HUNTSVILLE HOSPITAL
NEUROLOGICAL ASSOCIATES

Anjaneyulu Alapati, MD

Theodros Mengesha, MD

Dear Patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Neurological Associates for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please complete the online New Patient Forms prior to your appointment. Bring the completed forms with you on your appointment date, along with your identification cards, insurance cards, medication bottles, as well as your co-payments and/or deductibles.

We ask that all new patients arrive ***30 minutes*** prior to your appointment time, so you can be seen by the doctor at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be ***15 minutes*** or more late, please call our office at (256) 265-2695 as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Misty Hale, RN

Misty Hale, RN
Clinical Practice Administrator
Huntsville Hospital Neurological Associates

201 Sivley Road, Suite 200
Huntsville, AL 35801
(256) 265-2695
(256) 265-6386 fax

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NEUROLOGICAL ASSOCIATES

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Phone: (256) 265-2695 Fax: (256) 265-6386

PATIENT INFORMATION

PLEASE PRINT DATE_____

Patient's Name _____ Referred By _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell Phone_____

SS# _____-_____-_____ Sex M F D.O.B._____/_____/_____

Email Address _____

Patient's Occupation _____ Employer:_____ _____

Employer's Address _____Employer's Phone ( )_____ _____

Spouse's Name _____Spouse's D.O.B. _____/_____/_____ Spouse's SS # _____-_____-_____

Spouse's Occupation _____Spouse's Employer_____ _____

Employer's Address _____ Employer's Phone ( ) _____

Notify in case of emergency _____Relationship _____

City _____ State _____ Phone ( ) _____

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE ( )_____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature _____ Date _____Time_____

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HUNTSVILLE HOSPITAL
NEUROLOGICAL ASSOCIATES

DATE: _____ **APPT. TODAY WITH:** Alapati Mengesha

NAME: _____ **WHAT OTHER DOCTORS/SPECIALIST DO YOU SEE:**

DATE OF BIRTH: _____ **NAME/SPECIALTY** _____

AGE: _____ _____

REASON FOR VISIT: _____

ANY NEW OR WORSENING PROBLEMS? IF YES, PLEASE DESCRIBE: _____

_____

PLEASE CHECK IF YOU HAVE ANY OF THE BELOW:

PAST MEDICAL HISTORY:

- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ AUTOIMMUNE DISEASE (LUPUS)
- ☐ BILIARY CIRRHOSIS
- ☐ BLOOD TRANSFUSION
- ☐ BRAIN TUMOR
- ☐ CEREBROVASCULAR
- ☐ DISEASE (STROKE)
- ☐ CIRRHOSIS
- ☐ CVA/STROKE
- ☐ COPD (LUNG DISEASE)
- ☐ COLON CANCER
- ☐ CORONARY HEART DISEASE
- ☐ CROHN'S DISEASE
- ☐ CHRONIC RENAL FAILURE
- ☐ DEPRESSION
- ☐ DIABETES - JUVENILE ONSET
- ☐ DIABETES - ADULT ONSET
- ☐ DIVERTICULITIS
- ☐ DVT (BLOOD CLOT IN LEGS)
- ☐ GI BLEED
- ☐ GERD (ACID REFLUX)
- ☐ HEMOCHROMATOSIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HYPOTHYROIDISM
- ☐ HYPERTHYROIDISM
- ☐ GOITER
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ INFERTILITY
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ MI (HEART ATTACK)
- ☐ NEUROLOGIC DISORDER
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ PVD
- ☐ PUD (STOMACH ULCERS)
- ☐ RHEUMATOID ARTHRITIS
- ☐ SEIZURE DISORDER
- ☐ THYROID DISORDER
- ☐ TUBERCULOSIS
- ☐ VALVULAR HEART DISEASE
- ☐ UTI - RECURRENT
- ☐ VARICOSE VEINS/PHLEBITIS
- ☐ ABNORMAL PAP SMEAR
- ☐ BREAST DISEASE
- ☐ BREAST CANCER
- ☐ CERVICAL CANCER
- ☐ DES EXPOSURE
- ☐ GESTATIONAL DIABETES
- ☐ RH SENSITIZED
- ☐ SLEEP APENA
- ***USING CPAP YES/NO

OTHER _____

PAST SURGICAL HISTORY:

- ☐ AMPUTATION
- ☐ AV FISTULA CREATION
- ☐ AV GRAFT
- ☐ AORTIC VALVE REPLACEMENT
- ☐ AORTIC VALVE REPLACED
- ☐ APPENDECTOMY
- ☐ BOTH LEGS BYPASSED
- ☐ BACK SURGERY
- ☐ BRONCHOSCOPY (LUNG SCOPE)
- ☐ CABG (HEART BYPASS)
- ☐ CAROTID ENDARTERECTOMY
- ☐ CARPAL TUNNEL
- ☐ CATARACT EXTRACTION
- ☐ GALLBLADDER REMOVED
- ☐ COLON RESECTION
- ☐ CRANIOTOMY
- ☐ GASTRIC BYPASS
- ☐ HEMORRHOIDECTOMY
- ☐ HIP REPLACEMENT
- ☐ INVASIVE PAIN PROCEDURE
- ☐ KIDNEY TRANSPLANT
- ☐ KNEE ARTHROSCOPY
- ☐ KNEE REPLACEMENT
- ☐ KYPHOPLASTY
- ☐ LUMPECTOMY
- ☐ MASTECTOMY
- ☐ MITRAL VALVE REPLACED
- ☐ NEPHRECTOMY
- ☐ PACEMAKER IMPLANTED
- ☐ PARATHYROIDECTOMY
- ☐ PNEUMONECTOMY
- ☐ PTCA (ANGIOPLASTY)
- ☐ ROTATOR CUFF REPAIR
- ☐ ABD. HYSTERECTOMY
- ☐ HYSTERECTOMY/OVARIES
- ☐ **OVARIES REMOVED YES/NO
- ☐ PROSTATE SURGERY
- ☐ SHOULDER SURGERY
- ☐ SLEEP APNEA SURGERY
- ☐ THYROID SURGERY
- ☐ TONSIL'S REMOVED
- ☐ VASCULAR SURGERY
- ☐ BREAST AUMENTATION RIGHT/LEFT
- ☐ MASTECTOMY RIGHT/LEFT
- ☐ LUMPECTOMY RIGHT/LEFT

OTHER _____

FAMILY HISTORY: Patient name: _____ DOB: _____

	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐
HEART ARTERY DISEASE/HEART ATTACK	☐	☐	☐	☐	☐
KIDNEY DISEASE (CHRONIC)	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐
THYROID DISORDER	☐	☐	☐	☐	☐
CANCER (TYPE)	☐	☐	☐	☐	☐

OTHER:_____

SOCIAL HISTORY:

☐ MARRIED/SINGLE/DIVORCED/WIDOWED

☐ WORKS PART-TIME/ FULL-TIME

OCCUPATION:_____

☐ RETIRED

☐ DISABLED

☐ CHILDREN - YES OR NO

☐ RELIGIOUS AFFILIATION

_____

ALLERGIES OR MEDICATION REACTIONS: ☐ **NO KNOWN DRUG ALLERGIES**

ALLERGIC TO:	REACTION:
_____	_____
_____	_____
_____	_____

RISK FACTORS: (CHECK OR CIRCLE APPROPRIATE)

☐ CURRENT TOBACCO USE YEAR STARTED:_____

☐ TYPE OF TOBACCO: (CIRCLE APPROPRIATE)

CIGARETTES, CIGARS, SNUFF, VAPOR

☐ FORMER TOBACCO USE YEAR QUIT:_____

☐ NEVER SMOKED

☐ SECOND HAND SMOKE YES NO

☐ DO YOU WEAR YOUR SEAT BELT? YES NO

☐ CAFFEINE USE YES NO

HOW MANY DRINKS PER DAY _____

☐ ALCOHOL USE YES NO

HOW MANY PER DAY _____

TYPE: _____

HOW MANY DRINKS PER DAY _____

☐ EXERCISE YES NO

TIMES PER WEEK:_____

TYPE: _____

CURRENT MEDICATIONS: ☐ REFER TO LIST ☐ REFER TO BOTTLES

PLEASE INCLUDE THE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION (NO NEED TO LIST BELOW IF YOU BROUGHT A LIST OR BOTTLES)

NAME	DOSAGE	HOW MANY TIMES PER DAY	AS NEEDED (PRN)

Patient name: _____ DOB: _____

MEDICAL PROBLEMS: *HAVE YOU HAD ANY RECENT OR PERSISTENT PROBLEMS WITH THE FOLLOWING?*

General:
- ○ WEIGHT GAIN / LOSS
- ○ DIABETES
- ○ BACK PAIN

Skin:
- ○ RASHES
- ○ NAIL / HAIR PROBLEMS
- ○ ABDOMINAL MOLES

Extremities:
- ○ JOINT PAIN
- ○ GOUT
- ○ VARICOSE VEINS
- ○ LEG SWELLING

Neck:
- ○ GOITER
- ○ SWOLLEN GLANDS
- ○ THYROID

Mouth:
- ○ DENTURES
- ○ HOARSENESS
- ○ GUMS

LAST DENTAL EXAM: _____

DENTIST: _____

Heart:
- ○ CHEST PAIN
- ○ HYPERTENSION
- ○ HIGH CHOLESTEROL
- ○ CONGESTIVE HEART FAILURE
- ○ HEART MURMUR
- ○ PALPITATIONS

LAST EKG: _____

Gastrointestinal:
- ○ TROUBLE SWALLOWING
- ○ REFLUX / GERD
- ○ VOMITING
- ○ DIARRHEA
- ○ CONSTIPATION
- ○ BLOODY / BLACK STOOL
- ○ HEMORRHOIDS
- ○ HEPATITIS

LAST COLONOSCOPY: _____

Urinary:
- ○ FREQUENCY
- ○ TROUBLE STARTING OR STOPPING
- ○ URINARY PAIN
- ○ URINATE AT NIGHT
- ○ LEAKAGE
- ○ BLOOD IN URINE
- ○ KIDNEY STONES
- ○ INFECTIONS
- ○ PROSTATE TROUBLE

Neuro:
- ○ HEADACHE
- ○ HEAD INJURY
- ○ BLACKOUTS / DIZZY
- ○ SEIZURES / TREMORS
- ○ MEMORY LOSS
- ○ DEPRESSION / ANXIETY

Lungs:
- ○ PERSISTANT COUGH
- ○ COUGH UP BLOOD
- ○ EMPHYSEMA / BRONCHITIS
- ○ SHORTNESS OF BREATH
- ○ PNEUMONIA

Lifestyle:
- ○ REGULAR EXERCISE _____ TIMES A WEEK
- ○ LOW SALT DIET
- ○ LOW FAT DIET

Sexual:
- ○ PROBLEMS WITH SEX
- ○ MULTIPLE PARTNERS
- ○ HISTORY OF STD
- ○ HIV

ENT:
- ○ ALLERGIES
- ○ SINUS TROUBLE
- ○ HEARING LOSS
- ○ GLASSES / CONTACTS
- ○ BLURRED VISION
- ○ RINGING

LAST EYE EXAM: _____

EYE DOCTOR: _____

Women:
- ○ IRREGULAR PERIODS
- ○ PELVIC PAIN
- ○ BIRTH CONTROL PILLS
- ○ NIPPLE DISCHARGE
- ○ LUMPS IN BREASTS
- ○ SELF BREAST EXAM

PLEASE ENTER THE MOST RECENT DATE AND RESULTS OF THE FOLLOWING:

	DATE	RESULTS	PERFORMED BY WHO/WHERE
COLONOSCOPY	_____	_____	_____
PAP SMEAR	_____	_____	_____
MAMMOGRAM	_____	_____	_____
BONE DENSITY SCAN	_____	_____	_____
MENSTURAL PERIOD	_____	_____	_____
PSA (PROSTATE SCEEN)	_____	_____	_____

WHEN WAS YOUR LAST VACCINE ON THE FOLLOWING:

	DATE
FLU VACCINE	_____
TETANUS VACCINE	_____
PNEUMONIA VACCINE	_____
ZOSTAVAX	_____

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Phone: (256) 265-2695 Fax: (256) 265-6386

Medicare Secondary Payer Questionnaire

Patient Name: _____ Patient DOB: _____

Patient DOS: _____

Part I

1. Are you receiving Black Lung Benefits?
   - □ No
   - □ Yes – (Date Benefits began: _____) **Black Lung is Primary Only for Claims Related to Black Lung**
2. Are the services to be paid by the government program such as research grant?
   - □ No
   - □ Yes – **Government Program will be Primary**
3. Has the Department of Veterans Affairs authorized and agreed to pay for care at this facility?
   - □ No
   - □ Yes – **Department of Veterans Affairs is Primary**
4. Was the illness or injury due to work related accident or condition?
   - □ No – **Go to Part II**
   - □ Yes – (Date of Injury/Illness:_____) **Worker's Comp is Primary Go to Part III**

Part II

1. Was illness or injury due to non-work related accident?
   - □ No – **Go to Part III**
   - □ Yes – (Date of Accident: _____)
2. What type of accident caused the illness or injury?
   - □ Automobile – **Motor Vehicle Insurance is Primary**
   - □ Non-Automobile – **Go to question 3**
3. Was another party responsible for this accident?
   - □ No – **Go to Part III**
   - □ Yes – **Liability Insurance Carrier is Primary**

Part III

1. Are you entitled to Medicare based on:
   - □ Age – 65 and over – **Go to Part IV**
   - □ Disability – **Go to Part V**
   - □ Dialysis (End Stage Renal Disease) – **Go to Part VI**

Patient Name: _____ Patient DOB: _____

Patient DOS: _____

Part IV – Age

1. Are you currently employed?
   - □ No (Date of Retirement: _____)
   - □ Never Worked
   - □ Yes
     Employer Name:_____
     Employer Address: _____
     _____
2. Is your spouse currently employed?
   - □ No (Date of Retirement: _____)
   - □ Never Worked
   - □ Yes
     Employer Name:_____
     Employer Address: _____
     _____

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or a spouse's current employment?
   - □ No – **Stop**
   - □ Yes – **Go to Question 4**
4. Does the employer that sponsor's your Group Health Plan employ 20 or more employees?
   - □ No – **Stop**
   - □ Yes – **Stop Group Health Plan is Primary**

Part V – Disability

1. Are you currently employed?
   - □ No (Date of Retirement: _____)
   - □ Yes
     Employer Name:_____
     Employer Address: _____
     _____
2. Is a family member currently employed?
   - □ No
   - □ Yes
     Employer Name:_____
     Employer Address: _____
     _____

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or family member's current employment?
   - □ No – **Stop**
   - □ Yes – **Go to Question 4**
4. Does the employer that sponsors the Group Health Plan employ 100 or more employees?
   - □ No – **Stop Medicare is Primary**
   - □ Yes – **Stop Group Health Plan is Primary**

Patient Name: _____ Patient DOB: _____

Patient DOS: _____

Part VI – Dialysis (End Stage Renal Disease)

1. Do you have Group Health Plan coverage?
   - □ No – **Stop Medicare is Primary**
   - □ Yes
     Employer Name:_____
     Employer Address: _____
     _____
2. Have you received a kidney transplant?
   - □ No
   - □ Yes (Date of Transplant: _____)
3. Have you received maintenance dialysis treatments?
   - □ No
   - □ Yes (Date Dialysis Began: _____)
     If you participated in a self dialysis training program provide date training started:
     _____
4. Are you within 30 month coordination period?
   - □ No – **Stop Medicare is Primary**
   - □ Yes
5. Are you entitled to Medicare on the basis of either End Stage Renal Disease and age or End Stage Renal Disease and Disability?
   - □ No – **Stop Group Health Plan is Primary During the 30 Month Coordination Period**
   - □ Yes
6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on End Stage Renal Disease?
   - □ No – **Initial entitlement based on age or disability**
   - □ Yes – **Stop Group Health Plan Continues to Pay Primary During 30 Month Coordination Period**
7. Does the working aged or disability Medicare Secondary Payer apply (i.e. is the Group Health Plan primary based on age or disability entitlement)?
   - □ No – **Medicare Continues to Pay Primary**
   - □ Yes – **Group Health Plan Continues To Pay Primary During 30 Month Coordination Period**

HUNTSVILLE HOSPITAL
NEUROLOGICAL ASSOCIATES

132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person: _____

Address_____

Fax/Phone_____

Huntsville Hospital Requests Information for the Following Patient:

Patient Name _____ SS# (Optional)_____

Date of Birth _____

Address _____

Phone _____ Date of Service_____

Signature:_____

Patient Number

Requested information for treatment, payment, or operations:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ EKG Report
- ☐ Nurses' Notes
- ☐ Progress Notes
- ☐ Physicians' Orders
- ☐ Outpatient Record
- ☐ Emergency Dept Record
- ☐ Laboratory Results
- ☐ Imaging Results
- ☐ Other_____

_____

_____

_____

_____

_____

_____

Please send to:

HH Neurological Associates
201 Sivley Road, Suite 200
Huntsville, AL 35801
Phone: (256) 265-2695 Fax: (256) 265-6386

Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____

HUNTSVILLE HOSPITAL
NEUROLOGICAL ASSOCIATES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (_____)_____Date(s) of Service_____

Chart Number_____
Provider _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital Physician's Network is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ All /Entire Record
- ☐ Visit/Encounter Notes
- ☐ Laboratory Results
- ☐ X-Ray and Imaging Reports
- ☐ Problem list
- ☐ Medication List
- ☐ Allergies List
- ☐ EKG Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Immunization Record
- ☐ Drug and Alcohol Treatment
- ☐ HIV/AIDS/STD Treatment
- ☐ Registration Record
- ☐ Other _____
- ☐ Records Release Format (Choose one)
  - ☐ e-delivery (HealthPort Connect)
  - ☐ CD
  - ☐ Paper

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

For Office Use Only

Any portion of the record request found in paper chart? YES NO (Please circle one)

Huntsville Hospital
Neurological Associates