☐ Yes (please describe below) ☐ No

Family member:	Medical diagnosis:	Comment:
Mother:		
Father:		
Siblings:		
Children:		

SOCIAL HISTORY:

(Social history questions are **OPTIONAL**; only answer questions you are comfortable answering.)

Occupation: _____ Highest level of education: _____
Hobbies: _____ Hours of day watching television:_____
Who besides you, lives in your home? _____

Do you have an Advanced Directive or POLST (Physician Orders for Life Sustaining Treatment) in place? ☐ Yes ☐ No ☐ Not Applicable
Would you like information on these? ☐ Yes ☐ No

Are you: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Optional: ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partnership

Do you have children? ☐ Yes ☐ No If so, what are their ages: _____

Smoking: ☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?____packs/day)
Would you like information on resources to help quit smoking? ☐ Yes ☐ No

Marijuana: ☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?_____)

Cocaine, amphetamines, IV drug use, or other recreational drug use:
☐ Never ☐ Past (when did you quit?_____) ☐ Current (how much?)

Alcohol: on an average day, how many alcohol containing drinks do you have?
Alcohol: in an average week, how many alcohol containing drinks do you have?

Are you under more than normal stress? ☐ Yes ☐ No If yes, please explain _____

Do you use any of the following mobility devices?

Cane (What % of time? ____) Walker (What % of time? ____) Wheelchair (What % of time? ___)

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REVIEW OF SYSTEMS

CATEGORY:	If abnormal, please comment below:	
GENERAL (Weight change, fever, etc.)	☐ Normal	☐ Abnormal
EYES/VISION	☐ Normal	☐ Abnormal
EARS/HEARING	☐ Normal	☐ Abnormal
NOSE/SINUS	☐ Normal	☐ Abnormal
NECK/SPINE	☐ Normal	☐ Abnormal
BREAST	☐ Normal	☐ Abnormal
RESPIRATORY	☐ Normal	☐ Abnormal
CARDIOVASCULAR (Heart, chest pain, etc.)	☐ Normal	☐ Abnormal
GI (abdomen/stomach)	☐ Normal	☐ Abnormal
GU (bladder/kidney)	☐ Normal	☐ Abnormal
Gynecological (pregnancies, menses changes, pelvic pain, etc.)	☐ Normal	☐ Abnormal
MUSCULOSKELETAL (joint pain, muscle weakness, injury, etc.)	☐ Normal	☐ Abnormal
SKIN	☐ Normal	☐ Abnormal
PSYCHIATRIC/MOOD	☐ Normal	☐ Abnormal
SLEEP	☐ Normal	☐ Abnormal

_____

_____

_____

_____

_____

_____

_____

Together We Can Unleash the Cure!

The Headache Center at
PIERCEY NEUROLOGY LLC
650 SW 3rd Street, Corvallis OR 97333-4437
Phone: 541-207-3900, Fax: 541-207-3232
http://www.pierceyneurology.com

Patient Name: _____ **DOB:** _____

Main Headache Characteristics

Location: ☐ Mostly Right side ☐ Mostly Left side ☐ Both sides

Character (check all that apply):

☐ Throbbing ☐ Squeezing ☐ Icepick ☐ Pressure ☐ Exploding ☐ Imploding

Average Intensity: 1 2 3 4 5 6 7 8 9 10

Average Duration: ☐ Less than 4 hours ☐ 4-12 hours ☐ 24 hours ☐ Greater than 24 hours

Average Frequency: ☐ Daily ☐ Weekly ☐ Monthly

☐ Other (please explain): _____

Do you have other types of head pain? ☐ Yes ☐ No

If yes, please explain: _____

Do you have jaw pain? ☐ Yes ☐ No

Do you have Neck pain? ☐ Yes ☐ No

How many days of headaches did you have **this** month?

Headache-free days per month: _____

Mild headaches per month: _____

Moderate to severe headaches per month: _____

How many days of headaches did you have **last** month?

Headache-free days per month: _____

Mild headaches per month: _____

Moderate to severe headaches per month: _____

Over time the character of the headache has (check which one applies):

☐ Remained relatively stable

☐ Increase in frequency and duration over time

Nausea: ☐ Yes ☐ No

Vomiting: ☐ Yes ☐ No

Light sensitivity: ☐ Yes ☐ No

Sound sensitivity: ☐ Yes ☐ No

Smell sensitivity: ☐ Yes ☐ No

Neck tenderness: ☐ Yes ☐ No

Aura Symptoms that occur before the headache starts:

Numbness or tingling: ☐ Yes ☐ No

Changes in vision: ☐ Yes ☐ No

Word finding difficulties: ☐ Yes ☐ No

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Do you have any Headache Triggers? (check all that apply):

☐ Menses	☐ Skip meal	☐ Lack of sleep	☐ Oversleep	☐ Noise
☐ Bright	☐ Lights	☐ Alcohol	☐ MSG	☐ Stress
☐ Weather changes	☐ Foods	☐ Motion sickness		
☐ Tight fitting hats	☐ Tight fitting glasses	☐ Tight collar		

Other (please explain): _____

Family history of migraine: ☐ Yes ☐ No
If yes who in your family has Migraines: _____

Quality of Sleep: ☐ Good ☐ Poor
If Poor, check all that apply:
☐ Falling asleep ☐ Multiple awakenings ☐ Early morning awakenings

How much fluids do you drink daily?: ☐ Less than 4 glasses ☐ Greater than 4 glasses

How much do you exercise?: ☐ Greater than 3 times per week ☐ Less than 3 times per week
What kind of exercise(s) do you do? _____

How much caffeine do you drink? (including tea, iced tea and sodas):
☐ 0 Cups ☐ 1 Cup ☐ Greater than 1 Cup

Overall Mood (1 being severely depressed and 10 being very happy): 1 2 3 4 5 6 7 8 9 10

Do you have a history of head injury? ☐ Yes ☐ No

Do you have a history of neck, spine or back injury? ☐ Yes ☐ No

Do you get any neurologic symptoms with your headache? ☐ Yes ☐ No
If yes, please explain: _____

Does the pain awaken you from sleep? ☐ Yes ☐ No
Does your eye tear during the headache? ☐ Yes ☐ No
Does your nose drip during the headache? ☐ Yes ☐ No
Does your eye turn red during the headache? ☐ Yes ☐ No
Does your eyelid droop during the headaches? ☐ Yes ☐ No
Is the headache triggered by coughing? ☐ Yes ☐ No
Is the headache triggered by using the bathroom? ☐ Yes ☐ No
Is the headache worse when lying down: ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

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CONSENT OF TREATMENT

Print Patient's Name: _____ Date of Birth: _____

Medical Consent: I wish to receive examination and treatment for my medical condition or injury. I understand that my practitioner will inform me of recommendations related to my treatment and that, unless I object, this consent includes any routine tests or examinations. If a special procedure or surgery is needed, I understand that my practitioner will discuss them with me and an additional consent may be required. I reserve the right to refuse any particular medical treatment or health care procedure that is proposed by my health care practitioner.

Release of Information: I authorize Piercey Neurology to release information from my medical records to any insurance carrier or government agency for the purpose of processing my claims for medical benefits. I understand that if any insurance company or government agency is paying for my claims for medical benefits they may have access to sensitive information about my diagnosis and treatment. Additionally, there may be quality improvement employees, utilization review employees, or my physician who may look at my medical record. **If I choose not to release my medical record information, I understand and agree that I will pay for all charges in the event that payment is denied.**

Authorization of protected information: A separate authorization will be required for release of the following information: HIV positive diagnosis, drug/alcohol addiction program records, psychotherapy notes and/or mental health program records.

Financial Agreement: I understand that I am responsible for determining my personal insurance requirements including eligibility, referrals and authorization. I am financially responsible for charges not covered by insurance. I also understand that I am responsible for paying deductibles, co-insurances, and co-pays. I agree to make payment according to the Piercey Neurology credit policy. In order to avoid a finance charge, all charges accrued must be paid in full within 90 days of the first statement's closing date. I understand that a service charge of $25 will be assessed for all checks returned for non-sufficient funds or written on a closed account.

Insurance Assignment: I certify that the information I have supplied is true and accurate to the best of my ability. I assign to Piercey Neurology any insurance benefits payable to me for services rendered. I direct all insurance companies, health care service plans, and other third party payers to make payment directly to Piercey Neurology.

Medicare Certification and Payment Request: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act or Medicaid is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organizations furnishing the services or authorize them to submit a claim to Medicare for payment to me.

Prescription Refills: Everything Important Takes Time. Please understand medication refills may take up to 48 hours to process after the request is made. You are part of our team. Please request medication refills at least two days before you may run out. Thank you, the PN team. Together we can unleash the cure!

Patient/Patient Representative Signature: _____

Relationship to Patient: _____ Date: _____

I acknowledge that the Notice of Privacy Practices has been made available to me: (Initials) _____

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VOLUNTARY INFORMATION DISCLOSURE

Piercey Neurology strives to provide the highest quality of medical services for all of our patients. As our patient, we need your help.

As part of health care reform, medical providers using Electronic Health Records are being asked to collect information about their patients related to ethnicity and race. The information is used to benchmark trends in public health data. Your answers to the following questions are voluntary and confidential as protected by HIPAA laws. To learn more from Population Reference Bureau, see www.prb.org/Articles/2009/questionnaire.aspx.

Please take a few minutes to answer the following questions:

Print Patient's Name: _____ Date of Birth: _____

Race:

- ☐ Native American or Native Alaskan
- ☐ Asian or Asian American
- ☐ African or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____
- ☐ Patient refused
- ☐ Caucasian

Language:

- ☐ English
- ☐ Arabic
- ☐ Hindi
- ☐ Chinese
- ☐ Korean
- ☐ Spanish
- ☐ Russian
- ☐ Other _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient Refused

Status:

- ☐ Smoker
- ☐ Non-Smoker

At this time, our Clinic is requesting email addresses from our patients for future communications related to our Electronic Health Records. Your email will only be used for the purposes of patient communications and will not be shared with any third party. If you are willing to provide your email address, please write it below. **You will be given the opportunity to receive a real-time connection to your health information online, with access to your diagnosis history, medication details, immunizations and appointments.**

Email Address: _____

Please Complete,if Applicable

Permission to Release Medical Records and Medical Information

The Corvallis Clinic™
PHYSICIANS & SURGEONS

Please mail or fax completed form to: DBS Health Information, Attn: Evelyn or Teresa
3680 NW Samaritan Dr., Corvallis, OR 97330
Phone: 541-768-2368 | Fax: 541-753-1966 | www.corvallisclinic.com

In order to comply with your release request, please fill out this form carefully and completely! Much of the information is REQUIRED by federal and state law. Patient/representative may be charged a fee to complete the release of medical information authorized below.

Patient Name _____
First MI Last

Other Names Used _____

Current Address _____ Date of Birth _____

Daytime Phone _____ Home Phone _____ Last Four Digits of SSN XXX-XX-_____

1. Purpose of Release Request

- ☒ Changing Doctors
- ☐ Doctor Consultation/Referral
- ☐ Moving/relocating outside the area
- ☐ Other. Please Specify _____
- ☐ Legal reasons
- ☐ Self Use

This request is being made:
- ☒ at the request of the patient
- ☐ at the request of recipient

2. Type of General Medical Information to Be Released

- ☐ Physician notes and records (limited to two (2) years of information and excludes other protected records)
- ☐ Lab test results. Please specify tests and their dates
- ☐ Imaging reports (X-ray, MRI, etc.). Please specify tests and their dates _____
- ☐ Electrocardiogram (ECG/EKG) reports
- ☐ Vaccine and Medication record
- ☐ Problem list
- ☐ Operative reports (procedures done at the Corvallis Clinic)
- ☐ Health information summary
- ☒ Other records or test results. Please specify information and dates All Records
- ☐ Appointment times

By initialing in the spaces below, I specifically authorize the disclosure of the following information that may have additional state and federal protections:

_____ Mental Health Information
_____ Drug/Alcohol Conditions
_____ HIV/AIDS Information
_____ Genetic Information

Release of the above information is limited to:

___ Time period _____
___ Treatment dates _____

3. I authorize the information designated above to be released from (Please be complete and specific)

Name of Facility The Corvallis Clinic
Street Address 3680 NW Samaritan Dr.
City / State / Zip Corvallis, OR 97330

4. I authorize the information designated above to be released to

Name of Facility _____
Name of Doctor or Department (REQUIRED) Piercey Neurology
Street Address 650 SW 3rd St.
City / State / Zip Corvallis, OR 97333
FAX 541-207-3232. By providing a FAX number, I acknowledge and accept the risk involved in faxing records and that confidentially at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

5. Expiration of Authorization of Release (REQUIRED)

This authorization is valid for 90 days from the date of the authorization or until (specify date) 12/31/13 unless revoked by the patient orally or in writing at an earlier time. I understand that if I am requesting information from The Corvallis Clinic I can revoke this authorization by contacting the HIPAA Privacy Officer, 444 NW Elks Drive, Corvallis, OR 97330, telephone 541-754-1374. The exception is when the action has already occurred as instructed in this authorization. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

6. Disclosure & Authorized Signature (REQUIRED)

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services or reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. My refusal to sign this authorization will also not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in a health plan. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of The Corvallis Clinic or myself. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

_____
Signature of patient (or legally responsible person – state relationship to patient) Date

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Authorization to Verbally Release Protected Health Information to Family Members or Personal Representatives

I,_____ hereby authorize Piercey Neurology to verbally share confidential information to the following individuals:

Name:_____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Concerning:

- ☐ Appointment Dates / Times Only
- ☐ All matters relating to my health care including mental health, alcohol, and drug treatment, and communicable diseases

OR

- ☐ Only specific health care problems and treatment relating to: _____

_____

(Describe the conditions for which information may be released)

This authorization may be revoked at any time by notifying Piercey Neurology in writing, but the revocation will not affect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire upon my written request for change or revocation, directed to Piercey Neurology.

I understand and acknowledge that the confidential health care information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations.

Patient's Signature	Date of Birth	Today's Date