HAMPSHIRE
NEUROLOGY, LLC

Hadley Health Center
234 Russell Street
Suite 206
Hadley, MA 01035
413-406-3033 Phone
413-387-0560 Fax

Dear

Your Neurology Consult with Michael Rossen, MD, PhD is scheduled for:

_____

We request that **you arrive 15 min. early** to process this initial visit.

We have also enclosed a packet to be completed prior to your visit that consists of registration forms & medical questionnaires. **Please complete front and back of all pages prior to your appointment.**

Please bring the following documentation to your appointment:

- Hampshire Neurology packet
- Photo ID
- Insurance Card(s) - both Primary & Secondary
- Insurance Prescription (Rx) Card

Cancellation Policy

Hampshire Neurology **requires a 24-hr. notice to cancel** and/or re-schedule your appointment.

Phone: 413-406-3033 An Answering Service is available after business hours.

If you do not give proper notice, a fee may be applied. If you should need a language translator, please bring someone with you.

Thank you for your cooperation.

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DATE: _____

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____
STREET ADDRESS _____ EMAIL _____
CITY/TOWN _____ STATE _____ ZIP CODE _____
MAILING ADDRESS (if different from above) _____
PATIENT SOCIAL SECURITY #_____ / _____ /_____ HOME TELE.# (___) _____
CELL PHONE # (___) _____
FEMALE ☐ MALE ☐ PATIENT'S MARITAL STATUS: S ☐ M ☐ D ☐ W ☐
OTHER _____
PATIENT'S EMPLOYER _____ OCCUPATION _____
EMPLOYERS ADDRESS _____ PHONE ( ) _____
HAVE YOU PREVIOUSLY BEEN SEEN IN THIS OFFICE? YES ☐ NO ☐ DATE _____
BY WHICH PHYSICIAN? _____
REFERRING PHYSICIAN NAME: FIRST _____ LAST _____ M.D.
ADDRESS _____
PRIMARY CARE PHYSICIAN _____ ADDRESS _____
FIRST LAST

NAME, ADDRESS AND TELE. # OF PERSON TO CONTACT IN CASE OF AN EMERGENCY: _____

_____

RACE
- ☐ WHITE OR CAUCASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HISPANIC OR LATINO
- ☐ DECLINED
- ☐ ASIAN
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ OTHER _____
- ☐ UNKNOWN

ETHNICITY
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ DECLINED
- ☐ UNKNOWN

LANGUAGE
- ☐ ENGLISH ☐ FRENCH
- ☐ SPANISH
- ☐ OTHER _____

INSURANCE INFORMATION - WORK RELATED

IS THIS A WORK-RELATED INJURY? YES ☐ NO ☐ DATE OF INJURY _____
NAME OF WORKERS COMP. INSURANCE CO. _____ PHONE (___) _____
ADDRESS OF INSURANCE COMPANY _____
CONTACT PERSON _____ CLAIM # _____
EMPLOYER AT TIME OF INJURY _____

INSURANCE INFORMATION - AUTO RELATED

IS THIS AN AUTO-RELATED INJURY? YES ☐ NO ☐ DATE OF INJURY _____
NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
NAME OF AUTO INSURANCE CO. _____ PHONE (___) _____
ADDRESS OF INSURANCE CO. _____
CONTACT PERSON _____ CLAIM # _____

HEALTH INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE COMPANY _____
ADDRESS OF INSURANCE CO. _____
NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
INSUREDS DATE OF BIRTH _____ INSUREDS SOCIAL SECURITY # _____
INSURED EMPLOYER _____ OCCUPATION _____
ID OR CERTIFICATE # _____ GROUP # _____
SECONDARY HEALTH INSURANCE COMPANY _____
ADDRESS OF INSURANCE CO. _____
NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
INSUREDS DATE OF BIRTH _____ INSUREDS SOCIAL SECURITY # _____
INSURED EMPLOYER _____ OCCUPATION _____
ID OR CERTIFICATE # _____ GROUP # _____

*****PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARDS TO BE PHOTOCOPIED. THANK YOU.*****
*****PLEASE READ, SIGN AND DATE THE BACK*****

AUTHORIZATION

NAME OF PATIENT _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE PAYMENT DIRECTLY TO HAMPSHIRE NEUROLOGY, LLC OF MEDICAL/SURGICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY HEALTH INSURANCE POLICY.

I FULLY UNDERSTAND THAT I AM PRIMARILY AND FINANCIALLY RESPONSIBLE FOR FEES INCURRED BY THE ABOVE PATIENT; I FURTHER UNDERSTAND THAT PAYMENT TO SAID DOCTOR IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT BY WHICH THE ABOVE PATIENT MAY EVENTUALLY RECOVER SAID MEDICAL/SURGICAL FEES.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT. CO-INSURANCE OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY.

I HEREBY AGREE THAT I, THE UNDERSIGNED, SHALL BE LIABLE FOR ANY REASONABLE ATTORNEY'S FEES AND/OR COLLECTION COSTS INCURRED BY HAMPSHIRE NEUROLOGY, LLC IN THE EVENT THAT SUCH MEDICAL/SURGICAL BILLS ARE PLACED WITH AN ATTORNEY OR OTHER THIRD PARTY.

I HEREBY AUTHORIZE MEDICAL/SURGICAL TREATMENT, CARE AND/OR SERVICES BY HAMPSHIRE NEUROLOGY, LLC TO THE ABOVE PATIENT.

I HEREBY AUTHORIZE HAMPSHIRE NEUROLOGY, LLC TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF EXAMINATION OR TREATMENT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM, I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

I CERTIFY THAT THE INFORMATION THAT I HAVE FILLED OUT ON THE FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, I UNDERSTAND PAYMENT IN FULL, REGARDLESS OF MY INSURANCE STATUS, IS MY RESPONSIBILITY, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL OR MEDICAL CARE FACILITY TO PROVIDE ALL INFORMATION ON THE ABOVE PATIENT'S MEDICAL HISTORY TO HAMPSHIRE NEUROLOGY, LLC.

DATE:_____ **SIGNATURE:** _____

*Patient, Parent or Guardian

*IF PATIENT IS A MINOR, A PARENT OR GUARDIAN MUST SIGN.

PREFERRED METHOD OF PAYMENT

CASH ☐ PERSONAL CHECK ☐ BANK CHECK ☐ CREDIT CARD ☐

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Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Weight: _____ **Height:** _____

Your Medical History:

- ☐ Alcoholic (cirrhosis of liver)
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Celiac Disease
- ☐ Claustrophobia
- ☐ COPD or emphysema
- ☐ Depression
- ☐ Diabetes Mellitus, *Type 1*
- ☐ Diabetes Mellitus, *Type 2*
- ☐ *Left-Handed*
- ☐ *Right-Handed*
- ☐ Headache - Migraine
- ☐ Headache - other than Migraine
- ☐ Heart Disease
- ☐ Heartburn, acid reflux, GERD
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Failure
- ☐ Migraine, variant intractable
- ☐ Osteoporosis
- ☐ Panic Disorder
- ☐ Pregnant, currently
- ☐ Prostate Enlargement
- ☐ Sinusitis, recurrent
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Ulcer, stomach, intestine
- ☐ Vitamin B12 Deficiency
- ☐ Vitamin D Deficiency

Your Surgical History:

- ☐ Appendectomy
- ☐ Back - lumbar spine surgery
- ☐ Brain Surgery
- ☐ Carotid Endarterectomy
- ☐ Carpal tunnel release
- ☐ Gallbladder surgery
- ☐ Heart surgery
- ☐ Hip surgery
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Lumbosacral spine surgery
- ☐ Neck - cervical spine surgery
- ☐ Pacemaker implant
- ☐ Shoulder surgery
- ☐ Tubal ligation
- ☐ Metal Appliance that may prevent you from having an MRI
- ☐ No surgeries

Your Family Medical History:
(if yes, **which family member**)

- ☐ Dementia _____
- ☐ Diabetes Mellutis, Type I _____
- ☐ Diabetes Mellitus, Type II _____
- ☐ Headache _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Neuropathy _____
- ☐ Seizure Disorder _____
- ☐ Stroke, acute _____
- ☐ Thyroid Disorder _____
- ☐ Tremor _____
- ☐ Unknown family history

PLEASE COMPLETE REVERSE SIDE

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Social History:

Education

- ☐ Grade School
- ☐ High School
- ☐ Some College
- ☐ College Degree
- ☐ Graduate Degree

Living Situation

- ☐ Living alone
- ☐ Living in shelter/homeless
- ☐ Living with family
- ☐ Living with roommate (s)
- ☐ Living with significant other
- ☐ Living with spouse
- ☐ Nursing home

If you are employed, what is your occupation? _____

Do you use **tobacco** products? ☐ Yes ☐ No If yes, how many cigarettes, per day? _____

Former smoker? ☐ Yes ☐ No

Do you drink **Alcohol**? ☐ Yes ☐ No If yes, how many drinks per day? _____

If no, did you drink in the past? ☐ Yes ☐ No

Do you drink **caffeine**? ☐ Yes ☐ No If yes, how many cups of caffeine per day? _____

If no, did you drink caffeine in the past? ☐ Yes ☐ No

Preferred Method of Communication:

☐ Phone - cell ☐ Phone - work ☐ Phone - home ☐ Text ☐ Email ☐ Patient Portal ☐ Mail

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Hampshireneuro.com Website
Portal.hampshireneuro.com Portal

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Please enter your name and date of birth:

PLEASE CHECK BOX TO LEFT IF YOU HAVE HAD THE ASSOCIATED SYMPTOM WITHIN THE LAST 30 DAYS:

General:	☐	fatigue	☐	night sweats	☐	weight gain	☐	weight loss
Eyes:	☐	dry eyes	☐	vision change	☐	eye twitching	☐	
Ears, Nose, Mouth:	☐	ear ringing	☐	hearing problem	☐	sinus problem	☐	dry mouth
Cardiovascular:	☐	chest pain	☐	palpitations	☐	heart murmur	☐	
Respiratory:	☐	short of breath	☐	sleep apnea	☐	snoring	☐	
GI:	☐	nausea	☐	vomiting	☐	constipation	☐	diarrhea
Urinary:	☐	urgency	☐	frequency	☐	difficulty	☐	incontinence
Musculoskeletal:	☐	muscle pain	☐	joint pain	☐	back pain	☐	neck pain
Skin:	☐	acne	☐	other rash	☐	hair change	☐	
Psychiatric:	☐	anxiety	☐	depression	☐	hallucination	☐	
Endocrine:	☐	cold intolerance	☐	heat intolerance	☐	excess sweating	☐	
Heme-Lymph:	☐	easy bleeding	☐	easy bruising	☐	swollen glands	☐	

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING:

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

PLEASE LIST ALL MEDICATIONS THAT HAVE CAUSED YOU ALLERGIC REACTIONS:

Please enter the name and address of your local pharmacy, and mail-in pharmacy if your have this as well.

POS Reorder # 1720124

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ACKNOWLEDGMENT of RECEIPT of NOTICE OF PRIVACY PRACTICES

I _____ do hereby acknowledge that I have been
(Print Name)
given a copy of the Notice of Privacy Practices of Hampshire Neurology, LLC.

_____ _____
Signature **Date**

_____ _____
Personal Representative Date

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES

By signing below, I have authorized Hampshire Neurology, LLC to disclose my Protected Health Information to the following family members and friends:

Name	Relationship	Telephone #

Signature: _____ **Date:** _____