

**Please complete the new patient paperwork (pages 5-10, 12-22)  
and bring all of the following items:**

- ☐ Photo identification
- ☐ Insurance or medical card
- ☐ Advance Directives
- ☐ Current list of physicians
- ☐ Current medication list with specific dosage
- ☐ Name and/or phone number of primary pharmacy
- ☐ New patient paperwork filled out (Attached)
- ☐ Copies of relevant medical records, if available.

**Barrow Department of Neurology**

240 W. Thomas Road, Suite 404

Phoenix, AZ 85013

Phone: (602) 406-6262

## Language Assistance Services

If you speak English, language assistance services, free of charge, are available to you.  
Call 1(800) 443-1986 (TTY: 1(800) 855-7100).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.  
Llame al 1(800) 443-1986 (TTY: 1(800) 855-7200).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1(800) 443-1986 (TTY: 1(800) 855-7100).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。  
請致電 1(800) 443-1986 (TTY: 1(800) 855-7100)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.  
Gọi số 1(800) 443-1986 (TTY: 1(800) 855-7100).

주의: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
1(800) 443-1986 (TTY: 1(800) 855-7100) 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվակա աջակցության ծառայություններ: Ձանգահարեք 1(800) 443-1986 TTY(հեռատիպ)՝ 1(800) 855-7100)։

جه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما  
راهم می باشد. با 1(800) 443-1986 (TTY: 1(800) 855-7100) تماس بگیرید.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。  
1(800) 443-1986 (TTY: 1(800) 855-7100) まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните  
1(800) 443-1986 (телетайп: 1(800) 855-7100).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।  
1(800) 443-1986 (TTY: 1(800) 855-7100) पर काल कर।

حوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1(008) 6891-344 (رقم  
ف الصم والبكم: 1(008) 0017-558.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le  
1(800) 443-1986 (ATS: 1(800) 855-7100).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.  
Rufnummer: 1(800) 443-1986 (TTY: 1(800) 855-7100).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵੱਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।  
1(800) 443-1986 (TTY: 1(800) 855-8100) 'ਤੇ ਕਾਲ ਕਰੋ।

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.  
Ligue para 1(800) 443-1986 (TTY: 1(800) 855-7100).

# Barrow Department of Neurology

## Helpful Information About Your Provider Visit



### 1. Please bring the following items to your appointment:

- Photo ID
- Insurance Card
- Co-Payment (if any)
- Current medication list
- Any records/results requested for your appointment

### 2. Arrival Instructions

Please plan to arrive 30 minutes prior to the appointment to allow time for parking and completing paperwork.

### 3. Parking

Park in the 3rd Avenue Parking Garage. Take parking garage elevators to the 2nd floor, exit through the doors to the right and immediately turn left and follow the long hallway to the 240 building elevators around the corner. Use the elevators to access the correct floor for your services. Be sure to bring your parking ticket with you for validation in the clinic.

### 4. Obtaining Insurance Prior Authorization and Referrals

Many insurance plans require a mandatory prior authorization before a specialist can be seen. Please check with your insurance company to see if this is required on your plan before you come for your appointment. Your provider's office will have a staff member who handles prior authorizations and will be able to answer any of your questions. Authorization must be received prior to your scheduled appointment. Failure to receive prior authorization/referral may result in the need to reschedule your appointment to a later date. Please contact your insurance company for more information.

### 5. Telephone Communications

Calls to (602) 406-6262 are answered Monday through Friday. Our team is equipped to handle general questions and can direct calls, as appropriate. Additionally, our answering service is here to assist you after hours and on weekends or holidays. If necessary, the on-call provider can be

contacted through the answering service. For a life-threatening medical emergency, please call 9-1-1 immediately to activate your local Emergency Medical Service.

### 6. Written Communications

Please do not fax any time-sensitive communication or urgent medical advice questions to the office.

### 7. Electronic Communications

Barrow Neurological Institute participates in an electronic patient portal which allows continuous access to your patient information including, but not limited to, upcoming appointments, prior visit summaries, lab and imaging results. Additionally, the portal allows patients to securely communicate with providers directly. Our staff can provide you with an email invitation to set up your portal. Please discuss the procedure for secure electronic communications with your individual doctor or medical assistant.

### 8. Appointment Reminder

You will receive an automated message via text, email and/or telephone call to remind you of your appointments. Please listen to the message and select one of the following message options:

- Confirmation of your appointment
- Cancellation of your appointment and reschedule request
- General clinic information including address and hours of operation
- Request to not receive future appointment reminders

If you do not wish to receive an appointment reminder, please contact the front office staff.

### 9. Cancellation of Scheduled Appointments

In the event you need to cancel and reschedule an appointment, we ask that you kindly notify us as soon as possible and not later than 24 hours prior to the appointment. We can reschedule you in a timely manner and offer the open slot to another patient. If you are late for your appointment, you

may have to be rescheduled. Multiple cancellations with less than 24 hours notice or failure to show will impact our ability to care for you.

#### **10. Test Ordering and Results**

Your provider may order diagnostic tests as part of your evaluation and care. Some insurance companies require prior authorization and approval before your test can be scheduled. Your provider will submit orders for these tests and the staff within our clinic will send required documentation to obtain authorization from your insurance company prior to scheduling any test(s).

#### **11. Medical Records**

We are unable to share your medical records without a signed release from you. If you need a copy of your medical records from Barrow Neurological Institute, you will need to sign an authorization request. Select records are also available via the patient portal.

You may also pick up a hard copy of your medical records. Note that a fee for this service may be incurred. If you require copies of your medical records, please contact us at (602) 406-8988.

Upon receiving your signed request, a copy of your records will be mailed within two (2) weeks. Please ask our office staff if you have any questions.

In order for us to obtain records from other physician offices, additional forms may need to be completed and signed.

If you need records from a Dignity Health hospital—including lab tests or radiology results—please call the hospital directly and ask to be connected to the Health Information Department.

#### **12. Billing Inquiries**

Fees for services are due and payable at the time of your visit, including co-payments, co-insurance and deductibles. Patients are responsible for any services deemed “not-covered” by your plans. If you have questions about a bill you received that was generated from our office and doctor’s visit or procedure performed here, please contact Patient Billing Services directly at (602) 406-3860 or toll free at (877) 877-8311, or email [PBSCustomerService@DignityHealth.org](mailto:PBSCustomerService@DignityHealth.org).

#### **13. Prompt Pay Discount**

If you don’t have insurance, you have an option to pay cash at the day of your appointment for a reduced fee. This program is called the Prompt Pay Discount. For more information on this program and to see if you qualify, please contact our office.

#### **14. Patient Satisfaction Survey**

We strive to provide an exceptional patient experience. One to four weeks after your visit, please expect to receive a survey via email or mail inquiring about your visit. Your response is confidential and we appreciate your feedback. If there is anything we can do to ensure your experience is exceptional, please share with our staff prior to the end of your visit.

If you have any questions, please speak with your provider or one of our staff members.

**We look forward to joining your care team!**

PATIENT NAME: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

## Demographics

PATIENT INFORMATION				
Last Name		First Name		Middle Name
Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status
Race: <input type="checkbox"/> African American (Black) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Two or More Races				
Ethnicity: Hispanic/Latino/Spanish origin <input type="checkbox"/> Yes <input type="checkbox"/> No		Language		Preferred Language for Health Care Information
Mailing Address		City	State	Zip
Primary Contact Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work (       )	Secondary Contact Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work (       )	Preferred Notify Method <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other: (       )		
E-Mail Address				
Emergency Contact		Relationship to Patient		Emergency Contact Number:
RESPONSIBLE PARTY'S INFORMATION (IF OTHER THAN PATIENT) <input type="checkbox"/> Self				
Last Name		First Name		Middle Name
Social Security Number		Date of Birth		Relationship to Patient
Mailing Address		Primary Contact Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work (       )		Zip
City State				
FAMILY AND FRIENDS ACCESS (OPTIONAL)				
<input type="checkbox"/> I permit BNI to share my protected health information with the following people:				
Full Name:		Full Name:		Full Name:
Relationship to Patient:		Relationship to Patient:		Relationship to Patient:
<input type="checkbox"/> I do NOT permit BNI to share my protected health information with any individuals aside from myself.				
INSURANCE INFORMATION				
Primary Insurance Carrier		<input type="checkbox"/> Workman's Comp		Insurance Billing Address:
Certificate/Policy Number:	Subscriber Full Name:			Subscriber Date of Birth:
Secondary Insurance Carrier		Insurance Billing Address:		
Certificate/Policy Number:	Subscriber Full Name:			Subscriber Date of Birth:
Do you have an Advanced Directive in Place (Living Will and/or Medical Durable Power of Attorney)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
FOR OFFICE USE ONLY				
Advanced Directives: <input type="checkbox"/> Patient refused <input type="checkbox"/> Scanned in Chart <input type="checkbox"/> Pt Completed AD at Home <input type="checkbox"/> Provided AD Informational Brochure <input type="checkbox"/> Pt Requested More Information				

PATIENT NAME: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

## Review of Systems

### SKIN

- ☐ Change in hair or nails
- ☐ Itching
- ☐ Rashes

### HEAD

- ☐ Head injury
- ☐ Headaches

### EYES

- ☐ Change in vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Flashing lights
- ☐ Glasses or contacts
- ☐ Glaucoma/Cataracts

Last eye exam: \_\_\_\_\_

### EARS

- ☐ Change in hearing
- ☐ Dizziness
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Ringing

### NOSE/SINUSES

- ☐ Frequent colds
- ☐ Nasal stuffiness
- ☐ Nose bleeds

### ALLERGIES

- ☐ Asthma
- ☐ Eczema/Sensitive
- ☐ Hay fever
- ☐ Hives
- ☐ Sensitivity to:
- ☐ Dander
- ☐ Drugs
- ☐ Food
- ☐ Pollens
- ☐ Swelling of lips or tongue

### MOUTH/THROAT

- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Sore tongue

### NECK

- ☐ Goiter
- ☐ Lumps
- ☐ Stiffness
- ☐ Swollen glands

### BREAST

- ☐ Breast self-examination
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Pain

### RESPIRATORY/CARDIAC

- ☐ Blue fingers/toes
- ☐ Bronchitis
- ☐ Chest pain
- ☐ Cough
- ☐ Coughing up blood
- ☐ Emphysema
- ☐ Fever
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ HX of heart medication
- ☐ Night sweats
- ☐ Production of phlegm, color
- ☐ Rheumatic heart disease
- ☐ Shortness of breath
- ☐ Skipping heart beats
- ☐ Swelling in hands/feet
- ☐ Wheezing

### GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Change of appetite or weight
- ☐ Constipation

- ☐ Diarrhea
- ☐ Excessive belching
- ☐ Excessive flatus
- ☐ Food intolerance
- ☐ Heartburn
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Rectal bleeding/hemorrhoids
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Yellow color of skin (jaundice/hepatitis)

### URINARY

- ☐ Blood in urine
- ☐ Decreased urine stream
- ☐ Difficulty urinating
- ☐ Dribbling
- ☐ Frequent urination at night
- ☐ Incontinence of urine
- ☐ Kidney stones
- ☐ Pain or burning during urination
- ☐ Prostate infection
- ☐ Urgent need to urinate
- ☐ UTI

### PERIPHERAL VASCULAR

- ☐ Clots in veins
- ☐ Leg cramps
- ☐ Varicose veins

### MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Broken bone
- ☐ Decreased joint motion
- ☐ Gout
- ☐ Pain
- ☐ Serious sprains
- ☐ Stiffness
- ☐ Swelling

### NEUROLOGIC

- ☐ Fainting
- ☐ Headaches
- ☐ Incoordination
- ☐ Involuntary movement
- ☐ Loss of consciousness
- ☐ Loss of muscle size
- ☐ Migraines
- ☐ Muscle spasm
- ☐ Numbness
- ☐ Paralysis
- ☐ Pins & needles feeling
- ☐ Seizures
- ☐ Tremor
- ☐ Weakness

### HEMATOLOGIC

- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Past transfusions

### ENDOCRINE

- ☐ Abnormal growth
- ☐ Diabetes
- ☐ Excessive sweating
- ☐ Heat/cold intolerance
- ☐ Increased appetite
- ☐ Increased thirst
- ☐ Increased urine production
- ☐ Thyroid trouble

### PSYCHIATRIC

- ☐ Anxiety
- ☐ Change in mood/change in attitude towards family/friends
- ☐ Depression
- ☐ Memory problems
- ☐ Past treatment with Psychiatrist
- ☐ Sleep problems
- ☐ Suicidal thoughts
- ☐ Tension
- ☐ Unusual problems

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## CDC STEADI Fall Risk Self-Screening Tool

We are concerned about our patient's safety while visiting our Dignity Health facility, and want to ensure that we provide the highest level of care.

Please complete the following questions so that the health care provider may better serve you.

- | Yes                          | No                       |   |
|------------------------------|--------------------------|---|
| <input type="checkbox"/> (2) | <input type="checkbox"/> | I have fallen in the past year.   |
| <input type="checkbox"/> (2) | <input type="checkbox"/> | I use or have been advised to use a cane or walker to get around safely.            |
| <input type="checkbox"/> (2) | <input type="checkbox"/> | Sometimes I feel unsteady when I am standing or walking.                            |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I steady myself by holding onto furniture when walking at home.                     |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I am worried about falling.   |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I need to push with my hands to stand up from a chair.                              |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I have some trouble stepping up onto a curb.  |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I often have to rush to the toilet.   |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I have lost some feeling in my feet.  |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I take medicine that sometimes makes me feel light-headed or more tired than usual. |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I take medicine to help me sleep or improve my mood.                                |
| <input type="checkbox"/> (1) | <input type="checkbox"/> | I often feel sad or depressed.  |

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011:42(6)493-499).



### CDC STEADI FALL RISK SELF-SCREENING TOOL



SCRN

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Patient Label

# Dignity Health Staff Follow Up

## For Dignity Health Staff Use Only

- ☐ Patient is at high risk for falls (Score > 4 or "Yes" to any highlighted key question)
- ☐ Patient determined high fall risk by healthcare provider discretion

### Fall Prevention/Interventions - check all appropriate answers:

#### Identification

- ☐ Patient given yellow wristband to wear

#### Patient Assistance to/from exam room/treatment room or restroom

- ☐ Patient should be escorted with walker
- ☐ Patient should be escorted with wheelchair
- ☐ Patient can be escorted under own power (staff walks alongside patient)

#### Patient Assistance within exam room/treatment room/area

- ☐ Provide assistance whenever patient is moved from sitting/supine to a standing position and vice versa.
- ☐ Check Recommended Equipment:
  - Gait Belt
  - Other \_\_\_\_\_
- ☐ Ensure patient is never left unattended or without direct observation in the exam/treatment room while lying on exam or treatment table.
- ☐ If a footboard is utilized for any exam (imaging areas), the technologist will verify that the footboard is secure and locked on the table prior to setting the patient upright.
- ☐ In the event the patient is undergoing a procedure or treatment for an extended period of time, the patient will be taken off the table and seated in a chair with arms.
- ☐ Family/friends at exam/treatment table whenever possible

#### Education

- ☐ Patient instructed that a staff member should be present each time they walk
- ☐ Patient and/or family provided with CDC STEADI "Check for Safety Brochure" (all patients)
- ☐ While on the exam or treatment table, patients will be instructed not to move without assistance from the outpatient department/clinic staff

Signature: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_



### CDC STEADI FALL RISK SELF-SCREENING TOOL



SCRN

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Patient Label



## Important Information

*Read and initial for each section*

\_\_\_\_\_ **COVID-19 AND ILLNESS SCREENING:** Temperature and symptom screenings will be performed for each patient and visitor upon entry at the clinic. If you are experiencing any symptoms, please contact our office at (602) 406-6262 prior to your visit to determine if your visit should be rescheduled to a later date when you are symptom free.

\_\_\_\_\_ **VISITOR RESTRICTIONS:** In response to various periods of high infection, we may have restrictions and/or limitations on visitors on the campus. In general, it is best to limit visitors to only one adult.

\_\_\_\_\_ **CANCELLATIONS, LATE PATIENTS, AND NO SHOWS:** Our goal at Barrow Otolaryngology Clinic is to maximize the time your provider spends with you and minimize your wait time. In order to do so, we have a standardized policy for no shows, cancellations, and late arrivals. Cancellations related to illness do not apply to this policy.

- **Cancellation:** We require 24 hour notice of cancellation for any appointments.
- **Late:** You will be considered late if you arrive 15 minutes after scheduled appointment time.
- **No Show:** If you do not arrive for a scheduled appointment and do not provide the office notice at least 24 hours prior to your appointment, you will be considered a no show.
  - No show #1 - Documented
  - No show #2 - Warning letter mailed out to patient
  - No show #3 - Discharged from office

\_\_\_\_\_ **FAMILY AND FRIENDS:** You have the option to list up to three (3) individuals that you give permission to know about appointment dates, times, and/or billing information. These individuals may NOT give consent for any in office procedures, immunizations, etc.

\_\_\_\_\_ **MEDICATION REFILLS:** Please contact your preferred pharmacy to request medication refills. Once the request has been received, refills will be completed within three (3) business days.

\_\_\_\_\_ **PATIENT PORTAL:** Barrow Neurological Institute participates in an electronic patient portal which allows continuous access to your patient information including, but not limited to, upcoming appointments, prior visit summaries, lab and imaging results. Additionally, the portal allows patients to securely communicate with providers directly. Our staff can provide you with an email invitation to set up your portal.

\_\_\_\_\_ **FINANCIAL RESPONSIBILITY:** This may include co-payments, co-insurance and services not covered or paid by your insurance carrier. This financial responsibility also applies if your insurance carrier is not

PATIENT NAME: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

contracted with Dignity Health. **It is your responsibility to ensure that all services rendered by Barrow Neurological Institute on your behalf are paid in full within thirty (30) days of the statement date.**

We do not change billing codes once they have been submitted to your insurance company.

It is important that you bring proof of insurance each time you visit the clinic. Failure to do so may result in billing issues for your care. Please make every effort to let us know if your insurance carrier (primary or secondary insurance) or your personal information (home address, employer, and phone number) has changed since your last visit.

\_\_\_\_\_ **TELECOM AGREEMENT:** You agree that by signing below you consent and request that Dignity Health, its affiliates, and those acting on its/their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include those concerning the patient's care, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide or we obtain even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

\_\_\_\_\_ **HEALTH INFORMATION EXCHANGE (HIE) STATE PARTICIPATION ACKNOWLEDGEMENT:**

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Barrow Neurological Institute's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. (see pages 11-13)

I have read and understood the above.

\_\_\_\_\_  
Guarantor/Responsible Party or Patient Signature

\_\_\_\_\_  
Date

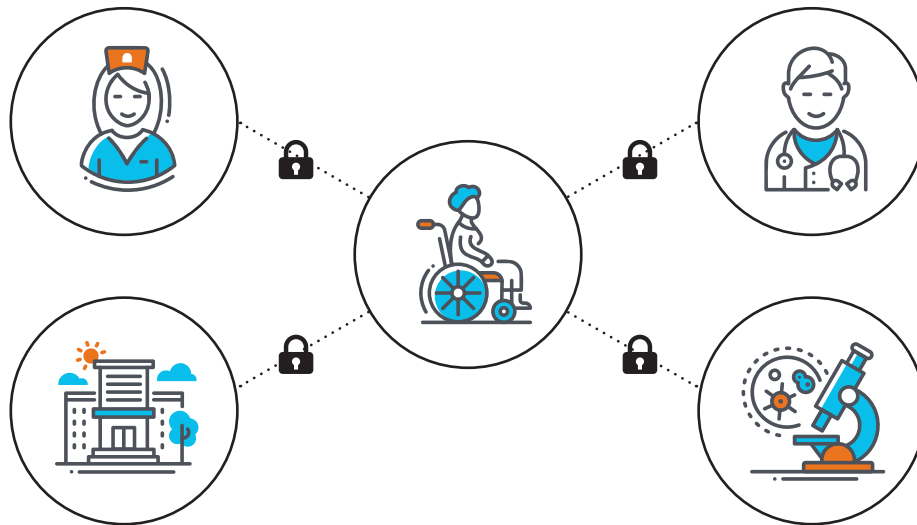
# Barrow Department of Neurology

## Secure Sharing of Your Health Information



### What You Need to Know

Doctors and hospitals can give you better healthcare by sharing your health information electronically. This is very important in emergencies. This sharing is done electronically through Health Current, Arizona's health information exchange (HIE).



Many doctors' offices and hospitals are switching from paper medical records to electronic medical records. During your most recent doctor's visit, you may have noticed your doctor using a laptop or tablet to type in your health information. Now that your health information is stored safely in a computer, it can be shared more easily among your doctors' offices, hospitals, labs, and radiology centers. Your health information is shared securely through the HIE.

### Secure sharing of your health information has many benefits:

- Better treatment in an emergency because your doctors will have information about your allergies and your previous problems.
- Prevention of errors and harmful drug interactions.
- Lower overall costs of healthcare by avoiding duplicate tests, procedures and prescriptions.

For details about how your health information will be shared and how it will be protected, please read the Notice of Health Information Practices you received at your doctor's office.

**NOTE:** If you do not want your health information shared through HIE, please ask your provider for an Opt Out Form. For more information, visit [www.healthcurrent.org](http://www.healthcurrent.org) and click on the Patient Rights button.

PATIENT NAME: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

## Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgement Form

Effective April 14, 2003, the law requires that Barrow Neurological Institute give every patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and if we change our notice, thereafter at the next treatment visit. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in patient's medical care, you acknowledge receipt of such. (see pages 17-20)

\_\_\_\_\_  
Acknowledgment Signature\_\_\_\_\_  
Date\_\_\_\_\_  
If not by patient, print name\_\_\_\_\_  
Relationship to Patient

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### For Official Use

I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_

I have attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Barrow Neurological Institute Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Department: \_\_\_\_\_

# Barrow Department of Neurology Epilepsy Medical History



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ ☐ Right Handed ☐ Left Handed

Zip Code: \_\_\_\_\_

Gender Identity: ☐ Man ☐ Woman ☐ Gender non-conforming ☐ Gender-queer  
☐ Trans man ☐ Trans woman ☐ Other, specify: \_\_\_\_\_  
☐ I choose not to answer

Preferred pronouns: ☐ He/Him/His ☐ She/Her/hers ☐ Other, specify: \_\_\_\_\_  
☐ I choose not to answer

**Reason for visit:** \_\_\_\_\_

Symptoms: \_\_\_\_\_

When does/did it occur? \_\_\_\_\_

Describe severity: \_\_\_\_\_

Made better by: \_\_\_\_\_

Made worse by: \_\_\_\_\_

## Past Medical History and Dates Diagnosed:

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes _____                | <input type="checkbox"/> Cancer/Tumors _____        |
| <input type="checkbox"/> High Blood Pressure _____     | <input type="checkbox"/> HIV/AIDS _____             |
| <input type="checkbox"/> Heart Attack _____            | <input type="checkbox"/> Surgery _____              |
| <input type="checkbox"/> Stroke _____                  | <input type="checkbox"/> Trauma _____               |
| <input type="checkbox"/> Seizures _____                | <input type="checkbox"/> Thyroid problems _____     |
| <input type="checkbox"/> Liver Disease _____           | <input type="checkbox"/> Ulcers _____               |
| <input type="checkbox"/> Asthma _____                  | <input type="checkbox"/> Back problems _____        |
| <input type="checkbox"/> Lung Disease _____            | <input type="checkbox"/> Heart Valve problems _____ |
| <input type="checkbox"/> Kidney Disease _____          | <input type="checkbox"/> Hyperlipidemia _____       |
| <input type="checkbox"/> Other Medical Illnesses _____ |   |

## Past Surgical History and Dates of Surgeries:

Date: \_\_\_\_\_ Type: \_\_\_\_\_

Date: \_\_\_\_\_ Type: \_\_\_\_\_

## Artificial Parts:

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Implants        | <input type="checkbox"/> DBS/VNS/RNS  |
| <input type="checkbox"/> Limb prosthesis | <input type="checkbox"/> Heart valve  |
| <input type="checkbox"/> Pacemaker/AICD  | <input type="checkbox"/> Other: _____ |

## Family History:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Seizures	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Parkinson Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
<input type="checkbox"/> Other: _____			

Father died age \_\_\_\_\_ of: \_\_\_\_\_

Mother died age \_\_\_\_\_ of: \_\_\_\_\_

Brother died age \_\_\_\_\_ of: \_\_\_\_\_

Sister died age \_\_\_\_\_ of: \_\_\_\_\_

\_\_\_\_\_ died age \_\_\_\_\_ of: \_\_\_\_\_

\_\_\_\_\_ died age \_\_\_\_\_ of: \_\_\_\_\_

## Social History:

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

Spouse: Age: \_\_\_\_\_ Health Status: \_\_\_\_\_

Children: ☐ Male ☐ Female Age: \_\_\_\_\_ Health Status: \_\_\_\_\_

☐ Male ☐ Female Age: \_\_\_\_\_ Health Status: \_\_\_\_\_

☐ Male ☐ Female Age: \_\_\_\_\_ Health Status: \_\_\_\_\_

Lost pregnancies/miscarriages: \_\_\_\_\_ Last menstrual period: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Language spoken at home: \_\_\_\_\_ First year moved to the United States: \_\_\_\_\_

Place of birth: ☐ United States (U.S.) ☐ Outside the U.S. ☐ Other, specify: \_\_\_\_\_

☐ I choose not to answer

Physical Exercise: \_\_\_\_\_ Stress: \_\_\_\_\_

Tobacco: ☐ 0 ☐ < 1ppd ☐ 1ppd ☐ > 1ppd ☐ Quit: \_\_\_\_\_ ☐ Years: \_\_\_\_\_

Alcohol: ☐ 0 ☐ 1-5 per week ☐ > 5 per week ☐ Quit: \_\_\_\_\_ ☐ Years: \_\_\_\_\_

Recreational Drug Use: \_\_\_\_\_ IV Drug Use: \_\_\_\_\_

HIV high risk behavior: \_\_\_\_\_ STD: \_\_\_\_\_

Do you live alone? ☐ Yes ☐ No

What is your housing situation today? ☐ I have stable housing, specify: \_\_\_\_\_  
☐ I do not have housing ☐ I have housing but I'm worried about losing it

Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

☐ Food ☐ Utilities ☐ Clothing ☐ Childcare ☐ Medicine or Health Care  
☐ Phone ☐ Internet ☐ Other, specify: \_\_\_\_\_

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? ☐ Yes, medical ☐ No ☐ Yes, non-medical

## Drug Allergies

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## Medication

Dose strength and frequency (prescribed and over-the-counter)

Name of Medication	Dosage (mg) # of pills	Frequency

## Pharmacy Information

Name of local pharmacy:\_\_\_\_\_ Phone number:\_\_\_\_\_

Name of mail order pharmacy:\_\_\_\_\_ Phone number:\_\_\_\_\_

## Provider Contact Information

### Referral Source (to Epilepsy Center)

*Check all that apply:*

- |  |  |
|--|--|
| <input type="checkbox"/> Self  | <input type="checkbox"/> Epilepsy Foundation, national             |
| <input type="checkbox"/> Family member/friend                                | <input type="checkbox"/> Epilepsy Foundation, local specify: _____ |
| <input type="checkbox"/> Primary care provider                               | <input type="checkbox"/> National Association of Epilepsy Centers  |
| <input type="checkbox"/> Emergency room or post-hospital discharge           | <input type="checkbox"/> Other community service agency            |
| <input type="checkbox"/> Neurologist   | <input type="checkbox"/> Insurance company/provider directory      |
| <input type="checkbox"/> Neurosurgeon  | <input type="checkbox"/> Other, specify: _____                     |
| <input type="checkbox"/> Other epilepsy center or epileptologist             | <input type="checkbox"/> I choose not to answer                    |
| <input type="checkbox"/> Social worker or social work agency                 |  |
| <input type="checkbox"/> Mental health provider (psychiatrist, psychologist) |  |

**Name of referring provider:** \_\_\_\_\_

Do you have a primary care provider? ☐ Yes, name: \_\_\_\_\_  
☐ No ☐ I don't know ☐ I choose not to answer

### Contact info for other providers:

Name: _____	Name: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____

Name: _____	Name: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____

Name: _____	Name: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____



## Seizure Information

1. When was your LAST **typical** seizure (your most common seizure type)?

- ☐ Today
- ☐ More than 1 day to 6 days ago
- ☐ More than 1 week to 4 weeks ago
- ☐ More than 1 month to 3 months ago
- ☐ More than 3 months to 6 months ago
- ☐ More than 6 months to 12 months ago
- ☐ More than 1 year to 2 years ago
- ☐ More than 2 years ago
- ☐ Decline to answer
- ☐ I don't know

***If your answer to the previous question was "Today", "More than 1 day to 6 days ago", "More than 1 week to 4 weeks ago", please answer the following question:***

2. How often is your **typical** seizure **during the past fourweeks?**

- ☐ Too many to count (i.e.,  $\geq 10$  per day most days)
- ☐ Multiple per day (i.e., 4 days per week with  $\geq 2$  seizures)
- ☐ Daily (i.e., 4 or more days in the past week)
- ☐ Weekly but not daily (i.e., 1 - 3 in the past week)
- ☐ Monthly but not weekly (i.e., 1 - 3 in the past month)
- ☐ At least once per year, but not every month (i.e., 10 or fewer in past 12 months)
- ☐ Less than once per year
- ☐ Frequency not well defined
- ☐ I don't know

3. Do you keep track of your seizure frequency?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ Not applicable

***If your answer to the previous question was "Yes" or "I don't know", please answer the following question:***

4. How did you track your seizure frequency?

- ☐ Paper Journal (for example, calendar, diary, etc.)
- ☐ Mobile Application (for example, SeizureTracker, MySeizureDiary, or other app)
- ☐ Electronic Diary (for example, calendar on phone, spreadsheet, etc.)
- ☐ Other, Specify: \_\_\_\_\_

5. In the past week, I/(my child) has missed \_\_\_\_\_ doses of the anti-seizure medicine.

6. Are you having any problems that you think are **side effects** of your medication?
- ☐ Yes
  - ☐ No
  - ☐ I don't know
  - ☐ Not applicable (for example, I am not taking any anti-seizure medication)
7. Rate the severity of side effects you/your child have experienced from your epilepsy medicine in the past month.
- 1** - Not present
  - 2** - Low severity
  - 3** - Low-moderate severity
  - 4** - Moderate severity
  - 5** - Moderate-high severity
  - 6** - High severity
  - N/A** - I don't take epilepsy medicine

### Things that Get in the Way of Taking your Anti-seizure Medication

We realize that taking medicine for your seizures can be hard at times. Some patients have shared that the following things get in the way of taking their anti-seizure medicine. Let us know which of these things, if any, apply to you related to taking your anti-seizure medicine.

8. Who is filling out this section?

- ☐ Patient
- ☐ Family member
- ☐ Health aide

9. **Things that Get in the Way of Taking your Anti-seizure Medication**

*Please check all that apply:*

- ☐ I have trouble remembering (e.g. Forget).
- ☐ The medicine tastes bad.
- ☐ The pills are too hard to swallow.
- ☐ I do not like the side effects (like sleepiness or dizziness).
- ☐ I do not want other people to know I take medicine.
- ☐ I do not think I need the medicine.
- ☐ I take too many medicines or it is too many times a day.
- ☐ The medicine does not always control/stop my seizures.
- ☐ I run out of medicine.
- ☐ The medicine instructions are confusing.
- ☐ It is inconvenient (for example, I have to cut my pills in half for dosing).
- ☐ Taking the medicine gets in the way of other activities (like sports or work).
- ☐ I cannot afford the medicine.
- ☐ Sometimes I choose not to take them.
- ☐ Difficulty getting to the pharmacy to pick up medicine.
- ☐ Insurance problems.
- ☐ I worry medicine may impact my ability to have children in the future.
- ☐ Other: \_\_\_\_\_
- ☐ **I have none of the above**

## Quality of Life *(Please complete for adult patients)*

**Instructions:** the **QOLIE-10** is a brief survey of health-related quality of life for adults with epilepsy. There are 10 questions about health and daily activities, one question about how much distress you feel about problems and worries related to epilepsy, and a review of what bothers you most. This questionnaire should be completed only by the person who has epilepsy (not a relative or a friend) because no one else knows how YOU feel.

Answer every question by circling the appropriate number (1, 2, 3...). If you are unsure about how to answer a question, please give the best answer you can and write a comment or explanation on the side of the page. These notes may be useful if you discuss the QOLIE-10 with your doctor. Completing the QOLIE-10 before and after treatment changes may help you and your doctor understand how the changes have affected your life.

*These questions are about how you have been FEELING and the types of problems you have been having during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.*

How much of the time during the past 4 weeks...		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1	Did you have a lot of <b>energy</b> ?	1	2	3	4	5	6
2	Have you felt <b>downhearted and low</b> ?	1	2	3	4	5	6
During the past 4 weeks...		A great deal	A lot	Somewhat	Only a little	Not at all	
3	How much of the time have your epilepsy or antiepileptic drugs caused trouble with <b>driving (or other transportation)</b> ?	1	2	3	4	5	
4	How much do your <b>work limitations</b> bother you?	1	2	3	4	5	
5	How much do your <b>social limitations</b> bother you?	1	2	3	4	5	
6	How much do your <b>memory difficulties</b> bother you?	1	2	3	4	5	
7	How much do <b>physical effects of antiepileptic drugs</b> bother you?	1	2	3	4	5	
8	How much do <b>psychological effects of antiepileptic drugs</b> bother you?	1	2	3	4	5	
During the next 4 weeks...		Very afraid	Somewhat afraid	Not very afraid	Not afraid at all		
9	How afraid are you of having a seizure?	1	2	3	4		
During the past 4 weeks...		Very good; could hardly have been better	Pretty good	Good & bad about equal	Pretty bad	Very bad; could hardly have been worse	
10	How has your QUALITY OF LIFE been (that is, how have things been going for you)?	1	2	3	4	5	
Reviewing all the questions you have answered in Part A, consider the overall impact of these problems on your quality of life in the past 4 weeks...		Not at all	Somewhat	Moderately	A lot	Very much	
11	How much does the state of your epilepsy-related quality of life distress you overall?	1	2	3	4	5	

Patient Weighted QOLIE-10-P (QOLIE-10-P) copyright by the QOLIE Development Group; Adapted from the QOLIE-10, copyright © 1993, Professional Postgraduate Services and the QOLIE Development Group.

Considering ALL the questions you have answered, please indicate the areas related to your epilepsy that are most IMPORTANT to you NOW.	
12	<p>Number the following topics from '1' to '7' with '1' corresponding to the most important topic and '7' to the least important one. Please use each number only once.</p> <div style="display: flex; justify-content: space-between;"> <div> <p>_____ A. Energy (tiredness)</p> <p>_____ B. Emotions (mood)</p> <p>_____ C. Daily activities (work, driving, social)</p> <p>_____ D. Mental activity (thinking, concentrating, memory)</p> </div> <div> <p>_____ E. Medication effects (physical, mental)</p> <p>_____ F. Worry about seizures (impact of seizures)</p> <p>_____ G. Overall quality of life</p> </div> </div>

## Mental Health *(Please complete for adult patients)*

### PHQ Q9

(validated for depression)

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the day	Nearly every day
1	Little interest or pleasure in doing things.	0	1	2	3
2	Feeling down, depressed, or hopeless.	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4	Feeling tired or having little energy.	0	1	2	3
5	Poor appetite or overeating.	0	1	2	3
6	Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
		0	1	2	3

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**GAD-7**

(General Anxiety Disorder-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the day	Nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
<b><i>If any of the above were scored more than "Not at all":</i></b>					
8	How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
		0	1	2	3

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**Good-Day/Bad-Day Question**

- In the past four weeks, considering your epilepsy and how it affects you, how often have you had "good days"?
  - ☐ Every Day
  - ☐ Most days (more than half)
  - ☐ Some days (less than half)
  - ☐ Once or twice
  - ☐ Never
  - ☐ I don't know / Can't remember / Didn't ask

**Routine Question**

- In the past four weeks, thinking about your usual routines, how often have seizures significantly changed those routines?
  - ☐ Every Day
  - ☐ Most days (more than half)
  - ☐ Some days (less than half)
  - ☐ Once or twice
  - ☐ Never
  - ☐ I don't know / Can't remember / Didn't ask

## Women's Health

### ☐ Form not applicable

1. Do you have menstrual periods?

☐ Yes, I have menstrual periods  
☐ I have not yet started to have menstrual periods  
☐ My last menstrual period was over 1 year ago  
☐ I had my uterus and/or ovaries removed

☐ I do not have menstrual periods because of my birth control method  
☐ Not applicable
2. Are you pregnant?

☐ Yes  
☐ No  
☐ I don't know  
☐ Prefer not to answer
3. Are you thinking about getting pregnant in the next year?

☐ Yes  
☐ No  
☐ I don't know
4. Do you understand how seizures during pregnancy may affect your unborn baby?

☐ Yes  
☐ No  
☐ I don't know
5. Do you know how anti-seizure medication may affect the unborn baby?

☐ Yes  
☐ No  
☐ I don't know
6. Do you know how your anti-seizure medication may need to be adjusted during your pregnancy?

☐ Yes  
☐ No  
☐ I don't know
7. Are you taking folic acid?

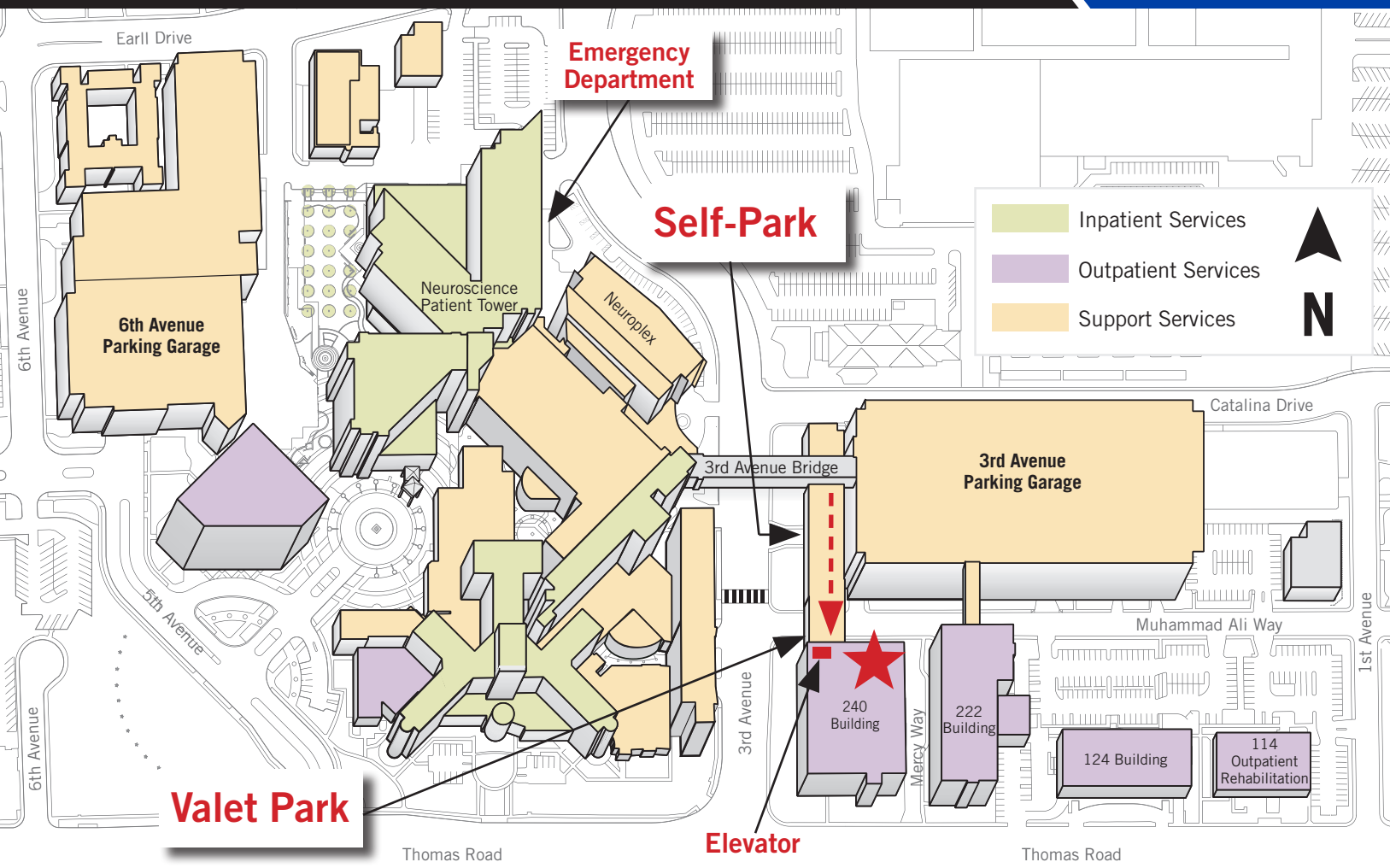
☐ Yes, on a regular basis  
☐ Yes, occasionally  
☐ No  
☐ I don't know
8. Do you currently use a method to prevent pregnancy? *(mark all that apply)*

☐ None  
☐ Abstinence  
☐ Rhythm method  
☐ Pill  
☐ Condoms

☐ Birth control shot  
☐ Subdermal implant  
*(hormone placed under the skin)*  
☐ Diaphragm  
☐ Intrauterine device (IUD)

☐ Tube ligation  
☐ Other surgical *(e.g., uterus removal)*  
☐ Not needed - not able to get pregnant  
☐ Other contraceptive method

# 240 Building



## Barrow Neurological Institute – 240 Building, 240 W. Thomas Rd., Phoenix

Outpatient Surgery Center	First Floor
Barrow Neuro-Rehabilitation Inpatient Unit	Second Floor
Muhammad Ali Parkinson Outreach/Wellness, Movement Disorders/Rehab, Alzheimer's/Memory, Balance	Third Floor
ALS, EMG, Epilepsy, Infusion, Migraine, MS, Neuro Muscular, Neuro Oncology, Neuro Ophthalmology, Stroke	Fourth Floor

### Self-Park

Park in the 3rd Avenue Parking Garage. Take parking garage elevators to the 2nd floor, exit through the doors to the right and immediately turn left and follow the long hallway to Neuro-Rehab or to the 240 building elevators around the corner. Use the elevators to access the correct floor for your services.

### Valet Park

Valet parking for the 240 building is located on Muhammad Ali Way one block north of Thomas Rd. just east of 3rd Avenue. The 240 building entrance is directly behind the valet. Use the elevators to access the correct floor for your services. ***Valet parking validation is available when you check into your appointment.***